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A study of outcomes measures in forensic mental health.

David Kwaku Sallah

Doctor of Philosophy

Aston University

May 1999

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SUMMARY

Aston University, Birmingham

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Outcomes measures, which is the measurement of effectiveness of interventions and services has been propelled onto the health service agenda since the introduction of the internal market in the 1990s. It arose as a result of the escalating cost of inpatient care, the need to identify what interventions work and in what situations, and the desire for effective information by service users enabled by the consumerist agenda introduced by **Working for Patients** white paper. The research reported in this thesis is an assessment of the readiness of the forensic mental health service to measure outcomes of interventions.

The research examines the type, prevalence and scope of use of outcomes measures, and further seeks a consensus of views of key stakeholders on the priority areas for future development. It discusses the theoretical basis for defining health and advocates the argument that the present focus on measuring effectiveness of care is misdirected without the input of users. It goes on to offer a model for effective involvement of users, particularly patients in their care, drawing together the views of the many stakeholders who have an interest in the provision of care in the service.

The research further draws on the theory of structuration (Giddens, 1978, 1984 and 1991) to demonstrate the degree to which a duality of action, which is necessary for the development, and use of outcomes measures is in place within the service. Consequently, it highlights some of the hurdles that need to be surmounted before effective measurement of health gain can be developed in the field of study. It concludes by advancing the view that outcomes research can enable practitioners to better understand the relationship between the illness of the patient and the efficacy of treatment. This understanding it is argued would contribute to improving dialogue between the health care practitioner and the patient, and further providing the information necessary for moving away from untested assumptions, which are numerous in the field about the superiority of one treatment approach over another.

Key phrases: Public services management, forensic psychiatry, consensus conferences, stakeholder analysis, and structuration theory.

ABSTRACT

Overall Aim: The overall aim of this research is firstly, to assess the types of outcomes measures, their effectiveness and extent of use within forensic mental health services. Secondly, to draw the views of key stakeholders together to reach a consensus of opinion on key areas of practice in order to develop outcomes measures.

Objectives: To assess the use of effectiveness measures in the health service in general and mental health in particular, focusing on their prevalence and how these measures are achieving their intended aims in forensic mental health.

To achieve a consensual approach to identifying areas to prioritise to develop into outcomes measures for use in the forensic mental health sector.

Design: An action research (multi-method) approach was adopted combining methods such as rapid appraisal, survey questionnaires, structured individual interviews, focus groups, organisational case studies and a consensus building conference under the overall umbrella of hermeneutical approach.

Setting: Forensic mental health in-patient institutions and in the community in England and Wales. This covers high security hospitals, medium and local secure units, and discharged users of the service in the community.

Subjects: Provider (hospital) multi disciplinary staff, commissioners of mental health services within health authorities and patients under the care of professionals from these institutions. Additionally staff in relevant government departments (Home Office and Department of Health) and views of service commissioners for high security care were also canvassed.

Main findings Generally, effectiveness measures in the forensic mental health sector are condition or disease specific, a situation which is consistent with that in general mental health.

Mainly, there are no specific outcomes measures that are regularly used across the service.

Some of the units and hospitals use the Health of the Nation Outcomes Scales (HoNOS), although some practitioners do not agree that they are appropriate for use in the forensic sector.

There is willingness across the service for action in developing measures that should take into account the needs of all stakeholders, particularly patients.

There is acceptance that the review of the service in 1992 (Reed Review) dealt appropriately with the issues but failed to match it with resources needed to develop the service.

There is a strong call for a national strategy and effort to develop the service, to ensure consistency of provision and quality of care.

Giddens Structuration Theory was used as a framework for collecting, analysing, interpreting and comparing data from two organisational case studies. The application of this theory is unique in that it is the first time that this approach has been used in the sector.

Structuration Theory postulates that all human beings are knowledgeable agents and that routines are the bedrock on which organisations can function effectively. It argues therefore that the study of the day to day life of the organisation (contextualities of reproduction) is necessary in identifying patterning of social activity.

Analysis revealed that, there is considerable distrust amongst staff, their representative groups and managers, and between patients and staff working in high security hospitals. Patients generally held the view that they have not been listened to in the past and did not believe that staff and their managers would listen to them in the future.

That the medium secure sector is better prepared than the high security hospitals in working towards developing outcomes measures because of their tendency towards involving other key stakeholders in planning of services and care.

Effective development of a programme of outcomes measures depends on identification and grouping of the various groups of stakeholders who have an interest in the sector and planning to meet their needs.

A consensus of opinion of key stakeholders of the service was reached on eight key areas for further research with a view to developing them into measures of outcomes

Dedication

This thesis is dedicated my wife, son and to the memory of my sister who died three months before the completion of this thesis.

Acknowledgements

My thinking on measuring outcomes has benefited from the affirming and challenging comments that I have received from colleagues both in the mental health (research and service) sector and in Aston University (students and lecturers). I gratefully appreciate and acknowledge the support, encouragement and critical but fair reviews of my research progress especially by my supervisor, Mr Mike Tricker and Mr Mike Luck who previously supervised my master's dissertation.

I also acknowledge without reservation the many subjects who freely volunteered their time and experiences in support of the research project. In particular the patients, staff and managers of the two case study organisations, personnel from the Department of Health, the Home Office and the High Security Psychiatric Commissioning Board, especially to its Strategy Director, Dr Dilys Jones for supporting and funding the consensus conference concept. In the same measure, I acknowledge the initial financial support from the Mary Seacole Bursary, which I was the first winner and to its then chair Ms Neslyn Watson Drue whose advice and guidance I value very much, to Mrs Nola Ishmael, Nursing Officer at the Department of Health for her encouragement and Mrs Deb Bourne for her intuitiveness.

The project has been a testing but empowering adventure for me and my thanks are due to my wife Kathryn for providing me with a stable home life, moral support and plenty of love.

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PART ONE

INTRODUCTION TO THE RESEARCH

Chapter One

Background

The context of measuring effectiveness

The need for the research

Outline of the issues studied

Structure of the thesis

CHAPTER ONE: INTRODUCTION TO THE RESEARCH

1. Background

This chapter sets the scene for what this thesis is about, which is the exploration of the extent to which outcomes measures were being used in the forensic mental health service, and if no appropriate measures are isolated as being appropriate, to identify areas of consensus amongst the many stakeholders for their future development.

Since the 1830s the health service has provided facilities of some kind for the treatment and care of mentally disordered patients under conditions of security. However their care in these institutions have been variously described as inadequate, ineffective and repressive. The Department of Health's Health of the Nation document (DoH 1992), set the policy focus for measuring effectiveness of interventions in the National Health Service (NHS). This policy was further built on by the clinical effectiveness initiatives launched in 1993 culminating in the focus on evidence based practice and developed further by concentrating on quality measurement by the new NHS white paper, *Modern Dependable* (DoH 1993 and 1997).

1.1 The context of measuring effectiveness

Over the years the objective of health care had been the prevention of ill health and maintenance of wellbeing through health promotion and provision of treatment to return the individual to his or her normal functioning level should they become ill. The inception of the NHS in 1948 was a monumental symbol of willingness to take collective responsibility fired by concerns to provide universal health care for the whole population. It too did not detract from that fundamental objective. However the concept of public responsibility for the health of individuals can be traced as far back as 1834 when the Poor Law Amendment Act was passed (Levitt et al 1995). This Act enabled the

establishment of workhouses with sick wards for its workers. In 1848 these facilities were extended to paupers living in the same communities as these workhouses who were unable to obtain medical care for themselves (Levitt et al 1995). Levitt and colleagues further revealed that the Public Health Act of 1948 acknowledged for the first time some responsibility for the health of the nation through the establishment of the General Board of Health.

Further changes to legislation built on the advances made in 1948 when the NHS was established. These changes were mostly designed to provide effective care to patients. Of note was the reform, which focused on integrating the NHS boundaries with those of local authorities. The aim of this reform was to provide effective care to communities by involving the NHS, local authorities and social services. In recent memory the most significant government policy was the consultation paper Patients First published in 1979 (DHSS et al 1979). Among the key objectives of the *Patients' First* policy document was that which focused on the effectiveness and efficiency of provision by *" moving decision making nearer to the patient."* This consultation paper was precipitated by recommendations from a Royal Commission which reported in the same year which was set up to consider in the best interest of patients and staff the best way of managing the manpower and financial resources (Cmnd 7615). The Royal Commission made numerous recommendations but the Conservative government which came into power in 1979 decided that the most crucial issue was the effective management of the service as this provided the best framework for the effective delivery of care to patients.

In 1982 changes were made to introduce regional health authorities to ensure that decision making was made locally. This shift in policy was a result of the ever-escalating cost of providing the service. The link between effectiveness and financial probity was therefore made. This reform brought to the fore discussions relating to privatisation of the service due to its proposals of encouraging patients to use private hospitals and nursing

homes and the contracting out of support services to the private sector to off set some of these cost pressures. Almost at the same time the government became impatient with the consensus management of the service believing that this management style was the real reason for inaction in the service. As a result of this the Griffiths Report officially known as the NHS Management Inquiry, was published recommending sweeping changes to the service both at national and local level (DoH 1983). General management was therefore introduced to the NHS to ensure that someone is in charge and accountable for the objectives of the service.

Additionally, the following strategies contributed to strengthening the focus on the measurement of effectiveness. These were:

I. The community care initiatives which introduced changes to the pattern of service delivery (DHSS 1989, DoH 1989a)

II. Quality of service provision and Charter initiatives emphasising the importance of customer centred approach (DoH 1989a & NHSE 1992)

III. Health of the Nation targets which promulgated clear outcomes of service delivery (DoH 1992)

Of the community care initiatives (ibid), the white paper Working for Patients (DHSS 1989) which became the Community Care Act 1990 was the most significant in promoting further the central position the patient has in health care delivery. The broad effects of the NHS and Community Care Act 1990, was to create consumer agents in health authorities who through general practitioners buy services from hospitals within its catchment area (Loveridge et al 1992 p3). The most significant addition to the effectiveness debate in the NHS had been the separation between health authorities as purchasers and hospitals or trusts as providers of healthcare. This separation became famously known as the internal market. However there was fierce opposition to the introduction of the internal market mainly due to the fear of managerialism - the promotion and implementation of management principles into health care. Opponents argued that the imposition of

quantitatively based measurement of efficiency was inappropriate in managing human and personal services. The NHS and Community Care Act 1990 was a watershed on two key points. First it strengthened the managerial ethos and introduced quasi-market principles into the service. Secondly, in the case of general management there were problems to its effectiveness, as they could not easily appeal to many of the traditions of the NHS to legitimate their authority (Cox 1992). This emanated from the view that general managers who mainly came from industry were seen as outsiders as they explicitly rejected many of the cherished assumptions about the uniqueness of the health service. This uniqueness drew its strengths from the co-operation of the professions.

Cox (1992) argued that the introduction of general management to the service came in the context of a radical set of government policies underpinned by a collage of right wing political philosophies. These placed competition as the best motivator in the NHS post Griffiths, leading to attacks on the service and its employees in general undermining morale and the moral basis for leadership. Anthony (1986 p198) further considered the impact of Griffiths on patients as consumers and as citizens, and argued that the responsibilities of general management was exercised through the governmental role of accountability to the general public. In the health sector these were exhibited through management discourse about public service, quality, consumer satisfaction, and efficient use of resources. The focus however had shifted from citizen rights about the health service that was based on a publicly accountable service, free from fear of commercial exploitation and protection from poor standards to consumerism since the introduction of the internal market. This ideological shift had concentrated efforts on satisfying the patient's needs through the provision of prompt, competitive, responsive, research base with choice and consumer satisfaction.

The dependency on professional cultures had shifted towards that of needs, expectations and wants of patients championed through the purchasing of healthcare leverage accorded to General Practitioners and Health Authorities.

The separation of providers from purchasers was necessary for the success of the internal market in that health authorities needed to concentrate on purchasing health care and free themselves from managing hospitals within their catchment area. Gradually these hospitals became trusts and by 1994 virtually all directly managed units had become trusts and the separation needed became complete. Because of the initial uncertainties within the health service at large, the forensic mental health services, including those in the high secure sector, were protected by government legislation. This protection however was removed for the medium secure sector in 1993 and these regional centres gradually became part of the trust within whose boundaries they lie. This research has specifically concentrated on the forensic services within the NHS sector.

1.2 The need for the research

As the reform of the National Health Service (NHS) gathers pace the need to define the impact the service has on end-users has become an essential part of service commissioning. Standard setting, clinical governance, audit of clinical efficiency and effectiveness has become the norm throughout the NHS with service purchasers and commissioning agents eager to ensure appropriate care for their resident population (DoH 1989a). In forensic psychiatry the need for achievement or performance measures has firmly taken root. In the Health of the Nation document (DoH 1992), mental illness is identified as one of the key areas for improvement. Three targets were set; one of which is to improve significantly the health and social functioning of mentally ill people. In the same year, the report of the Reed Review (Reed 1992) made 276 recommendations for the improvement of treatment, care and management of mentally disordered offenders (MDOs) or forensic

patients. Two further reports of the review (maximum secure service provision (Reed 1994), and services for psychopathic disordered people (Reed 1994a), have now been published thus making the total numbers of recommendations on services for MDOs in excess of three hundred.

Furthermore, the provision of a comprehensive service for mentally disordered offenders and others requiring similar services (MDOs) has been government priority for the service in terms of purchasing and service provision (DoH 1994 and NHSE 1996). The difficulty remains though that some services are more effective than others (Sallah 1994). This brings into focus the need for a co-ordinated set of indicators or measures that are nationally determined in order to encourage a degree of consistency in service provision and performance reporting.

These and many other policy documents all point to the need for effective gearing of the service in order to meet the challenges posed and to ensure quality in the delivery of care to patients. Given the complexity of the field and the potential risks its patients could pose if these recommendations are not adequately reflected in service commissioning, as happened when a mentally ill person attacked and killed a man unknown to him in a crowded London underground station (Ritchie et al 1994), the urgency to establish how the policy statements could be transformed into practice cannot be overstated. The need for the development of effectiveness measures as bench marks for service provision is therefore a necessary and essential step.

The need for conducting this study arose as a result of a completion of an evaluative study within a large forensic unit by the researcher and the identification of the difficulties practitioners were experiencing in identifying success indicators that address outcome issues (Sallah 1993). Further, the care of people who have committed an offence but are judged to have done so as a result of suffering a mental disorder is fragmented irrespective of

government policy. This has led to different levels of care provision, some woefully inadequate leading to in some cases, tragic consequences to the sufferer or members of the general public. It is anticipated that the use of outcomes measures would help to identify the activities, which are essential in minimising or eliminating these risks. Additionally, the experience of the researcher as a senior practitioner and manager shows that more needs to be done in consulting the patient insofar as providing effective information is concerned. Furthermore, a great proportion of the general public hold the view that forensic services exist only to dominate and incarcerate patients who are very dangerous. The research was therefore designed to meet some of the gaps that exists in the following areas of forensic mental health practice observed by the researcher as a senior practitioner.

I. To identify a researched, appropriate and valid measure to enable practitioners to describe the functional status of the patient at the initial assessment to ensure that a baseline is identified from where subsequent health gain could be made and measured.

II. To determine the degree to which measures that exist are used widely in the service and whether they measure the entirety of the experiences of patients and reflect accurately the picture of what happens to patients within the service.

III. There is no consistent approach or use of measures of process within the service from which to monitor effectiveness of therapy or treatment, as patients move from one stage to the next and from one hospital to the other, This has resulted in repetition of history taking, poor continuity of service provision and over assessment of functional abilities of the patient.

IV. Equity and equality of access is inconsistent between hospitals and patient groups, leading to complaints about the lack of effective services to some patient groups within the service. Services for women are frequently criticised for their lack of effective treatment and care, whilst the service is heavily criticised for its over representation, overuse of major tranquilliser drugs, poor diagnostic labelling of patients from the black and ethnic communities.

V. One of the key activities of the service is the ability to be able to predict levels of risk the individual patient may pose to themselves or others. It is often the case that patients who have received treatment within one *sector* and have been deemed well enough to progress to a lower level of security, fail to make the same or any progress at all. Outcome measures can assist practitioners in the formulation of treatment plans and changes to be made to them ensuring that continuity of care is maintained throughout.

VI. Progressing from one security level to the next is often problematic as services argue and worry about the level of independence that they should allow a newly admitted patient from a higher security level. Outcome measures that are accepted to be valid would improve decisions about placement.

VII. Various reports on the effectiveness of care of mentally disordered offenders hold the view that the service provided is more effective when there is multi-disciplinary and inter agency collaboration. Outcome measures would help particularly the NHS sector service providers to assess the level of support the individual patient and carers need when the patient is preparing to be discharged.

VIII. To what extent can outcome research improve the quality of communication between practitioners and managers, and between services?

1.3 An outline of the issues studied

The field aspects of the research were conducted in the forensic psychiatric or mental health sector. Forensic psychiatry is practised in the NHS in high secure hospitals, medium secure units, low secure units (otherwise referred to as locked wards in local hospitals), and in the community. Other areas include the criminal justice system e.g. prisons and in the private and the independent sector (see Figure 1.1). The participants in this research are mainly staff and patients within the health sector. The views of professional staff in provider units from medical, nursing, psychology, social work and occupational therapy to managers were canvassed. Commissioning agents or purchasers who have responsibility for commissioning services for the patient group within health authorities were also included. Policy making

senior staff within the relevant government departments (Department of Health and the Home Office) were also consulted.

In securing the acceptance for the research, this researcher followed the advice offered by Luck (1991). Luck advocated the establishment of good communication with service managers in order to secure agreement on objectives. Support for the project work was agreed with senior managers of the organisations within which the fieldwork took place in order to gain their co-operation for the project.

The methods used for data collection for this research are divided into the following categories. These are Rapid Appraisal, Survey Questionnaires, Interviews - Individual and Focus Groups, Organisational Case Studies by using Giddens' structuration theory under the overall approach of hermeneutics and a Consensus Building Conference. The scope of the study included interviews with users, policy makers, service regulators, providers and commissioners (purchasers) of health services.

The survey questionnaire was in two parts (providers and purchasers *views* on outcomes). These questionnaires both sort their views and comments on the following:

I. The degree and effectiveness of multi-disciplinary and inter-agency working

II. The effectiveness of the Reed Review (Inter-governmental review of the forensic services)

III. The effectiveness tools in use in the service and how relevance and appropriate they are

IV. The effectiveness of the service nationally

V. The key areas for which effectiveness measures could be developed

In particular, purchasers or commissioners of the service were asked to comment on the degree to which the services they purchase meet the needs of the population for whom they are responsible.

In the case of individual interviews, interviewees were asked to comment on the need for outcome measures in the forensic services, who to involve, the approach to take and the anticipated problems, what aspects of service provision and care to measure and how the measures could be used in the future. This information collected at this stage helped to explore the prevalence and necessity of outcomes measures in the service. The need to explain what is happening in the service was an essential aspect of the research process. Issues studied during this stage included a trawl of activity level of outcomes measures and how they are contributing to the effectiveness of service people receive.

There were focus groups of users of the service - in-patients and those in the community. They were asked to comment on their experiences, what in their views needed to change so that services meet their expectations and how these changes could be implemented in order to meet with their approval and support.

Case studies form the next part of the process. The studies were conducted in a high and medium security setting, using Giddens' structuration theory as an aid to ordering and analysing the data (See Chapter 4, 9 and 10). This part of the study was conducted under the overall umbrella of hermeneutical approach. The focus here was on the inputs these services apply to achieving the effectiveness of the service and the way patients were being involved in their own care through the aegis of advocacy, empowerment, partnership and subsidiarity. The study also assessed the potential for developing these outcomes together with opportunities and problems there may be in the process. It also addressed the degree of acceptance of outcome measures by users and staff and identified the prevalence of these

measures. Data collected through the use of these methods was collated and put to a panel of "experts" to identify areas for development. Their conclusions were put to a consensus development conference sponsored by the Department of Health in November 1997 and attended by 190 representative group of stakeholders of the forensic mental health services from the United Kingdom. Overall the approach adopted ensured that there was a clear linkage between one method and the next. For example the information derived in using the rapid appraisal method helped in developing the survey questionnaire and the information collated by these methods helped to form the basis of the case study schedule and so forth. This gradual progression to data collection ensured that the participants in general were involved in contributing to setting and developing the next stage of the research agenda and the choice of methods that is best suited to collecting information by the researcher.

1.4 Structure of the Thesis

This thesis is divided into six main parts. Part one introduces the research and its structure by highlighting the contextual issues, the need for the research and clarifies the key aspects relating to the research question. It concludes by providing a brief outline of what was studied.

Part two deals with the background literature. It starts by describing the field of the research and identifies the key stakeholders of forensic mental health care. It further clarifies the background information relating to outcomes research and the need for its measurement, discusses the policy framework for measuring effectiveness and identifies the instruments in use. It concludes by assessing the unique issues relevant to involving users in developmental work and discusses possible issues for the research.

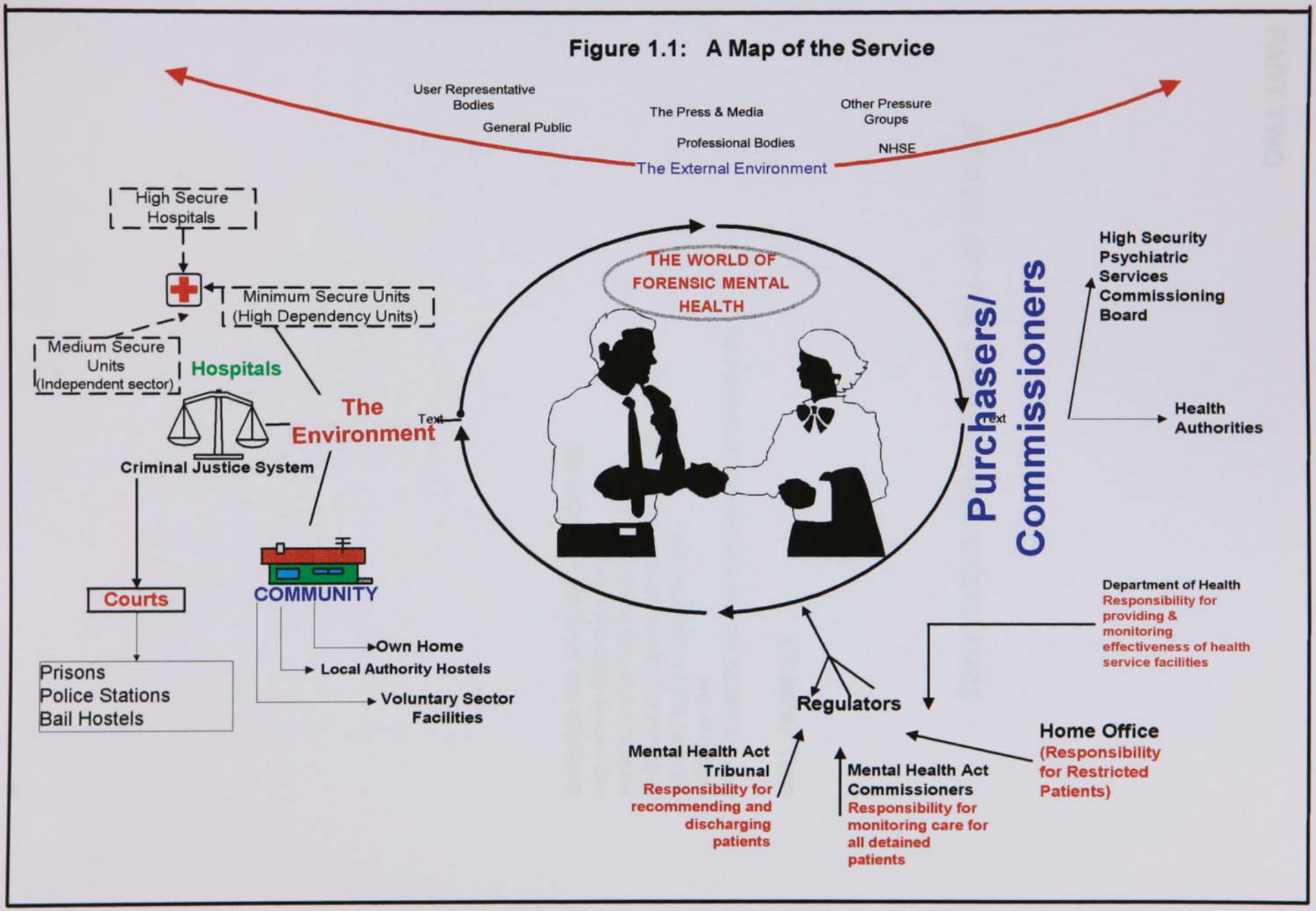
Part three discusses the philosophical issues impacting on this research, their relevance in terms of methodology, the theoretical perspective and its relation to the research and explains the process adopted for identifying stakeholders of the service.

In part four the methods used in collecting data are discussed. The research follows a multi-method approach in collecting data by combining strategies and process from both the qualitative and the quantitative paradigms.

Part five reports on the application of each of the methods including the description of the consensus building conference.

Part six summarises the key findings and draws conclusions on what has been contributed to the advancement of knowledge and theory. In each case the work is shown to go beyond the current state of knowledge in the field. Finally recommendations are made to improve management practice and ways in which outcomes measures could developed.

Figure 1.1: A Map of the Service



PART TWO

REVIEW OF THE BACKGROUND LITERATURE

Chapter Two

The context of the forensic mental health service
Introduction
The evolution of the service
Defining forensic mental health (psychiatry)
Environmental/structural factors
The contracting dimension
Managing stakeholder expectations

Chapter Two: The context of the forensic mental health service.

2.1 Introduction

In this chapter and the next the background literature will be reviewed. The research was conducted within the health sector of forensic mental health (see Figure 1.1 above). The terms forensic mental health and forensic psychiatry are used interchangeably, both reflecting the multi-disciplinary and inter-agency nature of the service. This review will centre on the contextual issues of effectiveness of the health service. It aims to provide an analytical, comparative and critical account of the existing studies in the area - organised within a clear thematic framework, focusing on the way thinking and approaches have evolved over time. It begins by clarifying the contextual aspects of the research and proceeds to identify the value that outcomes research leading to development of measures could add to the effectiveness of service to patients.

2.2 The evolution of the service

Institutions dedicated to the care of mentally disordered offenders (MDOs) in the United Kingdom have been in existence since the 1830s when the first high security hospital (Broadmoor Hospital in Crowthorne, Berkshire) was opened. There are now three high security hospitals in England (Ashworth in Merseyside, Broadmoor and Rampton Hospital in Nottinghamshire) serving the whole of England and Wales. The State Hospital (Carstairs) in Scotland caters for patients in Scotland and Northern Island. These hospitals were isolated from the community, often located in countryside where the local population was chiefly its staff. Patients tend to spend long periods of time within these hospitals, in most cases over twenty years often for minor offences. Since the 1st of April 1995, these hospitals have been involved in a massive programme of integration into the NHS. Although none of them

have achieved Trust status, they are allowed to set their own development agenda and can negotiate directly with a nationally appointed health purchaser - High Security Psychiatric Services Commissioning Board (HSPSCB) for finance and consequently for monitoring of the effectiveness of its contracts.

In the 1970s a major shift of emphasis in the way services were provided to mentally disordered offenders occurred (Glancy 1974, Butler 1975). New regional medium security units were established. Their role was to maximise the rehabilitation of patients. These medium secure units were intended for the treatment, care and management of people who are likely to respond to treatment within a maximum period of two years. The average length of stay within these units is between six to eight months. These units are now generally directorates within larger mental health trusts and are therefore much more integrated within the wider NHS and its related agencies. They provided the foundations for what is now referred to as forensic psychiatry or mental health services in England and Wales. The establishment of these units increased the numbers of service users, and consequently those who have a stake in the activities of the service. Effective management of the service has become a central issue as the service become more integrated in the environment within which it is situated. The policies and actions of various sections of the service have also become more transparent and therefore opened to critical review by policy makers, purchasers, the press and media, and users of the service.

2.3 Defining forensic mental health (psychiatry).

Bluglass et al (1990 pvii) define forensic psychiatry as that aspect of psychiatry whose field of operation is the overlap, interface and interaction with the law in all its aspects (criminal behaviour, civil litigation, family law) and the diagnosis, care and treatment of the mentally disordered patient. Forensic psychiatry or mental health is concerned mainly with the care of

people who have committed an offence but *are* judged to have done so as a result of suffering a mental disorder. It involves also the management of violence and the study of sexual deviance. The service provides the environment and the expertise for the care of mentally disordered offender patients and others requiring similar services. This latter group (others requiring similar services) are patients who because of their disruptive behaviours prevent the normal functioning of wards within local psychiatric hospitals. They may not be offenders.

Forensic psychiatry is therefore the interface between psychiatry and the criminal justice system. Because of the nature of the service, policy makers and service providers are always concerned with the influence the media, the general public and relevant others can have on the effectiveness of the service. In recent times this public influence has been instrumental in governmental decision to tighten service provider behaviour inasmuch as the care of this group of patients is concerned (NHSE 1994; DoH 1996).

The service is provided in diverse settings, ranging from maximum, medium and minimum security into the community in the health sector; the criminal justice system - particularly the prisons and in the independent or private health sectors (Figure 1.1). The focus of this research however is on health service facilities. Normally, provision of the service transcends the health, criminal justice, local authority and voluntary sectors. Parts of the service (medium, minimum security and community) operate within the NHS internal market. The internal market enables the function of health care to be split into two; namely purchasing and provider roles. There is governmental obligation on purchasers to ensure that they prioritise services for the patient group (NHSE 94).

Maximum or High security services (commonly referred to as special hospitals due to the special nature of their security) are not as yet fully within the internal market but are now special health authorities; however there are

moves to integrate them into the NHS. This change in policy has enabled these hospitals to have the responsibility for managing their own affairs under a structure akin to a directly managed unit (DMU) - a hospital, which has not attain full NHS Trust status. This, in part is due to the potential risk most of its patients pose to the general public and the Home Office's role in safeguarding public safety in so much as those patients who are restricted are concerned. The implication of this is that the discharge of patients particularly from high secure hospitals is not based on clinical outcomes only but also on the wider political consideration for the ability of the patient to be safely rehabilitated into the community. This is often a problematic process as these judgements are often difficult to make by using objective arguments (Crighton 1995). Never-the-less, aspects of contracting have been introduced into the maximum secure hospitals by the Special Hospitals Service Authority (SHSA) who has responsibility for ensuring that the hospitals meet their objectives. The SHSA was disbanded and replaced by the High Security Psychiatric Services Commissioning Board from 1st of April 1996.

2.4 Environmental/structural factors

The service is heavily laden with government directives and legislation e.g. Mental Health Act 1983, government and NHS Executive directives. This socio-legal dimension defines the nature and limitations of the behaviour of service providers. Not least, the media reporting of their perception of what constitute effectiveness of the service has always been adversarial. The tendency is to focus on the potential dangerousness of patients based on what crime they committed, often many years prior to their hospitalisation (Daily Express 1994, Guardian 1994a). Of course public opinion is highly shaped by this media reporting.

Management concern is therefore the development of the ability to respond effectively to these environmental factors. This is not to say the service depends on its relationship with its environment, particularly its outside environment entirely. On the contrary, the various parts of the service are organic enough to adapt to changing factors within its outside environment taking into account a degree of satisfying the interests of individuals and groups within its internal environment. This is borne out by the fact that the service's relationships are at its best very fickle with its outside environment as press headlines such as "nice mad murderer let loose by a shrink" suggests (Daily Express 1994a). Public opinion supports the development of the service, until it is to be established close to where they live and work. Further they hold the view that patients of the service are best kept within the walls of these units and hospitals. Paradoxically, the public is indignant if there is reported maltreatment of patients or bad quality patient care (Blom Cooper 1992).

Some service purchasers appear to be generally happy when a patient is admitted into the service believing that the problem (the patient) is no longer a worry for the local hospital or community. Recent trends however tend to suggest that the effective care of the individual has assumed greater importance of concern to them (purchasers) as the degree of detail in contracts with provider units become much more precise. This undeniably, points to the fact that the outside environment does not always present a consistent picture. This inability of the environment to be dependable has made it imperative that managers of the service need to be aware of who the key players are, ensure their behaviours are analysed and predicted, and plans put in place to meet any exigency that may arise. This approach will enable management to respond to the demands that are necessary for the survival of the service.

2.5 The contracting dimension

In the past, users of forensic psychiatric services have experienced a process of care provision that was provider-led. This was because the service was protected from the rigours of the National Health Service internal market. The normal process of admitting a patient to the service involved managers of the service identifying a suitable bed, the patient having been referred by any such designated professional staff. The referrer only needs to refer to the arbiter, (usually the Health Authority) when the decision relating to admission is not a favourable one. The same applies at the end of the continuum when the forensic services are experiencing problems relating to discharging a patient at the end of treatment. The environment was a lot more stable with providers certain about what their requirements were with their service users.

This certainty has in part provided providers and practitioners a safety umbilical cord that in part has not resulted in any real developments in service effectiveness as challenges or competition have in effect been removed from the service. Consequently, there was very little interaction except at the end of an episode of care or when there were bottlenecks within the service due to inefficient throughput. This may arise as a result of refusal of referring agents agreeing to accept a patient back into their care or the Home Office insisting on a patient staying in hospital even though there may be justifiable clinical reasons to the contrary. The Regional Health Authorities (RHA) who have responsibility for monitoring the efficiency and effectiveness of the service delegated this to an identified District Health Authority (DHA) for users of medium security care. In the case of maximum (high) security services, the Special Hospitals Services Authority (SHSA) and now the High Securiry Psychiatric Services Commissioning Board has responsibility for ensuring suitable patients were found beds within the three high secure hospitals in England and Wales.

Any difficulties preventing efficient throughput to and from the hospitals was ironed out either by the RHA and/or the SHSA, with a degree of collaboration with the hospitals and units concerned.

The Home Office however has a very peculiar but manageable relationship with these hospitals and units as they have a role in deciding where an offender patient is placed, transferred to, or discharged to or from the service (Mental Health Act 1983). This stability is reinforced by the contracting process, which ensures that the RHA within which the medium secure unit is situated have priority over the use of facilities within that particular hospital or unit.

Accessing the high security hospitals relies on the collaborative work between referring units or hospitals, the health authorities and the High Security Psychiatric Services Commissioning Board (HSPSCB). A review of the service made recommendations for improving the service, Reed (1992 and1994). The common strand throughout the work of the review team was the need for closer multi-professional and inter-agency collaboration and user involvement throughout the process of care. Other significant changes are the increasing need to know by end-users and carers as a result of the Patients Charter (NHSE 1992), and the increased scrutiny for the service by the Department of Health. These and many other exigencies mostly relating to the effectiveness of service provision (Ritchie 1994; Blom-Cooper 1992; Prins 1993), and the full integration of the service into the NHS internal market meant that the service is constantly evolving and under greater public scrutiny.

The situation now is much more complex than previously described. This is due to the impact of the reforms within the NHS and the introduction of Trust status for NHS hospitals. These Trust Hospitals are increasingly encouraged to take greater control of their own destiny and therefore accountable to its service users. In the case of the contracting process, these units (medium

and minimum security) can admit patients from anywhere in the country, provided they have contracts for their care. On the other hand they are permitted under the NHS Act 1990 to admit patients for whom they have no standing contract, these groups of patients are referred to as Extra Contractual Referrals (ECRs). One of the implications for this change in care provision is that there are more individuals and or groups to contend with making the care of end-users a very complex process. There is no doubt that the management of this relationship needs a new approach and the development of different sets of values. Pfeffer and Salancik (1978), see managers as adapters to social constraints and manipulators of their organisation's environment. They went on to argue that no organisation is completely "self contained because they import resources" from within that environment and depend on it for example, for recruitment.

All these factors have led to the situation in which managers of the service need to adopt a much more informed stance of dealing with service user expectations and be prepared to meet these changes effectively.

2.6 Managing stakeholder expectations

As discussed earlier the recent reforms of the National Health Service, have made it necessary for providers of forensic services to define the impact the service has on its end-users. This has become an essential part in satisfying the needs and wants of service commissioners and purchasers. Increasingly, purchasers of health care are taking greater interest in accepting what constitutes effective and high quality care. As a result their contracts with provider units include quality targets, which are progressively getting tougher to meet. The focus for management therefore lies in effective identification and manipulation of the contracting environment within which the service operates. Pfeffer et al (1978 pp 2), supports this assertion by noting that, because organisations are embedded in the environment comprised of other organisations, there is a need for being in-tune with it.

In order to survive and be viable, the service needs to demonstrate its effectiveness, which is shaped by managing the demands made upon it. Forensic psychiatry is linked with its environment by various user representative associations and groups, professional groups, service providers and purchasers, the media, the general public and competitiveness amongst units and hospitals within the wider NHS. Due to the diversity of the field, managers of the service will need to plan to manage this environment effectively. The importance of stakeholders' views to this research is discussed fully in Chapter 4 of this thesis. Meanwhile managers and professional groups need to be able to identify ways and means of operating efficiently and effectively, particularly how they react to individuals and groups within and outside the service.

Users of forensic psychiatry services are numerous and are spread across a multiplicity of agencies. The term "user" is loosely applied to encompass all those who derive any type of benefit or affected by any action, procedure or policy of the service. Given the complexity of the environment within which forensic services operate the importance of prediction of behaviours within that context cannot be overlooked. There is a school of thought that suggests that stakeholders do not share the same definition of any part of the service's problems. For example, two clinicians with identical training may adopt two completely different methods of intervention relating to the management of a distressed patient. Equally, members of the general public do express different views on the way services for the patient group ought to be delivered and managed. Because of this diversity of views the traditional approaches to problem solving, which presupposes prior consensus or agreement are much more difficult to apply. Because of these complexities there is a need for a perspective to enable managers to grasp the problems and make sense of their respective situations. Managers need to do this to enlist the support of their key stakeholders in developing their respective part of the service effectively.

Stakeholders of forensic psychiatry could for example, contribute to the service's viability through the contracting process, provides information which may or may not be of use to the service, add to the services legitimacy and assist it in mobilising support.

According to Bjork (1985 pp 48) at times of change, the most effective managers are those that can exert substantial influence by "defining organisational situations and providing future direction". This assertion supports the view that knowing the stakeholders and their possible actions and behaviours, not only enables managers to make predictions on their future actions and behaviours but it also provides the basis upon which the service can perform effectively. Stakeholder analysis is therefore important in order that managers can have a broader understanding of the psychosocial environment that surrounds them and of which they are a part (Mitroff 1983). Satisfying the needs of all stakeholders of the service is an arduous undertaking but the need to ensure that there is a plurality of opinions and of expectations by all is equally important. The next step focuses on identifying the key elements of outcomes measures and addressing how they contribute to the aims and objectives of the research.

Chapter Three

Outcomes research

Health and its consequences

Measures of health care outcomes

Mental health and outcomes research

Clinical effectiveness - the policy context

Classification of effectiveness measures

Managing user characteristics

Issues impacting on outcomes measures in forensic psychiatry

Issues for the research

Chapter Three: Outcomes Research

3.1 Background

Traditionally, health care staff have routinely asked if patients were feeling better or worse during the course of their treatment and care. However, this information is not routinely collected in order to inform the measurement of effectiveness of the care patients receive. Another anomaly in modern clinical practice is that patients' views of health, well-being and life satisfaction are often different from those observed by health professionals. For example, patients who may appear to be in good health report that they do not feel well, while others with debilitating medical and or mental health conditions may report total satisfaction with the quality of their life and health status. It could be said therefore that health might involve more than is presently being measured by such indicators as morbidity, mortality and limitations to functional ability. Clearly, this means that subjective health assessment, which is the patient's perspective on his or her health status, is important both for present day clinical practice and for research.

In the wider context of health, Jenkinson (1994 p 9), argued that in the past the general assumption by both governments and health care practitioners was the belief that if there is an adequate infrastructure, proper monitoring of the delivery processes and allocation of sufficient resources, then the delivery of health care would have been effectively targeted and controlled. He contended that, within this traditional model, government and medical experts decide what is good for the nation and consequently the patient. The result of this is often the narrow focus on intermediate outputs such as, length of stay in hospital, bed occupancy rates and the rate of throughput within hospitals or services to determine efficiency and therefore value for money. Enthoven (1993) generally acknowledged this view but added that because of the rapidly rising costs of care with very little decreases in disability, morbidity and mortality, expert attention has turned to the analysis of costs and benefits of health care, which is based on actual health gain from the patient's

perspective. This approach has shifted the focus from measuring intermediate outputs to concerns with final outcomes or effectiveness measures of health gain.

3.1.1 Measuring the effectiveness of interventions in health

The Rayner Scrutiny Programmes (Rayner 1986), advised the government as to ways and means of promoting efficiency in government departments. Its focus was to arrange fundamental examination of specific activities in government departments questioning their continuing necessity or the scope for carrying them out more efficiently. Over the five years the programmes was in place there was a saving totaling £421 million a year. During the period 1979 – 1983 few scrutinies examined dealt with effectiveness issues or those with a major policy content. However the programmes did not enjoy a smooth passage in the National Health Service. The national bodies representing Family Practitioners Committees and their administrators were opposed to the scrutiny on the grounds of timing and deferred their co-operation while further difficulties arose with the British Medical Association and the team was disbanded in 1982. The Rayner Scrutinies, nevertheless paved the way for measuring efficiency and to some extent contributed to increasing the profile of measuring effectiveness in the NHS.

However the first signs of clinical effectiveness measurement in the National Health Service (NHS) can be traced to the following milestones. Briggs (1972) reported into nursing competences and Alert (1976), recommended regular assessments of doctors' work for the very first time, thus introducing the concept of peer review into clinical effectiveness of doctors. Griffiths (1983) introduced the concept of customer service and quality management heralding competitive tendering into the public sector. By the time the government's White Paper (DoH 1989) introduced the split between purchasing and providing arms of health care provision, and by the time the new Labour government's white paper was published, (DoH 1997b) the concepts of canvassing the views of users, the importance of clinical

governance and of quality had been firmly established on the health service agenda.

A point of note however is that the historical account of the involvement of users in health care provision assumed a degree of ascendancy in the 1970s with the developments of charters for what consumers expect from public services, although the measurement of effectiveness of health care has its origins in Babylonian times (Harper 1904, Rosser RM 1988). The proliferation of charters in the health service can be traced to the 1980s when the voluntary sector took the lead in their development in association with some professional staff (Kelson 1995).

3.1.2 Defining the dimensions of health

In order to measure outcomes of health service interventions, it is important to establish what "health" means. The source literature is littered with various definitions. Over the years attempts had been made at defining what health is but a definitive conclusion has remained elusive (Elinson, 1994; Sackett et al, 1977; Heady et al, 1985 and Ham 1993(Pill and Stott 1982, Blaxter 1985). Herzlich (1993) following his pioneering study on lay concepts of health and disease, found that health was regarded as multi-dimensional, that is the absence of disease, a positive state of wellbeing and a "reverse" of overall health which is determined in large part by individual constitution. Despite the tendency to characterise health in a largely positive manner, individuals also have the ability to define health as co-existing with serious and/or long-term illness. The one which is quoted regularly is the World Health Organisation's (WHO) definition of health as "a state of complete physical, mental and social well being and not merely the absence of infirmity" (WHO 1947; Hanslukwa 1985). If the WHO definition is accepted, it follows that someone or a group of people has to make value judgements on what constitutes an improvement when there is no real objective measure of outcomes. The role of the recipient of health care in enhancing this assessment of health cannot therefore be overstated. Other terms used in the literature to signify an aspect or reference to outcomes measures are research focusing on needs assessment, health

status measurement, functional measurement scales, risk indices, severity scores, quality of life measures and effectiveness studies all of which contribute to outcomes evaluation. Having made an attempt at defining "health", the next logical step would be to consider what "outcomes" mean in health terms.

Measuring outcomes is about the benefit any user of the health service can derive from contact with professionals within it. It is therefore necessary to discuss what health is. Mulhall (1996 p36) asserted that health has been referred to negatively as the absence of disease. For those intent on measuring health, then, there is no simple solution. Jenkinson's (1994 p2,) analysis tended to confirm this view adding that it is possible that individuals can report symptoms and yet have no discoverable pathology, and to be assessed by the medical profession as diseased, and yet experience no negative symptoms. However the almost universal definition of health is that issued by the World Health Organisation in 1947 referred to earlier (WHO 1947). This definition allows for the conceptualisation of health on the basis of disease or disorder, impairment, disability and handicap but has failed to show the relationships between them.

The UK ClearingHouse on Health Outcomes (Nuffield Institute for Health 1993 & 1994) defined outcomes as "the results (effects) of processes". The aim of the UK ClearingHouse was to develop and promote approaches to health outcomes assessment within routine health and social care criteria. Until it was disbanded in 1997, they were encouraging a shift from process to outcome measures and were involved in raising the awareness of key issues in health outcomes measurement. Marchment et al (1993) defined an outcome of health care as any improvement in the health status of an individual patient relative to his or her health status without intervention. Such an outcome of health status may be directly related to the activities of a hospital as far as contracting is concerned. An outcome therefore includes output measures but is too often restricted to the medical care aspect of the hospital's objectives and not usually about eliciting the views of the patient on their experiences of healthcare.

Outcomes are therefore the state of the person, illness or condition remaining after undergoing an episode or procedure within the healthcare process. This definition denotes that health outcomes should result from patients' experiences of the service or any intervention instigated by a health professional. Leading the push for incorporating user perspectives into care planning is the government's Clinical Outcomes Group, which is chaired by the Chief Medical and Nursing Officers and the new proposed National Institute of Clinical Effectiveness (DoH 1998).

Outcomes, in general are results or effects of processes. They are that part of the situation pertaining after a result which can be attributed to the process. The crucial issue of attribution is too often overlooked however. Health outcomes are the effects on health of any type of health services. Health care services will obviously have health outcomes, as will specific clinical interventions, but so should other areas such as housing, social services, socio-cultural integration and employment, a situation, which is crucial for the measurement of outcomes in mental health services. Mostly these will be effects on health, but they also include patients' satisfaction with and attitude to the services. They may refer to the outcome for an individual or for groups of people such as a particular diagnostic group of people, the local community or a wider population. For the purposes of this research, outcomes measures is defined as:

> **The impact of treatment, care and management on the use of health and social services by an individual, which not only include the measures of clinical symptomatology and pathological behaviour but also on the functional integration of the individual into his or her occupational, social and cultural milieu; through consultation, particularly with the patient.**

CHAPTER THREE: HEALTH AND ITS CONSEQUENCES

3.2 Introduction

The NHS has experienced a process of substantial change over the last decade, beginning with the management reforms launched by the government white paper "Working for patients" (DoH 1989). This legislative framework laid the foundation for the significant developments in health policy introduced by the Health of the Nation, the Community Care Reforms, The Patient Charter, the Clinical Effectiveness Initiative and the movement towards a primary care-led NHS (DoH 1989a). Further the separation of purchaser and provider functions within the specialty of forensic psychiatry has many desirable features, although it is tending to create a gulf between the people who need information and the people who use it. Prior to this separation, information within the service was a closely guarded commodity, particularly in declaring the cost-effectiveness of the service, the type of treatment given and the efficacy of that treatment. It has always been the case that the service's ability to respond to clinical advances has been overshadowed by the need to stave off bad publicity and critical appraisal from the press and media, regulators and policy makers. This has made the practice of forensic psychiatry more a reactive rather than a proactive process (Kaye 1994 p 26).

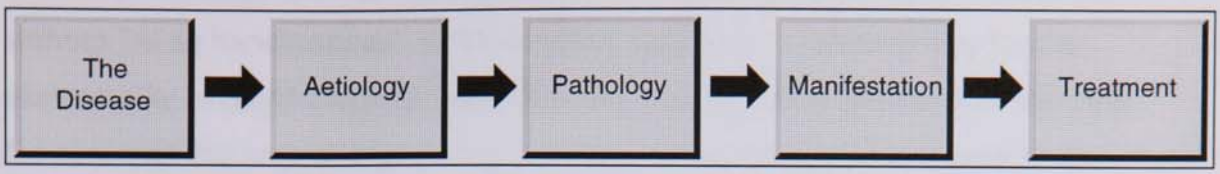
Measurement of clinical or generic outcomes is increasingly crucial for monitoring quality and achieving cost effectiveness. According to Frater and Costain (1992 p519), politicians are concentrating more on outcomes measures because of the belief that the objective of health care is to maximise the health of the nation and also that it offers a way of making the views of consumers central to the provision of health services known. This view is further supported by government in its Priorities and Planning Guidelines for 95/96, which stressed that improving health is the core purpose of the NHS and detailed further information necessary for the NHS Executive's (NHSE) plans to meet its objective of improving the effectiveness of clinical services (DoH 1994 & 1995). Both provider and purchaser unit

managers want it because of its ability of providing a better idea of how service utilisation is achieving what it has been designed to achieve. For clinical staff, measuring outcomes is a move towards managed care to mean providing the best and not just providing the cheapest. Frater et al (1992 ibid) concluded that the debate concerning the value of routinely used outcome measures as a managerial as well as a clinical tool has been fired by the prospect of a health care system that attempts to organise the provision of care from the basis of the needs of the population. If this argument is the case, then the next step on the continuum should be the identification of effective tools for measuring health gain, consequently shifting the focus on measuring of mortality and standardised mortality ratios which has been the preoccupation of health care practitioners, important as these are.

3.2.1 A theoretical foundation for health

According to Jenkinson (1994 p8), the practice of Western medicine is "germ theory" oriented and technologically driven. What this means is that the medical model of health care provision is disease oriented, which unfortunately predominates in the health care sector. The methodological implications this poses for research in the health service, in particular that for outcomes research is further developed in Chapter 4. As a result of this theoretical base health care workers have a vast array of technological innovations, such as sophisticated scientific equipment, drugs and procedures to search for the organic bases of disease. Further, in formulating treatment plans, proponents of the "germ theory" rely on the most recent technology in attacking pathology with scientific standard that has been proven to be effective in clinical trials. They also take social history of the patient from the patient and/or their relatives. Taken together, the test results, socio-demographic data and the patient's own description of symptoms of the illness, the practitioner is able to construct a set of objective and subjective indicators.

Figure 3.1 Diagnosing diseases



This information is used to construct the total diagnostic picture of the disease and the social history of the sufferer (Muller 1990, Wilson 1991 et al). Figure 2.1, shows the limited scope of the medical model, where the clinician, often medically trained, formulates a diagnosis based on the symptoms as described by the sufferer together with any other observable signs and tests. This information is compared with known facts about the disease in order to assess the degree of severity and to identify the best treatment option available.

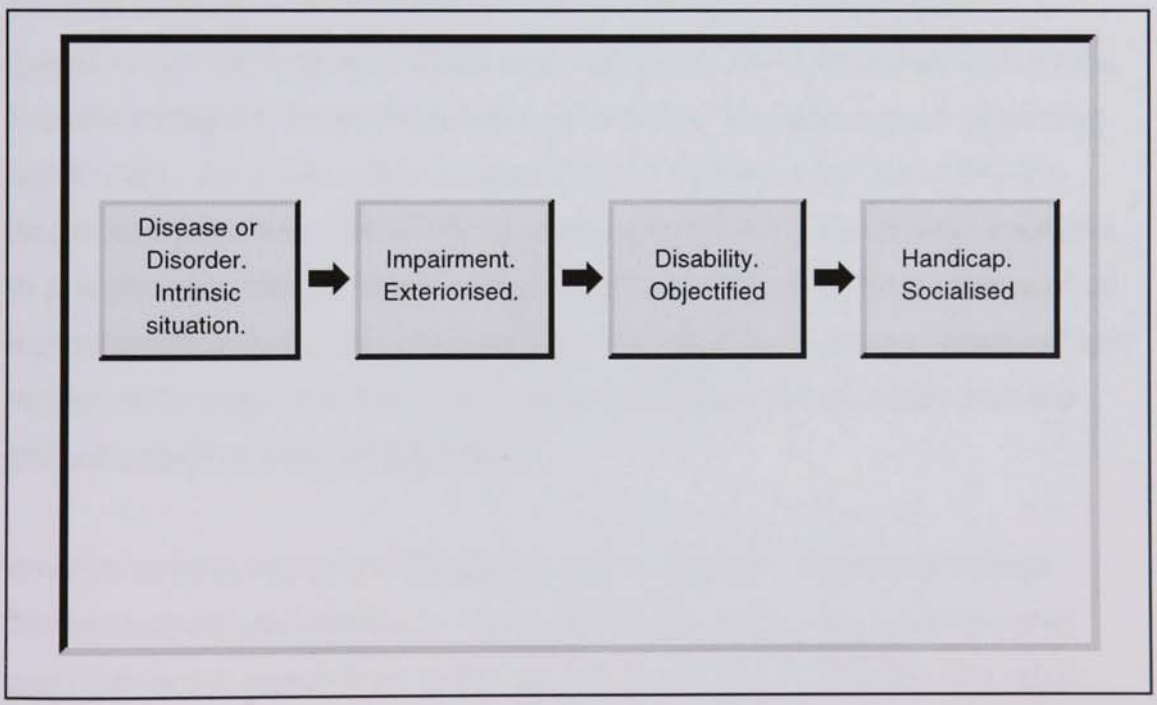
According to Albert et al (1988) the apparent bias of the scientific (medicine) method is to prefer objective tests results to subjective personal reports in determining an accurate diagnosis. However, there is evidence that supports the view that clinicians with clinical experience, often come to accept that social histories and personal reports are invaluable sources of data in ascertaining the epidemiology of the condition, the nature of a complaint, available resources and the types of treatment most preferred by patients (Waitzkin 1991). This change of emphasis is further elaborated by the fact that patients tend not to adhere to taking their treatments, particularly drug therapy, unless they are involved in the therapeutic process, understand their condition and therapy, have the resources to carry on with treatment and are motivated to do so.

3.2.2 A framework for understanding the consequences of ill health

Figure 3.2 depicts the linear symbolic representation of the consequences of ill health or disease. It shows a step by step development of ill health. However the consequences of disease are much more complex. It is possible

that impairment may lead to handicap without going first through the state of disability. Equally, one can be impaired without being disabled, and disabled without being handicapped. In this context impairment refers to any loss or abnormality of psychological, physiological or anatomical structure or function, for example the loss of a limb, any structure of the body and is therefore an aspect of disease that represents the exteriorisation of a pathological state. Any state where there is a restriction or lack of ability to perform activity in a manner considered normal is termed a disability. This may arise as a result of impairment and represents an objectification of impairment at the personal level. A state of handicap is that resulting from either impairment or disability that limits the individual from fulfillment of any function considered normal for that individual. According to the WHO (1980) classification of handicap, it represents socialisation of an impairment or disability and reflects the consequences for the individual, stemming from the presence of impairment or disability.

Figure 3.2 The consequences of disease



Cassell (1976) described 'illness' as what a patient who goes to the doctor is feeling, and 'disease' is what the person comes away from the doctor's

surgery with. Eisenberg (1996, p.11) puts it another way as: patients suffer illness, while physicians diagnose and treat 'diseases.' This short illustration has put diseases firmly in the medical paradigm. In this arena the reality of diseases are in a sense created through a professional discourse, which is shaped and governed by its mentor – natural science (Mulhall 1996 p39). What this means for outcomes research is the feeling of the sufferer indicated by feelings of pain and discomfort or perceptions of change in usual functioning and feeling needs to be captured. It is clear that people can feel ill without medical science being able to detect any abnormality or disease. According to Bowling (1991 p1), most existing indicators of health outcomes reflect the disease model. There is a need to redress the imbalance by concentrating more on what the patient feels rather than the over-emphasis on the clinician's perception and skills in diagnostic prediction. Despite this, the push in the health service is the further promotion of measures that are principally clinician focussed.

One such measure is the Medical Outcomes Studies Short Form 36. The Medical Outcomes Studies Short Form 36 (SF36) is a health status questionnaire developed in the United States as part of the Health Insurance Experiment by the Rand Corporation as a trial of alternative ways of funding health care. As the acronym suggests, it is a 36 item short form (SF) of a longer questionnaire. The SF36 has been promoted as the ultimate measure to practitioners, clinicians and policy makers. A recent headline comment on it proclaimed "measuring patient's views: the optimum outcome measure" and continued to argue that it is a valid, reliable assessment of health from the patient's point of view, (Ware 1993).

Another point to make is that between acute (sudden, sharp and intense illness) and chronic disease or illness (insidious onset, long term and very bad). While it is possible for medical science to find answers to most acute illnesses through tests and matching of signs and symptoms from a known base, the complexity and uncertainty of chronic illnesses makes it a lot harder to be precise in diagnosis and treatment. Chronic illnesses call for attempts at amelioration and promotion of needs which carry with it major implications for

social and welfare services. Mental health problems fall mainly into the chronicity classification and therefore require greater attention in terms of policy formulation and a greater degree of prioritisation. Gournay (1997 p221) identified this dilemma and put the view that before we begin to address the issues concerning clinical effectiveness in mental health, the difficulty of precise definition and classification of mental health problems must be tackled.

3.2.3 Implications for Forensic Psychiatry

The challenges posed by chronic ill health to forensic mental health services are immense, the need to identify effectiveness measures is therefore critical. It is important to sufferers, policy makers and planners in terms of finding new ways of meeting needs and it is important for clinical staff in finding treatments that work. These challenges are made more complex by the consequences of mental ill health, which are numerous for services caring for these patients. The uncertainties relating to definition and classification of mental health with its impact on diagnosis and treatment, and the medico-legal framework in forensic psychiatry makes it difficult to identify what health means and consequently the development of outcome measures.

There are other factors that impinge on this viewpoint. Notably, there is the relationship between psychiatric disorder and measures of poverty, low social class or deprivation. Faris and Dunham (1939) reported higher admission for psychosis (mental illness) in poorer inner city areas of Chicago than there were in more prosperous outer areas. Other researchers also confirmed the high concentration of mental illness particularly for schizophrenia than any other type of mental illness in the inner city areas of London (Eaton 1985). These has led to the debate over whether people born in inner cities are at high risk, a situation described as "social causation hypothesis" or whether mentally ill people tend to migrate to these urban areas irrespective of their place of birth, generally referred to as "Social drift hypothesis". Castle et al (1993) and Dauncey et al (1993) have found evidence that supports the social

causation hypothesis, although there is evidence albeit on a lesser scale that supports the latter view too.

The Jarman index or the Under-Privileged Area score (UPA score) is the tool most widely used to measure the link between deprivation and psychiatric disorder (Jarman 1984). Harrison et al (1995) used the UPA score and found that for those who were diagnosed as suffering from schizophrenia and other psychotic disorders, the correlation between admission rate and the UPA score to be 0.77. There is also evidence that supports the view that the rate and correlation is as high for people suffering from neurotic disorders (Lewis and Booth 1992). Guite et al (1995 p98) found that there is over-representation of Londoners in the forensic sector. For example, the prevalence rate in high security hospital in-patient population is 54.5% per million for London health authorities, while the figure is 29.5% for the whole of England and Wales. They also found that there is close correlation between secure bed use and unemployment rates. They also found an over representation of patients from the ethnic communities within the forensic services. They argued further that the high numbers of black patients within the forensic services might be due to the fact the police and others responding differently to black people.

Gunn et al (1991) also reported high levels of psychiatric disorders in remand prisoners and in the prison population as a whole. It is clear therefore that health and health gain for mentally disordered offenders mean more than just treating and managing the physical exteriorisation of the disease or illness. They have implications for functional, psychological, emotional, cultural and social aspects of the individual's life and wellbeing as well as having an impact on the life of significant others. In the case of measuring health in the forensic services, the general objective of health achievement can only be a starting point. This baseline will provide the basis from which wider elaboration or perspectives could emerge. Measuring positive health is both important and valid aim to pursue but there are pitfalls. Boorse (1977) put this in context by cautioning that:

"whilst I would not wish to deny the importance and validity of the notion of positive health, its application in instruments designed to measure need and outcomes of healthcare must be limited to those which aim to tap subjective experiences. Any attempt to incorporate positive health into objective measures risks imposing a particular set of value judgements about what is and is not desirable"

(Boorse 1977 p542)

This problem is not resolved either by adopting the method of canvassing the subjective views of patients alone. The danger here is that the patient may conceptualise health in terms of their own definition of positive health and may involve the absence of disease or illness. There is a need therefore to bring together the many other factors of health and social wellbeing of the individual to ensure a balanced assessment of individuals and their needs in the forensic services.

CHAPTER THREE: MEASURES OF HEALTH CARE OUTCOMES

3.3 Introduction

Moir (1993. p25) argued that it is scarcely a novel concept to assume that health care, whether preventive or therapeutic, should confer benefit. He went on to add that, as the range, and sometimes the cost and complexity of such interventions is growing rapidly there is increasing need to define more clearly the type and duration of benefit to health that each intervention causes.

It has been discussed earlier that information collated by health care staff from patients do not necessarily contribute to the formulation of the treatment plan. Another anomaly in modern medical practice is that patients' views of health, well-being and life satisfaction are often different from those observed by health professionals. Clearly, this means that subjective health assessment is important both for present day clinical practice, policy development, and for research.

Most current measures of outcome used in the NHS either comprise output indicators or mortality statistics. In their current state both of these measures are too crude to be of value in the measurement of forensic mental health care effectiveness, mostly due to the chronicity of conditions for treatment where small changes occur over a long period. Nevertheless, if performance review is to attain any scientific credibility, outcomes measurement is an increasingly urgent requirement and development work should be promoted within forensic services.

3.3.1 Outcome measurement theories, concepts and principles.

The advance of health technology, particularly after the launch of the Health of the Nation document in 1992 precipitated the setting up of the NHS Health Technology Assessment (HTA) Programme in 1993. The aim of this programme is to:

> *"ensure that high quality research information on the costs, effectiveness and broader impact of health technologies is produced in the most efficient way for those who use, manage and work in the NHS"*

The programme defines technologies broadly to include all methods used by those working in the NHS to promote health, prevent and treat disease, and improve rehabilitation and long term care. They cover the activities of all healthcare professionals and embrace the use of pharmaceuticals, healthcare procedures and care settings. The HTA programme is one of the many ways in which the NHS research and development programme funds research. Its uniqueness is the fact that it is a national programme, which is dedicated to evaluation of health service interventions, and it is needs led from the user, provider and purchaser perspectives. In their latest annual report some 4,300 suggestions have been put forward for investigation and 250 have been identified as priorities and has commissioned 119 research projects (NHSE 1997). The HTA programme is therefore well suited to advance the study of the different domains and perspectives of outcomes measurement.

Traditionally though, most of the models of care are developed from the theoretical base that health is an objective and measurable state. This is a disease based view, a bio-medical model which sees ill health as an abnormality. This theoretical view is seen by many as too limiting (Field 1976). Another theoretical frame of reference for health seems to be that which sees "ill health" as an illness. The strength of this approach is that chronic diseases are prevalent and these conditions and subsequently their intervention may not be a life and death matter, the focus therefore needs to be on the improvement of quality of life for the sufferer.

Building on from this theoretical shift, the measure of 'health gain' or outcomes has focused on the measure of distress relating to the condition, the degree of discomfort the individual experiences and the social and psychological distancing the individual suffers as a result of ill health. In mental health, this is particularly of interest as mental illness cannot be "cured" instead the focus of mental health care is on the alleviation of negative signs and symptoms of the condition the person is suffering from. Equally, the effectiveness of mental health care cannot be measured based on the model within acute medicine which concentrates on an episode of care intervention based solely on the success or lack of that intervention. This is because mental ill health affects the whole personality, the social and psychological functioning of the sufferer. The treatment of symptoms does not necessarily mean that the condition and its ill effects (consequences) are treated. The main principles emerging from this conceptual and theoretical shift are:

I. The measure of health gain needs to be multi-dimensional and developed in a way to capture the patient's point of view.

II. The measurement of health outcomes needs to shift from objective measures to subjective ones.

III. The developments of such measures need to take into account strategies necessary for the prevention of relapse and maximising rehabilitation.

IV. Effective risk assessment is the cornerstone of effective outcomes measurement in forensic psychiatry.

3.3.2 The genesis of measuring outcomes

The rise of subjective health outcomes measures in the United Kingdom (UK) and the United States of America (USA) can be attributed to the different forms of managed competition and what is close to a revolution in health care research, focusing on outcomes research leading to development of clinical guidelines in the two countries. In the U.S.A, outcomes research arose when it was detected that a considerable regional and practice differences existed

in similar conditions even when controlling for severity of the condition, patient health and socio-demographic characteristics (Wennberg 1990). In the drive to find the cause of this phenomenon, researchers began to focus on what works in medicine and to learn more about how to make clinical decisions that reflect more truly the needs and wants of individual patients.

In the UK, the genesis of outcomes research achieved a high profile in policy terms through the introduction of the commissioning process and the emphasis on health gain introduced in the government's white paper Health of the Nation (HoN) in 1992 (DoH 1992). The HoN is a health strategy, which was launched by the Department of Health and designed to secure continuing improvement in the general health of the population of England by "adding years to life, and life to years." It identifies five key areas for health improvement together with action plans and timetables for achieving them. Mental illness is identified as one of such key areas. This strategy was hailed as a strategy for health not ill health, or even for health care because it recognises that while there is much the NHS needs to do, the NHS alone cannot meet the objectives and targets. It called for active partnerships (healthy alliances) between many organisations and individuals to work together to improve health (DoH 1993). This policy lead has enabled the assessment of health services outcomes to the centre stage. However, the strategy document exercised caution in identifying outcome indicators for mental health (McColl 1993):

> "there is at present no straightforward and objective way of describing, aggregating or monitoring outcomes of care, nor any agreement on clear and reliable measures which could confidently be used as proxies for outcome measures....in the present state of knowledge it is unreasonable to set health outcome targets for these services."
>
> (McColl 1993 p77)

Despite this caution, the consultation exercise (green paper) preceding the white paper overwhelmingly wanted outcome targets to be set for mental health services. The white paper therefore proposed two quantified targets for

reducing suicide and an unquantified target for improving health and social functioning. These are as shown in Figure 3.3 below.

Figure 3.3 Health of the Nation targets for mental health

1. To reduce the overall suicide rate by at least 15% by the year 2000. (this is from the base of 11.1 per 100,000 population in 1990 to no more than 9.4)
2. To reduce the suicide rate of severely mentally ill people by at least 33% by the year 2000 (from an estimated 15% in 1990 to no more than 10%).
3. To improve significantly the health and social functioning of mentally ill people

Adapted from Health of the Nation handbook (DoH 1992)

Practitioners in the service started to develop outcome scales based on the HoN targets. Of note was the Department of Health commissioned research into outcome scales for the mentally ill. The Royal College of Psychiatrists, through their research unit led a multi-disciplinary group of health professionals to develop Health of the Nation Outcome Scales (HoNOS) which was designed to assess the extent to which the target is to be met (see Figure 3.4 below).

Figure 3.4 Health of the Nation Outcome Scales

Health of the Nation Outcome Scales (HoNOS)

HoNOS is a scoring system designed to provide a standardised measure of the health and social functioning of people with mental illness. It is a simple checklist of twelve items in areas in which mentally ill people may have difficulties. In the context of a Care Programme Approach (CPA) review, staff are asked to score each area on a scale of 0 (no problem) to 4 (severe problem). Service users are scored at their initial assessment and thereafter at major reviews or at the termination of their period of care. Ratings are recorded alongside diagnosis and Care Plan details. These data will form part of the new mental health minimum data set. HoNOS will enable:

- Clinicians to audit the effectiveness of their clinical work
- Service managers to ensure that resources are deployed effectively where the need is greatest
- Purchasers to ensure that services are developed to meet local health and social care needs
- Service users to be involved in planning and monitoring their care

Adapted from "Developing partnerships in mental health", DoH. February 1997)

Wing et al 1996 reported an increase in the use of HoNOS in mental health and this is providing a strong base for the improvement of information available to those who work with service users. Further, HoNOS aims also to provide aggregated data set that reflects the nature of the complexity and inter-agency aspects of mental health services. The Department of Health has declared its intention to monitor the use of HoNOS as a measure for the efficiency and effectiveness of the service (DoH 1997. p15).

3.3.3 Measuring effectiveness in the NHS Output measures – efficiency versus effectiveness

The measurement of hospital activity had received much attention following the government's introduction of the internal market. In the last three years this focus has been concentrated on intermediate measures or efficiency measures (length of stay, response rate, re-admission rates) in the form of efficiency index (League Tables) within acute care (DoH 1997a). Pettinger (1997) argued that the measure of bed occupancy has not really provided any

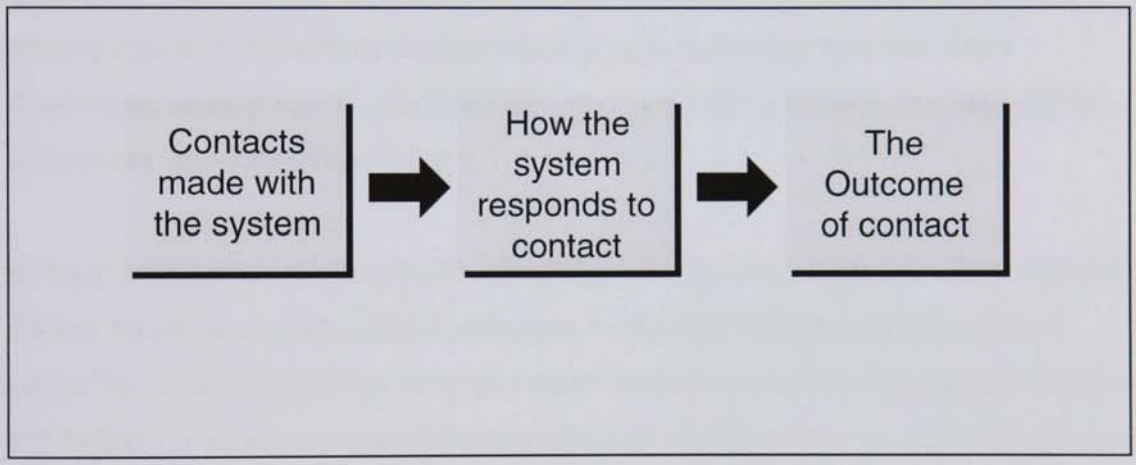
real measure of a hospital's performance. He went on to defend this assertion by saying that the measure of average bed occupancy can be statistically meaningless as the hospital as a whole includes various specialities which can provide varying data on bed occupancy. For example the average bed occupancy could include average length of stay on a particular ward, length of consultant episode or average length of stay in hospital.

This argument can be safely applied to measuring efficiency within mental health and in particular forensic psychiatry. A consultant psychiatrist whose average length of stay is high could be discharging patients pre-maturely. In the long run this may provide the hospital healthy efficiency figures but may not be useful to gauge the effectiveness of the treatment. However the nature of clinical effectiveness in mental health is a problematic one and it is a task that is truly Herculean as the situation in terms of activity to measure health gain in mental health is just beginning to scratch the surface (Lewis et al 1997). Gournay (1997 ibid) cited five problems that need to be surmounted; drug treatment, psychotherapy, training, research infrastructure and methodology or approach. In the case of drug treatments the argument that this is about the easiest area for identifying effectiveness is overshadowed as this is fraught with problems of compliance and attribution as drug treatment is always followed with a degree of social and psychological support as well as psychotherapeutic interventions. The difficulty of identifying the method or approach that works is also relevant to the effects of psychotherapy as well as training. In the case of method, Gournay cited randomised controlled trials (RCTs) as the gold standard for determining the superiority of one treatment over another (Gournay 1997). The effect of RCTs on health service research is further discussed in chapter 4 of this thesis.

The ability/capability gap - the discrepancy between what health care systems can do and what they cannot do, constitutes one of the greatest challenges for those concerned with health care and welfare. The World Health Organisation (WHO) elaborated on this view further, recommending that information is shared between practitioners and users of the service in order that the development of policies are more appropriate for the solution of the

problems for which they are meant to resolve (WHO 1980 p6). This view if applied to the letter would enhance the quality of the choices that people have to make based on a description of the situation as it is. It is true too that evaluation of the service needs to be goal oriented in order to enable appraisal of the extent to which the goals are attained. Cochrane (1972) supports the assertion by saying that clarification of the goal would permit the study of the extent to which these goals are being met, the effectiveness of the process, the inputs necessary to attain it, the efficiency of the process and its availability and uptake, and equality of distribution. The World Health Organisation recommended three aspects that are fundamental to any attempt to evaluate effectiveness (see Figure 3.5).

Figure 3.5 Process of Assessing Effectiveness



In this model the first stage i.e. contacts made with the system, would appraise numerically all contacts with the service. The second stage, that is the way the system responds to the contact, would address process issues such as efficiency, throughput or intermediate measures and recovery rate. The third phase, the outcomes of contacts, is concerned with the degree to which the outcome of contact relates to the goals of care - the main concern of this research. This is because the most basic requirement of any health care system is that some beneficial change in the user's situation or status should result from the contact. Conversely, in most cases the nature of the challenge (illness) changes as the burden of morbidity alters. The more chronic the illness the more difficult it is to assess the effectiveness of the

service. Mental health care falls into this category and therefore, presents the most difficult challenges for health care workers and others who are engaged in developing effectiveness measures, such as outcome measures.

This process is not too dissimilar from that proffered by the Donabedian classic paradigm of quality of care, which includes structure, process and outcomes as components, which has dominated effectiveness of health care provision since 1968 (Donabedian 1968). Although this research is concerned with identifying the key areas in which outcome measures could be developed, it is nevertheless important to state that the measures that are developed will have to take into account input and process issues to deliver the outcomes. This approach would support the ideal context within which mental health practice should be delivered - within a framework of therapeutic alliances involving the user. Merwin et al (1995) argued this point further by saying that it is necessary to determine how knowledge that has been developed regarding structural factors and processes of care can be built to determine the outcomes of care.

In their publication, Outcome Briefing, the UK Clearing House for Information on the Assessment of health Outcomes of the Nuffield Institute for Health called for a clear definition of what health outcomes are as the design of data collection for outcome research needs to incorporate controls akin to those in clinical trials (Nuffield Institute 1993). This is necessary in order that the outcomes can be attributed to the interventions. Secondly, they argued that specific instruments need to be judged on their own merits, as its responsiveness has to be tested to confirm that it can detect any clinically significant changes produced.

3.4 Introduction

In the United States, Mirin et al (1991) reported that the Social Security Amendments of 1983 which dealt with hospital reimbursement for the care of patients insured under Medicare, changed from a retrospective system based on actual cost of care to a prospective, fixed fee system based on the diagnosis of the patient. Though psychiatry was exempted from this system, it was not too long before provider units decided to measure effectiveness of care and developed a criteria based on pre-determined price for in-patient and out-patient care. They emphasised that treatment in hospital must be "medically necessary" and active rather than custodial. Consequently, insurers began to be reluctant to support inpatient treatment for all but the very acutely ill patients. Suspicion reigned that the justification for appropriate care was being driven by financial rather than clinical considerations. However, both insurers and providers saw the need to define the characteristics of those patients who require inpatient care, the type of clinical problems to address while the patient is in hospital and what should be addressed as an outpatient, and to determine what treatments are useful and cost-effective in particular patient subgroups with respect to both short and long term outcomes. In this context, insurers and health care organisations agreed to develop criteria for measuring medical necessity and effectiveness of care, whilst ensuring the quality of care is not to be compromised.

Significantly for mental health, effectiveness assessment of clinical efficacy tends to be with the predominant biomedical model rather than the adoption of broad range of outcome measures (Mirin et al 1991). Further, these measures are usually uni-dimensional rather than multi-dimensional and are disease specific. Unfortunately, inclusions of patients, their relatives and carers have not been consistent. While the disease model may suit acute conditions, it is not so effective in assessing mental health problems, because mental ill health affects the whole person and his or her functional abilities. However

the literature has remained firmly in the realms of measuring outcomes uni-dimensionally.

Figure 3.6 Typology of health and associated outcomes measures

Quantity of Life	Process based outcome Measures	Quality of Life *Health related quality of life* *Dimensions of health*			Satisfaction with health care
		Physical	**Social**	**Mental**	
Mortality		Measures of impairment	Measures of social support	Measures of depression	**Patient satisfaction surveys**
Avoidable Premature Mortality	**Re-admission rates**	Disease Specific Measures	Measures of disability	Measures social adjustment	
	Relapses				
	Complications	Measures of Functional Status		Needs Assessment	
			Measures of Handicap		
		Multi - dimensional health status profiles and indexes cover many of these dimensions in a single instrument			

Adapted from UK Clearing House for Health Outcomes 1993

Figure 3.6 shows the very wide range of outcomes measures identified by the ClearingHouse. Clearly majority of those in the quality of life domain are used in mental health. In the wider context, they cautioned that users of the measures should ensure that the details provided by the chosen instrument should match the intended use and listed three key pointers as a guide.

I. To evaluate the effect of interventions on individual patients

II. To compare aggregated results for different treatments or units during trials, medical audit or routine service management

III. To inform resource allocation and policy making

In forensic psychiatry the lack of motivating mechanisms, coupled with the tendency to concentrate on negative rather than the positive outcomes have

made it almost impossible for patients in secure units and hospitals to be discharged. Ham (1995) reiterated the importance of focusing on what works to ensure effectiveness. Press reports relating to discharged patients make frightening reading to the general public and therefore do not provide clinicians with the confidence needed to engage in risk taking (Seamark 1995; Evening Standard 1996). On the other hand inaction can result in institutionalisation, sometimes with patients being unnecessarily detained in secure hospitals, while others who are deemed to require the service most remain in prisons.

3.4.1 The relationship between needs and outcomes

According to Wing (1996, p69) needs assessment comprises the formulation of a problem profile, prescription of interventions for each problem, skilled staff for each intervention, and setting conducive for therapeutic interaction between health care worker and patient. A need in health terms can be defined as the presence or absence of given conditions that are amenable to preventive measures or treatment. Need should define the objectives of care. In forensic psychiatry however there is another dimension, which is the effect and implications of the mental health law on the practice within the service (MHA 1983). However it is possible to identify need for forensic patients after consideration of the impact of the type of mental health law under which they are detained in hospital or are being care for in the community. For example, some of the demands of the law may restrict the individual as to where to live and where to work on discharge from hospital if it is judged that they pose a threat to themselves or others. Wilkin et al (1992) offered another focus for need in health care, explaining that:

> *"To speak of need is to imply a goal, a measurable deficiency from the goal, and a means of achieving the goal."*
>
> (Wilkin et al, 1992 p35)

Wilkin and colleagues put forth the rationale for this assertion as if someone who is suffering from headache has a measurable deficiency from the goal. In order therefore to achieve the goal, the person may wish to take an analgesic.

The analgesic is therefore a means of achieving the goal. Given that pain is an adjunct to headache, pain therefore is a necessary indicator of malfunction in health. The problem arising from this is defining the level or degree of that pain and how to decide what level of deficiency constitutes a need.

In the mental health sector there is a great variety of players whose needs need to be met. For example, a person who is distressed and aggressive may be removed from the social area and separated away from others. It may be argued that his or her removal satisfied the needs of other patients as the potential source of injury is removed or that of the staff as the ward environment would be quieter and therefore better controlled - fostering a safe environment. The needs of the distressed patient may be served by his or her removal to a quieter area where there is less stimulation. Another point to consider here is whether that option is the only one available to staff and to what extent has the action resulted in satisfying the primary reason for the patient's distress.

The focal point is the view that "need" can be defined in different ways and from a variety of perspectives. It follows that any measure of need cannot be all encompassing or all embracing. Essentially, the definition of need can incorporate making value judgements about what should be accepted as appropriate goals and what constitute deficiency from these goals.

Assessing this need depends on satisfying the following; firstly, identifying an ideal standard against which to compare results. Secondly, identifying the minimum level against which people should not fall and thirdly, comparing with standards reached by other groups or individuals accessing that particular aspect of the service or technology. The question of who should be included in identifying the need, is best answered by saying that professionals, the individual patient and relevant others should all be involved.

Reed (1992) surveyed the needs of users of forensic psychiatric services by asking health regions in England and Wales to undertake the need of service usage. The report concluded by identifying problems with inadequacy in bed

numbers, difficulties in accessing the service and poor communication relating to discharges. This highlights the problems of effective assessment of need. The issues identified are those that any service planner would want to flag up but failed to canvass the expressed needs of users of the service.

Bradshaw (1972) identified four main types of need in healthcare, as shown in Figure 3.7 below. He described them as follows: *Normative* need is that which the expert or professional defines as need in any given situation; this definition may change in time as a result of advances in knowledge, the changing values of society, the expert or the professional as an individual. *Felt need or want* relates to the perceptions of the individual, which may also change relevant to the experiences of the individual. *Expressed need or demand* is felt need turned into action. *Comparative need* can be measured by the study of characteristics of the population receiving the service and defining similar characteristics as in need. It seems that assessment of mental health needs therefore require much more comprehensiveness in the way this is approached. This method, it would seem needs to involve collecting information about and from the individual and translating such information into a full picture of the health status to which the individual must be the central player. In the present push for user involvement and individualised care planning it must include the physical, psychological, functional, social, cultural and the environmental aspects which may have contributed to the dysfunction in mental health. Professional staff must not only

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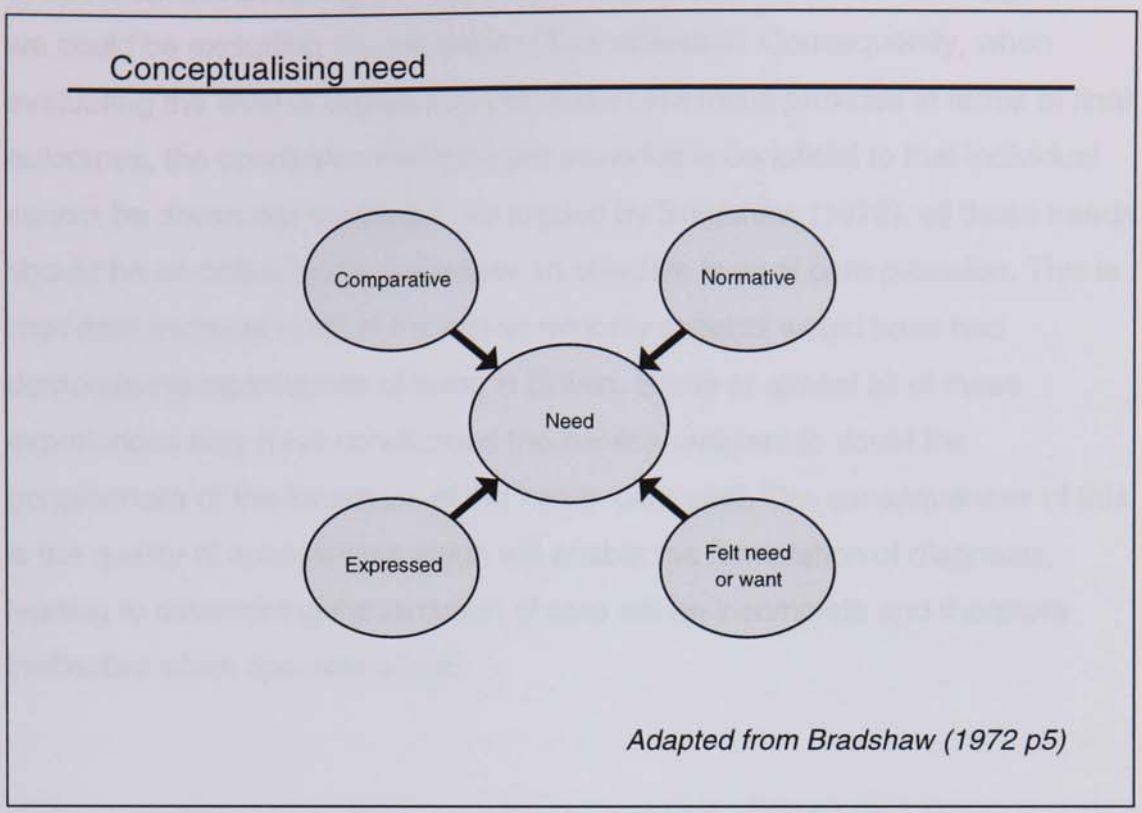
Figure 3.7 Conceptualising Need



concentrate on the screening aspects of identifying healthcare, which involves the application of tests, examinations and procedures in identifying a disease component.

Another point to consider is that of the minority ethnic communities in terms of assessing needs and its impact on effectiveness of care. It seems probable that the care of the ethnic minority service user does not include all the ingredients for the assessment of need Bradshaw (1992). For example, many studies have supported the view that the African-Caribbeans are more likely to access psychiatric services in larger numbers than their comparative proportion of the population. Many of them while in hospital often insist on being discharged, as they do not think they require the level of intervention. Some doubters may argue that the mentally ill patient lacks insight into their illness and therefore lack the ability to make effective contribution to their care. This may be true in some cases. We must however aim to actively redress the problem, for left unresolved this in itself would increase the aggravation with its consequences for disruptive behaviour. Where the professional staff might be right in diagnosing the need, it

seems perhaps too often the normative need as specified by the professional which is almost always given a priority. There is some evidence to suggest that we could be excluding the felt need of that individual. Consequently, when evaluating the level of impact that particular care focus provides in terms of final outcomes, the conclusion that the care provided is beneficial to that individual cannot be drawn nor sustained. As argued by Bradshaw (1972), all these needs should be co-ordinated to guarantee an effective level of care provision. This is important because most of the ethnic minority patients would have had demoralising experiences of living in Britain. Some or almost all of these experiences may have conditioned the service recipient to doubt the genuineness of the intentions of the health care staff. The consequences of this is the quality of assessment which will enable the formulation of diagnosis, leading to determining the direction of care will be incomplete and therefore ineffective when operationalised.

CHAPTER THREE: CLINICAL EFFECTIVENESS - THE POLICY FRAMEWORK

3.5 Introduction

Clinical effectiveness is concerned with the extent to which specific interventions, procedures, regimes or services do what they are intended to do. This clarification of the purpose of the clinical effectiveness agenda is to enable the NHS to ensure the best possible improvements in health, including well being and health related quality of life and within allocated resources. The Department of Health has taken the lead in the development of an infrastructure to promote action on clinical effectiveness. Some of these are the UK Cochrane Centre in Oxford, the NHS Centre for Reviews and Dissemination in York and other regional initiatives all designed to help practitioners improve the effectiveness of their practice. These and Executive Letters on clinical effectiveness, Effective Health Care bulletins which concentrate on providing systematic reviews of the research evidence on clinical and cost effectiveness, and the Priorities and Planning Guidelines for 1996/97 have laid the basis upon which this initiative were to be developed.

The term clinical effectiveness first appeared in the documentation that directs the priorities the NHS needs to address in 1993 (DoH 1993). Enhancing clinical effectiveness relies on clinicians changing their behaviour either to introduce more effective practices or to refrain from undertaking practices that have been shown to be ineffective or harmful. It focused on identification of gaps and areas in which outcomes measures are making effective impact. As Figure 2.8 shows the activity rate and the issue of two priorities and planning guidance documents demonstrate quite strongly the government's commitment to making service effectiveness central to its policy on the health service.

In the case of activity, the government funded NHS Centre for Reviews and Dissemination (NHSCRD 1995) conducted a worldwide review of research on

the effectiveness of health service interventions contributing to reduction in variations in health. The search criterion was narrowed to studies that report direct or intermediate health outcomes relevant to the Health of the Nation target areas and are experimental and quasi-experimental in design. This review conducted using known health databases produced 94 studies that met the search criteria and included studies in mental health (Morse et al 1992; Wasylenki et al 1993). This review as guide to the NHS recommended the following as the methods that are successful in delivering effective services to people with mental health problems. These are:

I. Systematic and intensive approaches to delivering effective interventions (assertive outreach).

II. Improvement of accessibility to services.

III. Promotion and encouragement to use of the services.

IV. Multi-facetted strategies including collaboration between interest groups, addressing the expressed or identified needs of the target population and the involvement of peers and patients in the delivery of interventions.

In the mental health sphere, the NHSCRD review found higher rates of schizophrenia diagnosed in males and females born in the Caribbean with this risk persisting in second-generation migrants. They also found that sources from which they were admitted seem more likely to be through the criminal justice system than via general practitioners. There is also evidence of increased risk of alcohol related admissions to psychiatric units among Sikh men and of suicide in young women of Indian origin.

Figure 3.8 Policy direction on clinical effectiveness

Dec 1993	EL(93)115	First executive letter to make reference to clinical effectiveness. It identified information initiatives on the subject and made recommendations to Health Authorities (HAs) to use the guidelines in contracting for services and to report on their progress.
July 1994	EL(94)55	NHS Priorities and planning guidance 1995/96. Clinical effectiveness as a medium term priority. This EL called on HAs to "invest an increasing proportion of resources in interventions which are known to be effective and to reduce investment in interventions shown to be less effective"
Sept 1994	EL(94)74	Update on sources of information on clinical effectiveness
June 1995	EL(95)68	NHS Priorities and planning guidance 1996/97. Clinical effectiveness still a medium term priority. It states HAs should "improve the cost effectiveness of services throughout the NHS, and thereby secure the greatest health gain from the resources available, through formulating decisions on the basis of appropriate evidence about clinical effectiveness". It called on HAs to invest in purchasing effective services.
Dec 1995	EL(95)105	Update on the importance of clinical effectiveness and made it known to the NHS that some interventions being researched and called on the NHS not to use these routinely.
Jan 1996		Promoting Clinical Effectiveness: a framework for action in and through the NHS. This document is the first policy to set the agenda for action for the NHS Executive, HAs and Trusts.
June 1996	EL(96)45	NHS Priorities and planning guidance 1997/98. Restated as a medium term priority. It called on HAs to "demonstrate a measurable change in the level of investment" which is based on evidence of clinical effectiveness.
Oct 1996		Reference pack on clinical effectiveness. Focused on co-ordinating information on clinical effectiveness
May 1997		The new government declared its policy intention on effectiveness by shifting policy from efficiency targets on to quality and effectiveness measures

Sources: DoH and NHSE (1993-1997)

The review also supported the assertion that there is evidence of unmet needs in the ethnic communities leading to lower rate of identification of milder mental health problems. It is clear from Figure 3.8 that the policy framework for ensuring that the NHS delivered effective service to users has been in place since 1993. This framework has been regularly updated, supported by information that is likely to galvanise purchasers to insist on effectiveness measures in their contract and clarification of roles of the

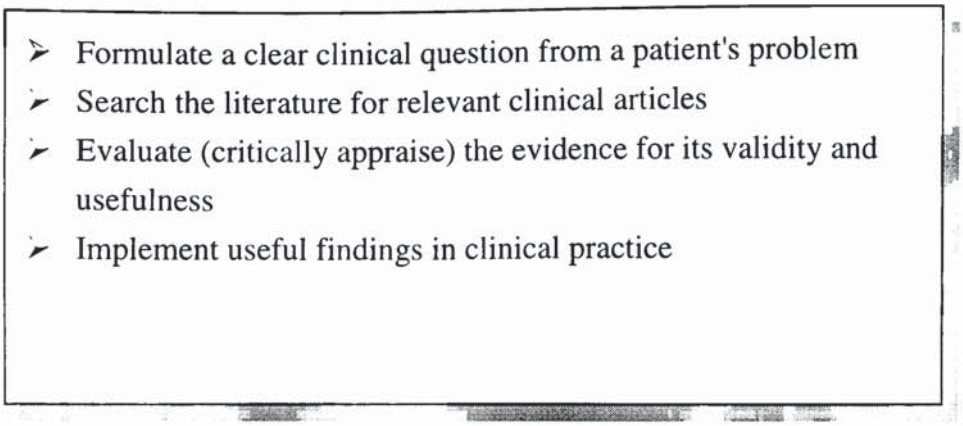
various bodies that are involved in delivering and regulating health care. Alongside Executive Letters (EL) the Department of Health has developed research and development strategy and performance management arrangements for HAs and Trusts to place effective care backed up by evidence central to the NHS. This "carrot and stick" approach has been used to change the behaviour of the NHS on one hand, while on the other there appear to be over concentration on efficiency tables (hospital league tables) which is focussed on issues of process.

3.5.1 Evidence based health service

Evidence based practice is central to the NHS push to achieve effectiveness of service. It is a process of turning clinical problems into questions and then systematically locating, appraising, and using contemporaneous research findings as the basis for clinical decisions. Rosenburg et al (1995 p1122) argued that the rise in the demand for effectiveness of clinical practice is justified because for decades people have been aware of the gaps between research and clinical practice. He raised the sceptre by stressing that the consequences in this disparity between research and practice is expensive, ineffective, or even harmful to appropriate decision making.

An aspect of evidence based health service is the model based on medicine or professional practice in general. Evidence based medicine or practice is normally practised in any situation where there is doubt about an aspect of clinical diagnosis, prognosis, or management. Figure 3.9 progresses the decision-making process through four key steps. The first step is to clearly define the problem and draw out an appropriate question necessary for conducting a literature review. This review is targeted to provide information to answer the problem being investigated.

Figure 3.9 Steps in evidence based practice



The final stages of the process are reached when the information collected is appraised for validity before the findings are implemented. Evidence based practice enables practitioners to upgrade their knowledge base as applied to a specific patient and the condition presented and thereby increasing confidence in decision making. It also improves multi-disciplinary working as it enables group decision-making, learning of new skills and increasing the input of junior members of the team. This approach would improve communication with patients as reasons for a particular decision could be better presented and explained. Evidence based practice can also improve the way resource decisions are made, thereby ensuring an effective use of resources.

Audet et al (1993) however considered that the main problem for this approach is the difficulty in evaluating its effectiveness. He argued that as a process of solving problems, it has the potential of having different outcomes depending on the problem being solved. Rosenberg et al (ibid) supported this view adding that to monitor all the possible outcomes would be impossible, especially since many are difficult to quantify and probably problems of attribution. It is possible that the same argument could be applied to situations in mental health. For example, if through literature searches it is discovered that intensive supervision has been successful say for a particular patient, would applying this finding to another patient improve safety levels? The problem for effectiveness though is this: is this improvement due to the social contact, compliance to medication or could the same situation be achieved if a

carer is found for this patient? The answer to this question is the strongest guide to the effectiveness of evidence based programme.

None the less, evidence of the effectiveness of evidence based practice is growing as the NHS Executive's responses demonstrate, particularly in co-ordinating the deluge of information that is emerging. In a recent review, the NHSCRD (ibid) concluded that systematic reviews are the best method for identifying effective information that could enable evidence based practice (Clegg et al 1998). Systematic reviews are an effective and rigorous method of evaluating, summarising and communicating findings and implications of an over growing body of research evidence to health practitioners. Clegg and colleagues went as far as to assert that systematic reviews are a scientific process and that it can allow assumptions and professional or commercial biases to be challenged.

3.5.2 Clinical Guidelines

There is increasing acceptance that standards for practice involve judgements not only by health professionals and managers but also patients and other users of the health service. Clinical guidelines are one means by which the principles of working together could be promoted. Clinical guidelines are designed to enable decision making on care and treatment. They are systematically developed national level of statements of good practice within specific conditions. They provide appropriate management options for symptom clusters, conditions or procedures with the principal aim of promoting the use of evidence based practice to improve patient outcomes and efficient use of resources across sites and between individual practitioners. The Royal College of Psychiatrists (RCP 1994) suggested that national clinical guidelines might be used to inform patients and service users about what constitute "quality care" enabling them to express preferences, where options exist, for interventions and outcomes. At the local level these statements are adapted to include operational details and are therefore known as protocols.

Figure 3.10 Attributes of clinical guidelines

ATTRIBUTE	EXPLANATION
Validity	Valid if, when followed, they lead to the health gains and costs predicted for them.
Reproducibility	Able to produce the same recommendation given the same evidence, methods and clinical group.
Reliability	Can produce the same interpretation and application for another practitioner if implemented within the same clinical circumstances.
Representative development	They should be developed by a process that entails participation by key stakeholders
Clinical applicability	Able to be applied to patient populations defined in accordance with scientific evidence or clinical judgement.
Clarity	Use unambiguous language, precise definitions and has user friendly format.
Meticulous documentation	Must record participants involved, assumptions made, and evidence and methods used
Scheduled review	State when and how they are to be reviewed (under two separate circumstances - the identification or not of new scientific evidence or professional consensus.

Source: Adapted from Agency for Health Care Policy and Research. Grimshaw et al 1993 p243

Figure 3.10 shows the desirable attributes and their explanation as far as clinical guidelines are concerned. Grimshaw et al (1993 p243) advanced the view that the role of clinical guidelines is to encourage good practice and thus generate health gain. They argued however that there is professional ambivalence towards guidelines, stemming from uncertainty about their effectiveness and how best to introduce them into clinical practice. However, in their systematic review of 59 rigorous evaluations, they reported improvements in the process of care in 55 studies and suggested that guidelines can change clinical practice if they are appropriately developed, disseminated and implemented. On the basis of their study, they concluded that greater validity is likely to follow from the use of systematic literature reviews, independent multi-disciplinary guideline development groups and explicit links between recommendations and scientific evidence. Corner et al (1998) further supported this view by observing that guidelines can prove ineffective if its development stage is unfocused and poorly drafted as it could result in unreliable, inapplicable, inflexible or ambiguous guidelines. They too concluded by calling for caution in implementing national guidelines without critical evaluation as these could result in poor practice and reduce

innovation. However, this viewpoint does have its difficulties as most practitioners would not have the time to devote to critically appraise guidelines before implementation. The new NHS white paper (DoH 1997b) is supporting the development of national quality standards or frameworks and the setting up of a national institute to address these issues. Obviously there is a shift in thinking towards standardisation of practice by politicians a situation which is likely to conflict with practitioners' preferred approach.

3.5.3 Audit and outcomes

Audit is increasingly being promoted as a means of involving patients and health service users in defining and evaluating the quality of care provided. This evaluation process, otherwise known as clinical audit has assumed the leading role in developing the framework, which embraces to some extent the measure of outcomes. Clinical audit is defined as the systematic critical analysis of the quality of clinical care, including the procedures used for diagnosis and treatment, the use of resources and the resulting outcome and quality of life for the patient (DoH 1989b). Fairfield et al (1996 p12) for example, conducted a survey of directors of public health and outcomes co-ordinator of audits known to them on the scope of outcomes and clinical audit. They found that only 9% of respondents indicated that outcomes are a focus for them and that outcomes tend to look at clinical conditions or interventions rather than services and packages of care. Additionally, they found that health commissioners tend to insist on the involvement of patients where audits are concerned, outcomes audits rarely addressed outcomes from a multi-disciplinary perspective. Finally, that outcomes audit was most common within the hospital setting (74%), followed by the community setting (53%) and the primary interface (48%). Only 22% of mental health services use outcome measures. 95% of those that are using a degree of outcomes in their audits found barriers and difficulties in operating them and stated that they found it difficult in understanding, defining and measuring outcomes. They also found it problematic in collecting and interpreting the data and that cultural factors tend to limit the use of outcomes. Long (1996 p14) commented on the findings of Fairfield and colleagues (ibid) and concludes that the barriers are

complicated by the lack of agreement on what an outcome is, identifying and selecting a suitable measure which is validated, can address quality of life issues, easy to use in the clinical context and able to promote a longer term data collection.

3.6 Introduction

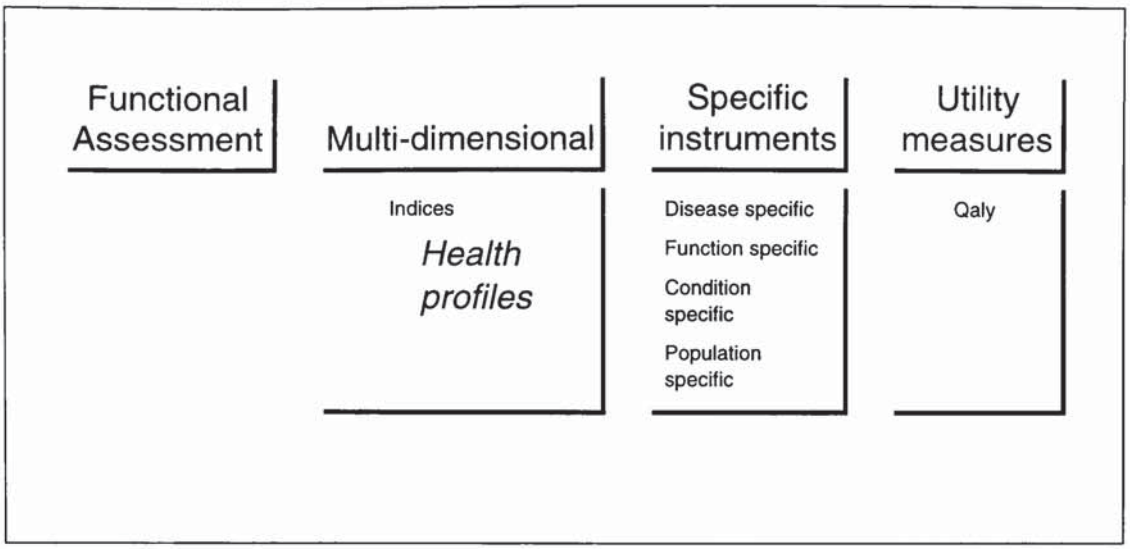
Rosser (1988) traced the measurement of health status to the Laws of Hammurabi inscribed in Babylon in 1750 BC. From this study Rosser identified a measure of health and derived from that a utility scale adjusted for socio-economic basis ranging from:

10	= death of freeman/loss of eye of freeman/loss of hand of surgeon (for surgical failures)
2	= death of slave/loss of eye of slave
0.2	= death of ox

(Brooks 1995 p16).

Florence Nightingale (1863) also contributed to the development of measuring effectiveness in Britain motivated by the great and unnecessary waste of life she saw in hospitals. She developed a model based on the number of people who were 'dead', 'relieved' or 'unrelieved' as an outcome of hospitalisation. Obviously her concern could now be said to be that of 'value for money' and was regarded as the first initiative in Britain to introduce medical audit, which was recorded in her *Notes on Hospitals* in 1863 (Brooks 1995). Today there are many effectiveness measures in use within the health service. It might therefore be helpful to begin by clarifying what is a very confused situation, (see Figure 3.11). The literature describes the following categories: functional assessment measures, generic (or general or global or multi-attribute or multi-dimensional) measures which can further be divided into two types - aggregated nature (sometimes termed 'index') and those which present health profiles (Brooks 1995). In addition to these, there are others termed specific instruments including many of the measures used in mental health. The final categorisations of these measures are those termed Utility measures.

Figure 3.11: Classification of effectiveness measures



3.6.1 Multi-dimensional/Generic Measures

These take two forms. Those which are indices and therefore aggregated and those which present health profiles. As the name implies they feature various attributes, such as mobility, physical and social function and measures to identify periods where symptoms are causing distress. In building health profiles groupings of conditions are identified. The term that describes these measures best is 'diagnostic related groups', which became very popular in the eighties. Health profiles originated from the belief that the aims of health care are to reduce sickness and its effects upon daily living. This group of measures includes instruments such as Nottingham Health Profile and the Medical Outcomes Survey Short Form 36(SF-36). These instruments are normally self-completion questionnaires intended to measure aspects of health, illness and the impact of illness.

Frost et al (1996 p30) suggested the combination of tools to assess effectiveness of care in the mental health sector. In their study they combined clinical data from an information system (comMent) with a multi-dimensional assessment schedule based on a set of clinical terms and an associated hierarchical coding system, known as FACE codes. The FACE codes were designed to provide a comprehensive descriptive base on five major problem

areas - mental health (self harm, harmful behaviour and problem behaviour), physical health, personal functioning, interpersonal relationships, and social circumstances. The study conducted in an acute setting in an inner city hospital found that by using the comment clinical information system it was possible to identify specific changes in the problem severity between admission and discharge. The change scores obtained by this method were validated against staff global assessment of change. They concluded that the sample showed deferential improvements in different problem areas and the distribution of problems and change scores both correlated with length of stay.

3.6.2 Functional Assessment Measures

These are concerned with prevalence of morbidity in large populations and include sickness data and information on ability to work. The tendency to hierarchically order classifications of disability to reflect severity of illness can be traced to the 1940s (Brooks 1995). Their development has been related to the concepts of impairment, disability and handicap, perhaps reflecting the domain within which they were developed; that is in the context of chronic diseases, geriatric medicine and rehabilitation. Of note is the work of Katz who provided an account of the developments in this field by pointing out that the information for these measures were obtained through concern for prevalence of morbidity in populations (sickness data and ability to work) in the late 1800s and late 1900s (Katz 1983).

3.6.3 Specific Measures

This group contains many of the measures in mental health or psychiatry. These are disease, condition, problem or population specific. They are designed to assess specific diagnostic groups or patient populations and are particularly aimed at measuring changes that may be of clinical importance for the practitioners concerned. These measures are numerous and are therefore not discussed here in full. Most of these measures in mental health are not outcomes measures but rather screening instruments, e.g. General Health Questionnaire and Zung Self Depression scale.

Other measures in this group include measures of social adjustment and support, and measures of perceived health.

3.6.4 Utility Measures

These measures are rooted in the economic framework and include cost analysis, cost minimisation analysis, cost-effectiveness analysis, cost utility analysis and cost benefit analysis. Some analysts have argued that the concept of utility is the best placed to provide a unifying structure in which to place health status and quality of life measurements, the term 'health state utilities' have also been suggested. Ryan et al (1996 p207) advanced the view that techniques of economic evaluation of health care is becoming increasingly common place. They added that the evaluations of many healthcare technologies will be incomplete and interventions that are thought to be efficient may in fact be inefficient and vice versa, if these evaluations do not take into account potentially important sources of benefit or not to the individual patient. They suggested two key analytical techniques: willingness to pay and cojoint analysis to facilitate empirical testing of these issues.

3.6.5 Other Classifications

Mervin and Mauck (1995 p313) reported the classification used by the National Institute of Mental Health's Advisory Council of USA. This classification assumed a different perspective than those previously discussed. Their classification includes those that are grouped in humanitarian, public welfare, rehabilitative, clinical and provider domains. Humanitarian measures are designed to maximise the sense of wellbeing and personal fulfilment of patients and their family members. Vulnerable populations, care settings, carer experiences and perceptions, and the promotion of wellness are the concepts studied in this domain. Public Welfare domain relates to violence to self and others, emphasising the need to aim at prevention of harm to the patient, family and community but no studies that dealt with patients within the forensic psychiatry sector were included in these studies. The next domain, rehabilitative focuses on the improvement or

restoration of social and vocational functioning, and promoting independent living. Clinical domain reflects the Donabedian components of structure, process and outcomes. The goal of this domain is towards the reduction or elimination of symptoms of psychopathology or the cure of specific mental illness. Finally, the provider domain related to the study of staff attitudes, burnout and relationships with patients.

CHAPTER THREE: MANAGING USER CHARACTERISTICS

3.7 Introduction

The literature here concentrates mainly on the way knowledge base relating to assessment of health both from the professional and user perspectives differ. Conway (1995 p22) conducted an extensive review that highlighted some of these problem areas. These are the mismatch between lay and medical knowledge, the selection of the best method to collect the information and feeding the results of the consultation into purchasing decisions. However the evidence for user involvement is patchy. In a review of London mental health services the authors reported that 67% of patients who score high on the Under-privileged area Score (UPA) were involved in planning services, while 79% of patients who score lower on the UPA score were involved. However there is much support, in terms of funding to the high UPA group, 67% as against 64% for the low score UPA group (Johnson et al 1997 p45).

3.7.1 Patient Satisfaction

Another aspect of examining user perspective is the assessment of satisfaction. Pascoe (1983) defined satisfaction as:

> *"Health care recipients' reaction to salient aspects of the context, process and result of their experience."*
>
> Pascoe 1983 p185

The complexities of the relationships between needs, healthcare provision and outcomes have contributed to the increased search for the measurement of intermediate outcomes, such as user or patient satisfaction. Increasingly, consumer satisfaction is being highlighted as an important objective of healthcare, as well as a key determinant of service quality and a useful indicator of outcome (Donabedian, 1992; Stallard, 1994). In their pioneering work on measuring patient satisfaction, Raphael and Peers used a 24 item instrument to survey 2148 patients in nine psychiatric hospitals (Raphael et al

1972). They reported that patients favour human factor related aspects, such as social activity, staff and treatment and dislike noise and overcrowding.

In forensic mental health settings, Huckle (1997 p230) referred to an unpublished survey that looked at five key areas. In this survey patients' views were canvassed on adequacy of resources available in the hospital, the degree of information provided, the extent of interaction between staff and patients, the prevalence of individualised patient care and whether the needs of female patients were being met. The conclusions drawn from this survey were that there was moderate satisfaction of care and interaction with patients and staff. Women patients in this sample felt isolated and lonely and some felt vulnerable and sexually threatened by male patients. Morrison et al (1996) also conducted a satisfaction survey within a forensic setting and found a high level of satisfaction but patients reported negatively on lack of privacy, noise and problems of boredom and difficulties of leaving the ward for recreational activities outside the wards particularly when they were being escorted.

However, is satisfaction a goal for intermediate or final outcomes measurement or is the way satisfaction is conceptualised universally accepted and more so what is the extent of patient involvement in planning, administering and evaluating these instruments? Huckle (ibid p230) compared the findings of two studies which used an adaptation of the Maudsley Inpatient Satisfaction Schedule (MISS) (Wykes et al 1993), and found that there were improvements in the way patients feel about the domains on which they were assessed. The results show improvements in diversity of daily activities, quality of food, level of noise, understanding their legal positions and privacy. He concluded that repeating such survey at appropriate intervals might help to measure changes and improve patient satisfaction. However Stallard (1996), found that the issues of reliability and validity are rarely considered, arguing that such surveys have low response rates and studies were typically one off events. Wedderburn-Tate et al (1995 p18), advanced the view that while managers show interest in patient satisfaction surveys, there is evidence that there is no incentive for them to include these views in the way they plan services. Further, they argued that managers also find it easy to question the

validity of these surveys and suggested that this is due to lack of rigour in methodology, the surveys are conducted when patients are still in hospital and are therefore inhibited in answering, and the questions asked often provides little information of value and advocated a new approach to design. In their study they focused on what happened to patients rather than asking them if they were satisfied with selected aspects of their care. They found that patients were still not given information about their care, the named nurse concept which is the bedrock of the Patient's Charter was ill understood by managers, patients and nurses themselves, and the results of surveys of patients' experiences were not routinely included in strategies for service delivery. Scott and Smith (1994 p353) advocated for a better conceptualisation of satisfaction in order to make results derived from these studies acceptable and meaningful to both patients and health care practitioners. They concluded by saying that if patient satisfaction surveys are to help maximise the satisfaction of patients then research efforts should be directed away from merely demonstrating that patients are satisfied and explicitly recognise the decision-making contexts in which the results are to be used (ibid p358). Clearly the answer to the question above depends on the extent to which patients are prepared to comment effectively on the issues of satisfaction and practitioners' willingness to include their needs in the evaluation of service effectiveness.

3.7.2 Quality of Life

According to Jenkinson accurate assessment of subjective health status is contingent on identification of the domains and dimensions that constitute health and health related quality of life and its grounding in theory (Jenkinson p16 bid). Patrick et al (1993) progressed this view further by identifying the principal theories used to underpin this type of research. These are functional theory from sociology, positive wellbeing and general quality of life theory from social psychology, and utility theory from economics. The domains within which health could be identified have been discussed earlier in this thesis. Quality of life (QoL) provides another dimension for measuring subjective health status. Oliver et al (1996) defined quality of life as "the sense of

wellbeing and satisfaction experienced by people under their current life conditions" (ibid p5). The mental health association, MIND defined QoL as a balance between stressors, life events, environmental/social factors and resources (knowledge, sense of competency, security, coping skills, a stable value, belief and support systems) (MIND/WFMH 1985, 22).

According to Flanaggan (1982) measurement of QoL began in the USA in the 1950s with the research objective of charting "the social progress of the nation and to develop a regular system of social reporting to inform efforts to plan and evaluate social policy" (Dann 1984 p2). QoL measurement is a value-laden subject and like quality it can be perceived in various ways. Oliver and colleagues approached the definition by classifying it in various categories. As Figure 3.12 shows it can be divided into personal characteristics, objective quality of life and subjective quality of life. At the core of this definition is the notion that QoL should be regarded as a sum total of its determinants or causes as understood in any particular time and cultural context. The question of whose understanding of quality of life measures, whether the patient or the practitioner is left unanswered. In Figure 3.12 demographic variables relate to age, gender, ethnicity and socio-economic status of the individual. Objective quality of life measures are social contact, income, housing, employment (socio-economic indicators); social skills, functional ability, life events and activities (behavioural competence/role) performance measures and physical and mental health status which deals with biological factors. In the case of the category of subjective quality of life, the subjective satisfaction content is further divided into perceived quality of life; for mental health the sub groups are positive and negative affect, affect balance, and stress. Happiness and morale is further sub divided while personality deals with self-concept, locus of control, extroversion/introversion. The final domain of adjustment, social adaptation and personal growth relates to mastery, independence and values.

Figure 3.12 Categories of commonly acknowledged quality of life determinants and examples of their concepts.

Categories	Contents
Personal characteristics	1. Demographic variables 2. Social/Economic indicators
Objective Quality of Life	1. Behavioural competence/Role performance 2. Biological factors
Subjective Quality of Life	1. Subjective satisfaction 2. Mental health 3. Happiness and morale 4. Personality 5. Adjustment, social adaptation and personal growth

Adapted from Oliver et al (1996 p35)

Given the breath of the domain covered by QoL measures, many reviewers of the measures or authors on the subject have all come to the conclusion that these studies have been hampered by poor design and inadequate assessment methods, (Bowling 1992 p9). The choice of QoL as an outcomes measure has been problematic as both practitioners, researchers and users of health care fail to identify commonalities in the selection and rating of domains. Bowling's review of QoL measures led her to conclude that few indicators attempt to measure patients' perceptions of improvement or satisfaction with level of performance, yet it is this element which is largely responsible for predicting whether individuals seek care, accept treatment and consider themselves to be well and "recovered" (Bowling 1992 ibid p10).

3.6.3 User Perspectives

The NHS Executive's Priorities and Planning Guidance for 1997/98 includes the medium term priority for "giving greater voice and influence to users of the NHS services and their carers in their own care, the development and definition of standards set for NHS services locally and the development of national policy both locally and nationally" (NHSE 1996). It went on to develop this theme by adding that "putting patients first" is a key motivating factor for those working in the NHS. However the provision and development of the health services and care that are truly responsive to the needs of users and patients remains a constant challenge for clinicians and managers alike. The Chief Medical Officer's communication to the service in 1996 advised that there is always scope to do more to identify and spread best practice, to develop and apply a proper evidence base and to ensure that organisational, cultural and resource constraints are identified and addressed (CMO Update 11 1996).

Building further on the ethos of the need for the NHS to be more patient responsive is another NHS Executive publication on the importance of collaborating with patients (NHS 1996a). This document highlighted the considerable progress made so far, sets out areas where it intends to take action to stimulate further progress and where it will seek to identify how it can best work in partnership with other national bodies and promote further debate. Over the years communication between the various agencies involved in the care of the mentally ill have been criticised by the press and independent inquiries for not being effective enough to ensure adequate care for patients (Avon Health Authority 1997). At its core is the importance of effective assessment of the patient's needs. The Care Programme Approach was introduced by the government to encourage practitioners to provide co-ordinated care as well as improving communication and information sharing. In April 1996 the government introduced the Supervision Register to ensure that local services focus effectively on those mentally ill people who have the greatest needs for care and active follow-up (DoH 1996). Preceding these, the Confidential Inquiry into homicides and suicides was set up which also has

identified communication as the weakest factor in involving patients in their care and the planning of their services. Despite these the involvement of users particularly patients in the development and evaluation of outcome is patchy. Neuberger (1993 p23) argued that consumers are genuinely interested in outcomes, but have a problem getting to grips with the subject, for a variety of reasons. These reasons include denial of information about the effectiveness of individual hospitals or clinicians, the belief that the choice of treatment modality results in the same outcome, the belief that everything about medicine is science and not an art: that personal attention of clinicians is just as important as the prescribed treatment in promoting positive outcomes, and finally the complicated language used by practitioners. She insisted that users are keen to see that their perceptions are taken into account, as what matters to them and not that which belong to practitioners.

CHAPTER THREE: ISSUES IMPACTING ON OUTCOMES MEASUREMENT IN FORENSIC PSYCHIATRY

3.8 Introduction

In the forensic mental health sector the issues discussed so far take on a different perspective. The issues of balancing security and therapy, the lack of effective flow of information to patients and carers, the debate on whether or not the high secure hospitals are to be managed as prisons and the constant reactionary management style within some of these hospitals have meant that the task for the service will be more daunting than for other sections of the health service. However there are other areas that need to be taken account of during the development and implementation stages of outcomes work.

3.8.1 Clinical aspects

The key question for outcomes development in forensic mental health is identifying what actually constitute an acceptable outcome and how it should be measured. There are many measures in mental health but few if any is used in forensic psychiatry. According to Dolan and Coid (1993 p247) the most frequently used measure of outcome is reconviction particularly for some groups of mentally disordered offenders. At the centre of this debate is the appropriateness of using criminal behaviour as an outcome measure, especially in the case of psychopathic personality disordered people. Robertson (1989) pointed out that the use of "criminological criteria to assess the usefulness of psychiatric interventions is mistaken in principle and impossible in practice". He argued further that the criteria used for mentally ill patients are the same for offenders as well as for non-offender, which is related to the mental illness. On the other hand, in the case of psychopathic disordered patients the tendency is the recourse to criminal rather than clinical criteria, especially where the medical concept is dubious and the illness ill defined.

Another problem area is the accuracy of recidivism measures as behavioural indicators to identify the presence or absence of psychopathic disorder. Dolan and Coid (ibid p249) assert that the use of recidivism as an outcome measure also produces associated methodological problems which make it scientifically invalid criterion of outcome. The implication of this statement is that, the treatment effect is only a very small factor among the multitude of other circumstances upon which reconviction will depend. The issues relating to using recidivism as an outcome measure could be compared with the impact criminal activity has on clinical practice within the forensic mental health field.

3.8.2 Assessing Risk

The degree of danger an individual poses to themselves or others is critical to the decision to admit them for treatment in forensic units and hospitals. Assessment of the risk the individual poses is therefore essential. From personal experience of the researcher, during the process of risk assessment, clinical staff readily accept the fact that risks involve balancing positive and negative outcomes. Unfortunately, there seems to be a tendency to concentration on the negative and therefore the harms that might result, focusing more on risk avoiding rather than risk taking. Clearly, managing risk in this way is a reactive approach while what is required is to adopt a proactive stance by calculating the degree of danger the individual poses, identifying the predictors that might contribute to the danger, planning to reduce predictors and teaching the individual strategies with which to cope.

Focusing service provision on risk avoidance has implications for the quality of care for patients. For example, there is much more concentration on security than therapeutic aspects of care, a situation that has been criticised over the years (Blom-Cooper 1992; Prins 1993). Forensic psychiatry as a fledgling specialty copied the wider psychiatry field and concentrated more on process measurements - (admission and re-admission rates, re-offending rates, bed turnover, length of stay etc).

3.8.3 Psychometrics of Outcome Measures

Measurement problems are rife when attempting measures of outcomes. According to Bowling (1992 p14), authors of various measures often make claims for reliability and validity based on achieved coefficients without any reference to acceptable levels. She criticised this practice by arguing that acceptable levels for validity and reliability range from 0.85 to 0.94 while 0.50 is regarded as acceptable for correlation coefficients. This suggests that some of these measures may not always be reliable or valid. This situation put into the forensic sector would make prediction a lot more unsound as staff could be relying on instruments that could be flawed. Validity is concerned with the degree to which the measure measures the underlying attributes. Validity has a number of specific aspects including face and content validity which is concerned with the selection and wording of items and how well they represent the aims of the instrument and what it is intended to measure. They are generally assessed by asking potential respondents or expert panels to judge the appropriateness and relevance of items. It is possible that because of the lack of agreed definitions of health it may be difficult to assess this for generic health status instruments. Another aspect of validity is that of criterion or construct, and it relates to process of comparing an instrument with a standard. Other measures of validity include predictive validity.

Reliability of the measure relates to the rate at which the measure repeatedly produces the same results when applied to the same subjects at different time periods. The use of "test-retest" method is one of its measures. This involves administering the instrument on two occasions with an independent check that no change has occurred. Tests of reliability depend on the measure of internal consistency, that is the degree to which items in a domain inter-correlated.

Measure of sensitivity is another factor that needs to be considered when outcome measures are being developed. Stewart (1992 p.478) agrees that sensitivity is "the instrument's ability to detect clinically important change". This measure of responsiveness is critical for experimental studies because of its direct connection to the power of the statistical test used. Lipsey (1990)

contends that the more sensitive the outcome measure is to the intervention, the larger its effect will be, resulting in greater power of the statistical test used. Intervention studies may some time fail to detect significant difference between the means of the experimental and controlled groups for a variety of reasons. Lipsey (ibid) thought these may be due to an insufficiently strong operationalisation of the intervention, too small a sample size to produce a statistically significant effect, too much heterogeneity with each group on the dependent variable, inadequate power of the statistical analysis employed, an ineffective intervention and lack of sensitivity of the measure of the outcome variable.

Mervin and Mauck (ibid 1995) argued that the selection of what to study, developing and using an existing conceptual model, measuring the process of care and developing or using reliable and valid instruments are major methodological issues facing outcomes researchers. Gournay (1997) had argued that the role of randomised control trials (RCTs) could not be overlooked in selecting the method that is best in enhancing a greater degree of attribution. Wells and Brooks (1989 p203) suggests that the problem selected should be relevant, have the potential for improvement and should commonly occur. They further concluded that most researchers within mental health services select their study population based on diagnosis, symptoms, specific clinical management problems and the provision of specific services.

Different practitioners prefer different theoretical approaches to assess effectiveness of their interventions. Van Servellen et al (1992 p118) identified the problems this can cause in terms of replication of the study and cautioned that poor operational definition of the intervention can cause poor understanding compounding the difficulty of measurement. As discussed earlier measurement raises issues of validity and reliability of instruments. Russell and Buckwalter (1991 p77) considered this and recommended the use of multi trait or dimensional and multi-method approach to the identification of outcomes to avoid systemic bias. Sensitivity to change as a criterion for selection of outcome measures has also been recommended as a means of linking the conceptual model's variables with the intervention

(Stewart and Archbold 1992 p477). They also called for complexity in research design in order to capture all the complex consequences of mental ill health.

Another concern for measuring effectiveness of interventions in the psychiatric sector and indeed in the forensic sector is that of the need to capture all aspects of the individual's care, including that of culture. The growth of research in cross-cultural psychiatry and psychology has provided another dimension for investigation. Flaherty et al (1988 p257) and Marsella (1978) called for a change in design of instruments to capture the needs of cultures. Marsella, for example called for compilation of a detailed description based on observation of the variable in each culture under study and advocated for construction of a single instrument that validly and reliably measures the variable in each culture. Flaherty (ibid) argued thus, while this method appears theoretically sound and feasible for the study of specific, distinct variables, it often proves unwieldy for multivariate studies. They call for careful review of the literature to identify instruments that are suitable and are proven to have been able to measure constructs across the cultures, psychometrically sound and are tested in the cultures, and instruments that have a high face validity. They identified five key dimensions that should be considered as taxonomy for developing culturally sensitive instruments should a new instrument be preferred. These are:

Content equivalence	The content of each item of the instrument is relevant to the phenomena of each culture being studied
Semantic equivalence	The meaning of each item is the same in each culture after translation into the language and idiom of each language
Technical equivalence	The method of assessment is comparable with the data it yields.
Criterion equivalence	The interpretation of the measurement of the variable remains the same when compared with the norm for each culture.

Conceptual equivalence The instrument is measuring the same theoretical construct in each culture.

Flaherty and his colleagues concluded there should be this degree of thoroughness in developing culturally sensitive instruments for measuring outcomes or effectiveness of service provision. But lamented that there is no such rigor being employed in developing complex instruments when large variables are being developed as most research instruments are just transported from one culture to the next without further attempt at "cultural validation".

3.9 Introduction

Ideally, the primary reason for human service organisations' existence is effective service delivery. There is however no consensus regarding causes of effective service outcomes. On one hand, Quinn (1988) suggests that effectiveness results from maintaining a high balance among competing values, while on the other hand, Barnejee (1995 p33) believes that it takes a diverse, trained and satisfied workforce. Somewhere in the middle, there is a view that asserts that effectiveness result from emphasis on client-centredness and service outcomes.

The focus in the NHS is on improving clinical outcomes. Assuming that each of these approaches are right in part, it follows that in the search for any effectiveness measure, attention needs to be paid to examining the multivariate relationships among these variable, i.e. effectiveness, job satisfaction, client-centredness, clinical and service outcomes. Equally it is true that the balance of these variables is not static. For example, the desired outcomes for community support might be different to that which is needed in hospital settings.

Methodologically, most of the studies are qualitative and did not use any advanced statistical analyses, although the field of study is so complex. Outcome measurement entails the measurement of the effectiveness of care. As discussed earlier, there is a strong case for arguing that it should include all aspects of the person and the effects of the total service on the individual. Traditionally, outcome measures have concentrated on mortality and in more recent times on morbidity and quality of life issues. The literature is therefore littered with research on needs assessment, health status measurement, functional measurement scales and many others. It is perhaps not widely accepted that they all contribute to outcomes evaluation.

In the forensic psychiatric sector most of the measures used tend to be concerned with the effects of medication on the individual. There is an argument that while the mental illness of the individual may have been treated or controlled with drugs, the pre morbid personality may be prone to propensity to criminal behaviour. The measure of effectiveness of care after an individual have experienced the forensic psychiatric sector should take into account the interface with the law but not to the extent that the clinical aspects become overshadowed by legal imperatives. Focusing solely on the treatment of the 'medical' condition too, which is the mental illness may have excluded other relevant factors. Another view is if the mental illness can be treated, there is no further need for the individual to be kept in hospital. There should therefore be the option to return the individual to serve the sentence for the crime in prison and then to be discharged from there.

Most of the hospitals and units within the sector rely on the Mental Health Review Tribunal (a board of case reviewers which is composed of medical, lay person and under the chairmanship of a judge) to discharge patients. They seem to accept the fact that their responsibilities should end when the tribunal makes the judgement based on the facts presented to it by the professional staff, the Home Office and the patient's advocate (lawyer) and the patient. This approach can be said to be shifting responsibility as providers have the expertise for the treatment of people who have a mental condition to be treated and so should take a much more positive stance. All these factors are pointing to the necessity of development of effective outcome measures as they could contribute to presentation of the case of the patient on a more scientific basis.

There is difficulty in defining need, which will have universal appeal and whose definition to take, similarly there is lack of agreement on what constitute effective and successful care or service pathways for patients. There is also a problem with definition and of classification of mental illness, which in turn makes it difficult for practitioners to be precise about the needs of distinct groups and of conditions they suffer from. Other issues to consider are the mental health legislation and its impact, the research agenda and how

the inputs into service provision could be linked with effectiveness measures. There is also the need to define the objectives of the health intervention, therefore making measurement of outcomes much more rigorous.

The lack of standards for much of the work encountered makes it difficult to decide what methodological advice to take. It is clear that where these studies take clinical trials model it provides a set of guidelines for research and experimental settings, but most outcomes work takes place in more mundane and uncontrollable settings of routine service delivery. The difficulty of identifying and choosing validated outcomes measures is a key problem within mental health. In forensic psychiatry it is non-existent as there is no appropriate and agreed measures and there is no "gold standard" from which to start. The work and the knowledge base needs to be built from the bottom and progressively advanced forward.

3.9.1 Summary of the literature

The literature relating to outcome measures have proliferated over the last decade, although measures of forensic psychiatric care have been absent. Within the general context of mental health, measures in use fall into the following category:

I. Condition specific clinical or functional outcomes - measures that demonstrate changes in the clinical condition of the patient.

II. Functional outcomes suitable for a variety of disorders - mental health status measures, measuring changes in the basic activities of daily living (ADL) or instrumental activities of daily living

III. Mental health status measures - social adjustment, dependency/independence, role effectiveness and interpersonal functioning.

IV. Comprehensive functional measures or global health status measures

There is also a lack of consistency in defining health, which has made it problematic for researchers to develop appropriate measures to ascertain health gain. However a general definition of outcomes measures has emerged from this literature review. The view is that outcomes, in general are results (effects) of processes and therefore the end result of interventions by health care practitioners into the problems identified through assessment of the patient. The main element for this approach is that the intervention should be attributable to the success or lack of change in the condition being treated. Sadly, this crucial issue of attribution is too often overlooked. Health outcomes are the effects on health of any type of health services but the total impact on the individual by healthcare practitioners' intervention extends beyond the health domain, more so for the mentally disordered offender.

For mentally disordered offenders this search should include specific clinical interventions, but so will other areas such as housing, social services and employment, cultural aspects and includes canvassing the views of the patient. They may refer to the outcome for an individual or for groups of people such as the local community or a wider population. As discussed earlier, the evaluation of health care effectiveness has been given increasing attention in clinical practice and there is growing recognition that the ability to measure outcomes of care is required in addition to the evaluation of process.

The question of methods and study designs, are issues that are of paramount concern and debate within the professions. There is a view that studies adopting qualitative methods in design are less favoured within the NHS, consequently most health services research tend to adopt the experimental model. According to Sheldon et al (1993), it is recommendable to conduct reviews by developing a hierarchy of evidence that can distinguish between study designs according to their susceptibility to bias. Sheldon and colleagues argued that Randomised Controlled Trials (RCTs) are more reliable than non-RCTs. That well designed experimental studies are more reliable than observational (epidemiological) studies when evaluating the effectiveness of interventions because of the greater control over the study variables and

confounding factors. This view has raised methodological issues for this type of research in the NHS, which is further, developed in Chapter Four.

In conclusion, this chapter has provided a review of the knowledge relating to outcomes measures and summed up the key issues in the literature impacting on their development within forensic mental health services. These issues range from the policy framework to the call by users to be included in the planning and evaluation of the care they receive. It is clear for this research that the main issues that need to be taken into account have to be the type and appropriateness of the methods to take in collecting the data and the clear and daunting challenge posed by the aim to develop a consensus for action coupled with the theoretical and conceptual framework necessary to achieve the objectives of this research.

3.9.3 Aims and objectives of the research

The care of people who have committed an offence but are judged to have done so as a result of suffering a mental disorder is fragmented. This has resulted in poor quality of care. This assertion is supported by government reports on tragedies within and outside the service that catalogue the poor quality of care, (Blom Cooper 1992, Crichton 1995, Prins 1993). Key among the plethora of reasons for these tragedies tends to be poor co-operation, communication and co-ordination of services across agencies concerned with provision of care. The **overall aim** of the research is to identify effectiveness measures in use within the service, assess their potential for measuring experiences of patients and where no such a measure exists draw the views of key stakeholders of forensic mental health care together to develop a consensus of opinions on the areas to prioritise for future development as outcomes measures. The focus of the research is to achieve this consensus where no relevant measures of outcomes were identified within the service. This aim was achieved through the following guiding principles:

I. Establishment of the extent of use of effectiveness measures within the service.

II. Establish the consistency of use of selected effectiveness measures within the service and their relevance to ensuring appropriate care.

III. Identify the degree of satisfaction with the current measures of effectiveness of care.

IV. Draw together the views of users, NHS staff and Service regulators on what in their opinion measures of outcomes of care should be.

V. Present the findings to a consensus development conference in order to seek agreement on key areas to develop as outcomes measures.

Given the complexity of the area researched the purpose and direction of the research was clarified to both the researched and their managers. In considering this point the need to specify the research question became paramount. The question was formulated so that it could identify activity levels in the way outcomes measures were employed in the service, to canvass the views of service stakeholders on the usefulness of the measures and the process to adopt in working towards a consistent approach to the development of areas that might arise as a result of the research. These considerations led to the broad formulation of the research question as thus:

What interventions of health, social, psychological and cultural in nature have been shown to be effective in measuring or influencing outcomes of care, and how could the unidentified areas be developed to achieve consensus for implementation?

Mental ill health is a complex and problematic area in which to assess effectiveness and as such the answers to this question need to take into account not only the health dimension but also many others.

3.9.4 The research hypothesis

Given the aims and objectives of the research, the literature relating to outcomes measures and the problems associated with the present system for care delivery, it was assumed that care that is being provided presently would not have any measures of outcomes to determine its effectiveness. The need

to secure a consensus within the service to develop outcomes measures therefore is of paramount importance to this research. The hypothesis to be tested is as follows:

Achieving consensus on priorities to develop as outcomes measures is a problematic undertaking and will not be achieved given the diversity of stakeholder needs and interests.

3.9.5 Key research questions

The following specific questions resulted from the clarification of the broad question for the research and helped in selecting the methods used in collecting data.

I. How do staff who work in these organisations determine what constitute effective and appropriate service?

II. What are the main effectiveness measures in use in the service at present and how satisfactory are they?

III. What is the level of satisfaction with the present system of care delivery from the perspectives of patients, providers and commissioners?

IV. To what extent are behaviours consistent in promoting pluralism in the way services and care intentions are communicated to patients and staff?

V. What are the expectations of patients before and during their progress through the service?

VI. Is there a consensus of views and priorities be obtained to facilitate the development of outcomes measures?

VII. What is the level of consensus for the areas identified through the consensus building process for future development?

VIII. What are the implications for the development of outcomes measures following this research?

PART THREE

RESEARCH DESIGN AND METHODOLOGY

CHAPTER FOUR

Introduction

Philosophical assumptions in social research

Theoretical perspective

Management research and the Health Service

A discussion on randomised control trials

Forensic psychiatry, structuration theory and outcomes

Defining stakeholders

Conclusion

CHAPTER FOUR: RESEARCH DESIGN AND METHODOLOGY

4. Introduction

This chapter outlines the general thinking underlying the overall approach to the research. It reviews the "scientific discipline" and its pursuit of "truth", and discusses research methods used in the mixed context of management within the health service. It also discusses the general assumptions underpinning research in the social sciences and focuses on the key debate relating to research methodology and will compare the main approaches to conducting research both from the positivistic and phenomenological perspectives. It will further discuss both the quantitative and qualitative approaches, drawing together the main differences and their relevance to conducting research in the social sciences. Finally this chapter will identify and discuss the theoretical base and its contribution to the research and will draw on an analytical framework for identifying stakeholders of forensic care. Specifically, this chapter is concerned with:

I. Discussion of the main philosophical base for research in the social sciences

II. Providing a short description of the basic assumptions that underpin social science research

III. Discussion of the quantitative and qualitative methods

IV. Comparing the deductive and inductive approaches in theory generation

V. Exploration of the role of theory in research generally and in particular the role it played during the process of this research

VI. Discussion of the lessons learnt as a result of using these methods.

In considering the nature of research, it could be discussed as a systematic investigation into and study of materials, sources and so on, in order to establish

facts and reach new conclusions. It is also an endeavour to discover new or collate old facts etc, by scientific study of a subject or by a course of critical investigation. Consequently, research may be simply defined as "fact-gathering" in a certain manner. This search for the facts depends on the curiosity of the mind in ascertaining the purpose of existence. As for the matter of existence, one is inclined to recognise one's existence through the process of recognising others existence in reality. When one realises others and commits oneself to being a member of others, the concept of "we" could be established. By the application of this reasoning a conclusion could be reached on recognising many other "we" and beyond. This argument stands for two important polaristic assumptions based on epistemology and ontology, in terms of how we perceive the world and how we perceive knowledge. It also involves reasoning logic, for example induction and deduction.

The development of science, leading to the "Scientific Revolution" of the 17th century, had contributed to establishing the distinctiveness of western civilisation. The adoption of the scientific method has contributed significantly to enrich the way of finding facts and relationships amongst each other. Science was a start of western civilisation in recent history and the way of conducting science had strongly dictated the way of thinking and recognising "the matter of existence" and of the "truth". Checkland (1981 p51) described three distinct domains within which research activity is practiced. These are reductionism, repeatability and refutation. The power of observation was one of the most fundamental disciplines of western science and has been further refined by "reductionism". However, reductionism was to be complemented with repeatability or generalisability by which scientific results should be testified and reproduced. Repeatability provides the measurement criterion of science.

4.1 Philosophical assumptions in social research

Research approaches employed by social scientists are based on interrelated sets of assumptions regarding epistemology (the essence of things), ontology (the theory or science of the method or grounds of knowledge) and human nature. All of which have implications for methodology and also reflect different worldviews (Burrell & Morgan 1979; Morgan & Smircich 1980). Morgan and Smircich (1980) have developed a framework for overviewing the way these interrelate with different research methods (see Figure 4.1 below). It is asserted here that the different assumptions regarding ontology and human nature, and the different worldviews they reflect leads to the belief that the grounds for knowledge may have to be different. The differences; hence the epistemological debate, are between the subjective and objective philosophies which are at the opposite and extreme ends of the same continuum (Figure 4.1).

According to Easterby-Smith et al (1996; p.22), there is a long standing debate in the social sciences about the most appropriate philosophical position from which methods should be derived. They identified positivism (objectivist approach) and phenomenology (subjectivist approach) as the position from where these debates are being generated. They argued further that over recent years there has been a noticeable shift towards phenomenology but observed that management research has adopted a more pragmatist approach by combining methods from both areas, which is the approach taken in conducting this research.

The approach taken in management research is further supported by Gill and Johnson who argued that the choice of approaches that is based solely on either one or the other, that is, between the subjectivist (ideographic) and objectivist (nomothetic) approaches is fundamentally flawed (Gill & Johnson 1991 p.127). They went as far as suggesting a 'methodologically pluralist' position; drawing support from the works of Troy who advocated for a creation of 'a kit of tools' by researchers

with which they can turn, to find methods and techniques most useful to the problems at hand (Troy 1957; p.33).

Figure 4:1 Network of basic assumptions characterising the subjective - objective debate within social science

Subjectivist Approaches to Social Science ⟷						**Objectivist Approaches to Social Sciences**
Core Ontological Assumptions	Reality as a projection of human imagination	Reality as a Social Construction	Reality as a Realm of Symbolic discourse	Reality as a contextual field of information	Reality as a concrete process	Reality as a concrete structure
Assumptions about human nature	Man as pure spirit, consciousness, being	Man as an social construct or, the symbol creator	Man as an actor, the symbol user	Man as an information processor	Man as an adapter	Man as a responder
Basic Epistemolo-gical stance	To obtain phenomenol-gical insight, revelation	To understand how social reality is created	To understand patterns of symbolic discourse	To map contexts	To study systems, process, change	To construct A positivist science
Some favoured metaphors	Transcendental	Language game, acccompli-shment, text	Theatre, Culture	Cybernetic	Organism	Machine
Research Methods	Exploration or pure subjectivity	Hermeneu-tics	Symbolic analysis	Contextual analysis of Gestalt	Historical analysis	Lab experiments Surveys

Adapted from Morgan & Smircich (1980 pp492)

Central to the criticism of quantitative methodologies is the focus on measurement, which can be said to have the potential for screening out interpretation. While the quantitative method appears to focus on developing predictions and controls, the qualitative methodologies focus on interpretation and the relationship between the

researcher and the researched. It can be seen from this short debate that there is no fixed point or truth but rather an attempt to capture peoples' experiences as they exist within a particular time frame. Gill and Johnson likened this debate to a heuristic device that could allow the researcher to differentiate between various methods in terms of their relative emphasis upon deduction and induction, their degree of structure, the kind of data they generate and the forms of explanation they create (Gill and Johnson 1991 p 36).

Figure 4.2 Qualitative versus quantitative methods - a comparison

QUANTITATIVE APPROACH	QUALITAIVE APPROACH
Test Hypothesis	Capture and discover meaning - immersion
Concepts as variables, focus on facts	Concepts in the form of themes, motifs, taxonomies and generalisations
Measures decided before data is collected	Measures adhoc - specific to setting and researcher
Coding is numerical, controlled observations, measurements	Data in the form of documents, transcripts, archives
Theory - causal, deductive, ungrounded, verification oriented	Theory (non-causal) grounded, discovery oriented exploratory and often inductive
Procedures: standard, reliability, critical. Data replicable	Procedures - particular, process oriented replication rare
Analysis: tables, statistics, graphs, Organisation of data to present a hypothesis. Evidence based.	Analysis: extraction of themes from Charts. Show relationship with coherent holistic picture
Data generalisable by sample population	Data generalisable with the context of the subject.

Figure 4.2 is based on a review of the writings of various scholars about the two philosophical standpoints (Eastersby-Smith et all 1996; Gill & Johnson 1991; Burrell & Morgan 1979). Positivism holds the idea that the social world exists externally, "out there", just like the natural world therefore its properties should be measured

through objective methods excluding any tendencies for inferring subjectively through sensation, reflection or intuition grounded in observation and experience. Some positivistic views about research are that the social sciences must follow the hypothetico-deductive methodology - such as the natural sciences with equal success. They believe knowledge and the explanations should be the same as that for natural sciences. For example, if A causes B then variation in A causes variation in B and that stimulus in A causes response in B. They argue further that human perception can influence this process somehow but the central argument is that human responses to situations can be determined by certain rules building on the view that explanations of social phenomena are relatively worthless. Positivists hold the view that the social world should be treated as the natural world.

According to Easterby et al (1991 pp 22-23), the nineteenth century French philosopher, Auguste Comte was an early and influential proponent of this view. They quoted Comte as saying "all good intellects have repeated, since Bacon's time, that there can be no real knowledge but that which is based on facts", therefore supporting the positivist position. This statement has two assumptions, that reality is external and objective; secondly, that knowledge is only of significance if it is based on observations of the external reality.

The implications that flow from this according to Easterby and colleagues, are that the researcher is an independent observer studying a phenomenon which is determined by an objective criteria and the aim of social science should be to identify causal explanations and laws that explain the behaviour. They added further that any investigation within positivism should proceed through the hypothetico-deductive framework starting with the development of a hypothesis, operationalisation of the concepts in a way which enables the facts to be measured quantitatively and to the breakdown of the problem into its simplest elements. They advocated for a selection of sufficient samples in order that generalisations could be made.

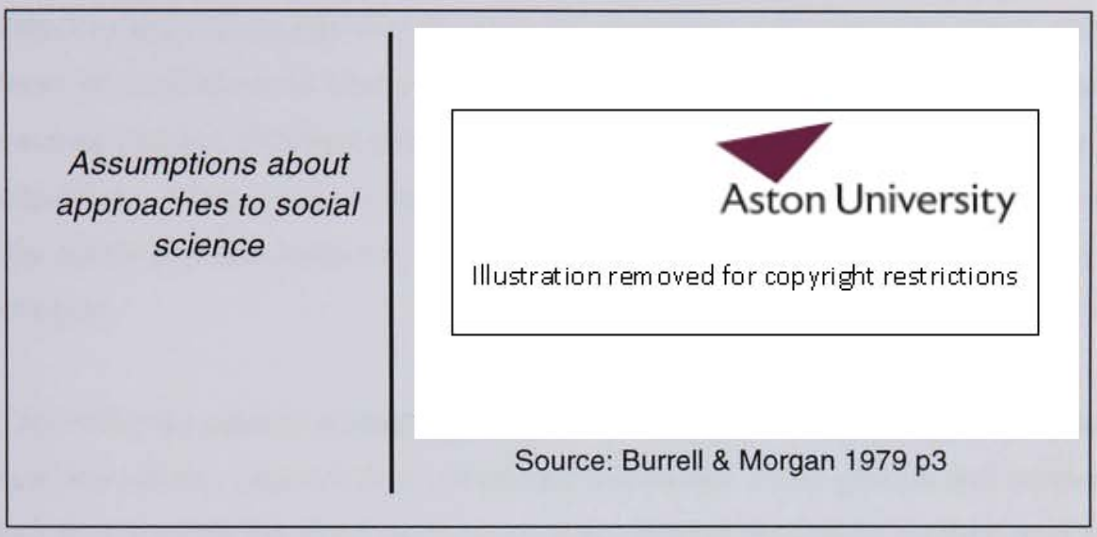
Conversely, subjectivist view on social research can be defined as an interpretative study of a special issue or problem where the researcher is central to the sense that is made. The focus is on human experience and therefore the subjectivities of people's realities. Subjectivism views reality as a social construction, which is embedded in the nature and use of language, labels, actions and routines - a symbolic construction. They oppose the process of acquiring knowledge with its explanation as advocated by posivitism. Subjectivism advances the belief that acquisition of knowledge starts with a stimulus. This stimulus is then interpreted as a consequence of previous experience, followed by a response or action. This view clearly supports the epistemological standpoint of phenomenology as it stresses the importance of understanding the process through which human beings relate with the natural world. Obviously this perspective diametrically opposes the existence of "objective" knowledge; relying on the belief that all knowledge is just an expression of the researcher's interpretation of the frame of reference the individual imposes on his or her world.

The subjective perspective starts from the point of view that reality is a social construction, therefore the social scientist should gather facts and measure how things occur. They advocate the use of the inductive approach by which explanations are developed by moving from the particular to the general and from observations to theory. The basic principle is to try to see to what more inclusive set of phenomena the observation might belong. Inductive reasoning focuses on human subjectivity, observed within the natural settings of the individual and the method of inquiry is largely process-oriented questions.

Figure 4.3 depicts the different assumptions relating to ontology and human nature pose as problems of epistemology. It has been argued earlier that they both pose a difficulty in that they are a source of two different bases of knowledge. Clearly, as one moves from assumption to assumption on the subjective - objective continuum the nature of what knowledge is changes. This viewpoint builds on the assertion that different ontologies, epistemologies and models of human nature are likely to incline

social scientists towards different methodologies (Burrell & Morgan 1979 p 3). Burrell and his colleagues offered a schematic representation for analysing assumptions about the nature of social sciences which illuminates further the understanding of the subjective - objective dimension.

Figure 4.3: The subjective - objective dimension



Source: Burrell & Morgan 1979 p3

Because of the way each discipline seems to be discussing what "reality" is, which moves progressively towards the opposite ends of the continuum (see Figure 4.1), knowledge acquired by any researcher using either one or the other paradigm will be different and largely uncomplimentary to each other.

4.2 Theoretical perspective

The ontological assumption adopted by the researcher is that reality is a social construction and mediated by man as a social constructor; man is therefore the symbol maker and the focus for production of knowledge for the research. The sum of the knowledge that is derived from the data of this research is a collection of the realities of the individual's understanding of their world - the world of forensic psychiatry. The basic epistemological stance is to understand how that social reality is created, changed and interpreted by individuals through their use of language,

social activities in which they are engaged, their accomplishments and expectations et cetera, within the context of measuring effectiveness or developing outcome measures. The approach taken in this research in collecting data is by triangulating methods, using a multi-method approach mainly from the ideographic and to a lesser extent nomothetic perspectives to ensure a high degree of rigour to the findings of the research. It is important to discuss this theoretical perspective in order to enable the development of a set of assumptions about the way effectiveness measures are, or could be developed and operationalised within the forensic mental health sector and the study of the rules that specify how these causes interact. Giddens structuration theory provided the best fit given the objectives of the research and the need to ensure that the researched play a part in the conduct of this research. The structuration theory is further discussed in this chapter.

The methods used in collecting data for this research are rapid appraisal, survey questionnaires, case studies, structured interviews, focus groups and consensus building through the application of an adaptation of the Delphi method and expert panel under the overall umbrella of hermeneutical approach (See Figure 4.2). These methods are discussed and the results gained through their application are discussed further in the next seven chapters. The adoption of this "mixed bag" of methods is designed to provide a degree of rigour to the finding and conclusions of the research; a process of triangulation which it is hoped would strengthen the findings of the research.

The researcher will attempt to deal with the question of outcomes measurement within forensic psychiatry by drawing on a theoretical framework of sociology. This approach is designed to provide meaning to the way outcomes research can either be impeded or advanced within a service which is notorious for its reluctance to involve patients in planning, implementing and evaluating care. This search of pluralism, it is argued, is the mainstay of outcomes research and its measurement in the service. The choice of the type of theoretical framework for this research was

influenced by the events in the past where any theoretical explanation of the field had assumed that fractured stance between service providers and users of the service, which has failed to adequately deal with the issues inherent in the field. Giddens theory of structuration provides the medium through which to assess this pluralism and was also used to collect and analyse the data derived from the case studies (Chapter 9 & 10).

4.2.1 The theory of structuration - an explanation

Giddens' theory of structuration (1976, 1977 and 1986) provides a medium for explaining the symbolic properties of the field of this research, particularly the organisations, which were the case study field sites (Chapter 9 & 10). The approach adopted to explain this phenomena is ontological rather than epistemological, in that it provides the researcher the opportunity to construct new "ways of knowing" or knowledge. Giddens (1982) provided an explanation to his structuration theory by stating its purpose as:

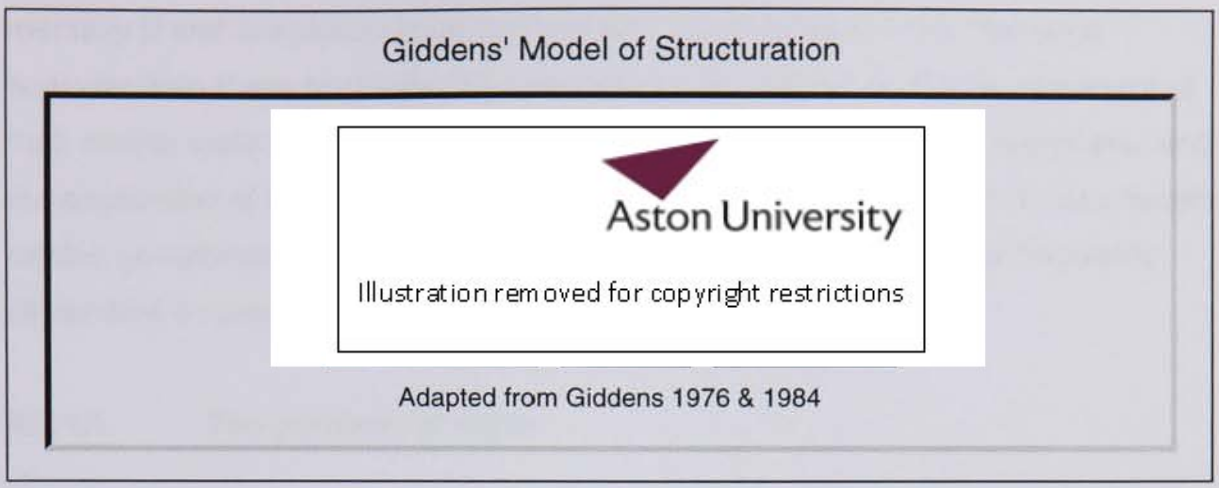
> *"....analysing the structuration of social systems means studying the modes in which systems, grounded in the knowledgeable activities of situated actors who draw upon the rules and resources in the diversity of action contexts, are produced and reproduced in interaction." (p.25).*

Giddens argued consequently that, social structures are both constituted by human agency (action), and yet at the same time are the very medium of this constitution (Giddens 1977 p121). Giddens' (1979 and 1984) work on structuration is best understood as a method for articulating a process oriented theory which treats structure as a product of and as a constraint on human behaviour. He provided the bridge that links the tenets of deterministic, objective and static notions of structure to that of voluntaristic, subjective and dynamic views by identifying the two key constituents language; grammar and speech and how the two entities interrelate.

Figure 4.4 represents Giddens' explanation of the institution, which is made up of structural principles of systems of signification, domination and legitimation. The structure of signification is described as "all types of rules that are drawn upon as interpretive schemes to make sense of what actors say and do, and of the cultural objects they produce" (Giddens 1977 p134). The 'exercise of power' relates to the fair distribution of resources, and it results in the structure of domination. He considered resources in two parts; authoritative which comes from the co-ordination of activities of human agents and allocative, which is the way control (power) of the materials is exercised. Giddens defined power as having 'transformative capacity' and added that this is communicated through the modality of 'facility' which relates to the resources that actors call upon to change or influence the actions of others. The "evaluation of judgement and conduct" is said to find its medium of expression through the structure of legitimation, which arises from the different aspects of action, norms and rules. This is further enacted through the use of sanction and rewards.

Realm of action refers to actual arrangements of people, objects and events in the social life of the organisation. This deals with the way people communicate, enact power and their methods of determining what acts to sanction or reward. Institutions can inform ongoing action only to the degree that their parameters are encoded in an actor's stock of practical knowledge, which consists of interpretive schemes, resources, and norms adapted to a particular interactional setting. Giddens called these elements of practical knowledge "modalities" and they constitute the scripts that prescribe appropriate behaviours and perceptions. The structure of signification is produced by and enables people to communicate meaning with each other.

Figure 4.4 A Model of Structuration



In structuration theory 'structure' is regarded as rules or 'codes of signification, and resources 'authoritative and allocative' which recursively are involved in the reproduction of social systems. According to Giddens, human social activities are seen to be continually 'recreated by social actors via the means whereby they express themselves as actors' (Giddens 1986 p2). Structuration occurs when the rules and resources of the social system 'institution' are produced and reproduced. There are three elements involved in the production and reproduction of the social system, these are, the communication of meaning, the exercise of power and the evaluation and judgement of conduct (Giddens 1986 p24; Figure 4.4).

Giddens has proclaimed as one of his aims to be the goal of "deconstructing those theoretical formulations, which claim to reveal some overarching historical law operating behind the backs of historically situated actors". The key phrase that can be said to be the launching pad of Giddens point for his "deconstructive" endeavours is:

"men make history, but not in circumstances of their own choosing"

A situation that could be likened to that experienced by forensic patients within secure units. They commit a crime or demonstrate extremes of behaviour while mentally ill and are placed in secure hospitals for treatment. Their discharge however from these hospitals does not necessarily depend on the improvement of their mental state but on much wider considerations such as feeling remorseful and the application of the test for public safety by the Home Office, which is not a health related government department. The behaviour of the Home Office is frequently dependent on political considerations.

4.2.1.1 The problem of order

Introducing Giddens' work Cassell (1993 p8) advanced the notion that " those who inquire into the question of how it is that society is ordered, rather than in a state of disorder, are driven, whether explicitly or implicitly to reflect upon the very nature of social life of its various ingredients and modes of operation". Cassell wondered how the patterning or recursive nature of social practice as advocated by Giddens could be explained and advanced the view that the three most important ingredients involved in the enactment of social practice are the production of meaningful communication; power and morality.

Cassell (1993 ibid) criticised this apparent order because of its lack of consistency in safeguarding the rules of the natural sciences as applied to the social sciences. He argued that the social world is shaped by the individual who constitutes its basic unit of life, adding that the social order therefore arise readily through the self-seeking activities of free-willed individuals who deliberately by their actions secure order through some sort of contractual arrangement or pact. This declaration would have provided theorists with conflict, if judged against the one that is projected by the natural world. This view accepts the notion that the social world is made up of the same material as the natural world and any form of tools that is used in studying the natural world is therefore applicable. The theory of structuration rejects the "centrifugal" images of the workings of the social world, arguing that how come that

human beings who are anti-social beings come to accept the burden of living in an ordered society. Giddens' theory begins with the assumption that there is a generalised attachment on the part of actors to the routinised character of social life. To illustrate his position he chose the basic unit of analysis as a recursive social practice i.e. the daily trip to work on the train etc. and how the recurrent nature of social practices could be explained.

4.2.1.2 Meaning, Power, Action and Structure

Social practices are organised through the medium of language. Giddens argued that for language to work, speakers must be able to fill in the gaps and deal with the ambiguities that are associated with language use. To do this, actors must skillfully and creatively mobilise the "stocks of knowledge" they hold in common with other language users. Central to this insight is that in order to enact a social practice, participants must necessarily draw on a set of rules. These rules are designed to give shape to the practices that they help to organise. Giddens' work does not support the view that everything anyone does (action) is governed by rules. He defended this notion by arguing that people sometimes engage in tricky business of "trying on" particular formulae to see if they fit. He argued that there will be situations where there will be no readily defined rules to deal with the social situation. Actors or people will have to make do with the best use of the rule based knowledge they possess in order to respond appropriately. He concluded that keeping social practices afloat requires the active involvement of skilled actors, but these actors in turn depend on the structuring properties of rules. A duality that incorporates "action" and what Giddens calls "structure" i.e. the rules that structure action - is therefore a necessary conjecture for the explanation of the enactment of social practice.

Structuration theory holds the belief that when social practices are enacted, more is involved than the communication of meaning (language) and following of the moral norms. Cassell (1993 p11) supports Giddens' views and summed this up by saying

that social practices involve actions that "make a difference" to the world in some way, no matter how small. Agents, that is those who are able to effect change, must possess appropriate resources in order to do so. He added that the transformations of nature and the deployment of persons that accompanies it are inconceivable without human access to power and the resources that must facilitate it. To explain how patterning of social life is enacted, Cassell introduced the notion of analysing the relationship between agents (managers) and workers (staff) and service users. The agents on behalf of owners of the organisation buying skills from workers and is regulated by the rules, i.e. workers sell skills and expertise for monetary rewards and in turn agents should provide the capital investment (in labour, equipment, research and training) that can generate benefit to satisfy stakeholders. The question of who the stakeholders of forensic mental health are and how they could be engaged is explored further later on in this chapter.

4.2.1.3 The duality of structure

The reproduction of structure is what Giddens calls "duality of structure". This is evident when structure and action are joined together, thereby creating "patterning" practices across time and space. Giddens sought to illustrate this duality of structure through the use of language. He argued that an actor (speaker) draws on an "absent corpus" of syntactic and semantic rules in order to make meaning of what is being said. Giddens went on to say that these structural features of the language are the medium through which utterances are generated thereby enabling the language to survive. This duality of structure is shown in its two-sided existence - both as the medium and unintended outcome, on which agents draw on rules in the enactment of social practices. Agents consequently have the capacity to modify the "rule". In understanding how this pluralism or consensus could be achieved, a discussion of a theoretical approach to identifying stakeholders of the service, drawing mainly on the work of Mitroff (1983) will be made (see chapter 5). The argument is made that, stakeholder analysis can help planners of the service to involve users of the service better than at present by identifying these groups and

making assumptions about their behaviour or responses to policy that affects them during its formulation stages. In the meantime the researcher's attention is focused on discussing how the preceding discussion impact on management and health service research.

4.3 Management research and the health service

Giddens (1984), argued that institutional activity is related to behaviours exhibited by individuals within the organisation. This dualism between "action" and the "system" needs to be overcome before an active collaboration between the manager and the managed could be achieved. Wilmott (1987 p249) strongly criticised this separation by upholding the evidence that empirical studies of managerial work have revealed a degree of disregard of bridging the gap between the "behavioural" and "institutional" accounts of managerial work. However Harvey-Jones (1989 p240), advocated separation of content from process when managers are setting about tasks, that is to say that there is a need for distinguishing conceptually the content (what job) from the process (how the job is accomplished). Management research is said to be in a state of fragmentation and in a field characterised by a high degree of task uncertainty and a low degree of co-ordination of research procedures and strategies between researchers (Whitley 1984). This view is further supported by Jill and Johnson who pointed out that there is a wide variations in the quality of management publications, the multiplicity of validation standards and the variety of recipients of research findings in management (Gill et al 1991 p2). They explained further that this is attributable to the multi-disciplinary nature of management as a field of study and differences in disciplinary backgrounds of management researchers. In the health sector management embraces professional groups such as medicine, psychology, economy, nursing, epidemiology and many others who bring to understanding and explanation of problems in the service different philosophical and epistemological perspectives.

Broadly, health and health services research provides reliable and valid data on which appropriate, cost-effective, efficient, and acceptable treatment, care or management of an individual patient's condition is based. The Medical Research Council defines health services research as the identification of the health care needs of communities and the study of provision, effectiveness and use of health services (Clarke and Kurinczuk 1992 p1675). Health service research is therefore about the assessment of quality and effectiveness of interventions of service provision as much as it is about assessing health need. Obviously the aim of health service research is a systematic and rigorous process of enquiry designed to develop explanatory concepts and theories for any health care problem. Ultimately the information collected adds to and contributes to the scientific knowledge that can be replicated.

The conduct of health service research is multi-disciplinary and involves various multi-professional groups within the health service itself and other related disciplines such as managers, health professionals, policy analysts, statisticians, epidemiologists, health economists, et cetera. This means that research into the health and health services would invariably employ an array of methods to assess the effectiveness of any interventions. This may involve the use of methods within the natural and social sciences. The consequences of these multi-disciplinary activities mean that there is a great potential for enriching the quality of health and health care research. Despite this rich environment for research, the tendency is an overemphasis on the use of the experimental or quasi-experimental method, particularly that of randomised controlled trials (RCTs). It is argued by the researcher that this over reliance on experimental methods has resulted in the denial of diversity in information gathering which could enrich the quality of the service that is offered to users. Pope et al (1993) and Webb et al (1966), argued that all methods in research have their problems and limitations, and the over-reliance on any one method, at the expense of using multiple research methods to investigate any phenomena of interest can lead to "a very limited tool box" sometimes with "questionable validity" and consequently leading to a limited

understanding of the phenomena under investigation. Management research in the health service has adopted many of the methodologies and therefore has not located itself adequately in a specific methodological framework.
In the case of outcomes research, due to the diversity of the aspects under investigation, application of the experimental method of investigation may not be suitable to address this diversity appropriately. Pope (1992) and Hunter et al (1993) provided further clarification for this view and argued that health services research is a space within which disciplines can meet and as an area of applied research, rather than a discipline. Management research in the health services has adopted this action science approach; that is using the best method for investigation rather than adopting a particular epistemological standpoint. This position is further supported by the difficulties that can arise during research in the mental health services such as explanation and understanding of the purpose of the method to be used, consent, ethical arguments of denying a particular treatment to some patients, the difficulty of meeting the rigorous criteria in order to eliminate bias, and compliance of the patient to the treatment programme. However, it is possible to focus on controlling the behaviour of the health care practitioner instead of the patient although the particular intervention needs to be shown to be effective in order for it to be generalised.

Outcomes research deals with the objective (professional assessment) as well as the subjective (user/patient) assessment of health gain. Measuring outcomes is multi-faceted as it relates also to the effective measurement of physical health and functioning, social functioning, social health (relationships, support and activities) psychological and emotional wellbeing. Measurement of all these domains involves application of varied research methods all addressing the question of whether or not the treatment leads to a life worth living, which the patient is well placed to provide an opinion on.

4.3.1 A discussion on randomised control trials (RCTs)

Shepperd et al (1997) asserts that RCT is generally regarded as the most scientifically rigorous method of testing hypotheses available in health service research. An RCT is a longitudinal study in which patients are randomly allocated to groups (study and control) for investigation (see Figure 4.5). The randomisation ensures that each patient has the same chance of receiving the treatment or intervention (active treatments or placebo) available. According to Pocock (1983) neither the individual allocating the treatment nor the participant can determine in advance which treatment the subject (patient) will receive. This method also allows treatments to be compared between groups. However, RCTs have been criticised in terms of motivational and ethical factors. The issue of ethics in the way RCTs are operated in the health service needs to be defined. Some of the ethical questions that could arise in the planning and conduct of RCTs are:

I. The possible risks of treatment and of failure to treat.

II. The legitimacy of exposing some people to possible harm from an untested treatment or withhold from others a possible beneficial treatment.

III. The justification for introducing a new treatment into use without first assessing its safety and benefits by a properly conducted trial

IV. The degree of explanation by practitioners and the understanding of the process by subjects (patients) before they agree to participate

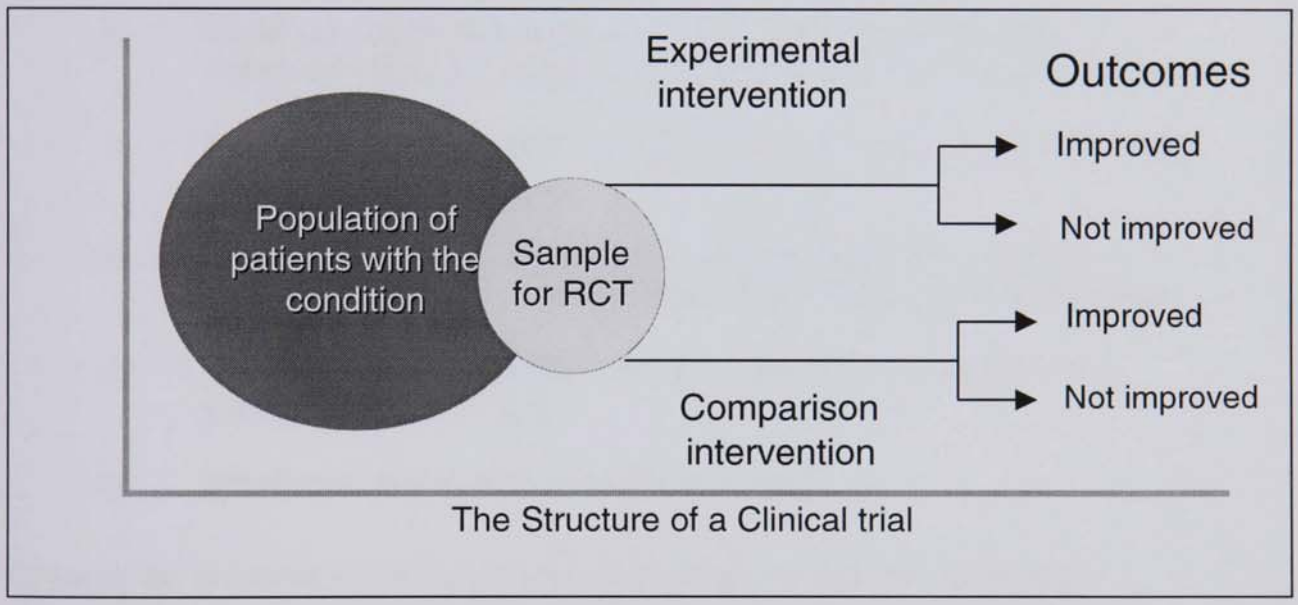
V. The safeguarding of the welfare and safety of participants while preserving the principle of "blind" assessment.

The importance of RCTs or clinical trials to research in the health service is not only due to its dominance as a process but also because it is considered the standard of excellence or the "gold standard" for scientific studies of the effects of treatment or interventions. RCTs are conducted by isolating for a study the unique contribution of one factor by holding constant, as much as possible, all other determinants of the outcome and with the consent of the patient. Sampling is key to effective

management of the RCT process as the kinds of patients included in the study will determine the extent to which the conclusions can be generalised.

Herein lies some of the most revealing questions as far as the application of the RCT process to mentally disordered offenders are concerned. For example, do they meet the study criteria that is, to what extent can the heterogeneity of the patient population in the trial be restricted. This is because the purpose of the health service is to be treated for any abnormality of a normal health status.

Figure 4.5 Structure of a Clinical Trial



This is achieved through treatment, which is usually considered as what the physician, or the doctor only can prescribe - drugs, surgery, diet exercise etc. In the case of measuring outcomes, this view can be challenged, in that the focus of outcomes research for this patient group (mentally disordered offenders) should focus on assessing wellbeing of the individual and the protection of others. Other forms of analysis or study such as cost benefit and cost utility analysis focusing on assessing the quality of life of the individual need to be included. This undoubtedly

will involve a degree of assessment that involves the subjective health status of the patient.

In the mental health field the usefulness of RCTs has been questioned on the grounds of psychological and motivational as well as ethical concerns. These concerns are related to explanation and compliance to the programme and the fact that most mentally ill people would prefer not to be taking medications nor be in contact with professionals. The Declaration of Helsinki issued by the World Medical Association in 1960 and revised 1975 set out ethical principles that need to be observed by people undertaking RCTs (Silverstone et al 1995 p75). They include:

I. All biomedical research should follow careful assessment of anticipated risks in comparison to benefits to the patient and others.

II. The interest of the patient is paramount and needs to override that of science and society

III. Each patient (potential subject) must be informed of the aims, methods, anticipated benefits, discomfort and hazards of the study.

IV. Must be informed that they can leave the study or abstain from participation at any time.

V. Informed consent must be given in writing

Consent too is critical in the way mentally disordered people are involved in research. In particular consent needs to be made on informed basis but some mentally disordered people are said to be unable to give this consent due to the type of condition they are suffering from. Silverstone and colleagues (ibid p75) provided another perspective by arguing that the ability to form a reasoned judgement on the study by the patient could be affected by delusional ideation of persecution and unworthiness. However, it seems right that this approach needs to be considered where there is a need to distinguish differences between groups in terms of assessing effectiveness of approaches.

4.3.2 Research design

Given the methodological considerations discussed in this chapter together with problems associated with the measure of outcomes in the health sector and mental health in particular the choice of methods for data collection was therefore crucial. Figure 4.6 shows the research design framework, which was partly discussed in preceding chapters and fully in the next chapter. It shows that clarification of the research question, which was shaped by observations within the service, has contributed to developing the conceptual framework necessary for effective data collection. It also shows the methods used and their relationship to the whole research process, which was based on providing meaning to what, the subjects of the research experienced in their world of forensic mental health. The use of the hermeneutical approach and the theoretical underpinning of structuration theory used in the collection and interpretation of data have helped to strengthen the interpretive approach of the research. However, Figure 4.6 further shows that methods within the quantitative paradigm were also used. In addition to this, the use of the expert panel and consensus building process provided the findings of the research a greater degree of rigour and validity.

While this research does not extend beyond the point after the use of the consensus conference, it is however anticipated that further work needs to be done to bring the very necessary ambition of developing outcomes measures a reality. This work, referred to as Next Steps at the end of the process in Figure 4.6 is continuing and is discussed in more detail in Chapter 14. The methods used in data collection and analysis are described in Chapter 5. The next section of this chapter will now turn to discussing the relevance of structuration theory within the forensic domain and identification of the stakeholders and their uniqueness to the research.

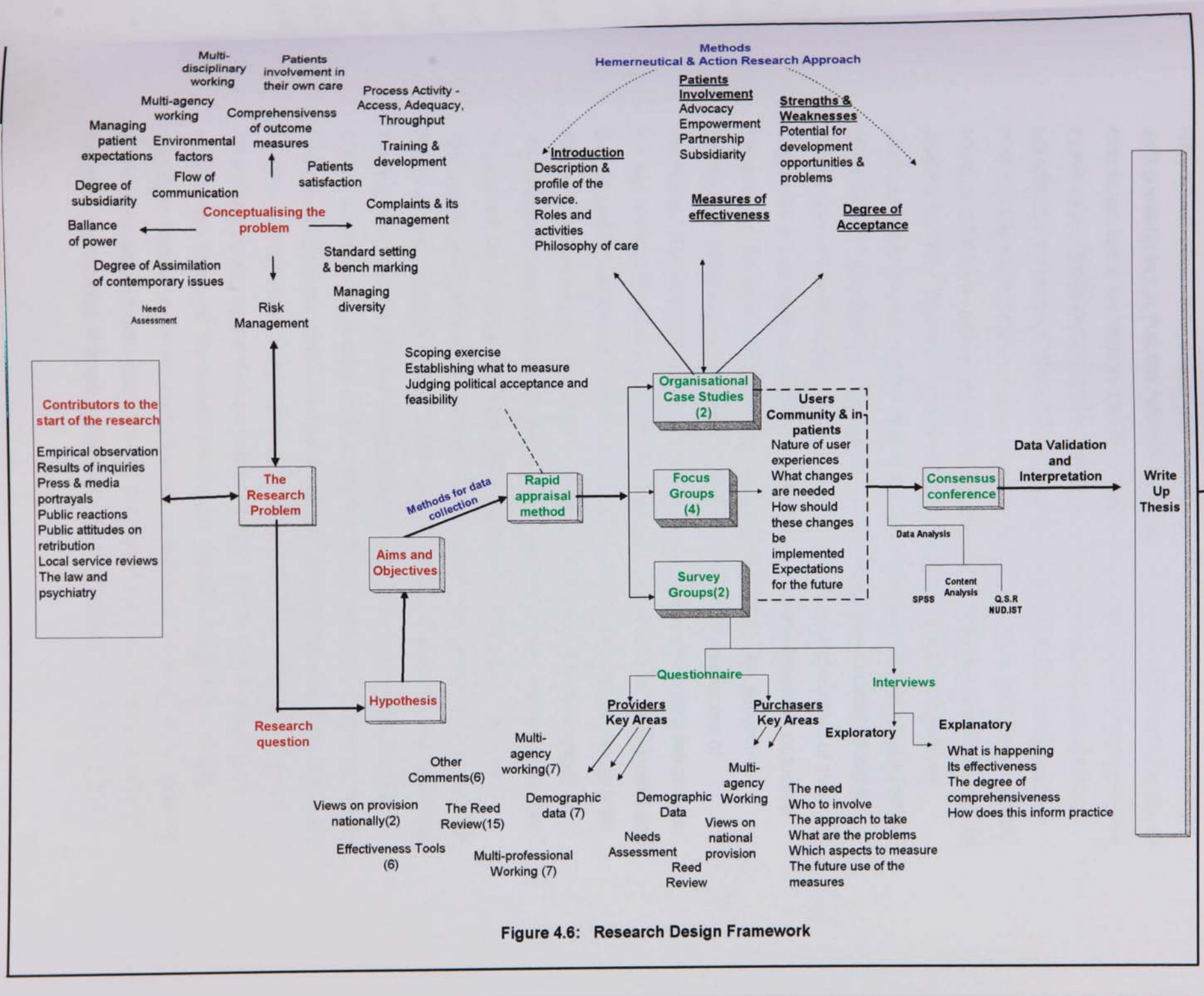


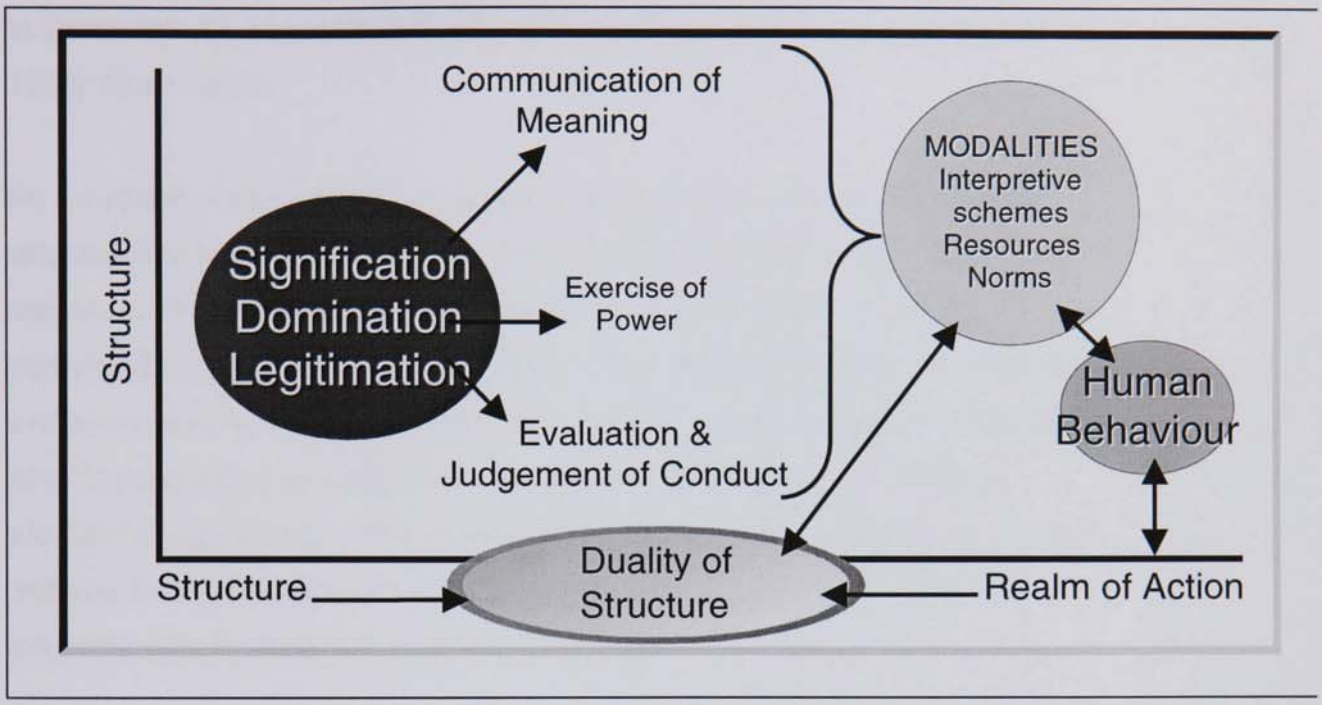
Figure 4.6: Research Design Framework

4.4 Forensic psychiatry, theory of structuration and outcomes

Giddens concept of structure is founded on the idea that it is "rules and resources" which structure social practices. This structure is both enabling and constraining in that the rules of language can enable the transmission of messages but if we wish to communicate we are constrained to abide by the same rules. Structure in the conventional social scientific usage signifies objectivity - an external existence. Giddens structure has no reality except that it is internal to agents in the form of memory traces. It is the agents that bring structure into being and it is structure, which produces the possibility of agency (action). Figure 4.7 attempts to provide a conceptual model to demonstrate how the various levels of the structuration theory discussed so far could be represented. This clarification is necessary in order to aid a discussion of how this theory was applied to the field and subject of the research. It has been discussed that the unit of measurement in outcome research is the user of the service (see Chapter One). The subjective feelings of patients are therefore central in developing measures of outcomes. While this is very important, the availability of service resources for the achievement of a plethora of activities, their effective deployment and the way all these are harnessed to deliver care that is successful both from the provider and user point of view is critical. Giddens' structure pillars of Signification, Domination and Legitimation equates to the way services are resourced, used and in particular their equitable distribution. The way managers and professional staff exercise this power accorded them through the level and diversity of resources was evaluated. The processes used and the impact it has on patients constituted the way structure integrated with action to create the duality of structure that is necessary in enabling change in these institutions which are necessary for developing outcomes measures of care and services. Outcomes measures depend on communication of intentions by managers and professional staff, which in turn engenders confidence amongst the patient population thereby promoting a degree of pluralism based on strong and effective partnerships. In promoting meaning, in the context of structuration theory, the objectives and rules as applied to the smooth running of these institutions will be identified and the process

through which this is communicated to patients assessed as to its compliance and the degree to which these rules are renewed and operationalised.

Figure 4.7 Structuration theory - A model



Source: Based on Giddens 1976, 1984

In forensic psychiatry, the structure element of Signification involves the legislation, which justify the continuing detention of a patient. The type of section of the Mental Health Act that legitimises the detention also instructs the responses service providers must take during the admission, treatment, transfer or discharge and after care of the patient. In some cases the nature of the response to treatment may not be the only determining factor in discharging the patient but also the consideration of the risk the individual is deemed to present to self or others if discharged from hospital. There are other rules that govern the way the service operates, some of these are through legislation from parliament, guidance from various government, professional and regulating bodies; and additionally service procedures and other unwritten rules.

The type of treatment can also be said to constitute the structure element of signification. The type of diagnoses and the nature of the offending behaviour determine the type of treatment and the environment within which the individual could be cared for. However, there is ample research evidence that support the fact that people who are from the minority ethnic communities (particularly African - Caribbean) are more likely to be admitted to these secure hospitals and units that constitute the forensic sector (Prins 1992; Cope 1995).

As a service sector organisation, the forensic services are charged with effective treatment of individuals. The discharge of this duty relates to the way the service recruits its staff, how they are prepared to meet the objectives of the service and how their effectiveness is measured. Managers and professional staff have rules and regulation, some of which is statutory and the way they operationalised this power determines the structure element of Domination. This is communicated to users of the service in the manner in which they exercise this resource power and in the way this interacts with the behaviour of human beings.

The last element of structure, Legitimation arises from the aspects of action as expressed through the way the patients and staff apply the rules that are inherent in the structure of signification and the resource power that the structure of Domination has with a degree of morality that could be judged and evaluated by others. These others involve service regulators, government officials and professional organisations and increasingly the general public, the press and media.

The explanation of the research information through the application of structuration theory is best achieved in the manner the elements of structure interacts with action which is enacted through the modalities of interpretive schemes, resources and norms. The human response to these activities reproduce social practice which is at the core of Giddens' theory of structuration, and manifested through the duality of structure. However, the identification of the actors, agents that are involved in the creation of social

practice needs to be defined in the case of the field of the research. This clarification will improve the analysis of the interaction within these hospitals, identifying in the process who has the power in terms of how resources are used and whether these resources are deployed ethically and morally. In order to enable this linkage, Giddens' theory of structuration provides the basis upon which an analysis of stakeholders of forensic care and their possible behaviours at the time of enacting the duality of structure which is discussed fully in the case studies (see chapters 9&10). In the case of who to include in the study and to what degree, a clarification of stakeholders of the service is necessary both in the context of their identification and the anticipation of their behaviours during the course of the research.

4.5 Defining stakeholders

The term stakeholder can be defined from many perspectives. It may be viewed from the political science, sociological and psychological perspectives. Political science and sociology defines it from the external perspective while psychology defines it from the internal perspective. In introducing the stakeholder as a concept Mitroff (1983), argued that the reflective manager needs to understand and apply it because the modern large scale organisation "is buffeted by a growing disparate array of forces most of which are beyond their control". This statement still holds true today. This array of forces he called stakeholders. He defined stakeholder as:

> *"all those interest groups, parties, actors, claimants, and institutions - both internal and external to the corporation- that exert a hold on it.*

Building on the notion that stakeholders can be defined both from the internal and external perspectives, he advanced the view that an amalgam of these two factions is the way forward. This assertion implies that stakeholders are all those who either affect or are affected by the organisation's actions, behaviours and policies. This view can further be elaborated on to say that organisations do exist to serve the needs and

wants of its stakeholders. In the forensic psychiatry field stakeholders can be defined as

> **All those who affect or are affected - including service end-users, their dependants and carers; by actions, behaviours and the policies of the service or the particular organisation.**

A true-life experience during the course of this research is used later to illustrate how behaviours of stakeholders of a particular decision can impact on its implementation. Within this context there is the implication that factors such as information technology has an effect on the service. This is the case because information about patients within the service is a very sensitive aspect of care. A new approach to information gathering is therefore a threat as the numbers of potential users and audiences for that information is increased.

There is also the view that stakeholders of an organisation do not exist independently. Because stakeholders do interact, organisations need to be aware of the potential pitfalls should they join forces (Ansoff 1965). This implies that the corporate or service objectives or agenda cannot be accomplished without the support of these groups or individuals. According to Mitroff (1983) stakeholders possess assumptions. These assumptions he defined as the building blocks of a person's make-up and of behaviour. It is what guides the individual and shapes their expectations and anticipations individually or as a group.

Wren (1994) identifies the source of the term "stakeholder" to have entered the literature in 1963. He claimed that the term was originated by the Stanford Research Institute in the United States and defined as "those groups without whose support the organisation would cease to exist". This definition is a lot harder to accept in the public sector, particularly where the care of the mentally disordered offender patient is concerned. It is totally inconceivable to contemplate the scenario where an individual or a distinct group acting alone can determine the future viability of the service. Anecdotal evidence showed that the various groups tend to operate very

much diametrically. For example, two patient representative groups can each promulgate a different viewpoint as far as the care of the mentally disordered offender patient is concerned.

According to Donaldson et al (1995), the stakeholder theory has been advanced and justified in the management literature on the basis of its descriptive accuracy, instrumental power and normative validity. These three aspects of the theory, although interrelated, are quite distinct; they involve different types of evidence and argument and have different implications. Donaldson and colleagues concluded that the three aspects of stakeholder theory are mutually supportive.

4.5.1 Stakeholder characteristics

As previously stated, stakeholders do not share the same definition for problems services are confronted with (Mitroff 1983). In order to make the analysis easier, Mitroff developed seven methods for identifying stakeholders. These are imperative, positional, social-participation, opinion-leadership, demographic, reputational and focal approaches (Figure 4.8).

There is a view held throughout this chapter that stakeholders do not share the same definition of the services' problems, it follows therefore that they may not share the same solutions. Management action should be on identifying them. Figure 4.9 provides a model for policy formulation by identifying stakeholders and their properties. This systematic approach will enable managers to plan effectively to meet any adverse reaction to their policies.

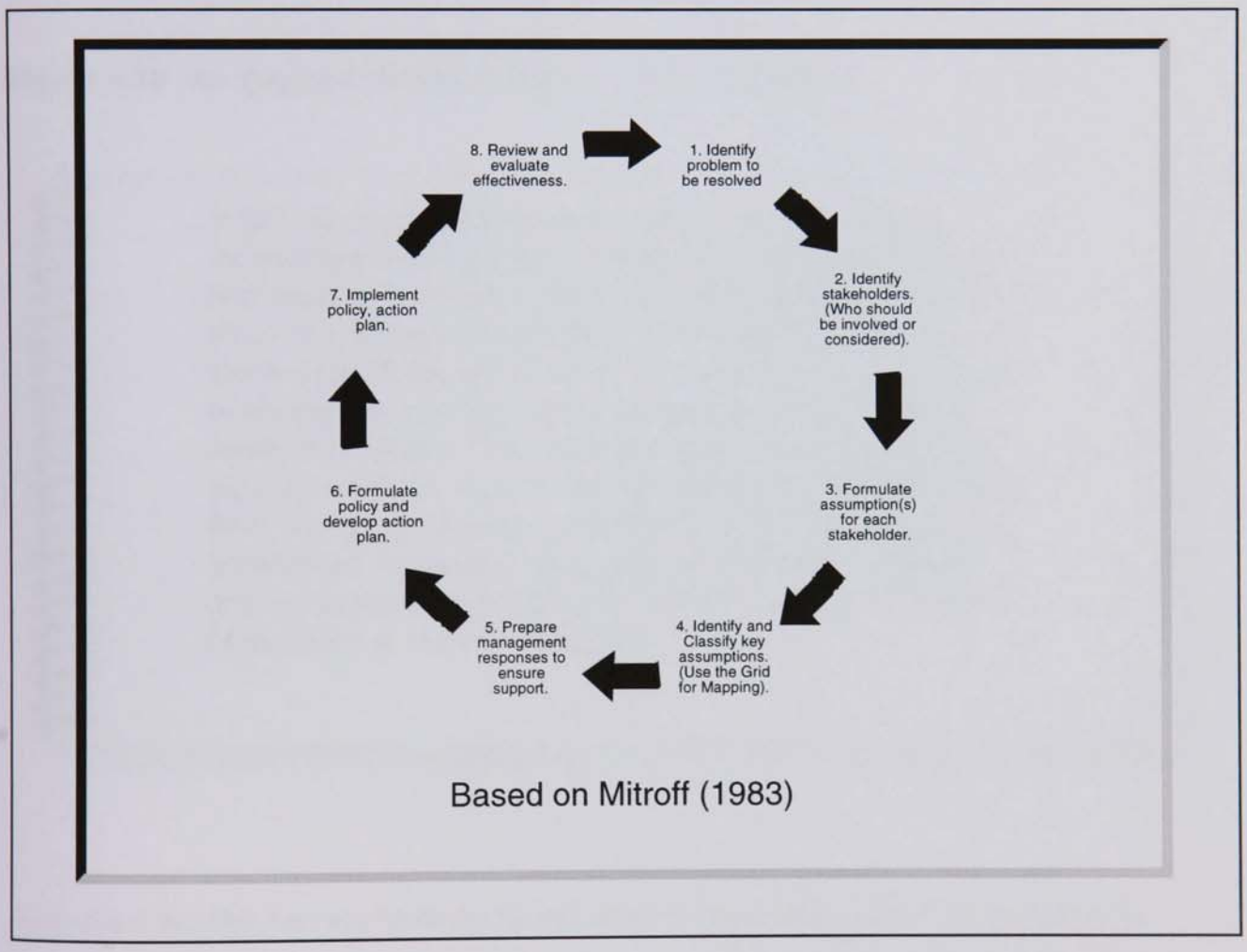
Figure 4.8 Approaches to identifying stakeholders

Type	Properties	Behaviour	Management Action/Response
Imperative Approach	Identify stakeholders who feel about the proposed policy or action.	Organises acts of defiance	Identify sources Consider each source as a separate stakeholder Anticipate type of action.
Positional Approach	Identify stakeholders who occupy formal positions in the policy making structure. -external and internal. E.g. key staff, policy makers etc.	They are often unorganised.	Identify individuals/groups. Anticipate type of action. No action may be the best approach in some cases.
Social-Participation Approach	Identify stakeholders who participates in activities related to the policy.	Involvement in meetings, associations and committees.	Identify key areas of conflict. Engage if possible
Opinion Leadership Approach	Identify stakeholders who tend to shape the opinions of other stakeholders. E.g. the press, media, staff organisations.	They are an imprecise group.	Requires more judgement on the part of the analyst.
Demograhic Approach	Identify stakeholders by such characteristics as age, religion, education etc	Focused activities. May join forces with other types. Also a floater tends to belong to the group which best serve own needs.	Assess political leverage
Reputational Approach	Identify stakeholders who have a stake but are difficult to identify.	Can operate covertly to undermine the policy.	Ask knowledgeable and influential individuals to nominate them to participate.
Focal Organisational Approach	Identify stakeholders who have direct impact on or are directly affected by the actions of the organisation	Can have resource power E.g. purchasers, users, employees and those with monitoring and regulatory	Invest in information sharing information openly. Focus on benefits and disbenefits that can result without the policy

Base on Mitroff 1983

As shown in this model the process is started from stage one where the problem is identified. This first step is followed by the identification of stakeholders who might be affected by the policy change. A prediction of their behaviours is made, their assumptions classified and management responses developed to meet these responses. The process is then followed through to formulation and implementation stages. The last stage provides management the opportunity to review and evaluate the effectiveness of the policy and any amendments made to it.

Figure 4.9 Stakeholder Analysis-Policy Development



Based on Mitroff (1983)

4.5.2 Analysing stakeholder assumptions

As discussed earlier, stakeholders have "assumptions" which guide the way they relate to organisations. Managers of the service must therefore anticipate their behaviour and include this in the way they plan for the future viability of their services or policies. Figure 4.11 demonstrates how a real life organisational problem which surfaced during the course of this research could have been resolved by analysing stakeholder assumptions and linking it to the types, thus enabling a more informed decision making. The problem to be resolved is as illustrated in figure 4.10 below.

Figure 4.10 An Organisational Problem. A Case Vignette.

A forensic psychiatric service, which has near enough monopoly within the health region within which it is situated, has decided to increase the numbers of patients for whom they have no regular contract. These are termed Extra Contractual Referrals (ECRs). This will provide extra funds to enable the development of an information technology networked system. This policy decision, it was explained would provide all users of the service information tailored to their needs. On average, the service is functioning over its contractual obligations as far as bed occupancy numbers are concerned. In principle the increase in the total number of its ECRs is therefore justified.

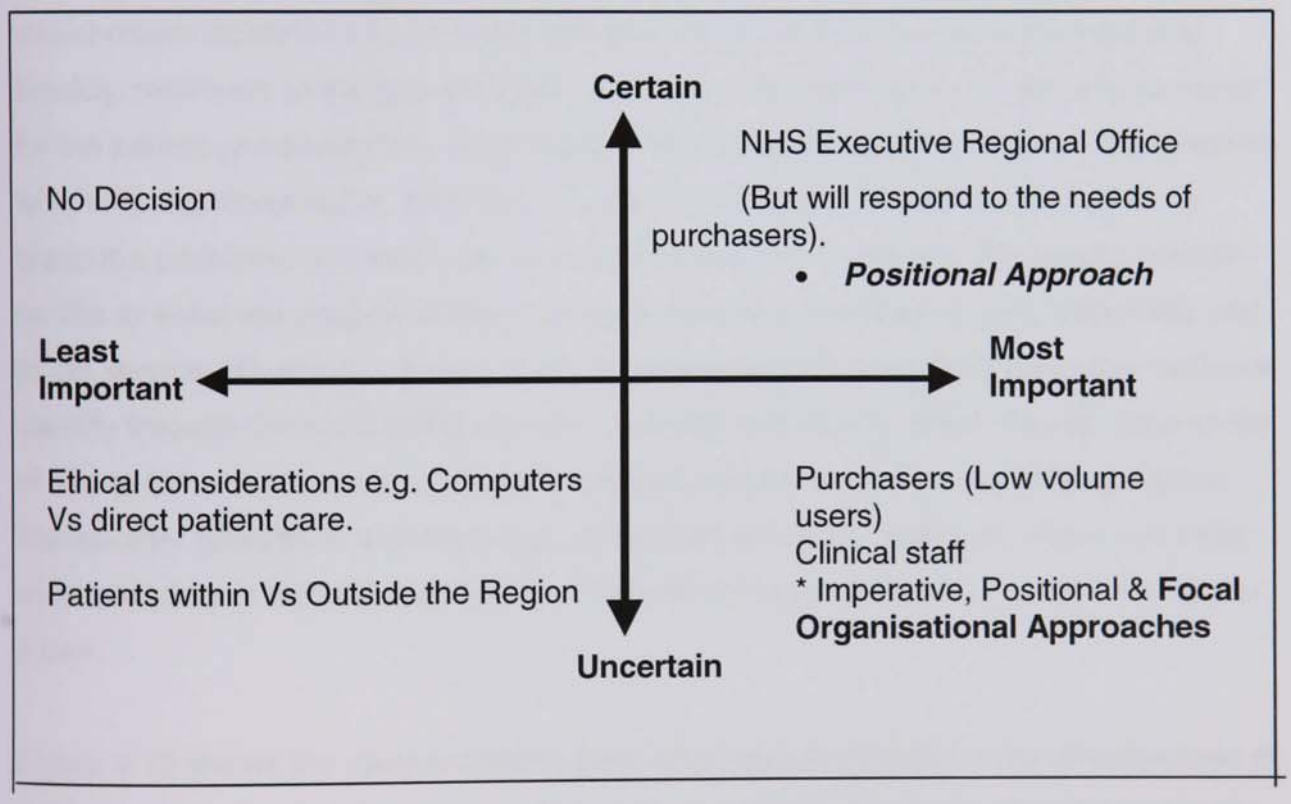
A problem like this has implications for the whole organisation, within and outside its boundaries. Firstly, although the service was over achieving its performance targets as agreed with the Regional Office of the NHS Executive, there was nothing to dissuade individual Health Authorities, who were low volume users to insist on having their fair share as and when they needed it. Secondly, the decision to treat another patient from

another region when there were patients from the region requiring similar services could be challenged both on ethical and political grounds. Thirdly, within the service itself individual clinical teams were not pleased with this decision as it affected the way they were operating in providing services to their respective catchment area hospitals. Managers within the service did not have the benefit of subjecting this decision to the analytical process in Figure 4.11 below. The policy was implemented but few clinicians supported it. They exercised their freedom to practice and refused to admit patients other than those referred from their catchment areas. Low volume users of the service insisted on their patients being admitted and threatened to withhold their subscriptions. The Regional Office officers learned about the problem. As indicated service managers were caught in a maelstrom of protests both within and outside the service. This generated ill feeling amongst the staff as well as other users of the service who hitherto have provided the service with much needed support. This conflict could have been avoided, if stakeholders of the policy change were identified earlier and assumptions made about their responses to the new policy. The first step will be to use the process (Figure 4.9) to enable identification of the relevant stakeholders. In this example, they are Health Authorities, NHS Executive Regional Office, other users within the region subscribing to the service and were low volume users of the service. Local press who were always antagonistic to the existence of the service and would not lose the opportunity to compound the service's dilemmas. Clinical staff within the service would also be interested in the effect it may have on the way they operate. Other users of the service from other agencies, such as the criminal justice system will also have a stake in this policy change. As it stands the only thing certain is that the service has a bed into which a patient could be admitted. Having identified the possible stakeholders of the change in policy, the next step will be to analyse their respective assumptions. Figure 4.11 below explains the analysis by use of a mapping grid.

The Mapping Grid identifies stakeholders who might have a say in the policy change. Although the Regional Office could support the service managers because of the high degree of service performance, they would respond to the needs of services that are faced with dealing with potentially explosive and dangerous situations involving patients

they could not manage. Clinical staff did not only refuse to co-operate but they also argued the point from the perspective of ethical considerations. This included the accusation that managers of the service were shifting resources away from direct patient care to a non-direct care area - computers. Furthermore they asserted that the policy was flawed, as it would mean patients from the region were being left in unsuitable locations and therefore not receiving appropriate care. While this action did not lead to people taking their placards and banners onto the street, it nevertheless contributed to lowering the image of the service and dissatisfaction within it. Effective implementation of the policy change was delayed for over a year.

Figure 4.11 Stakeholder Assumption Mapping Grid.



Pfeffer (ibid) stated that leadership involves skill at developing and exercising power; power being the basic energy to initiate and sustain action and to translate intention into reality - a position which is central to Giddens' structuration theory. This scenario

demonstrates that managers did not exercise their influence effectively and therefore did not translate their intention into effective action.

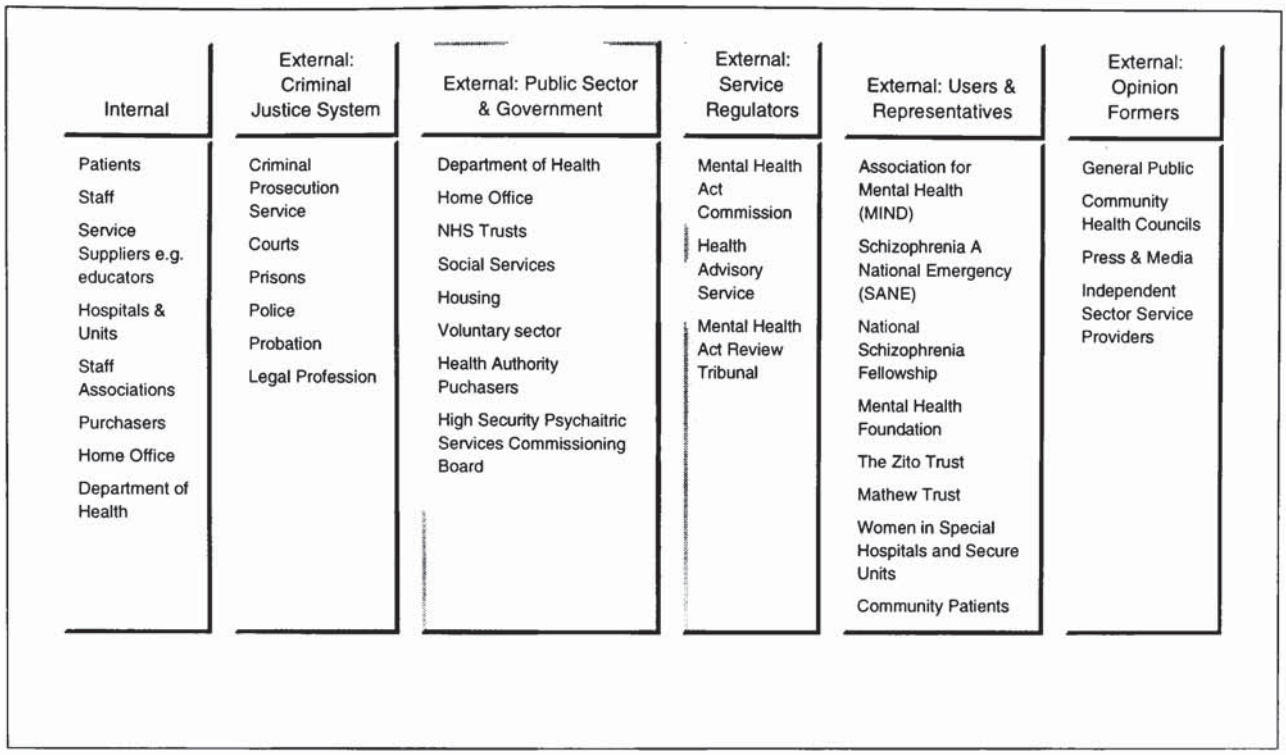
4.5.3 Stakeholders of Forensic Psychiatry

The need to identify stakeholders of forensic services is an important component in understanding the service in respect of measuring outcomes of care. Users of forensic psychiatry services are numerous and across a multiplicity of agencies. The term "user" is loosely applied to encompass all those who derive any type of benefit or affected by any action, procedure or policy of the service. Given the complexity of the environment within which forensic services operate the importance of prediction of behaviours within that context cannot be overlooked. There is a school of thought that suggests that stakeholders do not share the same definition of any part of the service's problems. Equally, members of the general public do express different views on the way services for the patient group ought to be provided and managed. Because of these complexities which management faces, there is a need for a perspective to enable managers to grasp the problems and make sense of their respective situations. Managers need to do this to enlist the support of their key stakeholders in developing their respective part of the service effectively. Stakeholders of forensic psychiatry contribute to the service's viability through the contracting process, provides information which may or may not be of use to the service, adds to the services legitimacy and assist in mobilising support. Stakeholder analysis is therefore important in other that managers can have a broader understanding of the psychosocial environment that surrounds them, of which they are a part.

Figure 4.12 shows the various stakeholders who have an interest in the effectiveness of the forensic mental health services. For ease of analysis, these are grouped under six key categories. The internal group refers to individual hospitals and units and the forensic provider service as a whole. The criminal justice system as one of the five main groups that constitute the external category, provides the greatest diversity of professional groups and so their needs are much more complex to analyse. The third

group represents public sector groups that needs to collaborate to ensure appropriate service provision and government departments whose action impinges on the effective management of the service.

Figure 4.12 Stakeholders in forensic psychiatry

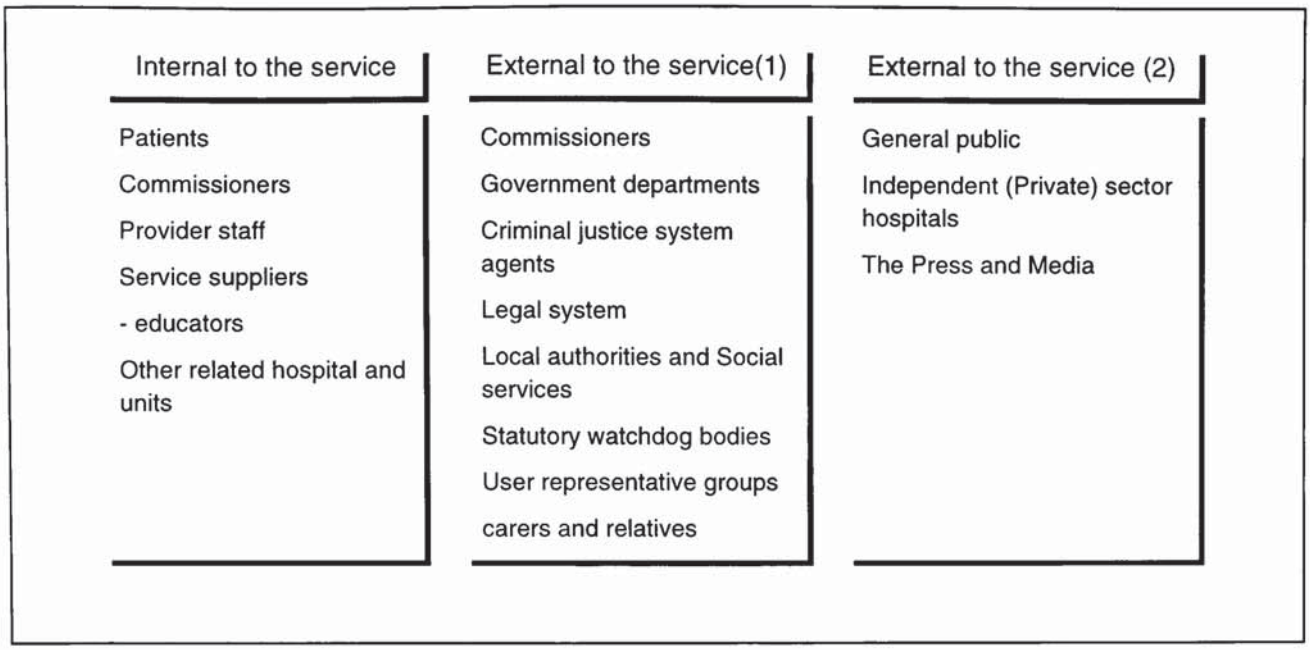


The Mental Health Act 1983, provides for groups such as the Mental Health Act Commission (MHAC) and Mental Health Act Review Tribunal (MHRT) to play a significant role in ensuring effectiveness of the service. The role of the MHAC' is to ensure that the care detained patients receive is sensitive to their needs and provides codes of practice which the service operates under.

MHRT on the other hand has the powers of a court of law to order the discharge of patients. User representative groups, carers and relatives form the next distinct group and lastly and perhaps the most important group that can influence the way politicians react to the service is the general public whose reactions are shaped by comments of the press and media. This short discussion illustrates the complexity of the arena of forensic mental health practice. For the purposes of this research, Figure 4.13 makes an attempt to clarify a very confused area where the identification of stakeholders of the service is concerned.
It shows that their classification could be organised into three distinct groups. The first relates to those who are internal to the service and must be considered before the success of a policy or an initiative is implemented. This also involves patients the main focus for this research in terms of consultation and involvement in care and therefore critical for the conduct of outcomes research and the development of outcomes measures.

The second group of stakeholders relates to those whose interests are mainly in working with the service but are sufficiently outside it to exert a degree of pressure to ensure its effectiveness. In this group purchasers of the service are a component part and demonstrate the dual role this group performs in terms of assuring effective services. For example they could work with the service to develop contracts for treatment and could use the monitoring of contracts as a means to improving the quality of care. Other key players in this domain include government departments such as the Home Office who also has a role in ensuring that patients are treated effectively.

Figure 4.13 Stakeholders of forensic mental health - simplified



The third domain also relates to those who have an interest but not directly. Leading this group is the role played by the media in informing and shaping the general public's view of the purpose of the service, which at times can be antagonistic.

4.6 CONCLUSION

The care of the mentally disordered offender is complex as it transcends various national and local government departments. The way the service is organised to provide care to mentally disordered offenders and others requiring similar services will change. All these changes in addition to others discussed in this paper will place more demands on managers to ensure effective system of care. Managers therefore need to understand the various ways users, both within and outside the service, will react to changes that are vital to the effective functioning of the service. The process for decision-making can be difficult, as users of the service would want to exercise their rights, needs and wants taking into account the wider considerations of service

provision. The ability to predict the behaviours of these individuals or groups who hold a stake in the viability of the service is therefore crucial.

In this chapter, the key elements of Giddens' structuration theory have been used to establish a theoretical framework for collecting and interpreting the case study data from the research. Further various groups who have an interest in the outcomes of this research and therefore entitled to be consulted were identified and a process of anticipating their behaviours discussed. This has helped in formulating the assumption that before outcomes can be measured there has to be dialogue between various groups and in particular with patients so that their subjective views are included in service development and care planning.

PART FOUR

METHODS USED IN THIS RESEARCH

CHAPTER FIVE

Introduction to the methods used
Rapid Appraisal Method
The survey
The case study
Focus groups
Lessons learned
Consensus building conference
Data analysis - Hemerneutical approach
Reflections and conclusions

CHAPTER FIVE: METHODS USED IN THIS RESEARCH

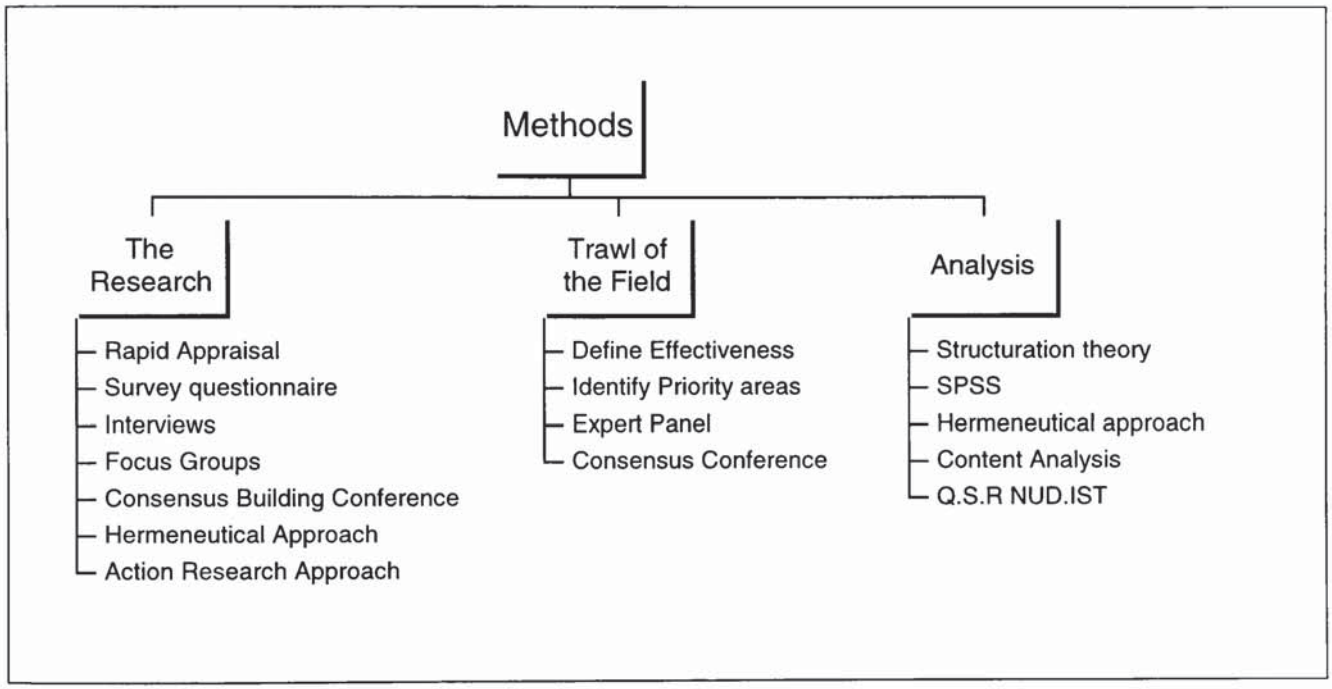
5. Introduction

This chapter describes the methods used in the research and offers an explanation for their choice. Figure 5.1 below shows the approach adopted by the researcher in collecting and analysing data for this research. Data collection for the research was undertaken by applying to it a multi method approach under the framework of hermeneutical and action research approaches. These methods included Rapid Appraisal, Survey Questionnaires, In-depth interviews, Case Studies, Focus Groups and culminated in a Consensus Development Conference.

In recognition of the dynamic nature of the subject, this research adopted an action science approach to data collection enabling a process which was interrelated and co-ordinated ensuring a step by step approach. This process has enabled the researcher to define the priorities and problems, and to devise the appropriate methods to meet the identified issues. According to Lewin (1946), action research is a method used in generating knowledge within social systems while simultaneously trying to change it. Today action research is used as a method of organisational development by awareness raising, empowerment and collaborative investigation between the researcher and other stakeholders (subjects). Action research has become a popular technique, which has been described as a critical, self-reflective, bottom-up and collaborative approach to enquiry. Its power is its ability of not treating people as "subjects" of the study but as active contributors to the research process. Bowling (1997) argued that this stance has the potential of leading to solutions that are appropriate for the research population and consequently a greater commitment to implementing the research outcomes. This philosophical viewpoint is also in concert with that of an hermeneutical approach, which was used in data collection for this research as both approaches operate in a context through which people can collectively clarify their problems and formulate new ways of envisioning their situations.

In the next section the methods used are discussed in the order in which they were applied during the course of the research. This triangulation of methods was necessary to provide a greater degree of validity to data collected and so to the conclusions drawn. This approach took into account the view that the scientific rigour and validity of the approach should involve the use of triangulated research methods (Bowling 1997 p367).

Figure 5.1: Methods used for the research



Another survey (see chapter 12) was undertaken in November 1997 to update current knowledge on the use of outcomes measures since the advent of health policy, which was introduced after the start of this research (DoH 1997). The conclusions are discussed in Chapter 12.

One of the overall aims of this research was to draw the views of key stakeholders of forensic psychiatric care together to develop a consensus of opinions and views on the priorities for improving the effectiveness of care delivery. The intention was that

this would lead to the development of a range of priorities and related outcomes measures that would provide stakeholders of the service with tools to measure effectiveness of care provision. This section discusses the actual methods employed in providing answers to the questions posed in chapter one. The overall object of the research is restated here as follows:

> To establish the extent of use of effectiveness measures within the service.
>
> To establish the consistency of use of selected effectiveness measures within the service and their relevance to ensuring appropriate care.
>
> To identify the degree of satisfaction with the current measures of effectiveness of care.
>
> To draw together the views of users, NHS staff and Service regulators on what in their opinion measures of outcomes of care.
>
> To present the findings to a consensus development conference in order to seek agreement on key areas to develop as a tool to measure effectiveness of interventions

Consequently, the overriding focus for the research was to understand the perceptions, behaviours and experiences, and intentions of stakeholders of the forensic mental health services in assessing effectiveness. To achieve this a range of qualitative and quantitative, descriptive and analytical methods were used to collect data for the research, some of which are discussed here in detail, and others discussed later on in this thesis. The choice of method used at each stage was based upon the type of issue for which an answer needed to be provided and the particular stakeholder groups on which the research was focusing at that stage.

The prevailing bio-medical model of health presupposes the assumption that disease is generated by aetiological agents, which leads to changes in the structure and function of the body. Bowling (1997 p19) provided the background to this viewpoint by arguing that this is because the medical view is based on the Cartesian philosophy which sees the body as a machine. Suggesting therefore that if a part

becomes dysfunctional, it can be removed or repaired, consequently treating the disease but not the illness, which is the subjective experience of the sufferer. All these views and factors impinged on the way the research was designed (Figure 4.6) to address the challenges posed by the research question (see Chapter 1).

The first attempt to clarify the direction of the research was to seek a consensus view of how outcome measures could be conceptualised, operationalised and possibly measured. In this preliminary stage the overriding objective was to explore the relevance and feasibility of pursuing the research. In order to establish a framework, the Rapid Appraisal method was used to collect data that could be used to guide the research process (see Figure 6.1).

5.1 The Rapid Appraisal Method

Rifkin and Annett (1988) defined the rapid appraisal method as "a method of getting information about a set of problems in a short time and without a large expenditure of time and expense". This approach provided the best fit for conducting this research in the initial stages because of the flexibility it offers and the need to ensure that there is political acceptance for the conduct of the research, and achieving the best solution in the case of the potential workload matched against the resources available to the researcher. The Rapid Appraisal Method is guided by three key principles, these are:

I. Identification of the information needed and specification of the method by which it is to be collected.

II. Involvement of the "community" to be researched in defining its needs and possible solutions.

III. Collection of the relevant and necessary information.

This method was chosen as an exploratory procedure rather than a confirmatory one. This allowed the involvement of some of the key stakeholders in identifying the

areas to target i.e. the bottlenecks and areas to be avoided. This method was used as a quick way to assess the views and perception of key stakeholders of issues relating to measuring outcomes in the forensic mental health sector. Rapid appraisal techniques have been used frequently in the NHS since the NHS Executive directed purchasers to seek the views of their local population about the pattern and delivery of health services (Bowling 1997 p370). Murray and Graham (1995) and Ong and Humphris (1994) found the use of rapid appraisal approach in communities valuable even though the information collated did not always relate directly to meeting health needs of people, as it is traditionally known. For example, Murray and Graham found that when they used the method to canvass the views of communities about their health needs, participants were more concerned about the means of travelling, play areas for children and shopping facilities than having to wait for or accessing health service facilities for treatment.

The conclusions drawn as a result of applying this method is presented as summary of the key areas and determinants in chapter 6. In order to provide a degree of rigour and validity to its findings, the method adopted involves many qualitative approaches, such as semi-structured interviews with selected but key practitioners, users and multi-disciplinary meetings (focus groups). Having identified the key areas to target for data collection the survey method was used to assess the extent of use of these measures.

5.2 The Survey - questionnaires

Surveys are a method of social research that has many approaches for collecting data, some of which are questionnaires, in-depth interviews, observations and content analysis. de Vaus (1991) argued that surveys are characterised by structured set of data. In other words data is collected about the same variable from many sources. Surveys as research tools are used to ascertain facts, confirm or refute theories, explore ideas and identify values and expand on their relevance once identified. They are therefore concerned with the way these facts and or

attitudes are distributed and associated. de Vaus (1994 p3), argued that the distinguishing features of surveys are the form of data collection and method of analysis they take. de Vaus went on to argue that surveys are a means through which data could be obtained on various attributes from a number of cases in a systematic and structured way. In the health service, surveys may be used to collect data on the identification or description and measurement or analysis of various aspects of health care such as epidemiology of health trends, diseases, effectiveness of service provision and the extent to which needs are being met. As Figure 5.3 shows the development of the survey process was systematic and well structured. This is to ensure a degree of control on the process and thereby ensuring that the findings from the survey process answer the fundamental concerns of this research, which is to access the attributes of the population under study in relation to the research topic.

The research problem and its conceptualisation, the specific questions (see Chapter One) and the results of the rapid appraisal exercise were used to construct two sets of questionnaires to assess the degree of use of effectiveness measures within the service (appendices 1&2). One set was sent to provider staff and the other to purchasers who have a commissioning responsibility for forensic mental health. The pilot for the provider questionnaire is discussed below with the results of the main questionnaires discussed in chapters 7 and 8 of this thesis.

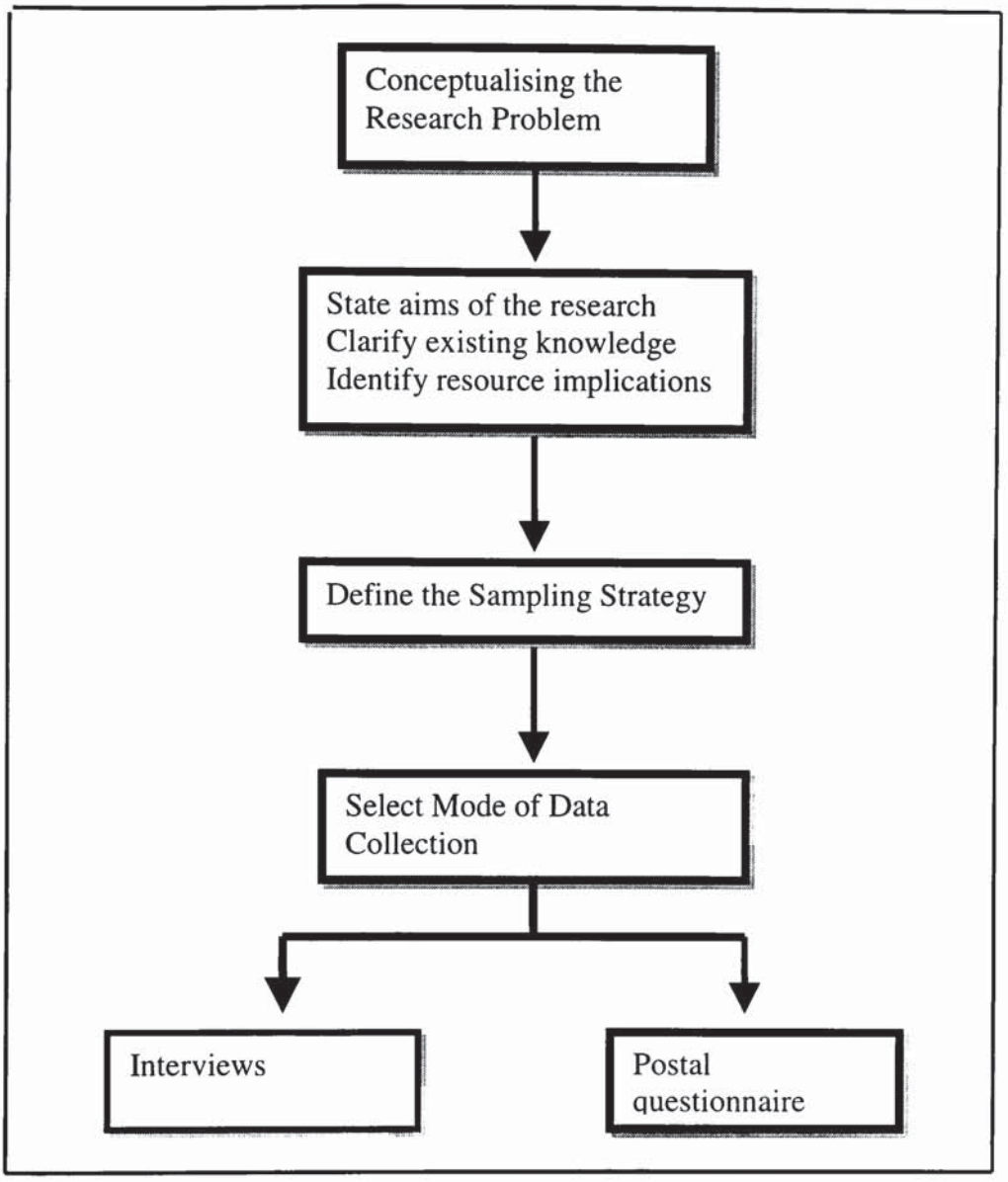
Gill and Johnson (1991 ibid), cautioned about the need to ensure that the variables are emphasised during the course of conceptualisation and structuring of the research. They further advised that this process need to be undertaken with due consideration to the literature, any existing research and theory. This research was designed to take account of this advice. The survey method is not synonymous with a particular technique of collecting information. de Vaus (ibid p3) identified the questionnaire, interviews, observation and content analysis as being appropriate survey methods.

Two techniques of the survey method were used for this research. These were postal questionnaires and in-depth interviews. As Figure 5.2 shows, postal questionnaires and interviews were used as the main approaches in the application of the survey method to this research. Postal questionnaires were utilised as a medium for controlling costs and as the best method to gather various viewpoints on diverse attributes for a particular question. Interviews on the other hand were used to further explore the conclusions drawn from the use of the rapid appraisal method and others used in this research.

5.3.1 The Survey: Postal questionnaires

In developing this survey questionnaire, the clarification and conceptualisation of the research problem has helped to identify the particular aims of the questionnaire method, led to appraisal of the existing knowledge and the various relevant aspects of the subject under study and have provided a strong basis for the development of the sampling strategy. One of the basic assumptions underlying the use of questionnaires is that the researcher and the respondents should share the same theoretical frame of reference and interpret the wordings, phrases and concepts the same way. It is therefore important to ensure during the process of planning and construction of the questionnaire that questions asked are not ambiguous and they are designed in a way that they can produce the desired answers to the questions being asked. A pilot study to assure these dimensions was therefore conducted.

Figure 5.2: The Survey Plan



5.2.2 The Pilot Study

This pilot study was undertaken over a three month period at the start of this research in 1995. The scope of the research and the nature of the field within which the research is being conducted demands canvassing of the views of the many

people or groups of people who have an interest in the service. Questionnaires are the easiest way of ensuring this systematic data matrix.

The questionnaire was developed following the review of the literature, the conceptualisation of the research problem and completion of some of the exploratory interviews through the application of the rapid appraisal method. The literature revealed key areas to address in the course of developing outcome measures and the exploratory interviews provided the practical service issues that needed to be included. Drafts of the questionnaire were discussed with my supervisor and essential amendments were made. After satisfactory completion of the questionnaire, the decision to pilot it was taken. Given the sensitivity of approach that was needed to conduct research of this nature, the researcher made the decision not to follow up non-returners. Additionally, the returned questionnaires represented an adequate cross section of the population. The return rate was 60%.

The purpose of choosing questionnaires to collect data for the research was to broadly answer some of the core questions guiding the research. These were designed in a way to identify the gaps in measuring effectiveness of care and are listed below.

I. What are the present standards to which service providers aspire in assessing effectiveness of care?

II. What are the levels of attainment of standards relating to effectiveness of service provision?

III. How has the attainment of the standard contributed to effective outcomes of patient care?

IV. What can be done to improve the quality of outcome measures currently available?

In a way, the reason for deciding to develop outcome measures of forensic psychiatric care was due to the inconsistencies observed by the researcher as a

senior clinical and managerial member of staff within the service. In time these observations have contributed to the development of the assumption that:

> **If the focus of care delivery is on identifying the needs of the patient, better co-ordinated and communications improved, the quality and standard of care will be better.**

The problem of how to undertake collection and analysis of data was shaped by the diversity of the field and the many professional groups and users of the service. The key objective was to find the most appropriate and cost-effective way of reaching as many of the stakeholders as possible. It was therefore imperative to get the questions right the first time as the questionnaires cannot be dispatched twice due to the mistakes that could have been avoided in developing the questionnaire. The questionnaire was therefore guided by the need to keep the language as jargon free as possible, avoiding too lengthy sentence construction, asking double barrel questions and leading questions. Some of the questions in the questionnaire could be said to suffer from the effects of prestige bias, (prestige bias arises if a question within a research schedule can be ascribed to an individual, particularly if the individual is renown). Specifically, questions 4-6, which addressed the recommendations of the government review of the service, (see appendix 1) could be said to have the potential to suffer from this fate. However the way these questions were framed by concentrating on how the recommendations of the Reed Review impacted on the respondent's own service therefore reducing bias. The questionnaire was developed specifically for this research project and so does not include any questions from any other source.

5.2.2.1 Minimising attrition in mail surveys

Central to improving the return rate of the postal surveys is the behaviour of non - responders. Non responders are a biased group who disproportionately possess or lack some characteristics of relevance to the study. It is arguable, if their absence from the respondent sample means that the results as a whole are correspondingly

biased (Luck et al 1988:202). Many studies have been conducted on attrition rates in postal surveys. Return rates for postal surveys have varied from lows of about 20% to highs of more than 90% (Ellis 1994 p183). Heberlein et al (1978) reviewed 183 mail surveys and concluded that the average return rate was 48% while Arnett contended that the average is nearer 30% (Arnett 1991 p553). To increase the return rate the researcher employed the following techniques:

I. A clearly written and polite letter was attached as cover letter

II. By using the university logo on all communications, credibility was assured

III. A stamped self address return envelop was enclosed

IV. Making sure that the questionnaire is well formatted and readable

V. The importance of the research and the future use of the findings were made clear

VI. Respondents were assured anonymity and confidentiality

These issues were addressed before the dispatch of the postal survey as it was not the intention of the researcher to chase up respondents who do not return their questionnaire.

5.2.3 The Pilot Questionnaire

Forty questionnaires were sent to clinical staff and managers of provider units in England and Wales. This is the first stage in the process of canvassing the views of stakeholders, as identified following the stakeholder analysis (see Chapter 4). Twenty-six questionnaires (65%) were returned fully completed with and very little structural adjustments recommended by the respondents. Some of the recommendations were:

- To extend the specific time limit for return of the questionnaire
- Format to change from landscape to portrait
- Provision should be made for more space for comments

The paucity of comments from respondents led to the formation of the view that the amount of time and attention that was given to the developmental stages of the questionnaire has paid off. In fact three respondents telephoned me to ask for permission to adopt the format to develop a questionnaire they were working on as they believed the structure and its clarity was the best they had seen for a long time.

The questionnaire was made up of nine sections and a total of 27 individual questions relying on the Likert scale in their development. Apart from one respondent who suggested splitting the questionnaire into two parts, all respondents thought the questionnaire was of manageable size. All respondents agreed that the questions were easy to answer. Most of the respondents do not use any effectiveness measures to identify areas where they think they were excelling. What was obvious was the high degree of concentration on process issues to measure success of the service they provide. Most of the decisions on the effectiveness of care were based on clinical judgement (the individual practitioner's knowledge and experience) or the legal authority the Mental Health Review Tribunal have to discharge patients.

Most respondents were aware of the purpose of outcome measures, which is to assess the effectiveness of interventions from various viewpoints including that of users. There was a general view that various stakeholders were approaching the problem from different points of view. As one respondent stated:

> *"unfortunately, purchasers have a different agenda to providers of services and co-operative planning and strategy is essential."*

Of note was the dissatisfaction of respondents on the question of adequacy of the service provided nationally. Respondents were of the view that there were too many

high security beds and not enough at lower levels of security. Further they were of the view that there was a need for increasing the number of long term medium secure beds.

Respondents agreed generally that services should be developed applying the Reed Review principles (DoH 1992 & appendix 1&2). The degree of enthusiasm for the principle "patients should be cared for as near as possible to their own families, if they have them" is not as highly rated as those for others. This is perhaps due to the fact that the service is a highly specialist one with patients numbers dispersed all over the country. There was evidence of the use of effectiveness measures by professional groups but these were not widespread nor were they multi-disciplinarily focused. Contemporary issues, such as the principles of the Reed were not incorporated into the planning of the service. Worryingly there was ample evidence indicating that there was a degree of sensitivity about research into outcomes as respondents warned about the implications of collaborating with the research. These issues and pressure points were duly noted and taken account of in developing the main survey and conducting the case studies.

5.2.4 The Main Survey - Questionnaires

The postal survey was in two parts (appendices 1 & 2). The first part sought the views of provider staff within the forensic mental health service and the other focused on purchaser staff. The later part of the postal survey targeted staff within health authorities and the High Security Psychiatric Services Commissioning Board (HSPSCB) with particular emphasis on those who have responsibility for commissioning services for mentally disordered offenders and others requiring similar services.

5.2.4.1 Provider Staff

The first part of this project concentrated on targeting the multi-professional staff of provider units (high, medium and minimum security levels). Of the two hundred and fifty questionnaires sent to NHS provider staff within England and Wales, one hundred and fifty were returned with all the multi-professional groups represented (see chapter 7 & 8 for detailed analysis). The one hundred and fifty (N=150) returned questionnaires amounted to 60% return rate. Distribution took the form of sending out questionnaires to chief executives or clinical directors of high and medium security hospitals, and staff working in the community to be completed and returned to the researcher. This process was adopted to ensure that acceptance and support for the research is secured from the top of the individual organisations. A proportion of the questionnaire was also distributed at conferences and others sent directly to staff whose names were provided by their professional associations who have agreed to releasing these names to the researcher.

5.2.4.2 Purchaser (Commissioning) Staff

In line with the research design (Chapter 1), purchasers and service regulators were also sent questionnaires which were designed to draw out their specialist contribution to the care of mentally disordered offenders in all sectors of the service. One hundred questionnaires were sent and eighty-four questionnaires were returned (N=84). This amounted to a return rate of 70%. The names of purchasers were taken from a database maintained by the HSPSCB.

5.2.4.3 The Main Survey: Individual Interviews

Interviews with key stakeholders of the service were conducted to ensure data, which was collected, was relevant and accurate. Some of these interviews were structured, while others were follow on interviews, in particular some key issues identified from the results of the survey questionnaires. Further, group interviews

were conducted with patients. In total, the researcher had conducted one hundred face to face individual interviews with health related professionals, managers and government officials, and a total of fifty patients. In addition, a total of four focus groups of patients was conducted, also the findings of the research was presented and discussed with an expert panel of ten practitioners and put to a consensus conference attended by 190 representatives from all disciplinary backgrounds within the health sector of the service.

5.3 The Case Study

Yin (1994) advanced the view that the three research strategies (Exploratory, Explanatory and Experimental) all have a role to play in conducting case studies depending on whether or not they satisfied any of the following conditions. These are:

I. The type of the research question posed
II. The extent of control an investigator has over actual behavioural events
III. The degree of focus on contemporary as opposed to historical events

The case study as an empirical inquiry was used to investigate the phenomena of outcomes measures as conceptualised in this research within the forensic mental health sector. This choice of method was to explain how the organisations chosen as the sites were evolving the clinical effectiveness agenda to include the subjective views of users of the service. The case study was used to formulate an understanding of the dynamics within the two field sites (a high secure hospital and a medium secure unit both in England and Wales) in respect of their enactment of social practice in achieving and communicating the rules that ensures effective functioning of these organisations. In particular, Giddens' structuration theory was used to explain the activities within the organisations that promoted the development and implementation of effectiveness (outcomes) measures.

Giddens structuration theory postulates that structuration occurs when the rules and resources of the organisational life are produced and reproduced through the elements of communication of meaning, the exercise of power and the evaluation and judgement of conduct of the various actors (patients and staff) of that particular organisation (see Chapter 4 for a fuller discussion). The main pillars of the theory are the entities of social structure (Signification, Domination and Legitimation) which in turn determines and constrains the behaviour of people. In the case of this study, the behaviour of managers, staff and patients was examined focusing on the way they created the environment for dialogue between practitioners and patients. The study focused on the way the rules and regulations that were essential for effective functioning of the organisations were communicated, the way power or control was exercised through the allocation and distribution of resources, and how sanctions were applied to ensure stability within the organisations. In all stages the views of patients on what is happening in the two case study field sites was sought to provide an understanding of how the aims and objectives of the organisations were being met.

This pluralism of approach was necessary to identify what was happening and to assess the degree to which it was benefiting those that it was intended to help. Giddens' structuration theory calls this pluralism a "duality of structure." "Duality of Structure" occurs when the pillars that constitute structure are joined by action creating "patterning" practices across time and space. In delivering this duality of structure, Giddens argued that agents (managers) of the organisations are best placed to change the rules that determine the behaviour of others within the organisation. The analysis of data from these sites took into account the degree to which managers were able to change the behaviour of the organisations in assuring effectiveness of practice.

5.3.1 The Design

The initial design of this research included the plan to undertake three case studies, i.e. high, medium and low security environments. They were chosen and permission sought and agreed by the various managers of the service. Although two sites would have been adequate given the comprehensiveness of the surveys and the consensus building conference, a third site was built into the design in case circumstances prevented access. In the event two of the sites will be reported as the service chosen to represent the minimum secure environment was experiencing a lot of managerial and employment issues that would have adversely impacted on the findings of the research.

The approach adopted has enabled the researcher to triangulate methods comprising of observations, unstructured interviews and archival searches to ensure a richer data collection and analysis. The role of the researcher in collecting data was that of a participant observer in one of the sites and as an observer in the other.

Figure 5.3 Case study design using Giddens Structuration theory for analysis

Elements of Giddens structuration theory	Theoretical framework	Data collection dimension	Mode of analysis/Realm of action
Structure *Modalities* *Realm of action* *Duality of structure*	Signification	Interpretive schemes	Archival searches, written documentation
	Domination	Resources; allocations, sanctions and rewards	Observation, interviews & focus groups
	Legitimation	Rules, regulations & judgement of conduct	Observations, patients and staff commments

Figure 5.3 shows the domains examined during the interaction stage (Duality of Structure). In the first instant a description of the service was made to assess the preparedness of the individual service in delivering its objectives. This included the size, capital and revenue costs of running them. Another aspect examined was the profile of the organisation, which included the length of stay, the diagnostic classification of patients in the service and the cost per case. The next aspect focused on clarification of roles in respect of representation for patients and staff and how the activities of these groups impact on the organisation and functioning of the service in terms of how relationships were formed both internally and externally.

Data was collected through a series of individual interviews by the researcher with staff and patients, examination of archival records and observations of interaction between key stakeholders. In particular data was collected on providing an overview of the services under investigation, focusing on building a profile of the service and a discussion of the issues that impinged on the conduct of this study. Next, this study examined the degree to which patients were involved in their care. Finally, the strengths and weaknesses of the case study sites were examined in respect of their ability to initiate and respond to change, evidence and the effectiveness of their structures in place for involving patients in care and the extent to which patients views were taken into account in planning and developing the service and their individual care plans. To conclude the case studies the degree to which effectiveness measures were being used was assessed. In particular the involvement of patients in their care in terms of advocacy, empowerment, building partnerships and the degree of subsidiarity in terms of freedom of action and the use and balance of power were made (see appendix 3).

5.3.2 The study sites

Case Study Alpha focused on activities within a high secure hospital while Case Study Omega was based on the experiences of this researcher in a medium secure unit. The sample group selection was based on the application of the outcomes of a

stakeholder analysis to identify the key groups that needed to be targeted (see Chapter 4 for fuller discussions on stakeholder analysis). In all two focus groups of patients were conducted within each of the two sites (Alpha and Omega). In the case of Alpha one of the focus groups was a cross section of members of the patients' council, involving twelve patients from all service areas (mental illness, women, learning disabilities and psychopathic disorder) of the hospital and from various diagnostic categories. The second focus group was conducted using a mixture of eight patients at different levels of recovery who were diagnosed as suffering from a type of mental illness. A total of twenty individual interviews of patients from various areas of the hospital were also conducted. Twelve members of the multi-disciplinary staff and six managers were also interviewed. Other methods used included observations and access to all records that were relevant to the research, such as the hospital's business plan, audit reports, the complaints' register, minutes of multi-disciplinary clinical team meetings and care plans. Recruitment of participants for the focus groups and individual interviews were mainly voluntary although a few numbers of patients contacted the researcher to be involved while a number of patients also refused to be involved. In the case of meetings, the researcher was allowed to observe and participate, providing clinical and management guidance to staff where necessary to improve their skills level. It had been mentioned that the role played by the researcher was that of participant and an observer. The researcher conducted this case study in this environment (high secure) employed as a consultant to improve levels of patient care over a twelve-month period (July 1995 - July 1996). During the period the researcher had helped in establishing a multi-disciplinary audit system which involved contribution from patients, a system for conducting clinical reviews also involving patients and a care planning system that involved the identification and planning of care based on assessed needs of patients. In return this researcher was allowed free access to all areas of the hospital, staff and patients. This unprecedented access was managed sensitively so that requests for co-operation with the research were not found to be threatening to participants. All individual interviews and focus groups were audio taped, transcribed and similar themes identified through the use of content analysis.

The same process was adopted for the study conducted in the medium secure sector (Case study Omega) expect that the collection of data was conducted by the researcher as an observer and lasted seven days. Two focus groups were also conducted, one involved eight patients from the rehabilitation unit and the other involving four patients from the assessment unit. Six individual interviews were held and consisted of four out patients and two in-patients. In the case of staff, the clinical director, two consultant forensic consultants, a senior nurse manager, one representative from psychology, occupational therapy and social work were interviewed. Additionally, six nurses (four unit based and two working in the community), a nurse tutor, a nurse behavioural therapist were also interviewed. While access to staff and patients were organised by this researcher in case study Alpha, due to the short term nature of stay in case study Omega access as to who to see and when to see them was organised by a senior clinician and manager. The results of the application of the case study method for the two sites are discussed in Chapters 9 & 10.

5.4 Focus Groups

Originally called focussed interviews, focus groups has its roots in the Office of Radio Research at Columbia University in 1941 when Robert Merton was asked to assist in evaluation of audience response to radio programmes. Focus groups are a form of group interview that capitalised on communication between research participants in order to generate data. Kitzinger (1995 p299) advanced the view that although group interviews are often used simply to collect data from several people simultaneously, focus groups explicitly use the interaction as part of the method. Kitzinger went on to argue that this is the case because the focus group method allow individual members of the group to talk to each other by asking questions, exchanging anecdotes and commenting on each others experiences and points of view. This assertion may seem to imply that focus groups could be unstructured and ill directed.

On the contrary, they are highly directed and structured interviews that have a defined goal and purpose.

Kitzinger argued that in the past decade focus group interviewing has gained so much popularity that the term is often used inappropriately. It is not unusual to see the term focus group applied to group discussions (study groups, community hearings, listening exercises), that are considerably different from the core principles that have historically been the hallmark of focus group interviews. Focus group interviews typically have five characteristics. These are that they involved a limited number of people, who possess certain characteristics and are engaged in providing data of a qualitative nature in a focused direction.

5.4.1 Features of focus groups

Goldman (1962) defined the term Focused Group Interview as having the following features. Firstly, it is a group activity and involves a number of interacting individuals having a community of interest. Secondly, it seeks information that is more profound than is usually accessible at the level of inter-personal relationships; it is therefore an activity of some depth. Thirdly, because of presence of a moderator who uses the group as a device for eliciting information, it is therefore an interview. Equally important is the need to sequence questions (see Figure 5.4).

They typically are composed of five to ten people, but the size can range from as few as four to as many as twelve. The size is conditioned by two factors: it must be small enough for everyone to have an opportunity to share insights and yet large enough to provide diversity. A rule of thumb is that the more expertise participants have on the subject the lower the number of participants in the group. They are composed of people who are similar to each other. The nature of homogeneity is determined by the purpose of the study. This similarity is a basis for recruitment, and participants are typically informed of these common factors at the beginning of the discussion. Traditionally, focus groups had been composed of people who did not know each

other, but more recently they have been very successful with people who are familiar with each other. However, power differentials between participants should be avoided. For example mixing health providers with users may be unwise because of the tendency for patients to be intimidated and defer to those who supposedly have more insight about the subject. Likewise mixing different categories of users or providers in the same group will limit open communication.

5.4.2 Uses of focus group method

According to Stewart (1991 p15), they are useful at virtually any point in a research programme but are "particularly useful for exploratory research where little is known about the phenomenon of interest." Its advantages lie in its ability to obtain data from a group of people quickly and cheaply. The groups can also be assembled very quickly as demonstrated during the pilot stage of this method, which is reported later on in this chapter. It can also enable the researcher to interact much more effectively with the group by asking for clarification of responses by group members and to observe their non-verbal responses.

5.4.3 Moderator's Role.

It is the role and function of the moderator that makes the process an in-depth interview. The responsibilities of the moderator include ensuring that the group discussions proceed smoothly. The essential features of the researcher's moderating strategy was the awareness of the fact that although asking quality questions is important, the acceptance of the influence that could be exerted on the results is similarly crucial. In short quality questions are important, but results can be jeopardised by the moderator by the desire to inject own opinions, answers, or values and these were curtailed. Listening too is very important. The role adopted by the researcher in terms of moderating was neither that of a teacher, providing instructions nor a participant in an engaging conversation but more like a sponge soaking up the insights of participants. The main approach was to guide the group

discussion using questions, pauses, probes, and eye contact to encourage participants and to engage to participate in the discussions.

5.4.4 Focus Groups - the pilot

The researcher decided to conduct four 45 minutes long focus groups so that the analysis of the results could look for patterns of themes across the groups. In the context of using this method, the researcher found that the groups produce data of interest, which was different from other groups where the goal is to reach consensus, provide recommendations, or make decisions (see chapter 12). The researcher found that the group worked particularly well within the rather narrow purpose of using this method which is to determine perceptions, feelings, and thinking of respondents to ideas, services, or opportunities. This focus was based on them expressing their views on their experiences of the service. Figure 5.4 shows the sequencing of questions, which was designed to gather answers and comments in both the respondents' own words, otherwise known as emic data as it arises in a natural and indigenous form. On the other hand etic data represents researcher imposed view on the situation.

Figure 5.4 Questionnaire Schedule: Sequencing (Order) of Questions

Group identifier: ***Name of Hospital:***	**Comments**
How long have you been in or out of Hospital? How many wards have you been on since your arrival in the Hospital? How long was your admission this time? What were your expectations before your arrival? Which of the wards you have been on best met these expectations? In what way did this ward meet your expectations? Now, do you think you are involved in deciding the way your care is/was planned? What do you think should be done to improve it? What do you think needs to be done before you are discharged from hospital? What support do you receive in the community? What would you suggest is the best way the effectiveness of the hospital is measured? If you are given the opportunity what do you think should be done to improve your care? When do you prefer to be asked about your views on your care? If your views do not agree with that of staff's what do you think should be done? Do you think that sometimes it is better to leave the decision making to staff? At what stage during your stay in hospital do you think staff are best left to make decisions on your behalf? What sort of decisions would you say are best made by you? What efforts do you think the Hospital has made to enable your views to be heard? Do you have any other comments do you have to make on your care?	

Further, questions at the beginning of the focus group were typically more general and were designed to enable participants to gather their thoughts, reflect on their experiences, and hear about the experiences of others.

The pilot was an opportunistic activity. It took place during a conference organised by the Department of Health to seek user perspective on a government report (DoH 1993). This report made various recommendations for the future provision of mental health. One of the report's recommendations was:

> *"That professional groups should work in collaboration with users in planning services and jointly in delivering the care"*
>
> DoH 1993

The sample group selected for this exercise comprised of eight ex-users of forensic services, having last accessed in-patient services in the past year. Three were currently receiving aftercare from the service and the rest, (five) no longer under the care of the service. All the patients were asked if they had used the service beforehand. Because the conference was a national one, most of the subjects selected were former users from various parts of the country and therefore had experienced different forensic services and brought to this meeting a very wide range of personal experiences.

This recommendation was a change from the normal government guidelines, which had consistently been recommending that users should be consulted when services are being planned. The group members were randomly selected. Participants were asked to note key areas, which were of concern to them, and to join others to discuss it after the conference plenary session. The recommendation was read out to the participants and explained as intended by the Department of Health, therefore setting and outlining the agenda and the structure of discussion. The approach adopted by the researcher was less structured to allow for issues that were of interest to them to be aired. This is so as to allow the group to function effectively after the initial complaints, dissatisfactions and comparisons with other services

across the country have been aired. This flexibility was allowed so that all participants could feel that they too have benefited from participating in the group and to allow participants to discuss what was important to them than merely fitting into the research paradigm.

The session lasted for forty-five minutes. At some stage during the discussions some of the patients started to compare the forensic services with general psychiatry and different sectors of the service. Though the information was useful it was rejected, as it did not provide any locus on the direction of what was on the agenda. These interruptions were allowed from time to time in order to ensure no information was missed. Stewart et al (1990 p11) discussed the use of such information and suggested that it is useful to the researcher to allow this flow of information provided the important issues for the research are satisfied. Although this latitude was allowed, the researcher adhered to the agenda that gave rise to the focus group which were - the types of information sought, the specificity of the information required and the way the information will be used.

At one point one of the participants who was consistently disrupting others walked out of the meeting when other members of the group decided not to allow the interruptions any further. This behaviour was important in understanding researching user characteristics in mental health. Within the context of this group, there were users who were at different levels of recovery and therefore able to behave inconsistently. The group member who walked returned to the group without prompting after a while and contributed effectively thereafter.

5.4.5 Lessons learned

The lessons learned with this pilot was that the information derived from this research is different in that it is in the participants' own words and needed to be analysed to draw out consistent themes. It was obvious from this pilot that the behaviour, particularly disruptive and persistent ones needed to be identified and

contingencies developed to take account of them should they happen during the main project. This process also allowed the researcher to ask for qualification on responses of participants and to identify key issues associated with their responses.

The pilot also helped in developing the schedule in Figure 5.4 above. Although one of the participants did try to disrupt the proceeding, albeit unintentionally, the researcher found that his absence did not curtail the quality and flow of discussions. Similarly the disruptions did not divert attention from the agenda but importantly group members asserted their rights to be heard. In particular this method was useful in the following ways:

1. As a first stage in the development of a questionnaire, they provided the researcher with the means for exploring ways of learning how potential respondents may talk about events and for identifying alternatives for closed-ended survey items.

2. It may be possible to use the approach as a confirmation of the findings of the research as similar questions and answers generated from one or more such groups can be said to be sufficient to be a representative sample of the larger population.

3. This method was helpful in obtaining general background information for the research, for seeking new ideas and concepts and had helped in generating views of users on service quality, effectiveness and appropriateness. The data generated by the use of this method showed that there were gaps in the services on offer.

4. On the negative side the group members could be said to possess a certain characteristics which may not be consistent in the larger group of service users. They may therefore not be representative of the larger population. This may be due to the fact that they were at various stages of recovery and the fact that they were a selected group invited to this conference has put them into a category, which may not be shared by others. Additionally, this method did not provide any hard data and so was difficult to quantified.

Focus groups provide data solicited primarily through open-ended questions but also through observations of respondents in group discussions. Generally focus groups are audio taped to capture ideas in the participants own words. However, the limited

number of participants and methods of selection of participants made quantitative presentation of data inappropriate. In the case of this research, a variety of recording which included audio tapes, contemporaneous note taking and eliciting the help of an assistant with short hand writing skills were used. Discussion topics or questions in the focus groups were carefully predetermined, sequenced, and targeted to provide answers on critical aspects of the study. The questioning strategy was used and involved asking prepared questions in a uniform manner in order to assure a degree of consistency and ability to compare responses from the various groups. The conclusions reached through the application of this method are reported in chapters 9 and 10.

5.5 Consensus Building Conference

Consensus building can be defined as a process whereby a decision is reached through the participation and contribution of members of a team to resolve an organisational problem. This process of decision making has been prevalent in the NHS prior to managerial reforms of the service, Griffiths (1989). Even though this approach has almost but disappeared in the management of the service, its use for changing service provision has increased. Professional staff have continued to use this approach to set clinical standards and to agree how these standards could be measured. The main aim of this approach insofar as the research is concerned is to enable an expert panel of service commissioners, providers and users of the service to act as a validation panel to re-examine the findings of the research and prioritise areas where outcomes measures could be developed. In addition to the information arising from the research, the panel was asked to comment on wider issues such as, how the findings of the research could be disseminated, ways in which the findings could be incorporated into planning the care of patients and the impact of political, legislative and regulatory considerations can have on the implementation of the findings. A shared view emerged from the participants taking into account the very diverse areas of expertise and of priority in terms of service planning and delivery.

The approach used, its usefulness and the conclusions of the conference are reported in chapter 12.

5.6 The hermeneutical approach to qualitative analysis

The hermeneutical approach begins with the assumption that facts are a construction, a part of a whole or meaning units (Ricouer 1981). It argues further that interpreters of data must keep in mind the larger context in which the text is embedded if he or she is to truly understand its meaning, whether the information is a numerical fact or qualitative text. This would enable the interpreter or researcher to truly understand its meaning. The method therefore maintains that a particular text must be understood in the light of the entire text and likewise the entire text must be understood in terms of its components.

Key to this approach is the acknowledgement that the interpreter brings to the analysis his or her "fore meaning" or assumptions based on previous experience - that of research, as well as personal and cultural knowledge. Rather than being an objective and "value neutral" undertaking, hermeneutical analysis is seen to be the result of the interaction of a unique interpreter, who draws upon his or her full means of comprehension and intuition in order to understand a text. Gadamer (1984) describes this process of understanding of the text as "all its newness". Interpretation of the text is undertaken in a systematic and orderly manner which is described as intellectual craftsmanship (Mills 1984).

There is also a difference between hermeneutical and standard quantitative analysis in terms of methodology. Basically, the hermeneutical approach does not depend on a particular method but the view that the approach is a way of viewing social reality. The focus of the approach is on the researcher respecting the integrity of what is being said and making deductions based on what emerges from further questions. Another aspect of this approach is that perfect agreement between researchers is

not expected but where differences of interpretation appear, it must be clear how each arrive at their respective conclusions.

This approach was used to interpret data derived from interviews with patients (focus groups), individual interviews and the case studies (appendix 2). This approach was necessary because of the nature of the service, which is, traditionally suspicious of any research, which focuses on patients. The interpretive nature of this approach enabled the researcher to observe behaviours of interviewees in their usual settings and to learn what is meaningful or relevant to them, how they experience hospital life, record their aspirations, and assess the degree to which what is being said relate to that of others within the same environment. It was expected that comments made during interviews may not be entirely an accurate reflection of what is happening and that their meaning may lie in the wider contextual issues. The researcher is aware of some of these issues and is in a position to provide the understanding necessary.

Consistent with the hermeneutical approach and therefore the orientation of this study, the information derived by applying these methods and approach was put to a consensus building conference. The hermeneutic approach was used in order to confirm a standpoint that social scientist's task should be to appreciate the different constructions and meanings that people make of different situations. Within the forensic sector, patients generally accept the reality of being "locked up" and wanted to make the best of the situation they find themselves in. Any researcher needs to experience or be able to learn and share their trials and tribulations and the way the individual react to them in order to access a meaningful and richer information.

5.6.1 Data Analysis

The data from the pilot study of the survey has been reviewed, the full report has been discussed earlier in this report. The data from the survey method (individual interviews and questionnaires) was collated and SPSS used to aid the analysis. In

the case of the focus groups and aspects of the case studies the data collected by using a conceptual framework based on Giddens' structuration theory. Content analysis was also used to develop the thematic approach to the analysis of the data.

According to Miles and Huberman (1994), interpretivism as an approach to data analysis holds the view that researchers are no more detached from their objects of study than are their informants. They argued that 'researchers have their own understandings, their own convictions, their own conceptual orientations; they too are members of a particular culture at a specific historical moment'. The choice of hermeneutics was designed to promote this standpoint.

5.7 Reflections and conclusions

To conclude this chapter, the researcher attempted to offer an explanation of the rationale underlying the methods chosen in this research and discusses the lessons learned during the course of their operationalisation. The central belief throughout the course of conducting this research in as much as the methodology is concerned, is the belief that the methods chosen are linked to the assumptions the researcher holds about research in the social sciences. Which is that it is possible that the two ideological standpoints (positivism and phenomenology) could co-exist in social science research. The important point to follow is that the method selected was the best to meet the objectives of the research plan in terms of the nature and source of the data required. The differences between phenomenology and positivism have been discussed and so were the basic assumptions that underpin their influence on research methods. Given the secrecy that pervades within the forensic mental health service shrouded under the guise of patient confidentiality, the methods used in this research had proved to be acceptable to the majority of stakeholders.

The measurement of outcomes generally assumes a focus that is clinician or service provider led. It is true that staff do ask how patients are feeling but these views are not elicited in order to develop a standardised measure that is able to record the

minutiae of changes in the individual's health status. The focus of this research is not an attempt to standardise care per se, it is however a means of identifying what could be done within the resources allocated by reaching a consensus on what is best practice from the commissioning, provider and the user points of view. It also built on current best practice by evaluating procedures and measures, and assessing ways in which these could be developed.

The approach adopted to identify issues to prioritise during the course of the research had been evolutionary but systematic. It started with identifying the issue for the research and then selecting the most appropriate method for data collection. In this sense the approach could be likened to action research. Action research is a variant of quasi-experiments. It involves a planned intervention into some naturally occurring event. The effects of the intervention are then monitored and evaluated with the aim of discerning whether or not that action has produced the expected consequences. In this paradigm the researcher has acted on his beliefs and theories seen in the wider context of the experiences of participants of the research. The next six chapters will report on the application of the methods discussed so far.

According to Miles and Huberman (1994), interpretivism as an approach to data analysis holds the view that researchers are no more detached from their objects of study than are their informants. They argued that 'researchers have their own understandings, their own convictions, their own conceptual orientations; they too are members of a particular culture at a specific historical moment'. The choice of hermeneutics was designed to promote this standpoint.

PART FIVE

Application of the methods - Results

Chapter Six

Rapid appraisal method

Introduction
Discussions of the findings
High security hospitals and the effectiveness agenda
Effective commissioning and outcomes measurement
Advocates for change
Engaging the external environment
The change agenda
Reflections and conclusion

Chapter Seven:	Survey questionnaire (Provider staff)
Chapter Eight:	Survey questionnaire (Purchaser staff)
Chapter Nine:	Case study (High security hospital)
Chapter Ten:	Case study (Medium secure unit)
Chapter Eleven:	Comparing methods

Chapter Six: Application of the methods - Results (1)

6. The Rapid Appraisal Method

In this chapter the results of the implementation of the Rapid Appraisal Method (R.A.M) is reported. This chapter summarises the one to one interviews conducted during the start of this research, which was designed to increase the knowledge of the researcher of the researched. Subjects for this part are mostly senior NHS practitioners and government officials in the Department of Health and the Home Office. The R.A.M is a method of getting information about a set of problems in a short time and without a large expenditure of time and expense. Figure 6.1 represents the interviews conducted to gather preliminary data for the conduct of the research using the Rapid Appraisal method. Forty practitioners were consulted and each was asked to suggest issues and views that are pertinent to the measure of outcomes for the mentally disordered offender. The issues raised were collated and presented to the participants to prioritise; each practitioner was allocated a total of ten marks to award, with five marks the highest they could award to each issue. The top twelve issues are as depicted in Figure 6.1 below.

Issues raised during the application of the Rapid Appraisal process were helpful in developing the research design and in particular, the questionnaire surveys. As shown in Figure 6.1 below, some of the key areas that the interviewees thought needed to be addressed to advance the research to its successful conclusion are listed. Obviously the problems of access is an essential issue to be resolved in as much as the type of questions asked and the selection of field sites for the case studies.

Figure 6.1 Outcome of Rapid Appraisal Method

N=40

Practitioners consulted Scores (*)		**Issues raised**	**Priority scores** Aggregate X 5 marks
Service Providers			
Professor of Forensic Psychiatry	(2)	Involvement of patients	**30** (*150)
Consultant Forensic Psychiatrist	(5)	What is being done to measure outcomes.	**30** (*150)
Director of Nursing	(4)	What's happening with Reed	**20** (*100)
Senior Nurse	(4)	How do patients want their effectiveness of service to be measured.	**38** (*190)
Primary Nurses	(6)	How are staff judging the effectiveness of the service they are providing	**40** (*200)
Nurse Tutor/Educationalist	(2)	Nature of Clinical Outcomes measures	**25** (*125)
Social Worker	(2)	Multi-disciplinary working contribution to effectiveness.	**25** (*125)
Occupational Therapist	(3)	How are purchasers assessing service effectiveness	**35** (*175)
Clinical Psychologists	(2)	Balance of empowerment between staff and patients.	**25** (*125)
Chief Executives	(2)	The extent to which patients are involved in planning their care.	**33** (*165)
Policy Formulators			
Department of Health	(2)	Ways of involving others in developing risk packages	**30** (*150)
Home Office	(2)	Managing Access problems	**25** (*125)
		Developing common languages	**20** (*100)
		Recruitment, training and development of staff	**24** (*120)
Service Purchasers			
Health Authority	(2)		
High Security Psychiatric Services commissioning Board	(2)		

6.1 Discussion of the findings
High secure hospitals and the effectiveness agenda

Majority of patients who use the forensic services are within the high secure hospitals. This means that assessment of effectiveness of care starts from and ends there for most of the patient population. Their role in advancing the effectiveness of intervention is a critical one. The High Security Psychiatric services Commissioning Board (HSPSCB) has national responsibility for commissioning and purchasing of all services for three hospitals in England and Wales. The Director of the HSPSCB was asked to comment on how he could influence the effectiveness agenda as commissioner of healthcare for the high security hospitals, he said:

> *"Well I mean the first thing is through the purchaser/provider mechanism, is what I should be doing over the next four to five years is, I shan't be trying to tackle every single issue with a scatter gun. We'll focus on four key aspects and work together to improve quality of care."*
>
> **Service commissioner**

He went on to describe the importance of linking the views of users to the selected areas and form a network of users across the country to monitor and assess the effectiveness of the service based on the selected criteria. He thought that focusing on performance management would clarify the external profile of the Board as one that is working towards involving users in all stages of care provision. He further discussed other areas of development his Board was working on to improve the quality of the service. The first of which was training and development, which involved developing curricula with the Royal Colleges. Secondly, the development of long term medium secure facilities to transfer those patients in the high security hospitals who do not need to be there but are not as yet ready for transfer into existing facilities was another agenda he was pursuing with the Board. Finally, the research agenda is what in his opinion would lead the organisational change that was needed to meet the demands.

> *"And the third bit that we control directly, is the research agenda. You know, we have a huge research budget and I will put in place new mechanisms that wasn't there before to see that research in this field is at the highest quality that*

I can drive it, making sure that three special hospitals are treated just as rigorously as the rest of the NHS."

Director of commissioning

Asked in the light of the change agenda, if the development of outcomes measures was a priority, he said:

"One of the priorities we have set in this year is to say that because we know so little about what constitutes both input and outcome in PD (psychopathic disorder). We are giving particularly high priority in the first couple of years to pushing for more greater research in personality disorder. We have got to take bite size chunks as specific areas, and say, right ok let's start and stimulate some work there. But the agenda is so huge".

The issue of effective care and treatment of people who were diagnosed as psychopathic disorder was one that required a lot of thought. The purchaser approach in terms of assessing the effectiveness of the care was to link that with offending behaviour (see chapter 7). There was a view that forensic psychiatry cannot completely guarantee offending behaviour as it has nothing to do with mental illness. The guarantee that the general public and the press want is total abstinence from criminal behaviour. Obviously, mental health services cannot guarantee this where there is no clear evidence there is a mental illness and that such criminal behaviour relates to the disorder. This theme was further expanded on by the director who linked it with the current debate in the national press about mentally disordered people who commit murders.

"Now the asylums are not there it can't be hidden in the same way and, put it this way, nobody goes to a cardiac surgeon and says, we demand from you a 100% success rate. No cardiac surgeon can guarantee that. So why does society have the right to ask mental health practitioners 100% guarantees."

Director of commissioning

Reminded that the message was not getting through to the public, he asserted:

"But again because of that one of the medium term priorities of the next two years is to look specifically and give priority to ways in which the Department of

Health, and the national level can start, perhaps thinking about some campaigning tactics to help challenge some of that stigma."

Director of commissioning

He contended however that the education of the public was just one of the many options on the agenda to be tackled. He argued that the constant complaint of staff who work in places such as the prison and the high security hospitals that they were looking after the most dangerous of patients in the mental health field did not provide others the confidence to change their attitudes towards the mentally ill. He suggested an approach that was individualistic and focused on review of incidences that were thought to be critical in the life of the patient as a form of care planning.

6.1.2 Effective commissioning and outcomes measurement

The importance of developing risk assessment and management packages that are consistent and are researched for their validity and their reliability is an important one in the case of any organisation, which is charged with protecting the safety of patients and others. This question was put to a service commissioner with a view to using the risk assessment model as a means to effective purchasing. He replied:

"Well it can. But what you really need to do is to say OK we will do that together we will take the risk together and share the problems together, manage it together. If you say to them (providers) take risks and we will support you from a distance, they will think you are mad, with justification. It is a question of putting your money where your mouth is, if you are asking people to experiment you should be there to support them if things go wrong. Its a very risky and political environment but you have got to do it otherwise you are not going to see huge improvements".

Senior commissioner

He went on to argue that this approach is needed to provide some "cushion" in case problems arise as a result of positive risk assessment. He added that the beauty of contracting within the forensic environment was precisely to use it as a lever for change in culture, keeping cognisance of the history that have and continue to beset the service particularly within the high secure hospitals

sector. He cautioned however that this approach of support and encouragement in contracting needed to be backed up by involving patients.

> *"From the premise which supports the idea that patients should be involved actively, not lip service, actively involved we need to ensure that the outcomes can be demonstrated to us and we need to have that demonstrated and it has to be done under contract".*
>
> **Commissioning manager**

Delivering this agenda needs to involve patients more than is presently the case. Another purchaser was asked if this could be achieved through the contracting process. She answered

> *"Commissioner need to check, need to talk to people, the people who matter, the patients. We need to engage patients, and relatives - they are very important, previously they have been left out in terms of how services are provided, we need to bring them into the fold and they need to be involved as partners".*
>
> **Commissioning Manager**

The degree of importance attached to involving patients as a theme was taken up with a senior civil servant in the Home Office. The Home Office has a role in the way mentally disordered offenders are managed in the forensic sector. They can refuse to grant permission for restricted patients to be transferred to or discharged from any hospital and can also determine where such a patient should live and what to be engaged in when in the community. This civil servant was asked to comment on how the Home Office could influence the behaviour of clinical staff and managers to increase their effectiveness by involving their patients in the planning, implementation and evaluation of their care. She explained:

> *"You may be aware of the home Secretary's role is to assure protection for the general public from some 3,000 patients, in hospital and in the community by ensuring that they are only discharged when they are safe to be discharged. I do think in discharge of this role we may be right to insist evidence before making decisions, and we do, much to the angst of clinicians. The staff at the Home Office dealing with these patients are not trained clinically. We are now being advised by clinical staff on this, and we will be issuing a new risk assessment protocol which will add to better care to the patient."*
>
> **Head of Section**

6.1.3 Advocates for change

Patients' relatives or carers as advocates are one of the many innovations arising from the patient empowerment agenda. A commissioner was asked to explain what impact relatives or carers could make to the benefit of effective care provision to patients. She commented:

> *"They can be good patient's advocates. People who are genuinely interested in-patients - they too can be used to improve the quality of service. I don't see why we should not work closely with them with patient's permission to check the health of the organisation because they know. They have years and years of experience, its one way of getting information".*
>
> **Strategy Director**

When asked to comment on how commissioners can influence that change she concluded that:

> *"Commissioners are the biggest and strongest patient advocates. The feedback one gets is one way and one can always find out what the state of any organisation is by the extent to which the patients complain. You can find out a lot through the turnover rate extent I think this is a reliable indicator as to what is going on. You expect in any organisation to have a certain amount of turnover of staff so if people are leaving in droves or not leaving you ask yourself why".*

Arising from the view that commissioners are good patients' advocates, a commissioning manager was asked to comment on the way the contract for services in the high security hospitals could be used to change behaviours in terms of developing outcomes measures. He replied:

> *"One of the things that is quite relevant is the issue of measuring outcomes, what the outcomes are before one start measuring. In forensic psychiatry we haven't really looked at that and I have a belief that through commissioning you can push people into effective outcomes".*
>
> **Commissioning manager**

He continued by outlining the way this could be achieved but felt that there were issues in the system, which were militating against taking this approach. He thought that the high secure hospitals were not fully integrated in the wider NHS in order to use the contracting agenda to effect change within these hospitals. He added that the contract with these hospitals were in 'block'

instead of per 'case' basis. This meant that the focus was on achieving efficiency and not effectiveness targets were being prioritised. He concluded by saying that:

> *We block contract for services as block, we treat patients as a category, we don't tailor that to the needs of a particular individual, we look at them as a group and contract to them for a group. I think that if we are looking at outcomes we should begin purchasing on behalf of individual patient and by that I mean looking at the patient's needs".*

Another commissioner commented on the usefulness of clinical protocols and practice guidelines and concluded that the language used in psychiatry is not universal enough to rely solely on them to determine a change in culture towards effectiveness measures:

> *"I think the language we use is not common to the practitioners in the UK less in the international context, we need to develop an international language so all practitioners could understand what the clinical agenda is thereby helping effective research".*

He went on to lament about the difficulties surrounding the definition of "Personality Disorder" and the complex nature of finding effective treatment programmes for them. The need for developing effective treatment rests with research, development of staff and the service to fully meet the need of the patient. This should be done in a concerted manner. He added:

> *"We must find a catalyst for moving away from the medical model so that we can have a broad generic model which takes into account patients' social, educational, psychological, clinical, physical needs and so forth. The programme is massive and need a lot of convincing to gain professional confidence. A programme of this nature must be supported".*

Some practitioners asserted that the call for the development of a common language is a diversion from insisting on effective and appropriate care. A senior medical practitioner defended this approach by arguing that a common language should help us all appreciate the importance of communication in the clinical context but went on to assert that:

"The immediate things we could be doing is look at quality of life issues, the need to put more emphasis on how patients can lead an independent life outside hospitals, how they can walk into social amenities for instance".

Director of Public Health

In improving health care for mentally disordered offenders the issue of effective purchasing cannot be overlooked. There is also the distinction between care and treatment to contend with in this area. A senior director of commissioning was asked to comment on the effectiveness of the service purchased from the high security hospitals. He started by clarifying the difficulty in developing effectiveness measures in the mental health service by drawing on experiences from other sectors of the health service. He commented:

"Well the truth is in mental health, nobody knows. The example I often give is oncology. I could go anywhere in the world, and if I said TNM stage 3-breast cancer, it did not matter whether I was in Rochdale or Rio de Janeiro. If I said TNM stage 3-breast cancer we all knew what we were talking about in terms of tumour mass, nodes, metastatic spread, and we knew to the n^{th} degree what we were all talking about. You look for similar definitions in mental health, in schizophrenia or particularly personality disorders; there is a distinct lack of common language. What you call, or how you define personality disorder in England and how you approach that might be quite, quite different to Holland or Sweden or in Scotland. So in mental health we lack a robust common language which is an immediate problem in my view".

Director of HSPSCB

Asked to expand on how critical was the development of a common language to the effectiveness agenda he argued that the link between a common language and outcomes is a very strong one as many practitioners find it difficult in separating what constitute a process or an outcomes issue. The development of a common language seems an appropriate aspect to pursue but it is much more difficult in practice to develop a consensus. This commissioner was asked to develop further his view as to what the steps ought to be. He replied:

"Oh, I am a pragmatist. If we wait for Royal Colleges and other groups to do it, we'll be here forever. I think what we've got to try and do is what I call "quick and dirty" and we've got to do it from every angle"

He went on to cite examples of the complexity of the task from finding a high profile mental health interest group, working with users and the professional staff to come up with the key areas and agree a common measure that was acceptable to all stakeholders. He argued that if a patient who was suffering from a schizophrenic form illness would prefer to be "free of hearing voices" and a practitioner prefers this patient to be taking medication to control the voices with debilitating side effects, there should be a common ground for a compromise if the patient was able to manage the commands of the voices. He added that this approach would enable better targeting of the needs of the patient, which may be better accommodation and support to live constructively in the community. He drew on his past experience to support the line of his argument by saying:

> *"I chair a facility where I work with a lot of very damaged people who have been users of services for years. They will often say to me, look I'll trade hearing a few voices for a lower maintenance base of anti-psychotic medication. I'll handle the voices, I know how to do that, and I've had 20 years experience. Let me trade a somewhat lower dose of maintenance so I get rid of these nasty side effects. I'll live with the voices, but by lowering that and giving me less problems I am more able to keep on, or perhaps have a chance of getting up, getting a job, getting some social contacts, getting myself together better, but I need to have professionals that respect me and trust me enough as an individual citizen to trade with me, but we don't do that in forensic mental health enough".*
>
> **Director HSPSCB**

He developed this theme further by adding that we need to take the holistic view of what we mean by a good outcome and endeavour to include the users of the service more in decisions that affect them. He argued that taken that the average length of stay particularly in the high security hospitals was eight years, while others could be there for more than twenty-five years this approach was worth taking given the complexity of the problems presented within these environments.

> *"It seems to me that what we have got a chance to do in forensic mental health is a far more intensive debate with our users because we get to know them better, and really do some interesting work around this, in a way perhaps that mental health might not be able to do so readily".*

While this method of negotiating treatment options with the mentally disordered offender may be a preferred option the reality of it might not be particularly easy as a sign of mental ill health is often the inability to retain a great degree of insight into the illness. This view was put to the commissioner but he retorted:

> *"Nor can women with breast cancer. If you look at all the research by Peter Maguire in the early 80s, he found that when a woman is diagnosed with malignant breast cancer the psychiatric morbidity goes through the roof in those women, and their mood changes dramatically while they are coming to terms with living with a life threatening disease and all the uncertainty that comes with living with breast cancer."*
>
> **Commissioner**

He argued that if oncologists can work with that in oncology, the same should apply to people working in mental health. He went on to draw comparisons with people living with AIDS and HIV to explain the emotional fluctuation people go through and concluded that health workers were working successfully with these groups. There is a view that the chronicity of the disorder in mental health means that care providers are often frustrated and demoralised with repeated failures. He defended his line of argument that:

> *"If you are going to engage a group of people using services in a meaningful way, you don't have to do one snapshot and say there we are we've done it. It's like painting the Forth Bridge. You start painting the bridge; you get to the other end and have to start all over again. It's a continual loop of feedback and communication, and that's the approach that this work should going to have to have".*

6.1.4 Engaging the external environment

There is evidence that supports the view that, politicians, the press and the general public do not accept risk taking for patients in these environments. This means that any new strategy that does not have the certainties defined from the beginning makes it harder for staff within these hospitals to work effectively. This approach can inhibit creativity and effective rehabilitation of patients. A senior practitioner was asked to explain why this was so and how effective risk management models could be used to improve the effectiveness of the service. She thought this is due to multiple reasons but highlighted one:

"It is the fear of the other poor outcome, particularly, I mean whether we like it or not society expects us, as professionals to do as much as we can within our professional roles to protect the public. To maintain the public's safety - and I suspect that people use that bit of the outcome to dominate the whole agenda. The result is you get a command and control mentality because that bit of the outcome takes precedence over other bits of the outcome. Now politically it is easier to understand why that happens, but it seems to be our job as professionals to work with users to find sensible ways to manage that".

Consultant Forensic Psychiatrist/Clinical Director

Asked if she thought the service can guarantee that public safety at all costs and at the expense of professional development and effective practice, she replied:

"Well in high security hospitals the public expects that if the patient is committed to a high secure environment, they're not going to escape.

Consultant psychiatrist

When pressed to discuss the security aspects and what impact that could have on the treatment of patients in these hospitals and to broaden the discussion to include the rest of the service particularly at the point of discharge from forensic services, she said:

"Well that's the reason for identifying outcomes, isn't it?"

Another point was that expressed by users by not wanting anything to do with the forensic mental health services once they were discharged and did not have any legal reason to be in contact with the service. A senior practitioner thought this might be due to the following factors:

"I have worked with users all over Eastern Europe and the truth is that so much of what we, the professionals, want to offer is based around therapy, somebody's model of care, a clinically dominated agenda. When you talk to users, particularly those with enduring mental health problems, they will accept some of that, they're not blind to that, but frequently they say well I want somewhere where I can be a social animal, where I can have relationships as a normal human being, not as a schizophrenic or a manic depressive. Where I can go to an environment where I'm just going to be me, and people are going to treat me as me."

Director of Nursing

Another thought it might be due to the way medication is used and seen by users as the only method of caring for people. In mental health in general there is a high degree of default on medication, thereby lowering the compliance level to worrying degrees. He explained the issue as due to:

> *"Well there is a recent study from the Royal Pharmaceutical Society of Great Britain on compliance with medication. All research and everything shows very clearly that the more information the individual citizen gets from a skilled professional who is happy to share that information openly and in a way that suits the individual compliance goes up. That's where we've got to get to".*
>
> **Consultant Psychiatrist**

6.1.5 The Change Agenda

Some of the commissioners suggested a change agenda, which included the development of clinical guidelines or protocols that could help in establishing an effective framework for outcomes measurement. They warned however that the agenda was complex and needed to be well directed. It was suggested this approach would help standardise treatment protocols across the forensic services. Another way of improving the care and treatment patients receive was to define the need to prescribe an appropriate dose of medications that was beneficial to the patient and not debilitating to the patient in terms of their adverse reactions. Equally contentious was the seclusion of the mentally ill from the ward social environment when disturbed. Information Technology too was said to be crucial in the development of outcomes measures. Areas of note should be the capacity to understand and accept the rudiments of effectiveness from the patients' point of view and should concentrate on the following:

1. Insight
2. Treatment issues - particularly the use of clinical judgement
3. Compliance
4. Co-operation

Another point of note is the issue of moral judgement. Should patients who have committed a crime be said to have forfeited their rights and that the

punishment of removal from the community is the retribution the public deserves? If that is the case do practitioners have further right by withdrawing rights as citizens while in the hospital? What happens when the patients' behaviour in hospital makes it unsafe for others, for example when they are "acting out" aggressive behaviour. Is there a need for further retribution? Can the patient be said to be culpable by the behaviour exhibited in the hospital? Is the hospital a microcosm of society and are practitioners society's role models and police.

Most of the interviewees were of the view that, it should be the mental disorder that necessitated admission to hospital and not criminality. Although they were unanimous on the fact that the clarification needed was not as yet available. They argued that the definition of mental disorder was not clear nor was its aetiology and as such there would be people who were on the borderline of normality and disorder who might find their way into the hospital system. The main action to take therefore should be to be guided by the available evidence in determining placement of offenders. They were of the opinion that once someone was admitted into hospital their status as patients should be assured. However, this perception has its opponents as recent documentary on the high secure hospitals on the British Broadcasting Corporation has shown (Sallah 1997). According to the programme aided by some key stakeholders of forensic care concluded that the humane policy introduced into one of the high secure hospitals which placed an emphasis on the function of the hospital as hospital with patients and not as prisoners failed. This, it was asserted was due to the lack of control which staff in the old system had in managing patients effectively and the present situation where patients are allowed a greater say in their care and management.

6.1.5 Conclusion

Key policy makers, clinical leaders and managers were also asked to comment on the viability and the political acceptance of the research project. The interviewees were of the view that the measure of effectiveness of care of mentally disordered offenders is very important and that patients should be

involved but were not quite sure at what stage of their illness. They thought that the Home Office must be included in the determination of any criteria for measuring effectiveness because of their executive function which is enshrined in the Mental Health Act 1983 (the Home Secretary has the power to discharge or transfer a patient who is detained in hospital). They also thought the exploration of the degree to which the Home Office and the Department of Health review of the service (Reed Review) might also be useful.

However they cautioned that problems of confidentiality, patient co-operation without the fear of recrimination, co-operation of professional staff for fear of discrediting their work and access to the service may be the main barriers to the success of the project. All the interviewees agreed that a measuring tool of this nature should be designed to embrace all aspects of care, including the views of the patient. They further agreed that future use of these measures would enable the service to set national standards and would be useful in informing commissioning decisions and policy formulation. The use of this method has provided a snapshot of the issues that needs to be addressed in developing outcomes measures for use in forensic mental health services. It has enabled the researcher to involve professionals and others from the outset as their acceptance and agreement of the objectives, scope and nature of the research is crucial, as they are the key stakeholders of the research findings. This approach has provided a degree of stability upon which the research could progress, emphasising the view that this type of research cannot rely solely on what health practitioners think but should also include the views of users. What was clear from this position was that the main aspect of developing outcomes measures in the service will be a process of fitting jigsaws together to provide an environment where consultation with all stakeholders could be made. The conclusions drawn following the use of the Rapid Appraisal Method together with the impressions formed during the review of the literature helped in conceptualising the research problem and the identification of issues that were taken into account in the development of the survey questionnaires which is described in the following chapters.

Chapter Seven: Provider staff questionnaire

Introduction
Demographic profile
Views on service provision
The Reed review
Multi-professional working
Inter-agency working
Measuring effectiveness of care
Conclusion

Chapter Seven: Provider staff questionnaire

7. Introduction

The main postal survey was conducted in two parts. The first one was to trawl the views of professional and managerial staff on the effectiveness of service provision for mentally disordered offenders from provider staff and the second part addresses the views of purchasers or commissioners of healthcare who have responsibility for commissioning services for mentally disordered offenders. In the case of provider staff 300 questionnaires were despatched and 150 (50%) returned (N=150). Service commissioners were sent 150 questionnaires and 100 (71.7%) were returned (N=100). No other reminders were sent as this would have raised respondents suspicions unnecessarily. The general areas addressed in both sets were the level of experience and places of work of respondents. Respondents' views were also asked for on the national adequacy of service provision and so were their comments on the government inter-departmental review of the service in 1992 (DoH 1992). Further their comments were sought on the multi-disciplinary and inter-agency collaboration nature of their services. Finally, comments were asked for on how service effectiveness is being measured in the service and what areas could be prioritised in developing outcomes measures. This part of the questionnaire concentrated on eliciting the views of respondents on whether or not they thought their respective services are effective, what effectiveness measures they were using and how they rate these in terms of achieving what they were intended.

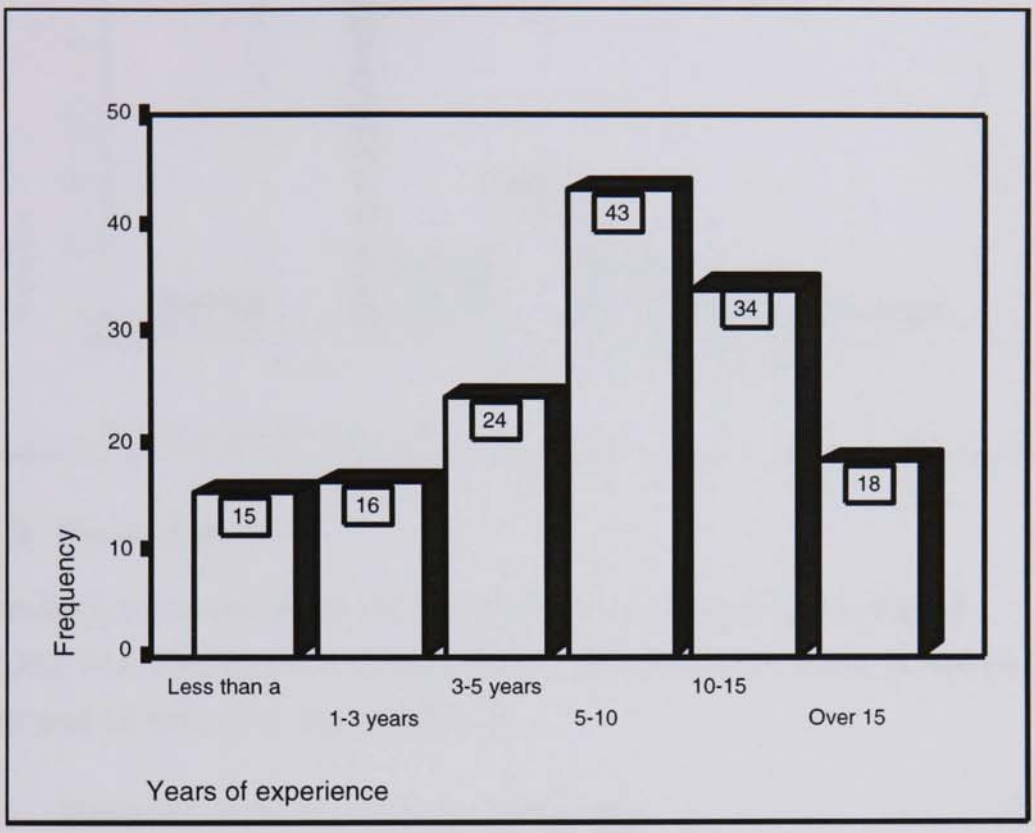
7.1 Demographic profile

The questionnaires for the provider staff were distributed through their service managers, at conferences and mailed to individuals on mailing lists of some of the professional organisations who offered to submit a list. In all 150 questionnaires were returned and the decision was made to proceed with their analysis without further prompting. This decision was made taking into

account the views of individuals who responded to the pilot questionnaires. The areas for which responses were collected are discussed below.

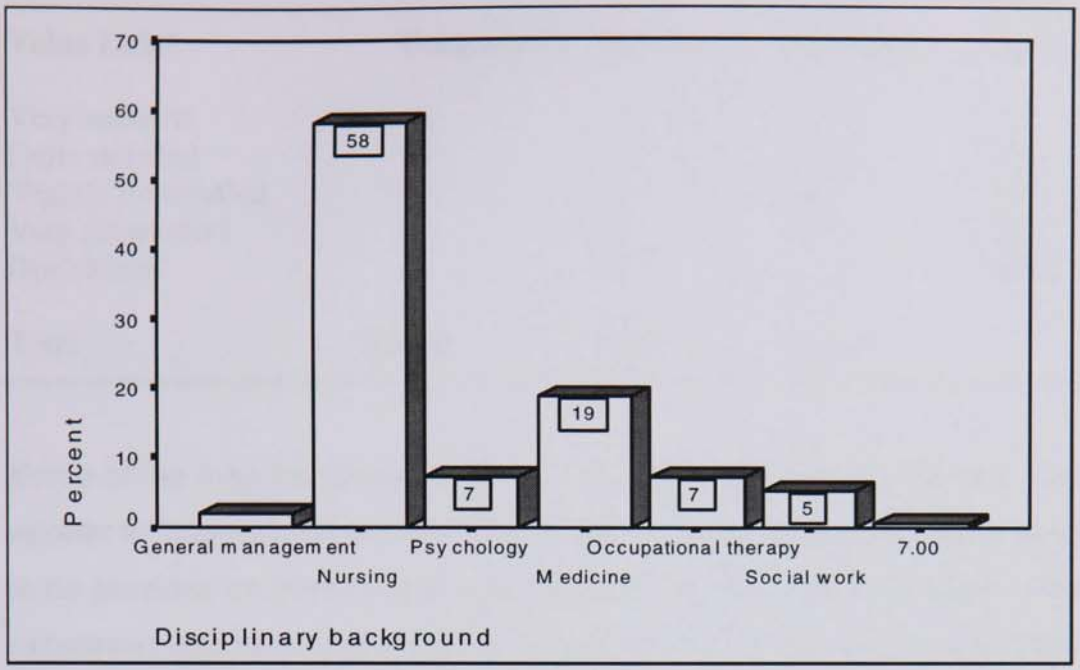
7.1.1 Years of Experience

Table 7.1: Years of Experience



Respondents were asked to identify the number of years they have been involved with the care of the mentally disordered offender and others requiring similar services (MDOs). As Table 7.1 shows most of the respondents to this questionnaire were experienced forensic practitioners whose average years of experience fell within the 5 - 10 years range and that most responders have experienced within the service of over three years (mean=3.8years) and the standard deviation being 1.47 years. The disciplinary base of respondents were shown in Table 7.1a. It shows that most of the respondents are from the nursing background, follow by medicine (psychiatry) and the least represented group is general management. This may be due to the fact that most of the respondents do have a professional background even though they may be operating within these hospitals as general managers.

Table 7.1a Disciplinary Background



7.1.2 Place of Work

Of these questionnaires 55 (36.7%) was from high secure hospitals, 77 (51.3%) from the medium secure sector, 6 (4%) from the minimum secure units and 12 (8%) from the community.

7.2 Views on service provision, nationally

Table 7.2 below shows the degree of dissatisfaction staff who work within the service have for the lack of comprehensiveness of service provision. It shows majority of respondents were not satisfied with what is on offer (slightly dissatisfied=46.7% and very dissatisfied 40.7%).

Table 7.2 Satisfaction with national provision

Value Label	Frequency	Percent	Valid Percent	Cum Percent
Very satisfied	4	3	2.7	2.7
Quite satisfied	14	9	9.3	12.0
Slightly dissatisfied	70	47	46.7	58.7
Very dissatisfied	61	41	40.7	99.3
Don't know	1	0.7	.7	100.0
Total	**N=150**	100.0	100.0	

Some of the reasons given for this dissatisfaction are listed in figure 7.1 and appear to hinge on the fact that there are no justifiable reason for the service to be provided on parallel basis with general mental health. Concerns were expressed that the service had not moved on that much over the last thirty years in terms of providing patients with interventions leading to effective outcomes, and developed on multi-disciplinary basis.

Figure 7.1 Reasons for dissatisfaction

Adequacy of Services

Insufficient government response to its own service reviews (Reed 1 and 2)
Inadequate number of medium secure provision
Poor community facilities (human resources - hostel staff)
Long term low and medium secure provision before independent living
Too little, poorly managed
Poor services for women
Better co-ordinated approach to service planning
Some patients in prison should be in hospital
Too many private facilities with poor quality of care standards
Hidden tariff imposed by the Home Office
No national strategic plan - service provision appears to depend very much on interest from providers
Too centralised and institutionalised (high security hospitals)
Patchy court diversion

Discharge Planning

Some patients are not assessed, treated adequately prior to be discharged.
Lack of range of discharge opportunities/methods from maximum secure hospitals
The use of 37/41 with psychopathic disorder
Inadequate aftercare provision

Therapy Vs Control

Imbalance between patients and staff rights in secure hospitals.
Nursing skills and exercising of controls are difficult.
Inherent fear among staff of doing anything which may 'upset patients'
Advocacy and autonomy has reduced the role of the nurse to that of a 'helper'
Overemphasis on short term management (security)
Poor response to rehabilitation in the high security sector

Clinical Effectiveness

Reduced symptomatology
Lack of action in addressing patient behaviour in a more structured, educated and monitored fashion.
Clinical skills undervalued
Inappropriate skills training i.e. overemphasis on counselling
New ideas are very slowly introduced hence loss of enthusiasm
Non medical personnel are making decisions that affect clinical practice

Resources Management

Financial limitations
Poor attention given to multi-professional education and training

While some of the respondents advocated for an integrated approach with the general mental health services others expressed the view that the high secure hospitals should provide parallel services. This viewpoint was best summarised by a respondent thus:

> *"High security provision is effectively served by the special hospitals, however longer term medium secure provision does require investment. If the special hospitals were encouraged to "branch out" into this area of need I believe MDO care and provision of appropriate facilities nationally would benefit dramatically"*
>
> **Service Manager**

Another viewpoint that seem to pervade the whole fabric of the high secure hospitals is summed up as follows:

> *"My dissatisfaction is based upon a belief of an existing imbalance between client and staff rights within the special hospitals. Promoting the advocacy and autonomy of patients to such an extent has effected the role of the forensic nurse to more of a 'helper'. Exercising nursing skills and necessary controls are difficult due to burgeoning complaints and rights systems, which seem to be out of context. There seems to be an inherent fear among nursing staff of doing anything which may 'upset patients', and this cannot be good for long term patient progress".*
>
> **Ward Manager**

The resource factor was quoted by some as the main reason why the medium secure sector is not responding effectively to the needs of patients. The contributions of the NHS Trusts who have a stake in the medium secure sector were said to be destructive.

> *"Fragmented infrastructures. Variable quality probably relating to Trust attitudes to forensic patients. No central or pooling of resources to improve training and education. Local initiatives vary in quality of curriculum planning".*
>
> **An Educator**

The clinical focus was said to be ignored in the provision of services in the high secure sectors, as offending behaviours were left unchallenged:

"There appears to be little provision made for addressing mental health and offending behaviour. Many patients return to the community with significant areas un-addressed.

Community Psychiatric Nurse

The contribution of the private sector was also highlighted as critical to the effectiveness of service provision.

"Being in the private sector, we obviously rely on NHS ECRs for our business. I think there should be more liaison and provision between the public and private sectors in the care of MDOs"

Private Sector Manager

Generally respondents were consistent in criticising standards across the service, the dominance of psychiatry and the role of consultant psychiatrists as responsible medical officers which they argued was stifling the development of quality service. The role of commissioners of the service in backing developments was also blamed for the lack of comprehensiveness in provision and consequently blocking effective resourcing of the needs of the patient group. Respondents also cited a perceived rivalry between the Home Office and the Department of Health, complaining that the approach of the Home Office was piecemeal and typified by the difficulty of transferring prisoners to hospital for treatment. The morass created by the inadequacy of service provision was described by a respondent as being the main contributory factor in ensuring effective transfer of patients between various service sectors.

"Patients identified as requiring high security care are unable to be transferred as no beds are available. Several medium secure establishments are too selective regarding criteria for admission. Also local NHS establishments are 'unwilling' to cope with patients/clients with problematic behaviour".

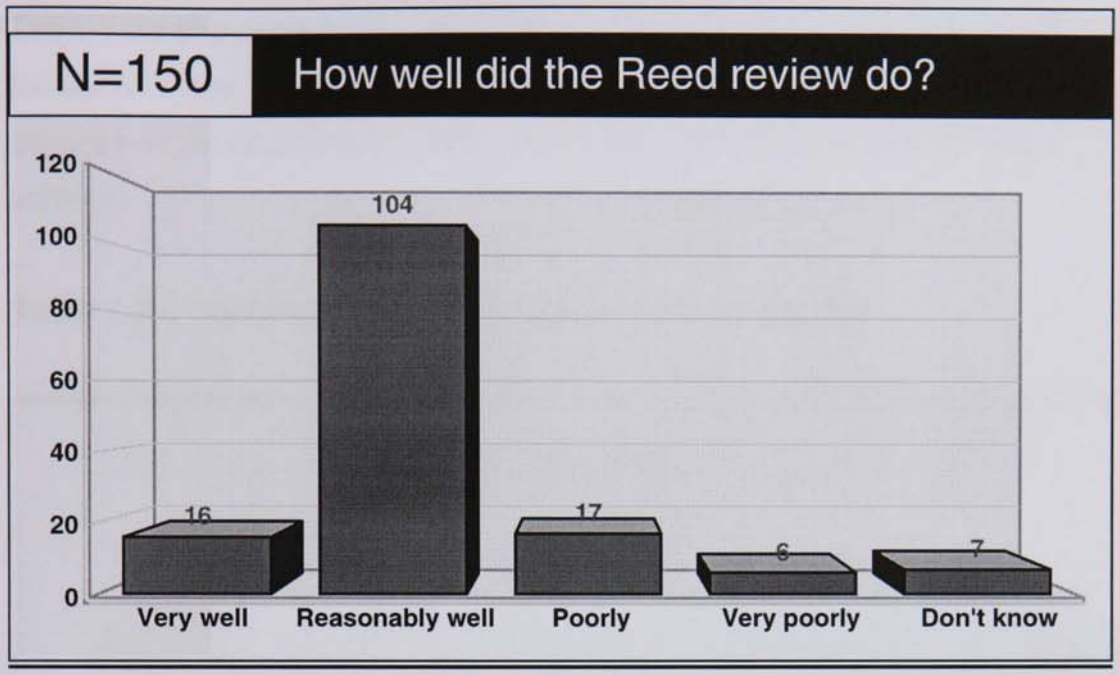
Senior Nurse Manager

7.3 The Reed Review

The Reed Review was a joint project undertaken by the Home Office and the Department of Health to evaluate effectiveness of the service and to identify key components for effective service provision (DoH 1992). Respondents were asked to express a view on whether they have heard of the Review;

94% of the 150 respondents have heard of the Review. They were further asked to comment on how well they thought the review dealt with key issues related to service provision (see Table 7.3)

Table 7.3 Satisfaction with the Reed Review



Clearly majority of respondents thought that the Reed Review dealt with the issues confronting the service either very well (10.7%) or reasonably well (69.3%); N=150.

7.3.1 The six principles of Reed

The Reed Review team identified six key principles, which should guide service development across the service. Respondents were asked to indicate the degree to which they agree with these principles (see Figure 7.3a below) which shows that a very large proportion of respondents either agree totally or partly with the way the Review dealt with the key issues relating to service provision for the patient group.

7.3.2 Reed principles and service development

The Reed Review sets out six key principles, which should guide service development. Respondents were asked to indicate the extent to which they agree that services should be provided by applying to it these principles. Table 7.3a shows that most of the respondents agree totally (minimum 68%) except for when they were asked to express their views on that of developing services as far as possible, in the community rather than in institutional settings.

Table 7.3a Degree of acceptance with Reed principles

N=150

	Agree totally	Agree partly	Disagree	Don't know
1. With regard to the quality of care and proper attention to the needs of individuals	138 (92%)	12 (8%)	-	-
2. As far as possible, in the community rather than in institutional setting	57 (38%)	83 (55.3%)	10 (6.7%)	-
3. Under conditions of no greater security than is justified by the degree of danger they present to themselves or to others	131 (87.3%)	19 (12.7%)	-	-
4. In such a way as to maximise rehabilitation and their chances of sustaining an independent life	130 (86.7%)	20 (13.3%)	-	-
5. As near as possible to their own families if they have them	102 (68%)	44 (29.3)	4 (2.7%)	-
6. With respect for patients' rights as in-patients	122 (81.3%)	25 (16.7%)	3 (2%)	-

As shown in Figure 7.3b below, most of the respondents agree totally or partly that the Reed principles were guiding them in the way their individual services were developed.

Table 7.3b The Reed principles and individual services

N=150

	Agree totally	Agree partly	Not at all	Don't know
1. With regard to the quality of care and proper attention to the needs of individuals	57 (38%)	90 (60%)	3 (2%)	-
2. As far as possible, in the community rather than in institutional setting	30 (20%)	88 (58.7%)	28 (18.7%)	4 (2.7%)
3. Under conditions of no greater security than is justified by the degree of danger they present to themselves or to others	52 (34.7%)	89 (59.3%)	6 (4%)	3 (2%)
4. In such a way as to maximise rehabilitation and their chances of sustaining an independent life	48 (32%)	85 (56.7%)	12 (8%)	5 (3.3%)
5. As near as possible to their own families if they have them	35 (23.3)	73 (48.7%)	31 (20.7%)	9 (6%)
6. With respect for patients' citizen rights as in-patients	71 (47.3)	70 (46.7%)	7 (4.7%)	2 (1.3%)

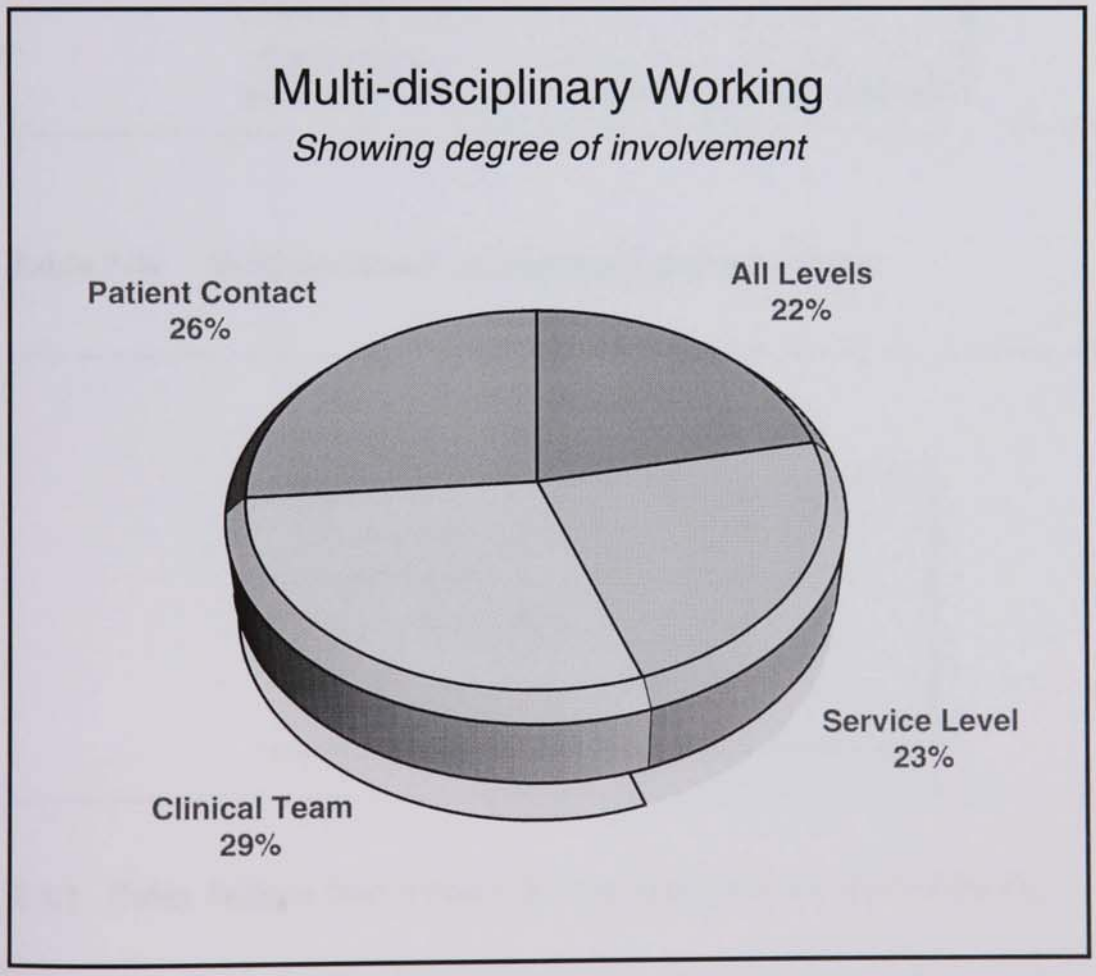
7.4 Multi-professional working

Respondents were also asked to express a view on the Reed Review recommendation that services should be provided on a multi-professional basis and were further asked to comment on the extent to which they consider their own services are already doing this (Table 7.4). However the scope of multi disciplinary activity was taking place at the clinical interface and also shows a very low uptake (less than 30%) across the service (Table 7.4a).

Table 7.4 Multi-professional working & individual services

	To a very great extent	To some extent	To a very limited extent	Not at all	Don't know
At all levels (N=148)	22(14.7%)	79 (52.7%)	40 (26.7%)	3 (2.0%)	4 (2.7%)
At service level (N=150)	29 (19.3%)	81 (54%)	37 (24.7%)	1 (0.7%)	2 (1.3%)
At clinical team level (N=150)	72 (48%)	63 (42%)	15 (10%)	-	-
At patient level (N=150)	51 (34%)	71 (47.3%)	26 (17.3%)	2 (1.3%)	-

Table 7.4a Scope of multi-professional working



Respondents were further asked to comment on the extent to which they believe multi-disciplinary working has already contributed to improving the

quality of their services (Table 7.4b) and again to comment on whether they believe increased multi-disciplinary working could contribute in increasing their service's effectiveness (Table 7.4c). It shows that 61% of respondents expressed the view that their services would benefit from increased multi-professional working.

Table 7.4b Contribution of Multi-professional Working to quality of service

N=150

	Frequency	Percentile
To a very great extent	39	26%
To some extent	81	54%
To a very limited extent	26	17.3%
Not at all	1	.7%
Don't know	3	2%

Table 7.4c Multi-professional approach and the Future

N=147

	Frequency	Percentile
To a very great extent	89	60.5%
To some extent	56	38.1%
To a very limited extent	2	1.4%
Not at all	-	
Don't know	-	

7.4.1 Other factors that could improve multi-professional working

Respondents were further asked to indicate what changes would they most like to see in improving the multi-professional approaches to care. Figure 7.2

shows the key areas that need to be addressed to ensure effective application of the concept of multi-professional working.

Figure 7.2 Areas to improve in multi-professional working

Team working
Multi-professional input in training and development programmes
Full implementation of the CPA
Multi-disciplinary audit system development
More standardised approach to documentation
Improved/joint assessment procedures
Better communication processes/pathways
Greater degree of equality within clinical team - less medically led.
"RMO" title to be replaced with "designated key worker".
Medical dominance is militating against effective multi-disciplinary working
Medical staff stopping being "God Juniors"
Multi-disciplinary research development

Resources
Increased psychology input
Occupational therapy involvement in the community.
Elevation equally of MDT members
Increased involvement of other staff. (Input at ward level shift basis)
Psychiatrists engaging in direct patient care outside the parameters of RMO responsibility
Less blanket decisions made by managers with no clinical qualifications
Revision of the MHA and the Code of Practice to deliver better care

Collaboration
Greater collaboration between community services and in-patient services
Multi-professional principles should be applied to the management of the whole service, as much as to delivery of care.
Clearer definition of roles and responsibilities
Cutting down professional boundaries
Stopping territorial arguments between disciplines
Better collaboration between forensic services and local services
Greater input of psychology

Advocacy/Empowerment
Proper advocacy rather than tokenism
Acceptance of common skills
Acceptance of nursing contribution as critical
Increased input from non-medical disciplines
More support and trust in nursing reports
Better input for nurses - move away from medication, security/crisis management

7.4.2 Other Comments

Comments were made in support of developing an effective model of service that is multi professional in the respect that team members respect each other and the need to reduce the emphasis on the medical model approach, which was thought to be working against effective team working. A respondent summed up this view as thus:

> *"The multi-professional approach to care is an admirable principle, however it is met with difficulty because of different professional groups attitudes towards nursing staff. This most valuable group is often undervalued and left to deal with all basics while other professional groups deal only with the 'higher activities'. This leads to disunity and barriers, which need to be bridged by closer working and respect for individual skills. So often work carried out by professionals other than nurses is carried out away from the nursing environment. The principles of patient focused care would go a long way towards improving multi-professional approaches"*
>
> **Staff nurse**

The resources aspect of what people were saying was that greater input by other professional groups at ward level would increase collaboration within the teams:

> *"I would like to see more flexible working hours for all professionals to be able to respond to patients needs speedily on a 24 hour basis. I feel, the core working hours of 9am - 5pm for most professionals leave a lot of unmet needs of patients, especially at weekends and beyond the core working hours. The existing arrangements for on all are less than satisfactory".*
>
> **Senior nurse manager**

Team training was identified as important in moving the multi-professional agenda forward, but the lack of funding to promote working together was cited as a reason for the lack of progress on this:

> *"Bunker mentality of each profession in working in opposition to others could be countered if more attempts at joint funding for training, either pre or post qualification is made."*
>
> **Consultant psychiatrist**

The call for focusing on the needs of patients was made by most respondents together with the value in appointing a case manager to co-ordinate patient care. This was best summed up as:

> *"A willingness to look at the needs of patients -and the skills and abilities needed to meet that need. To try and step out of professional tribalism and fit the person who functions most effectively and has the skills to meet the need of the patient. Role blurring/multi-skilling is vital. A case manager could be given responsibility for meeting 'needs' thus reducing the time spent at multi-professional meetings to discuss the patient. This would leave more time for actually working with the patient by all professional groups"*
>
> **Social worker**

In the case of changes in service models, some felt that the best enabler would be a move away from the medical powerhouse to a more representative model:

> *"Change in RMO status and pairing of such status with managerial responsibilities regarding service provision. Better representation of range of professionals in management and service development and academia".*
>
> **Consultant psychologist**

Some respondents felt that the status quo should be preserve with increase in resource allocation to these groups:

> *"More multi professionals with better communication within consultant psychiatrist led teams"*
>
> **Senior registrar in psychiatry**

7.5 Inter-agency working

Inter-agency working was next assessed. The Reed Review recommended that services should be provided on inter agency basis. Respondents were asked to indicate the degree to which their services have implemented this recommendation. Table 7.5 represents the collective views of respondents. This shows that the main areas of activity were at the patient and clinical team level.

Table 7.5 The Scope of Inter-agency working

	At all levels	At service level	At clinical team level	At patient level
To a very great extent	11 (7%)	12 (8%)	38 (25%)	26 (17%)
To some extent	68 (45%)	70 (47%)	58 (37%)	62 (41%)
To a very limited extent	52 (34%)	55 (37%)	47 (31%)	54 (36%)
Not at all	10 (6%)	4 (3%)	3 (2%)	3 (2%)
Don't know	-	6 (4%)	1 (.7%)	1 (.7%)
Valid Cases	N=145	N=147	N=147	N=147

Table 7.5a shows the impact that aspects of inter agency working is having on services. Respondents were asked to express a view on the extent to which they believe inter agency working has already contributed to improving the quality of the service they provide to patients.

Table 7.5a: Contribution to inter-agency working and the need to improve services through inter-agency working

Contribution of multi-agency working improvement			**Further inter-agency**	
	Count	**%**	**Count**	**%**
To a very great extent	14	10%	77	53%
To some extent	78	53%	56	38%
To a very limited extent	44	30%	10	7%
Not at all	5	3%	-	-
Don't know	5	3%	3	2%

Further, Figure 7.3 shows also the extent to which respondents believe inter agency collaboration could contribute to improving the way services are provided in the future.

7.5.1 Further changes in improving inter-agency collaboration

Respondents were further asked to identify areas that needed to be changed in order to enhance multi agency collaboration. Figure 7.3 summarised the main areas of concern to them. It shows that the key areas to change were in developing joint planning forums and improving communications between agencies. Further the need to improve attitudes and education and training were also mentioned. Finally, a new model of focusing on the needs of patients was seen as an aspect that needs to be operationalised.

Figure 7.3 Areas to change for the future

Planning and Communications
Improve liaison and involvement of local practitioners
Liaison at management level
Improve communications between clinical teams and other agencies.
Multi-disciplinary/professional involvement
Involve also the probation service

Attitudinal Changes
Less territorial mind set to all disciplines especially by medic, psychologists and social workers
Greater awareness of what outside statutory & voluntary agencies can offer.

Education and Training
More education and secondments
Improved education of each others' roles and abilities

Needs Based Collaboration
Joint funding and focussed care delivery
Focus on Patients needs in purchasing/commissioning.

Generally, respondents were adamant that a new way of service provision must be developed in other to meet the needs of patients, particularly in the community. This was summed up as:

"A 'mental health authority' linking financially and managerially with health and social services for the MDO i.e. removing social responsibilities from local social services and integrating them into district teams should be developed"

Consultant psychiatrist

This view seen in conjunction with the call for better understanding of roles and responsibilities among the various agencies involved describes the situation as it is presently. The view was that the lack of understanding of roles has meant that the patient misses out on effective care as the various agencies tried to prove how important they feel their own roles were. Others call for face to face meetings to improve communications between the agencies. There were calls for services to move away from the present conceptualisation of collaboration but views were expressed about the need to move cautiously. One respondent expressed this view quite succinctly as:

"this requires creativity, vision and skill particularly in organisations that are caught up in bread and butter aspects of business planning. Many organisations merely follow the leaders and have neither the required ability or wider support in risk taking to carve their own niche. The internal market principles in their primitive format fuel petty, blinkered approaches, often clinical service delivery and the meeting of patients needs get lost in the wider world of mission statements and business plans. Value must be attached to the product - clinical services".

Clinical director

This new model was seen as critical for the future but the need for senior management in each agency to recognise and commit resources to enable effective inter-agency approaches to be developed was also made. This approach backed up by the flow of communication between agencies was seen as an essential component in the model. The low level of inter-agency working was also criticised and calls made for widening its scope.

"Inter-agency approach already exists at strategic level, but at patient level commitment appears to be confined to housing associations and voluntary organisations. More input required from social services, probation services etc."

Director of nursing

The social services approach to assessing care, *"Care management"* was seen as not being helpful in meeting the needs of the mentally disordered

offenders as it is seen as a medium where everyone is trying to avoid taking responsibility for the most difficult clients.

7.6 Measuring effectiveness of care

Assessing the degree to which effectiveness measurement is practised in the service is the main object of the research. Respondents were therefore asked to comment on the extent to which they believe their services were providing effective and appropriate care to the patient group.

Table 7.6 Service effectiveness rating

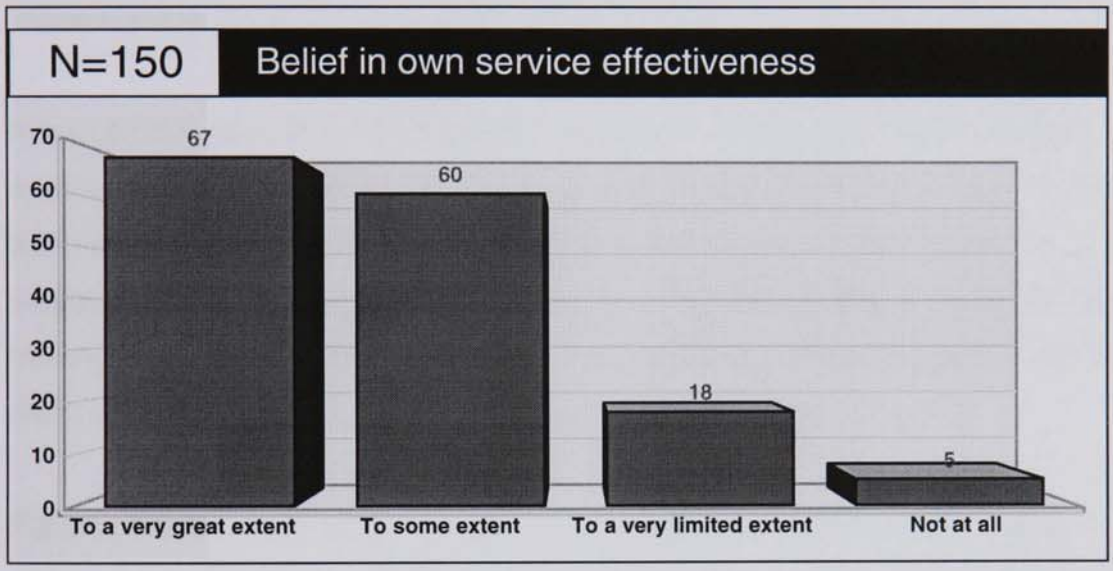
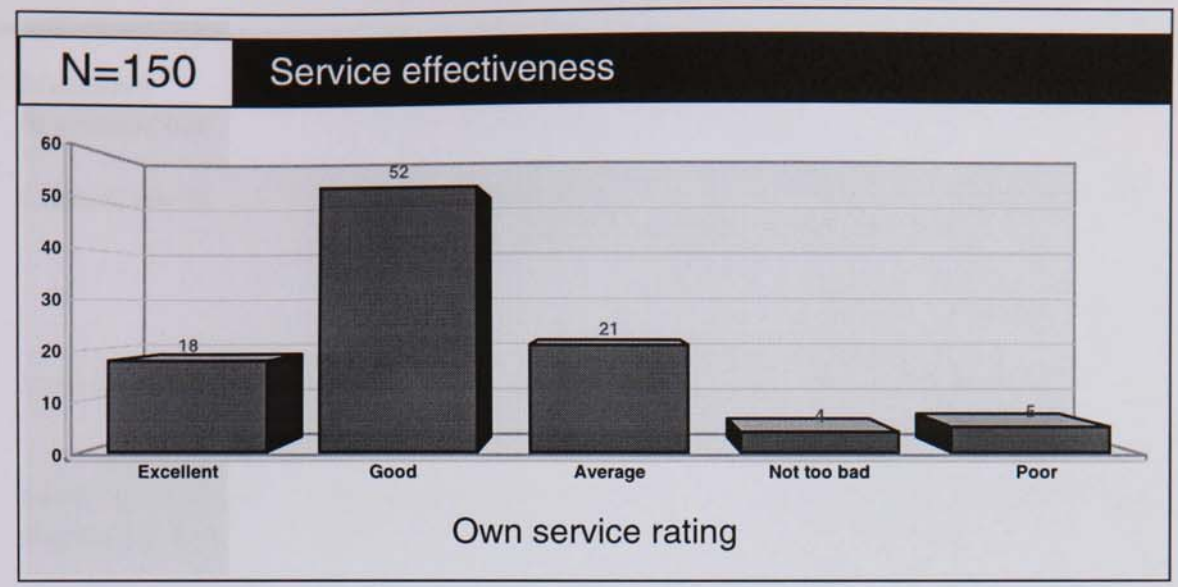


Table 7.6 shows the extent to which respondents thought their services were providing effective and appropriate services. It shows that most respondents (67 (40%)) believe that their services were providing effective services to some extent.

The general view in terms of adequacy of services was that the provision was not enough to meet the demand. This means that respondents have knowledge of other services around the country and so could be in a position to make comparisons. Table 7.6a shows that respondents were largely of the opinion that their own services were either excellent (18%), good (52%) or average (21.3%) compared with other similar services.

Table 7.6a Comparison between services



In an effort to ascertain the degree of satisfaction attached to effectiveness measures in use within the service, respondents were asked to state whether the measures they are presently using were appropriate, the strengths and weaknesses of the measures and to confirm whether or not they thought the measures should be refined and what changes they need to make to them to make them appropriate to the needs for which they were designed.

Figures 7.4 and 7.4a show the many effectiveness measuring tools being employed in the service. They range from audits to using recidivism as means of assessing the effectiveness of the service they provide patients.

Figure 7.4 Measures in use - strengths and weaknesses

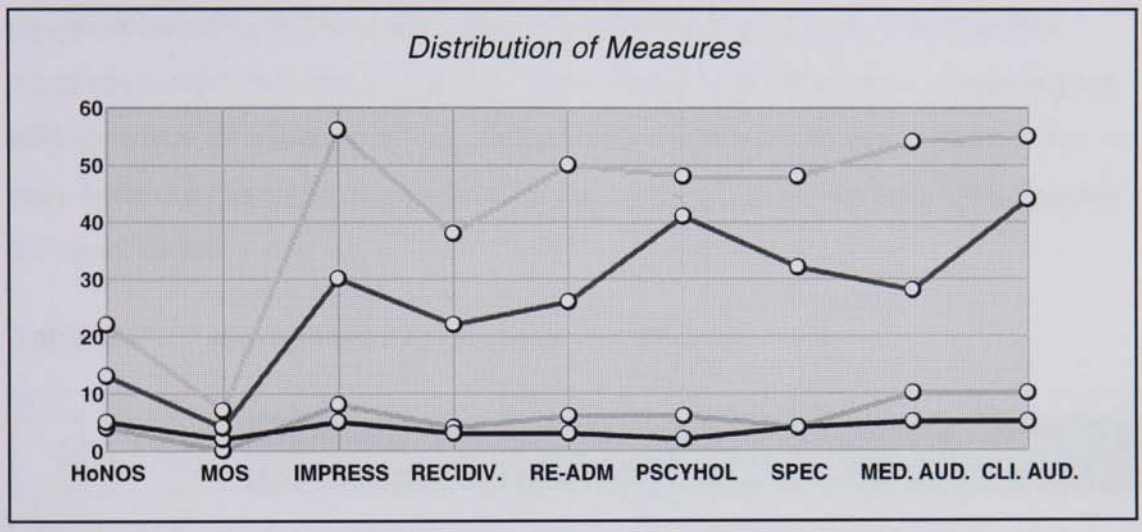
Measures in present use	*Strengths*	*Weaknesses*
Clinical Audit	Multi disciplinary focus Objective and works reasonably well.	Used as stick to beat staff Inflexibility Difficulty in team assessment
Medical Audit	Gets medic involved	Uni-disciplinary Relies on effective records
Multi-disciplinary standard setting	Generated at clinical level	Poorly patronised, little commitment
Quality standards	Narrow focus-incremental	Too limiting in scope
Environmental audits	Global look at standards	Reliability low
Research	Objective, increased knowledge	Inappropriately abused Projects are weak Methodologically unsound
Recidivism	Ultimate measure of effectiveness Measures outpatient support	Not an effective measure. Does not show link between mental illness and criminal behaviour
Care evaluation	Short term directional	Ignore centrally due to difficult issues (index offence)
Critical Review	Flexibility	Subjectivity
Bench-marking	Insight	Co-operation from other providers
Service level agreement.	Measurable	Cold, inflexible
Weekly review	Multi-disciplinary	Too subjective
Psychological Measures	Research based	Limited use, unidimesion
Length of stay	Unclear packages	Long term facilities are few
Patient satisfaction	Involves patients Empower patients	Is retrospective and is inaccurate
Discharged pts'. Satisfaction	Unfettered users' views.	Anonymity, focus on past

Figure 7.4a Measures in use - strengths and weaknesses

CASPE	Another tool but not appropriate	unreliable
Patients Charter	nationally recognised	Political, process based and easy to achieve
Bed occupancy Budgets	Helps costing	Blockages (long stay patients)
Oscar	Research based Better than nothing	Subjective uni-disciplinary (input and output based
HoNOS	Partially	Practitioner focused
Functional performance record	Occupations oriented	Poor measure of effectiveness
Nursing process	Targeted & based on evidence	Lacks consistent use. Uni-professional
Global assessment	assessment of clients abilities	Poor patient involvement
MDT meetings	Exchange of views	Subjective, excludes the patient
Relatives & Agency View	Views of others	Subjectivity
Grasp	Identify achievement standards	Not always appropriate Poor follow on action
Incident reports	Monitors individual or group behaviours over-time - can be qualitative. Compared to events, changes in treatment life cycle	Not Quantitative
Home Office Assessment of dangerousness	Another perspective	Lacks focused evidence Politically determined
Problems & targets	client & carer rated Valid & reliable	training needed time consuming
Purchaser quality standards	targeted	Poor reliability Subjective and not evidence based
MHAC visits	independent	unreliable
MHRT decisions	independent	unreliable but the blame is somewhere else

Figures 7.4 & 7.4a show that no recognised measures was in use at the time of the research. At the outset of the research project it was predicted that a question of that nature might not unearth any of the recognised measures. This view was formed on the basis that people might confuse output with effectiveness measures. Table 7.6b shows that there were measures not mentioned in Figures 7.4 and 7.4a.

Table 7.6b Selected known measures



Key

HoNOS:	Health of the Nations Outcomes Scale
MOS:	Medical Outcomes Survey SF36
IMPRESS	Subjective Clinical Impression of Change
RECIDIV	Recidivism or re-offending rate
RE-ADM	Re-hospitalisation
PSYCHOL	Psychological Measures e.g. MMPI
SPEC	Condition Specific Measures e.g. Beck's Depression Inventory
MED. AUD.	Medical Audit
CLI. AUD.	Clinical Audit

Medium Secure
High Secure
Minimum Secure
Community

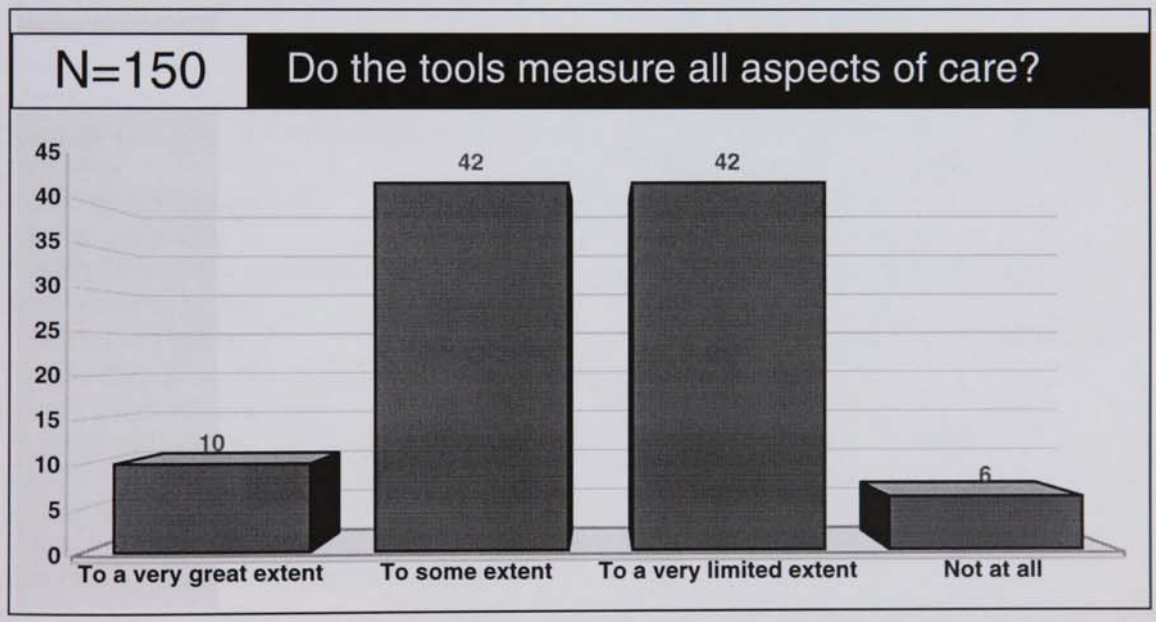
Table 7.6b shows the key activity areas for effectiveness measures was the medium secure sector followed by the high secure sector and that the community being the least developed area for using effectiveness measures.

7.6.1 Effectiveness of the Measures in Use

In addition to determining both the strengths and weaknesses of the measures in use (Figures 7.4 & 7.4a), respondents were asked to assess the extent to which they believe the measuement tools they were using were effective in measuring the full range of benefits patients could have from using their respective services.

Table 7.7 shows the extent of the belief held by respondents that the measurement tools they were using within their services measure the full range of benefits patients who use their service could have. It shows that most respondents believe that they were using tools that were measuring the effectiveness of services they provide to some extent (62 respondents) or to a very limited extent (63 respondents), the range is from "to a very great extent" to "don't know".

Table 7.7 Perception of Effectiveness of the Tools



7.6.2 Aspects to measure

The overriding aim of this study was to identify new areas to be developed for future use in the service. In order to assess the feasibility of this next venture, respondents were asked to identify key areas of treatment and care they wish

to be developed into effectiveness measures. Figure 7.5 shows the areas for development, which were wide ranging indeed.

Figure 7.5: What to measure in the future

Clinical outcomes	Staffing and better use of skill mix
Treatment planning	Better training and clinical supervision of staff
Effect of treatment on delusional material and attitudes towards index offence	Social
Patient satisfaction	Clinical
Effectiveness of treatment	Psychological
Efficiency	Cultural
Individual care	Physical
Waiting time	Needs identification, following reliable and valid assessment
Input from all disciplines	Welfare rights
Attitudes	Compliance and education of medication
Quality of care	Restructuring of social network
The effect of illicit drugs use	Personal hygiene level
Quality of life	Quality of in-patient care
Development of fundamental needs in chronically ill patients	Quality of service to catchment areas
Prioritise those that will lead to the greatest improvement, safety to staff, patients and public.	Evolutionary development
Quality of decision making (multi-professional Vs dictatorial)	Contact and workload management
Communication between staff and with patients	Supervision recording
Resource management	Outcome measures as opposed to output measures
Dangerousness	Access to services
Continued and elaboration of assessment of risk	Length of stay, re-hospitalisation, re-offending rates
Resource implication	Accuracy of assessment
Contacts with professionals	Risk assessment and management
Comparative measures	Discharge planning
Explaining to patients of decisions about medication and treatment changes	Patients' perception of problems and self improvement
Feeding back to patients of decisions about their treatment and aftercare	Pre-cursors to violent behaviour
	Seclusion rates and reasons
	Public satisfaction
	Purchaser satisfaction
	Relapse prevention

7.7 Conclusion

To conclude this chapter on provider staff views on effectiveness measurement within the forensic mental health service, respondents were asked to comment on the general issues that could impact on measuring effectiveness. This free text opportunity yielded some very pertinent comments. These ranged from blaming managers for not prioritising effectiveness to the questioning of the need to conduct such studies.

> *"I think the damage of measurement is line management. It costs more than the benefit, which accrue. There is little point in measuring the obvious i.e. medication improves symptoms or measuring what is societal attitude - there is already evidence in attempts at integrating patients. We are not good at using measuring tools."*
>
> **Consultant psychiatrist**

Some respondents complained about the sheer size of the multi-professional team, which they fear might compromise its effectiveness.

> *"The multi-disciplinary approach involves a large number of people working for patients. The process is cumbersome, very time consuming"*
>
> **Social worker**

Others complained of the bureaucracy pervasive in the service citing that this has led to high degree of repetitious history taking and duplication of clinical notes amongst the professions. There was also the view that development of the service was budget led but there was an unnecessary pressure on clinicians to provide evidence based on the needs of individual patients. Others lamented about the paucity of use of effectiveness measures but held the view that the development of the HoNOS project would change attitudes within the service. Measuring effectiveness, particularly outcomes measures must be a priority for the service but others felt that there was a great deal of cynicism about how data could be used particularly in the political arena, concluding that this has led to reluctance for clinical staff to take an interest in developing effectiveness measures. Finally, this chapter concludes by quoting a respondent on the importance of developing the measures.

"I think developing effective outcome measures should be one of our highest priorities. Some of the standard instruments are inadequate but we have to at least make a start now and to improve and refine the instruments further later"

Consultant psychiatrist.

APPLICATION OF THE METHODS - RESULTS (3)

CHAPTER EIGHT: PURCHASERS STAFF QUESTIONNAIRE

Introduction
Demographic profile
Views on service provision
Assessing the need
Evidence based commissioning
The Reed review
Multi-agency working
Measuring effectiveness of care
Further comments on developing outcomes

CHAPTER EIGHT: PURCHASERS STAFF QUESTIONNAIRE

8. Introduction

This part of the questionnaire survey was conducted between January and February 1997 and involved any one who has responsibility for commissioning services for mentally disordered offenders (MDOs) at Health Authority level and are on the database of the High Security Psychiatric Services Commissioning Board (HSPSCB). Commissioners working with the HSPSCB were also sent questionnaires, as they were responsible for the commissioning of services for the patient group in the high secure hospitals. In total 100 questionnaires were sent to commissioners through Health Authority (HA) Chief Executives to the identified commissioners, eighty-four (84%) questionnaires were returned.

8.1: Demographic profile

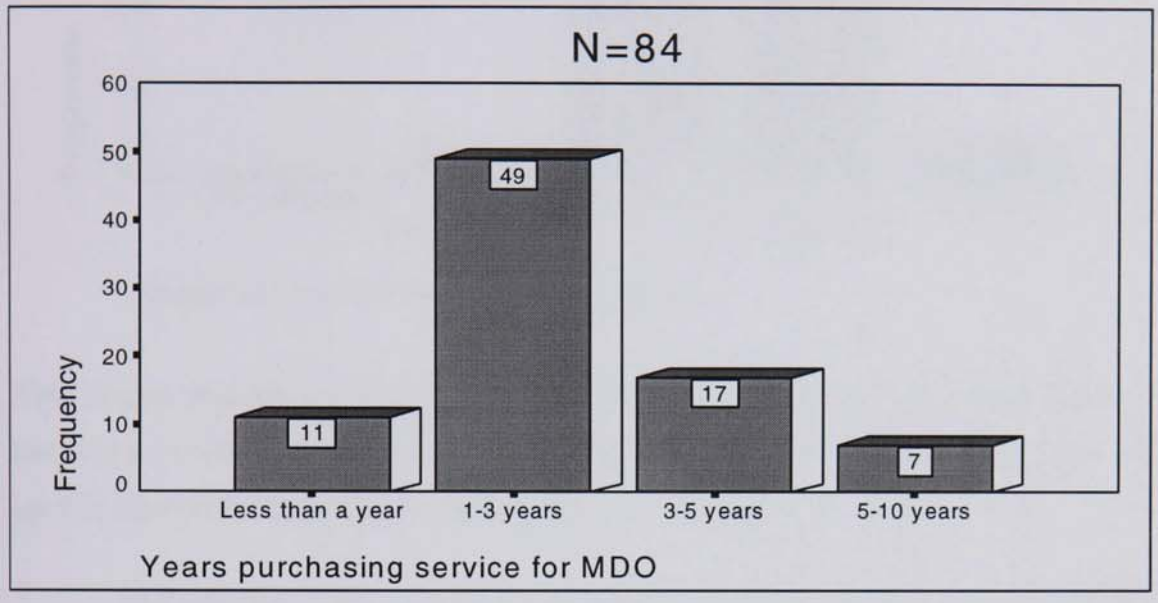
The disciplinary breakdown of respondents shows that the key groups were from mainly medical, then nursing and general management disciplines, and are as shown in Table 8.1 below.

Table 8.1: Disciplinary breakdown of Purchasers

Disciplinary Background	Percentile
General Management	26
Medicine	32
Nursing	30
Occupational Therapy	4
Psychology	5
Social Work	4

Table 8.1.1 shows that most of the respondents (74%) have been involved with the care of the patient group for less than 3 years. Further 71% have been involved with purchasing care for MDOs a period ranging between 0 - 3 years (Mean=2.238; S/D = .786) and 8% of respondents have been involved between 5 -10 years.

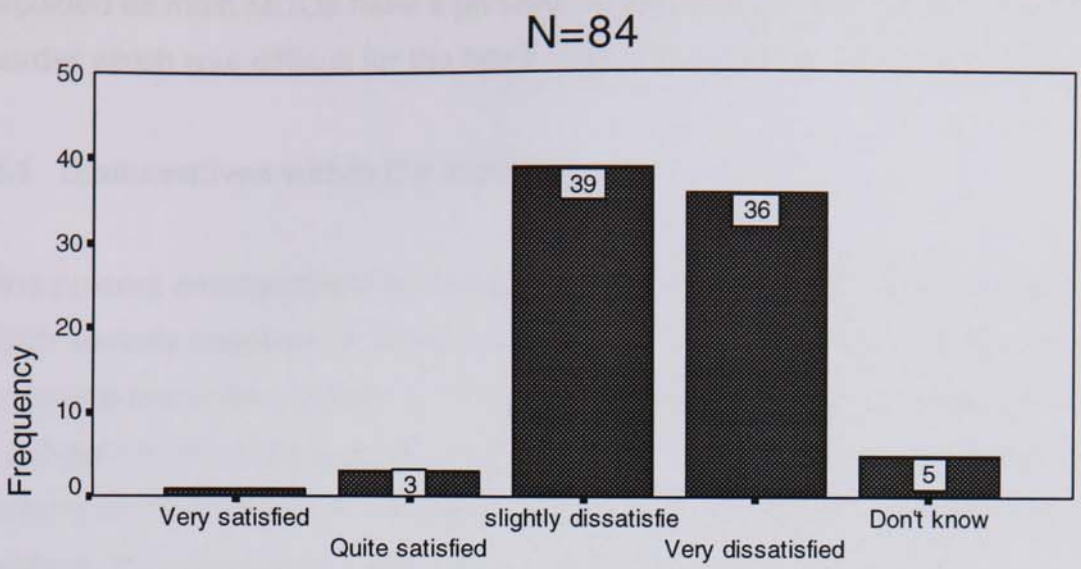
Table 8.1.2 Years of Experience



8.2 Views on service provision, nationally

Respondents were asked to express the degree to which they were satisfied with the effectiveness of service provision in terms of achieving its purpose. Table 8.2 shows that majority of respondent were dissatisfied with service provision (slightly dissatisfied = 46%; very dissatisfied = 43%).

Table 8.2 Satisfaction with service provision



Views on service provision nationally

This shows that 89% of the 84 respondents were dissatisfied with the way the service is configured and being developed, nationally. One commissioner summed up the reason for this dissatisfaction as:

> *"Full implementation of recommendations have been stopped, national policy is poorly articulated and disseminated with insufficient acknowledgement of resource implications. Provision is proceeding by creeping growth, partly under the auspices of opportunistic private sector provision. There is lack of after/continuing care in the community, insufficient communication between government departments, hospital facilities are hard to access. Too many in prison or not sufficient mental health services in prison"*

Commissioners complained of the lack of cohesion and the strategic approach to service provision, arguing that this group of patients were far too marginalised and called for integration of mental health services with clear policy decisions from the government. Some showed their dissatisfaction by comparing the experience in the UK with that of the USA. A commissioner said:

> *"I believe the strategy to divert such MDOs from custody, courts or prison is flawed and not evidence based. There is evidence from the USA that suggests that proper treatment throughout normal judicial processes and punishment leads to reduced re-offending and symptom reduction. In addition I am not confident that the NHS can cope with the demand or meet the need to maintain public safety"*

Others thought that the concentration of care provision within the health sector was misguided as most MDOs have a primary diagnosis of personality psychopathic disorder which was difficult for the health services to treat and manage effectively.

8.2.1 Disincentives within the service

In the present arrangements following the reforms of the NHS, treatment of patients in high security hospitals is funded centrally. Health Authorities (HAs) do not pay for the service but when a patient is being transferred out of such hospitals purchasers do not get any financial help. In short the money does not follow the patient. It is therefore in the interests of HAs not to encourage discharge of patients from these hospitals. This disincentive provided another criticism for respondents.

> *"Unnecessarily complicated and cumbersome arrangements. HA should be fully responsible for purchasing all types of provision, to remove perverse incentives and encourage comprehensive integrated approach"*

An implication of this policy as pointed out was that large numbers of people were unnecessarily detained in conditions of high security. Another commissioner maintained this theme and pointed out that:

> *"Inadequate clarity of roles of secure hospitals, CJS (Criminal Justice System), local HA and SSDs (social services department). Clients frequently end up in one part of the system or other for no coherent reason. Also there is increasing transfer of responsibilities from CJS and secure hospitals to HAs with no transfer of resources"*

One of the main drivers of the effectiveness of the NHS reforms is the power HAs have in withholding contracts from providers who are not performing effectively. Their role to perform this task effectively, it seems has been supplanted by that of the Home Office's legal duty to safeguard public safety. In practice, this means that the Home Office can refuse transfer to another hospital or the discharge of restricted patients when it so wishes. The courts too can also direct hospitals to admit patients. HAs were therefore powerless in managing the system - the internal market. Provision of a comprehensive service was seen as key to removing some of these disincentives and ineffective service provision. A senior commissioner asserted that:

"There has quite rightly been a call to ensure that MDOs where appropriate are provided with health and social services, this includes a large proportion of individuals who might otherwise have been within the CJS. There has been no shift of resources from the Home Office to facilitate this change of provision".

Another added

"No clear monitoring of MDOs except by specific MDO service. No assertive outreach in treating drug and alcohol problems. No provision yet for those at high risk of becoming MDOs but who have not as yet offended. Inadequate medium secure and long term medium secure provision. Also problems with provision of low secure places. Inadequate therapeutic input in special hospitals - particularly learning disabilities"

The power of courts and the Home Office of making decisions which HAs have to pay for but without their involvement from the outset was lamented on by a commissioner as:

"Special (high security) Hospital purchasing should be devolved to HAs. In practice we do not have much control over what we purchase - we learn retrospectively that courts have sent people to RSU etc - and it is usually a matter of sending patient wherever there is a bed - not a matter of choice".

8.2.2 Integrating the service

Others felt that there was a lack of integration of the service:

"There is lack of cohesion or a strategic approach to service provision for this group who are often marginalised. Lack of integration of general and forensic psychiatric services. There is no central direction. Provision is uneven, therefore access too dependant on geography"

The call for a range of services took another dimension when another senior commissioner pointed out that:

"Still too many people inappropriately in the prison service need closer waiting between health and probation how do you monitor effectiveness - not just about keeping all MDOs out of prison - some people with a psychiatric diagnosis should be in the CJS (Criminal Justice System)".

Another remarked:

"Although the MSU (medium secure unit) network in my region is beginning to work well - provision in community, adequate supervision is sadly lacking. No additional funding for HAs to purchase such services as part of diversion approaches".

The care of MDOs transcends many professional groups within the public sector, independent and voluntary services boundaries. Their effective co-ordination is therefore essential for effective service planning and delivery. One commissioner thought this was important:

> *"Because there is inefficient co-ordination between responsible agencies on the whole".*

The cost of the service in the present culture of the NHS was also an area of dissatisfaction. A commissioner thought that:

> *"Range of services not always reflected in prices; gaps in service available; excessive load on mainstream services."*

6.2.3 Issues relating to psychopathic personality disordered patients.

The problems associated in caring for people with personality disorder are a problematic one for the service. This is due in the part to the fact that professional staff do not feel adequately prepared to deal with the many problems associated with their care within secure units and hospitals. A commissioner summed this up as:

> *"The range of facilities available is unsatisfactory, the courts appear to see the responsibility for people who may be vulnerable in a prison setting as being that of the health service and by using consultant psychiatrists who are not working in an MSU. For example, we have to find places for people at exorbitant rates who may have a personality disorder, who use resources which are not available to prevent people with mental health problems avoid committing offences".*

8.3 Assessing the Need

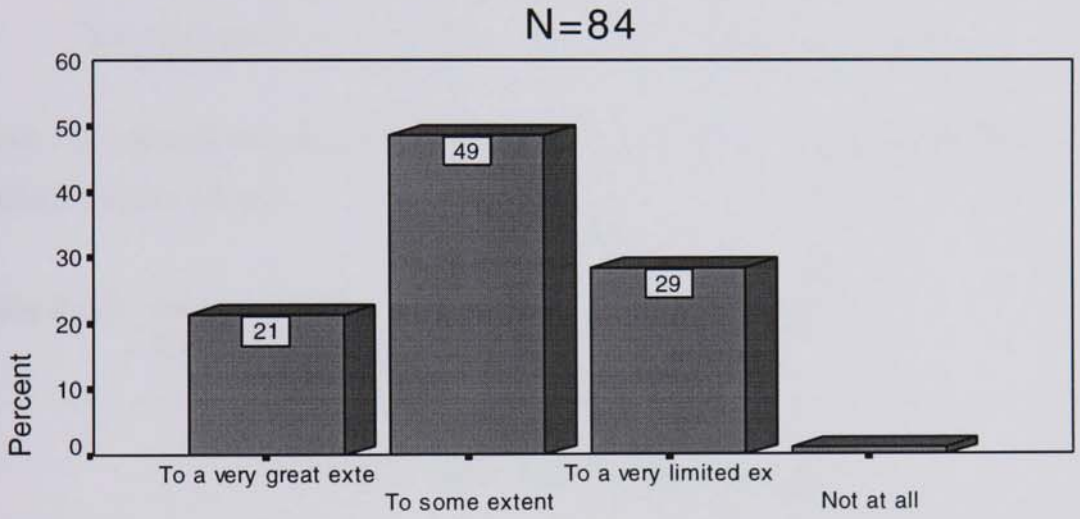
The executive letter EL(93)68 (DoH 1993) directs that the NHS executive regional offices should ensure that there was a regular assessment of needs of their residents for secure provision and non-secure hospital needs of MDOs, up dated annually. Respondents were asked to express the extent to which their purchasing plans were being influenced by this directive. Table 7.3 shows that 49% of respondents felt that their purchasing decisions were influenced by this executive

letter. However, a high proportion (29%) did feel that their purchasing decisions were only being affected to a very limited extent.

8.3.1 Care Programmes - high secure hospitals

Commissioners were further asked to comment on the stage at which they were involved in compiling a care programme for patients from their locality in the high secure hospitals.

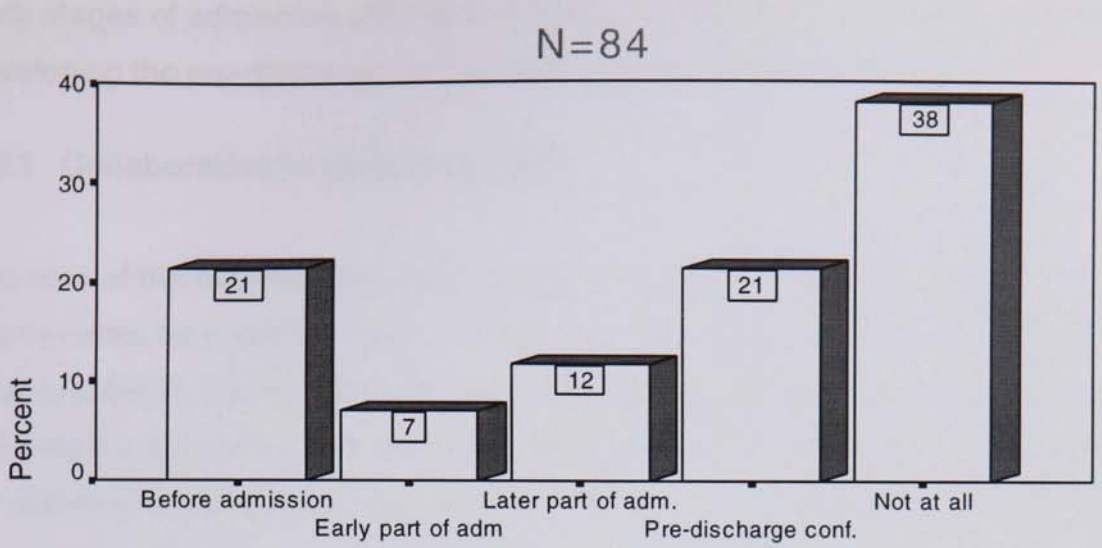
Table 8.3 Compliance with EL(93)68 (Assessing the Need)



Influence of EL(93)68 on purchasing plans

Table 8.3.1 below shows that 38% of respondents were not consulted when the high secure hospitals were compiling care programmes for patients in high secure hospitals. It shows too that 21% were consulted before patients were admitted to these hospitals but only 21% were involved in the pre-discharge case review conference before the individual left hospital.

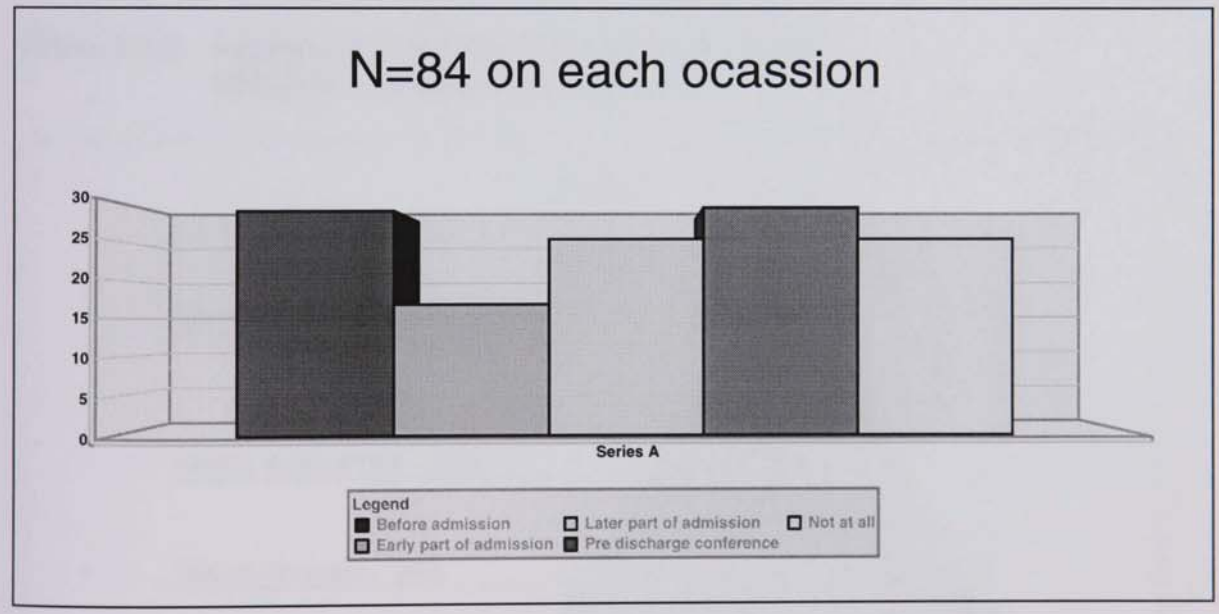
Table 8.3.1 Care Programming for High secure Hospitals



Involvement in care programme for high security patients

Table 7.3.2 shows the responses to the same question for patients within the medium secure sector.

Table 8.3.2 Involvement in compiling care programmes for medium secure patients



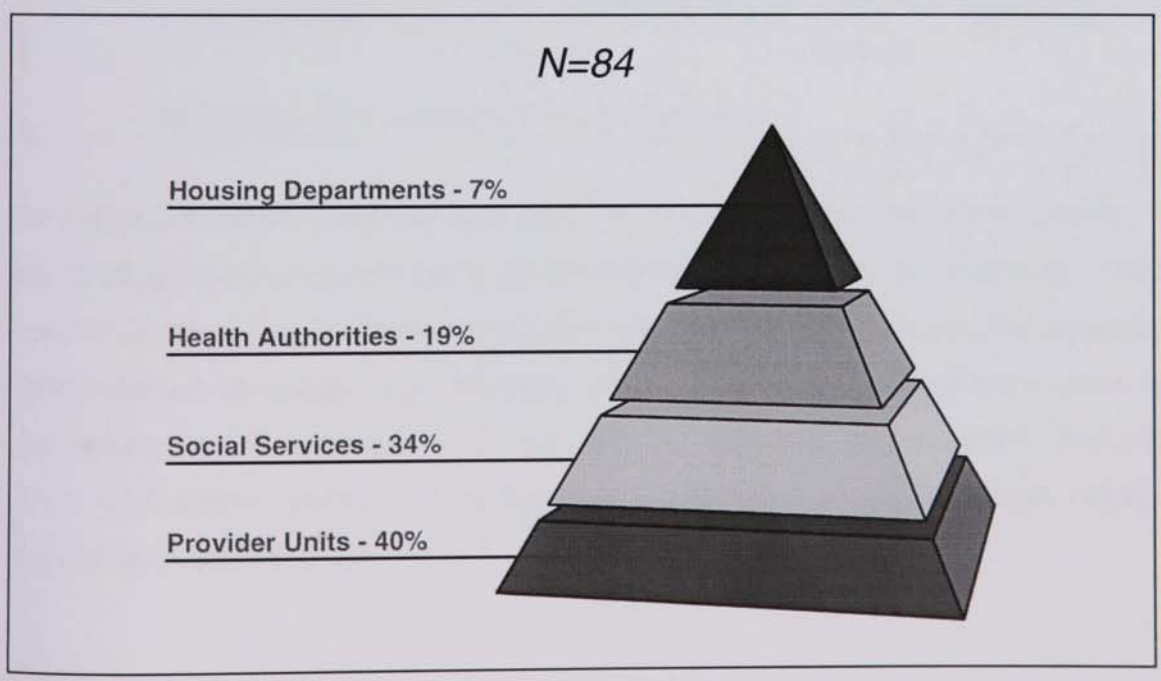
It shows that 28% of respondents were involved before admission, 16.7% during the early stages of admission, 25% at later stages of admission, 29% were involved in developing the pre-discharge care programme and 25% not involved at all.

8.3.1 Collaboration in assessing need

The care of the patient group requires that consultation and joint working mechanisms be in place to monitor adequacy and appropriateness of the service on offer to patients. Commissioners were asked to comment on whether or not they were aware of any involvement by any other agency in compiling care programmes for patients in high secure hospitals. Respondents (40%) were aware of only health service providers being involved in preparing care programmes for patients leaving high secure hospitals.

In the case of the medium secure units, commissioners' responses when asked to identify agencies involved in compiling care programmes for patient in these units differ from that given in the case of the high secure hospitals. Table 7.3.3 shows the extent to which respondents agreed that relevant agencies were being involved in compiling care programmes for patients in the medium secure units.

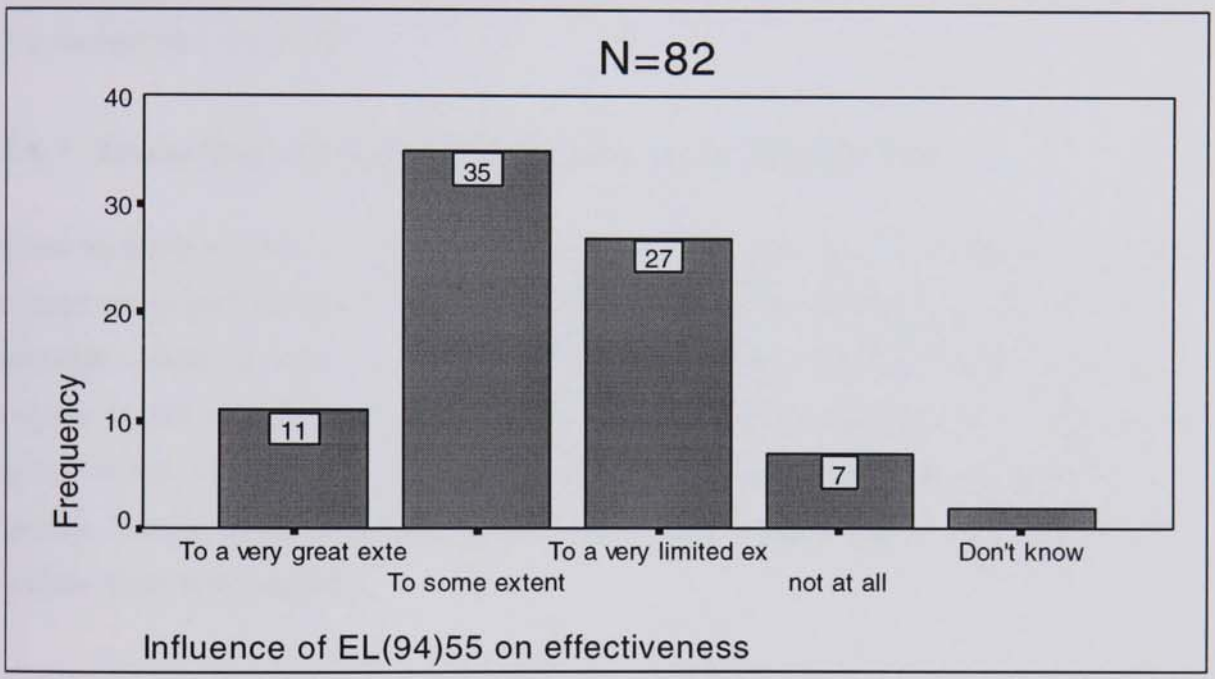
Table 8.3.3 Agency involvement in care planning for Patients in medium secure units.



8.4 Evidence based commissioning

The government's Priorities and Planning Guidance for the NHS for 1995/96 (EL(94)55) recommended that HAs should invest in terms of resources in interventions which are known to be effective and where outcomes can be systematically monitored, and reduce investment in interventions shown to be less effective (NHSE 1994). Commissioners were asked to comment on the extent to which their purchasing decisions were being guided by the direction in the executive letter.

Table 8.4 Degree of Compliance with EL(94)55



As Table 8.4 shows, most respondents (41.7%) were of the opinion that their purchasing intentions were being guided by this directive "to some extent". There was however evidence that supports the view that compliance with this executive letter was not consistent. For example only 13.1% thought the influence to be "to a very great extent" whilst 32.1% thought it to be "to a very limited extent" and a further 8.3% felt that they were not adhering to this direction; 2.4% did not know of the existence of the directive.

8.5 The Reed Review

In 1992 the government set up a committee to review services for mentally disordered offenders and others requiring similar services (DoH 1992). The degree of satisfaction with the review has been a contentious issue, particularly with the comprehensiveness of the review. Some practitioners felt that the service had shirked the more thorny issues, such as the way to deal with those who were diagnosed as suffering from personality disorders and the lack of effective provision of a range of services that best meets the needs of patients. On the whole 91.7% of the respondents have heard of the Reed Review Report, 73.8% thought that the review team dealt with the issues "reasonably well" and a further 9.5% agreed that the review did "very well".

8.5.1 Explaining comments on adequacy of the Reed Review

Commissioners were of the view that this review which was conducted by a national expert team was comprehensive and have established the pillars upon which services could be developed. They felt also that it has helped focus attention on mental health issues and has alerted purchasers of mental health services to get a grasp of the issues which although reviewed on a national level were applicable locally. They argued therefore that the review had raised the issues of assessing needs on to their agenda.

Further they thought the review had set out a framework for joint working with other agencies e.g. police, CPS, Prison. One commissioner thought the Reed Review recommendations has helped him in raising the issues within his own organisation.

> *"Reed reports are very comprehensive and useful in facilitating inter-agency work and in persuading HA colleagues to give higher priority to MDOs."*

However others thought the review was a balanced and humane series of reports addressing all the major issues and not fudging problems. They thought never the less that it was a little bit hung up on definitions as opposed to meeting needs of patients and have therefore failed to address the issues of adequate funding for the

service. Commissioners also felt that its recommendations (about 273) were too many to implement successfully. There was a view that the review was too inner city oriented and so did not deal with the particular issues of rural shires.

> *"We have low levels of MDO actively in a large rural county and have to access MSU facilities in other parts of the region. Main investment to date has been in beds but we wish to direct more resources to community facilities".*

Another area of complaint was that on psychopathic personality disorder. Some made the point that it is not cost effective for residents in a £20,000 per annum facility (prison) who need £5,000 per annum care (psychiatric) to be cared for in hospital at £90,000 per annum. They concluded the problems were identified adequately but issues of treatability of the psychopathic personality disorder patient were not confronted. They called for the culture of the criminal justice system to be changed so that the philosophical assumptions that underpin the Reed Review could be absorbed. This would enable better placement and care for the particular patient.

8.5.2 The Reed principles and service development

The Reed review further identified six further principles for service planners and providers to follow in service development. These principles (highlighted) are discussed below:

Respondents were asked to express a view on the extent to which they agree with the principles. The first principle asks providers and planners to develop services **with regard to the quality of care and proper attention to the needs of individuals.** All the respondents agree totally (83%) or partly (17%) with this principle. 93% agree with the next principle of providing services that were **"as far as possible, in the community rather than institutional setting".** The need to provide effective services that meets the security needs of patients was a theme for the next principle which stated that services should be provided **"under conditions of no greater security than is justified by the degree of danger they present to themselves or to others"**, there was 100% agreement with this principle. This view did not seem to be driving the policy agenda, as estimates suggested that between 40%-60% of patients in high security hospital need not be there. In the case of

treatment and care of the patient population, 97% agreed that services for patients should be designed **"in such a way as to maximise rehabilitation and their chances of sustaining an independent life".** The support for patients as in-patients and while in the community is essential, as far as improvement in their psychological well being is concerned. The next principle for benchmarking in providing services for patients is being **"as near as possible to their own or families if they have one",** 92.8% of respondents agree with this principle. The six and final principle dealt mostly with ensuring patients within forensic services, particularly in the high security hospitals were cared for **"with respect for patients' citizen rights as in-patients".** This recommendation seemed to have arisen due to a series of inquiry reports which criticised the denial of rights to patients (Bloom - Cooper 1992, Prins 1993). All respondents (100%) agreed with this principle.

7.5.3 The Reed principles and practice

Respondents were further asked to comment on the extent to which they agreed that each of the Reed principles were guiding their purchasing decisions. 92% thought their purchasing decisions were made "**with regard to the quality of care and proper attention to the needs of individuals".** 85% agreed that their purchasing decisions were being shaped by consideration for **"as far as possible, in the community rather than institutional setting",** while 93% agreed that patients should only be cared for **"under conditions of no greater security than is justified by the degree of danger they present to themselves or to others".** Further 94% of respondents agreed that they purchase services for patients, which were designed **"in such a way as to maximise rehabilitation and their chances of sustaining an independent life".** A large majority, 85% agreed with the principle that services should be developed for patients **"as near as possible to their own or families if they have one"** and a further 88% agreed that services they commissioned were provided **"with respect for patients' citizen rights as in-patients".**

8.6 Multi agency working

The Reed Review also recommended that services should be provided on inter agency basis. The analysis of stakeholders of the forensic care showed that they are numerous. Services such as the police, courts and local authority all contribute to effective service provision to the patient group. Commissioning decisions should therefore emphasise the need to collaborate; 79.7% felt that their decisions were being made with this in mind.

Some commissioners were of the view that effective inter-agency working was failing to identify people who were vulnerable but have not committed any offence to receive care that was best suited to protecting them and others. One summed up this view as:

> *"Court diversion schemes are in operation in our district and beginning to work well. Often we are concerned that when we know individuals who offend and who are not mentally disordered but may be vulnerable people who have refused voluntary care. Criminal Justice agencies are understandably reluctant to prosecute. We have two people at present who have committed sexual offences who are unlikely to be prosecuted because of their perceived vulnerability, but who do constitute a particular danger to others although they have no active mental health problems".*

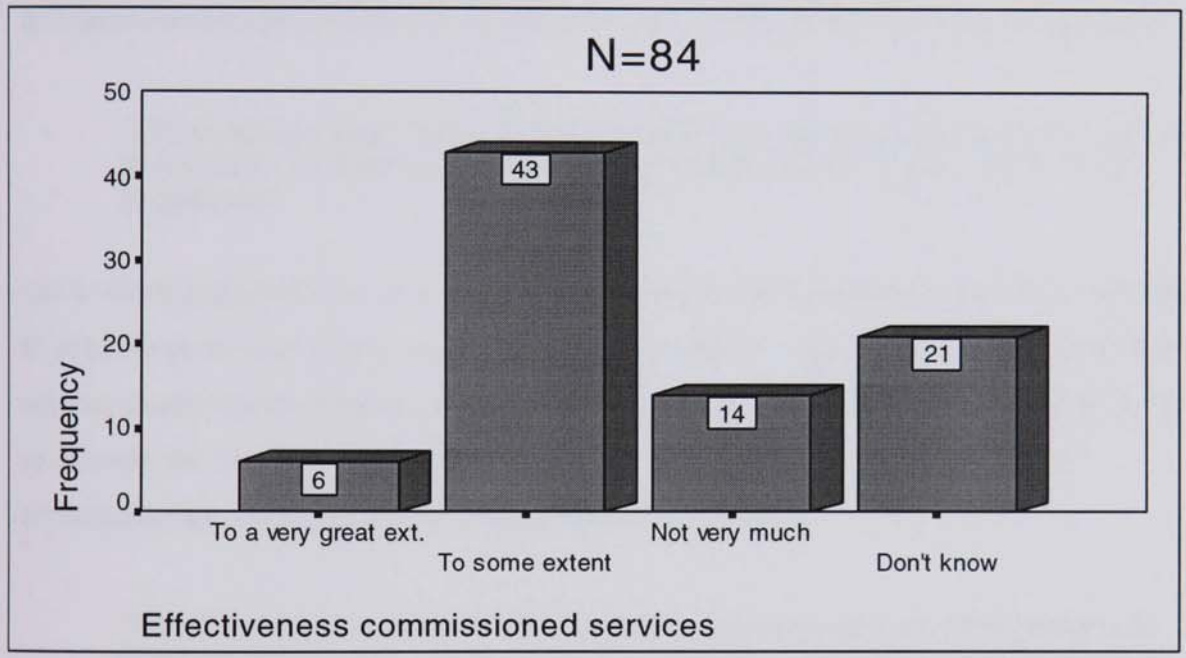
This assertion raised the need for better co-ordination of services with a greater involvement of local services for care in the community as much as in hospitals. The importance of working in partnership was raised with an emphasis on involvement of local services when patients are admitted to high security hospitals. One commissioner pointed this up by saying:

> *"Multi-agency work is essential for this client group. There needs to be continuing involvement of local services once individuals are admitted to higher security facilities".*

8.7 Measuring effectiveness of care

As discussed earlier the Reed Review has provided the benchmark against which services could develop successfully. It is clear from the above figures that services being provided ought to be effective. On the contrary, as Table 7.5 shows only 6% of respondents thought services they commission were effective to a very great extent and a further 51.2% agreed that services they commission were effective to some extent. Worryingly 16.7% of respondents think services they purchase were not very effective and a further 25% do not know whether they were or not.

Table 8.5 Effectiveness of commissioned services



8.7.1 Measuring effectiveness, presently

Commissioners were further asked to state how they measure effectiveness of the care they purchase. This free text opportunity provided very diverse comments on effectiveness measures commissioners' use. Some commissioners complained that they did not get any feedback and were therefore not able to identify any measuring tools being used by providers. Some said that the reasons why they were not using any was due to the focus of the NHS policy that is on financial probity and not on quality.

Other commissioners who although were not as yet using effectiveness measures were in the process of developing one. Comments such as the following were prominent.

> *"Not involved in measuring but from outside it looks inconsistent. We are developing new methods and measures and are at embryonic stage of development"*

Others were using clinical reviews organised by provider staff and listening to "noises in the system" as effectiveness measures. All the measures listed represented process measures and so address to a degree the efficiency of the service provided. Some commissioners said they attended case conferences and join in to review care plans on ad hoc basis or expect local clinicians to maintain an active involvement and regularly attend reviews with their forensic counterparts.

> *"We do not use any objective evidence of effectiveness measures. When we attempt it; it is only in a limited way and we focus on processes through clinical audit programme"*

On a more pragmatic level, some of them monitored reported delays from providers in admitting to and discharge from different levels of security, and were involved in review placements regarding safety and mental health status of patients. Majority of respondents mentioned re-offending or recidivism rates as a measure of effectiveness. This was summarised by one as thus:

> *"We do not have at present effectiveness outcome measures. Effectiveness is therefore measures in relation to lack of offending being reported and social re-integration success"".*

Some use statutory evaluation tools such as the Care Programme Approach, and the Supervision Register while others use evidence of multi-disciplinary working as well as inter agency working and a sense of confidence in the provider as a measure.

> *"Sense of confidence in the provider and this only occurs at NHS medium/low secure care and in that these are the providers I meet regularly"*

The only recognised measure of effectiveness identified by this trawl of commissioners is the Health of the Nation Outcomes Scales (HoNOS). This measure is extensively discussed in Chapter 3. Other measures identified by commissioners are categorised in Figure 8.1 below.

Annual review meetings were also a source for commissioners to assess effectiveness of the services they commissioned. On the whole the issues of managing resources was thought to be one of the areas that provider units were excelling. On the more specific issues regular individual case reviews, analysis of reports, contract compliance and review groups that were multi-disciplinary and from various agencies were thought to be somewhat effective as measures for the patient group.

Figure 8.1 Summary of Measures (Commissioners)

Structural (Organisational) Measures

Preventing danger to others
Adverse incidents
Visits
Ability of the service to meet the needs of MDOs in our population
Use of special hospitals and medium secure facilities and links to local intensive care
Contract monitoring

Process Measures

Level of activity (e.g. Readmission rates, discharge rates, and throughput)
Successful placement (follow up of individual patients, on a sampling basis).
Extra Contractual Referral (ECR) spend on medium secure
Through patient complaint systems.

Clinical measures

Subjective professional judgement
Clinical audit programme
Reports from professionals
Attend reviews on request
Individual case reviews
Needs assessment
Establishing whether patients care plans have been discharged fully

Research & Development Activity

R&D into local patterns of mental health, prison and probation use.
Evidence based publicity/reviews
Clinical audit - very early stage
Training and experience of staff

Collaboration and Partnership

Joint agency group
User and carer feedback
Compliance
User participation in purchasing
Quality of Life questionnaire
Community Health Council involvement

Intermediate outcome measures

Impact on admission and length of stay in medium secure acute in-patients
Suicide and homicide and other untoward incidents
Return to local services
Anecdotal

As Figure 8.1 shows, service commissioners' views are grouped into six key areas. These are Structural (Organisational) measures, Process measures, Clinical measures, Research & development activity, Collaboration and partnership and Intermediate outcome measures. 66% of respondents maintained that the effectiveness measures they were using were not effective and a further 78% thought that the measures need to be refined or modified. Commissioners were further asked to comment on the measures they were using in terms of their effectiveness.

As Figure 8.2 below shows the measures in use range from none at all to named instruments. While some commissioners talked about their plans to develop outcome measures others talked about some of the areas that they were currently using to measure the effectiveness of services they commission.

Figure 8.2 Range of comments on measures in use

NO MEASURES

We do not use any objective evidence of effectiveness measures. When we attempt it, it is only in a limited way and we focus on processes
The service to the group is not monitored for its effectiveness routinely if at all
No method but we use monitoring of ECRs, meeting Courts requests and Home Office demands and listening to "noises" in the system
At embryonic stage of developing means to assess effectiveness
Difficulty to assess in current financial position with funding shortfalls. At present much of care provision in crisis management.
Not involved in measuring but from outside it looks inconsistent. We are developing new methods and measures
As purchasers we get no feedback therefore any measure available to us.
Multi-agency/multi - disciplinary team currently waiting as an evaluation approach MDO service. Do not monitor "effectiveness of MDO services".
We do not use any standardised instrument at present .
We don't

OFFENDING

We do not have at present effectiveness outcome measures. Effectiveness is therefore measures in relation to lack of offending being reported.
Longer term outcomes - e.g. request offence rates and social re-integration success.
Early days. Providers look at outcomes such as re-offending rates. Major evaluation of sex offender treatment programme encouraging at interim stage
No re-offending

Annual Reviews
Attending reviews, case conferences and reviewing
Report from providers (case conference)
They dealt with resource issues well
Individual case reviews
Evidence based publicity/reviews
Receive update reports from provider
Attend reviews on request
Analysis of reports, i.e. quality reviews
Contract monitoring
Inter-agency group to review/co-ordinate
Joint agency group

Needs Assessment
Ability of the service to meet the needs of MDO in our population
Needs assessment

Care Planning
Care plan monitoring and review on a sample basis
Establishing whether patients care plans have been fully discharged
Engaging in discussion with relevant care team.
Regular attendance at case conferences

Clinical Audit
Clinical audit - very early stage
Auditing
Clinical audit programme

Subjective Clinical Judgement
Reports from professionals
Subjective professional judgement

Critical Incident Appraisal
Adverse incidents
Suicide and homicide and other untoward incidents
Level of untoward incidents
Preventing danger to others

Monitoring Admission/Discharge (THROUGHPUT)
Reported delays from providers in admission to and discharge from different levels of accommodation.
Impact on admission and length of stay in RSU (medium secure) acute in-patients
Follow up of individual patients, on a sampling basis.
Level of throughput
Readmission rates
Level of activity
Re-offending rates
Return to local services
Admission rates
ECR spend on medium secure
Anecdotal

Placements within the System

Regular reviews of placements regarding security level, safety, mental health status - with forensic team
That there is movement to reliable levels of security.
Subsequent experience within mainstream services
Use of special hospitals and medium secure facilities and links to local intensive care
Successful placement

Reputational

Sense of confidence in the provider (only occurs at NHS medium/low secure care and in that these are the providers I meet regularly.
Expectation that local clinicians maintain an active involvement and regularly attend reviews

User Participation

User participation in purchasing
CHC (Community Health Council) involvement
User and carer feedback
Talking to patients to whom care has been commissioned
Through patient complaint systems.

Measures In Use

Quality of Life Questionnaire
HoNOS

Research and Development Activity

Training and experience of staff
Research and development
R&D into local patterns of mental health, prison and probation use.

General

Measures of recidivism, risk, re-admission, HoNOS and process measures such as CPA, supervision register, supervised discharge.
Visits
Liase with provider directly as required
Compliance with contract

8.7.2 The strengths of the measures

Commissioners were further asked to identify the strengths in the measures they were using to assess effectiveness of the services they were purchasing. Some

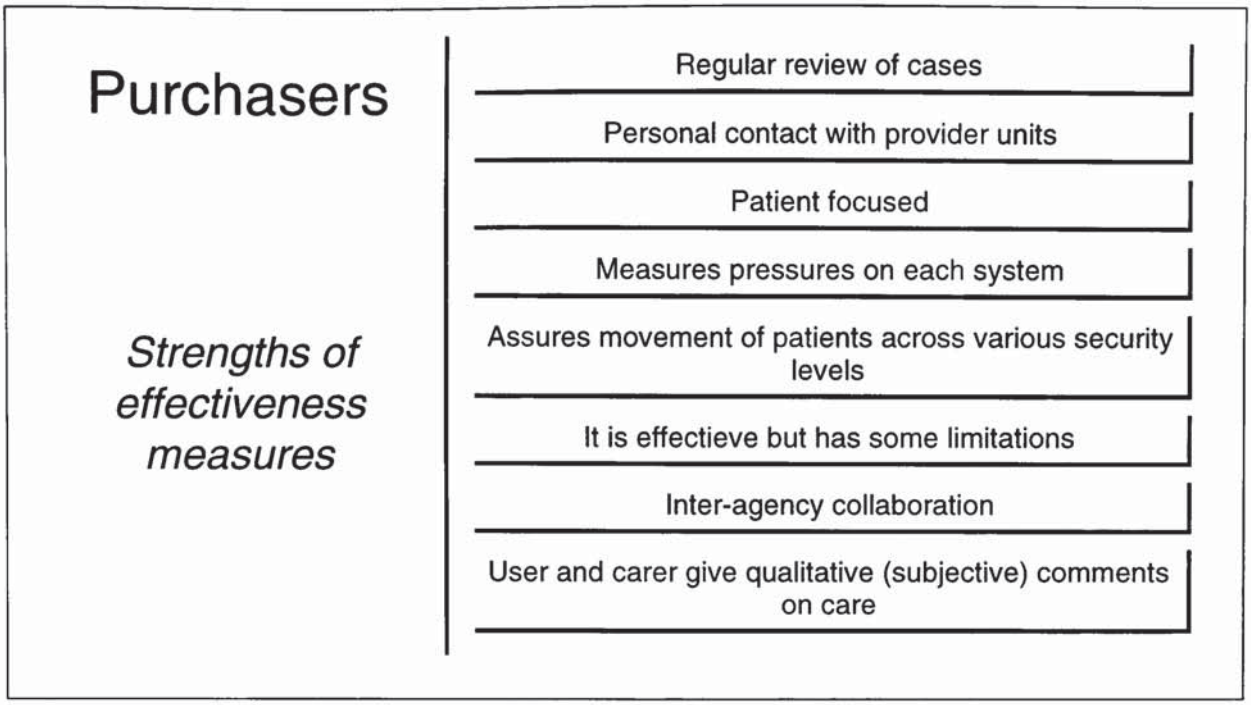
believe that the measures they use would enable local clinicians to maintain an involvement and participate in developing and evaluating care plans while others could not identify any strengths within them.

Others thought that they could achieve commitment from providers if effectiveness measures were developed to achieve effective outcome measures that could become part of the routine evaluation of services. One concluded:

> *"This approach will give an added value to both purchasers and professionals. Commissioning services after a health needs assessment, developments of strategy such as networking services across health authorities would commit the provider to a care plan"*

Others thought the strengths of the measures they were using enables them to gain an overview of progress, appropriateness of care packages and the present and future plans of providers to improve patient care. There was a strong view that the measures provided commissioners a means of accessing the service, develop joint working structures and to ensure that the service was patient focused. Some commissioners argued that the measures were ensuring that the tendency of providers to exclude them from participating in clinical work was reduced. Others defended the validity of the tools they were using on the grounds that the objectives set were achievable, affordable, understandable, easy to measure, reliable, simple and that they relate to real issues. A summary of the strengths of the measures is listed in Figure 8.3 below.

Figure 8.3 Summary of Strengths of Measures



8.7.3 Main weaknesses and limitations of the measures

Commissioners complained of the short term and unsystematic nature of the measures they use. One commented that effective development is at risk because:

> *"No long term follow-up data is as yet available".*

While another complained that the effectiveness of the measure is in question because it is carried out by the provider units albeit by a separate audit department within the same hospitals. This brings into question the validity of these reviews leading one to conclude that in the ideal situation purchasers should have a more direct input monitoring effectiveness and lamented that:

> *"There is a major lack of meaningful, reliable outcome measures. Most HA officers simply want a 'quite life' and are not keen to get stuck into real effectiveness evaluation".*

While the HoNOS scale is the most regularly used measure its comprehensiveness was questioned by commissioners. One commented that:

"No individual assessment of health and social functioning using say HoNOS".

Others pointed out the difficulty of comparing some research effectiveness studies and outcomes (evidence) at local level where the evidence does not support the claims made by these research findings. This suspicion of the quality of research in the context of the ability of its findings to be generalised was summed up as:

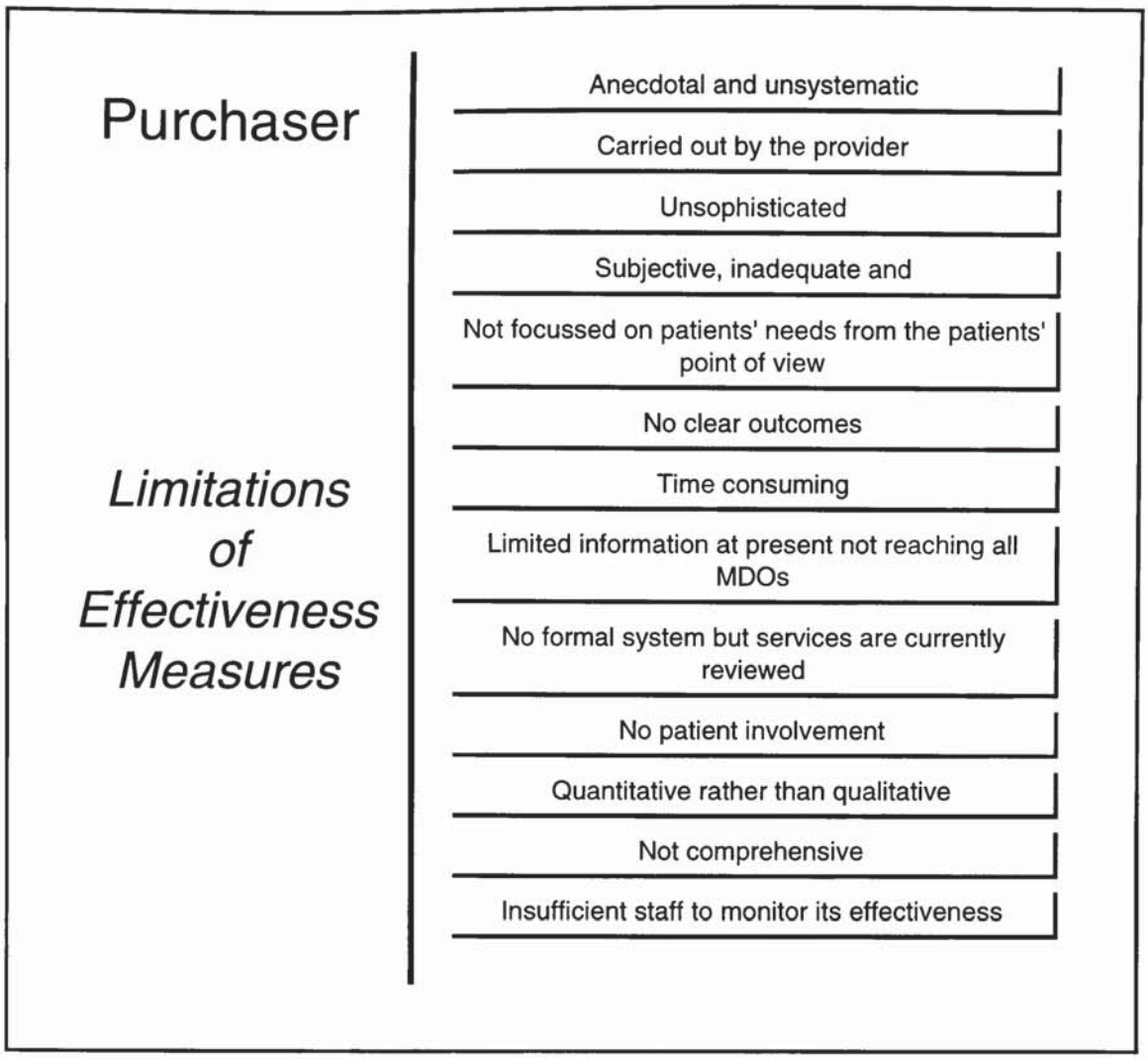
"These projects take some time. There need to be appropriate research and development backup for commissioners. This will make it easy for health purchasers to ensure appropriate analysis of the services' effectiveness".

Others continued this theme of the difficulties of implementing research findings by criticising the need for clinical audit. They questioned the contribution of clinical audit by pointing out its main weakness and limitation which, they pointed out was an inexact science often with misguided focus on what is measurable rather than what is important. Commissioners also thought that the data collected was not reliable and was based on clinical preference of practitioners and not comprehensive enough. One concluded that this has led them to accept what was presented to them on paper:

"Tendency to consider feedback on its face value rather than diving into the environment and attempt to hear "feel" for what is happening".

A summary of the major limitations of the measures commissioners were using at the time of this survey is provided in Figure 8.6 below.

Figure 8.4 Limitations of effectiveness measures



8.7.4 Suggested changes for the measures

It has been discussed the high numbers of respondents who felt that the measures they were using needed to be refined. They were asked to comment on what ought to be done to rectify the situation. Some said that they have started work on developing standardised assessment protocols. They argued that this approach was useful, as good assessments were process indicators of an efficient service. They also called for appropriate housing to be built into outcome measures.

Some felt what was needed to change the situation was more skilled knowledgeable professional input in purchasing, building up the contract and its monitoring and to develop a focus on quality. One commissioner supported this by adding:

> *"present teams do not have the knowledge, skills credibility or any interest in challenging providers or really getting stuck into these issues".*

They also called for an "expansive scale of actual R&D programme" linking mental health and offending with the quality of service planning". This they argued would enable provider units to change from their present admissions criteria, which they claimed was based on diagnosis to a needs based one. A commissioner summed this up by saying:

> *"Changes in admission policies of provider units to be more flexible towards accepting patients who need a service rather than patients who conform to definitions, diagnosis or acceptable criteria".*

To operationalise this research programme they called for investment nationally in research and development in mental health and better training/education in audit skills. They also called for a greater involvement of purchasers in focus groups with providers jointly exploring ways of linking research, development and application of this to clinical practice. They argued this would lead to:

I. Replacement of the present system with better measures of effectiveness.

II. Development of more objective measurement and reliable assessment tools.

III. Quality information flowing from research activity and the development of practice protocols

IV. Raise level of sharing information between purchasers on evaluation of quality of such services

They concluded that this new model of building partnerships needs to be evolutionary to enable the development of a more detailed clinical information base to replace the present unplanned and chaotic process which, was difficult to access and did not support patient effectively. Others called for increased involvement of

patients in the process more than they were currently doing and a shift from block contracts for services to an individualised patient base ones. Others advocated for an increase in the range of outcomes based clinical services, with clear objectives to patients and staff. This type of service will focus positively on involving patients and their carers to elicit their views and experiences, able to work with other agencies in partnership and collaboratively on the agreed care plan for the patient which should be designed to reduce readmission and re-offending.

8.8 Other comments on developing outcomes measures

To conclude this chapter the views of service commissioners were in favour of developing outcomes measures which are designed to meet the treatment needs of the whole population of MDOs instead of the few. They felt that assessment times should be specified so that, patients could be dealt within an appropriate timescale and that the focus should be on measuring effectiveness instead of activity. They were of the view that the Care Programme Approach principles should be extended to cover all the diagnostic groupings within the service and called for consistent use of the Health of the Nation Outcomes Scales (HoNOS). The view that any such measure should take into account the views of the general population was seen as one way of winning the public over. They also called for integration of the forensic services into mainstream mental health services in order to increase knowledge and skills base for local mental health teams. Further, that funding should move with the patient to the NHS with the shift from inappropriate custodial care. While all respondents felt it necessary that outcomes measures are developed as a priority others felt that this should be done in evidence based way. This was summed up by a commissioner as:

> *At this stage of development much effort is focussed on the process of care which being multi-agency requires much understanding, communication and collaboration. Rehabilitation and restoration of normal living could be worthy goals, but insufficient is known of the effectiveness of many interventions and care processes. Hence it is difficult to be outcome driven in commissioning services.*

In the next two chapters the evidence derived from the previous methods will be used as a basis to explore any residual and pertinent aspects of measuring outcomes.

CHAPTER NINE

APPLICATION OF THE METHODS - RESULTS (4)

Case study Alpha (High security hospital)

Background to the high security hospitals
Management of the hospitals
Introduction to Alpha
Access to the service
Realm of action
Discussions
Duality of structure
Reflections on Alpha

CHAPTER NINE: CASE STUDY ALPHA - High security hospital

9. Background to the high security hospitals

Case Study Alpha is one of the three high secure hospitals, otherwise known as 'special' hospitals in England and Wales. The Secretary of State for health has as a duty to promote a comprehensive health service under the NHS Act 1977. This is further clarified in the case of forensic psychiatry that:

> *"a duty to provide and maintain establishments for persons subject to detention under the MHA 1983 who in his opinion require treatment under conditions of special security on account of their dangerousness, violent or criminal propensities". (Section 4 of NHS Act 1977)*

Basically this means that Special Hospitals hereafter referred to as high secure hospitals can only admit persons who are:

I. *Subject to detention (except informal patients - i.e. detained patients in hospital whose detention has expired but are awaiting discharge after Mental Health Review Tribunal and with their consent).*

II. *Further the Secretary of state can use the high security hospitals for any other purpose if he or she so wish. This may happen if a person who is suffering from a contagious disease and is seen to be behaving irresponsibly that the safety of the general public is put at risk.*

People who fall within the scope of these categories require special security level of accommodation in order that this duty to the general public is preserved. Special security has been defined as 'that which is applicable to that which is required for category 'A' prisoners'. In the case of a hospital providing treatment for mental disorder, this means that arrangements should be in place to prevent compulsorily detained patients from leaving the hospital (except with authorisation), and from causing harm to themselves, other patients or staff.

In practice the security in the hospitals is preserved by a secure perimeter wall, locked wards, vigilance of adequate numbers of well trained staff, a system of procedures and checks properly communicated and carried out

effectively and constant review of procedures to ensure that they are at optimum efficiency (DHSS 1981). Gostin (1986) however argued that these security measures were not designed to prevent an organised and well planned attempt from outside to enable a patient to escape. Gostin argued further that although the DHSS directive related to patients who were dangerous, violent or of criminal propensities, and the discretional powers of the Home Secretary, there were however grounds for judicial review of the Home Secretary's decision and these are exercised from time to time by patients (Gostin ibid p304.3).

9.1 Management of the Hospitals

The high security hospitals were administered centrally by the Secretary of State for Health and Social Services who had direct control of and managerial responsibilities for staffing, finance, supplies and building. This power was delegated to a body called Office Committee for Special Hospitals. This committee which was based in London delegated its managerial responsibilities to more local Hospital Boards but the management of the day to day activities of the hospitals remained in the hands of civil servants who were sent to these hospitals to manage it.

During the reforms of the NHS in the 1980s and following numerous inquiry reports when the management of the service was criticised for ineffective management, the need for a new centralised body was identified to provide the service with a degree of health service management experience thereby creating separation between the hospitals and the civil service. In 1989, the Special Hospitals Service Authority (SHSA), a centralised body was created with the direction that the plan for modernising the hospitals and their integration into the NHS should be operationalised.

In 1996 the government disbanded the SHSA and formed the High Security Psychiatric Services Commissioning Board (HSPSCB) to further integrate the hospitals into the NHS. The membership of the HSPSCB consists of representatives of the Health service purchasers, providers from outside the

high security hospitals, the criminal justice system and government officials from the Welsh Office, Home Office and the Department of Health. The Board acts as a purchaser of services for patients for all the three high security hospitals in England and Wales (Figure 8.3)

Figure 9.1 The three High Security Hospitals for England and Wales

Hospital	When Opened	Original Purpose
Broadmoor	1863	As a criminal lunatic asylum. Ran by Home Office
Rampton	1910	Opened by the Home Office and passed on to the MInistry of Health in 1974
Ashworth	1974	Started as Moss Side Hospital in 1914 by the war Office. Taken over as by the MInistry of Pensions in 1920 as an epileptic Colony. In 1933 taken over by the Ministry of Health as a state institute for mental defectives. Became a special Hospital in 1959.
		A new Hospital called Park Lane was built to house patients from Broadmoor Hospital was opened in 1974 on the same site as Mosside Hospital.
		The two hospitals: Moss Side & Park Lane were amalgameted and became the New Ashworth Hospital in 1989
		* All the hospitals are now within the NHS

The special hospitals staff were employed by the DHSS and therefore were persons who "hold office under Her Majesty" and were subject to the Official Secrets Acts 1911 and 1921 which prohibits the unauthorised disclosure of information; thus, prior authority must be obtained before the disclosure of any information about the special hospitals which they themselves have not officially made public. This historical background is important in understanding the way information is handled in these hospitals even though they are now within the NHS.

9.2 Introduction to Alpha

Case study Alpha was a high security hospital in England providing treatment and care to mentally disordered offenders and mentally impaired patients who need a safe environment because of their dangerous, violent or criminal tendencies. It is one of the four high security hospitals in the United Kingdom and became a Special Health Authority in 1996. This allows the hospital to act autonomously through its board of directors but with government overview by the NHSE through the HSPSCB. The study was conducted over a period of twelve months between July 1995 to July 1996.

The hospital is situated in a rural 250-acre site. Its chequered history began in 1870 as a convalescent home for children from workhouses and latterly as a hospital for shell-shocked soldiers during the 1st World War and became a State Institution in 1933. The hospital in its present form consists of 25 wards capable of housing a total of 500 patients and the proportion of men to women patients was in the ratio of 10:1. The average length of stay in the hospital was about eight years although a minority will spend the rest of their life in the institution due to the severity of their mental disorder or political considerations.

9.2.1 Access to the Service

To be admitted to the hospital as indeed it is for all the high security hospitals in England and Wales, the patients must meet the following criteria:

I. *They must be detainable under the Mental Health Act 1983, having been diagnosed as suffering from one of the categories of mental disorders. These are mental illness, mental impairment, severe mental impairment and personality psychopathic disorder.*

II. *The condition must be treatable and each person must be regarded as presenting a danger to the public or themselves.*

A total of 421 male and 49 female patients were admitted to the hospital in 1996, of the male population 282 (67%) were diagnosed as suffering from a

type of mental illness, 117 (25%) patients have a diagnosis of psychopathic disorder and 22 (8%) as mentally impaired. The female patient population comprised of 23 mentally ill, 25 psychopathic disorder and one mentally impaired. Approximately, 70% of patients were admitted from the penal system (prisons, remand centres, young offender institutions or police custody and the remaining 30% from hospital settings (NHS). The diagnostic split of the patient population was, 65% suffering from a mental illness, 30% psychopathic disorder and about 5% were classed as having a learning disability.

On admission each patient was assessed for a period of three months on an admissions ward before a decision was taken on the appropriate treatment and the ward to which he or she will eventually go for further treatment and rehabilitation. All wards were considered to be intensive in the care delivered but some wards were classified as high dependency with higher levels of staff. In 1996, at the time of this study 179 referrals were received, 147 cases were considered by the admissions panel (multi-disciplinary group charged with ensuring consistency of decision making on admissions to the hospital). Of this figure 49 were accepted as suitable and were admitted to the hospital. The rest were either deemed not to be of immediate danger to the general public and therefore were refused admission and the remainder were placed on a waiting list for admission. The admissions panel was only involved where the consultant forensic psychiatrist who had completed the initial assessment for admission thought it necessary to obtain the support of this multi-disciplinary group on the type of decision to make.

A total of 91 patients were discharged from the hospital in 1996/97. The medium secure units (see chapter 9) admitted 41 patients, 20 were sent to prisons, 13 discharged into the community, while 5 were sent to specialist units and 8 discharged to other hospitals in the NHS or the independent sector. In the same year from the male patient population a total of 25 (17 mentally ill, 3 psychopathic disorder and 5 mentally impaired) and 3 female patients (2 mentally ill, one psychopathic disorder) were sent to units in the wider NHS to test their suitability for discharge on trial basis.

9.2.2 Resources

Figure 9.2 No of Staff in Post in 1996/97

Staff mix for 1996/97

	Numbers
Nursing	878
Medical	29
Administration	156
Support Staff	149
Social workers	27
Senior managers	86
Rehab services	72
Other Professionals	22
Psychologists	27
Patients' Education	26
Total	1,472

Figure 9.2 shows that the largest number of clinical staff at the time of this study was in the nursing group followed by psychiatry, while Figure 9.3 shows the distribution of the budget allocated to it by the HSPSCB. The hospital had a budget of £44, 491,000 to deliver treatment care and management programmes for patients. The breakdown of the budget at the time of this research was follows:

Figure 9.3 Distribution of the budget

Category	Price per Year per patient	Cost to the Hospital
Learning disabilities	£ 85,520	£2,138,000
Female patients (mental illness and psychopathic disorder)	£ 124,860	£6,243,000
Male patients (mental illness and & requiring high security care)	£ 106, 196	£11,894,000
Male patients (personality disorder & requiring high security care)	£ 90,773	£6,808,000
Male patients (requiring care in long term medium security)	£ 73,542	£8,825,000
Male patients (requiring care in other psychiatric settings)	£ 69,864	£8,224,000
Clinical Audit	£ 19,000	£ 19,000
Research	£ 164,000	£ 64,000
Independent Living	£ 156,000	£ 156,000

9.2.3 Mission Statement

Its mission statement was to create together a valued, quality, secure psychiatric care for patients through learning and achieving in partnership. The management and staff held the belief that the hospital should work towards achieving excellence in the assessment, treatment and rehabilitation of those legally detained patients experiencing mental health problems who require conditions of special security. Achieving this mission depended on clarification of the hospital's strategic direction. The hospital's strategic direction was declared as working in partnership with others, to review and maintain the progress on the effective purchasing and provision of comprehensive mental health services to enable people with mental health disorder to receive effective care and treatment in the most appropriate setting, in accordance with their needs. Another aspect of the strategic

direction was to improve clinical and cost effectiveness of services and thereby securing the greatest health gain for resources available, through supporting research and development and formulating decisions on the basis of appropriate evidence about clinical effectiveness.

Finally, the hospital aimed to achieve its mission through the development of the organisation as a good employer with particular reference to workforce planning, education and training, employment policy and practice, the development of team work, rewards systems, staff utilisation and staff welfare.

9.2.3.1 The Action Plan

The strategic direction as set above was to be achieved through a series of action statements. The hospital has identified the following as the key areas they need to develop in order to achieve the objectives they set for themselves in response to purchaser intentions during the time of this study. These were to concentrate on:

- Clinical effectiveness
- Bed management
- Personality disorder patients
- Responding to staff needs
- Risk assessment
- Organisational development
- Equality of opportunity

Figure 9.4 shows the values that were declared to be essential to achieving the goals set out in its strategic direction. It shows also the priority given to ensuring effective clinical practice and the focus it placed on the need to involve patients in their own care.

Figure 9.4 The values underpinning the strategy

- Patients having the right to assessment, treatment, care and a right to participate in the formulation of their individual treatment plans
- Patients having rights to choice, privacy, dignity, access to an advocate, treated in the least restrictive environment and reducing dangerousness
- Patients having a collective voice through the Patients' Council
- Treatment and care being provided in a non-prejudicial way
- Staff working in teams with collective responsibility to work together with integrity, trust and respect for each other.
- Work of the highest ethical and professional standards, continually developing and improving through research and staff training and development.
- An effective organisation responding to the changing needs of the patients, staff, purchasers and the community.

9.3 Realm of Action

In order to assess the impact and the effectiveness of the delivery of the hospital's action plan, the researcher undertook an interview to collect the views from both patient and staff on various aspects of the hospital's strategic plan. Within the context of Giddens' structuration theory, this section will concentrate on the way the three elements of signification, legitimation and domination, which are communicated through interpretive schemes, exercise of power in allocation and distribution of resources, communication of meaning, and evaluation and judgement of conduct combine to create duality of structure within case study Alpha.

9.3.1 Training

Training and development was seen as central to the achievement of effectiveness in the hospital, particularly the clinical agenda. The human resources director who has direct responsibility for training agreed with this by

asserting that the main objective of the hospital was about enhancing the clinical agenda for the best possible results for the patients. She concluded:

> *"That is what we are here for. That involves a lot of things like research, a lot of things to do with academic knowledge as well as translating that into practical skills in the wards and so on, and working effectively with the patients and developing skills in that area".*
>
> **Human resources manager**

She lamented the fact that management skills were not valued and not seen as useful for the achievement of the clinical agenda. She thought that it was right for clinicians to develop and implement systems at ward level to ensure effective care was provided for patients. She concluded however that whatever system that was in operation at ward level at some point, there has to be somebody who has responsibility for members of staff working on that ward at that particular time. She continued by adding that, responsibility involved the person using management skills. She was concerned that this schism was preparing team leaders at ward level without the management skills to effect change that was needed to advance the clinical agenda.

> *"There isn't a recognition that (team leaders, ward managers, clinical leaders) have quite a specific role with the people side of staffing. But it's only if they get that right that they'll actually be able to move that clinical agenda forward because they should be looking at things like, who are the group or team, dare I say team, of staff on a ward and what are their needs to achieve the objectives".*

Another senior manager thought that there was knowledge and skills gap in the workforce and that was bound to affect the quality of care that people receive. He concluded this theme by arguing that there was a lack of sharing of knowledge within the workforce. There appeared during the course of this study that there may be confusion between the role of clinical work and operational management at ward level. This observation was put to a ward manager who stated that:

> *"I assess the skills and developmental needs of staff regularly. It concerns me that team leaders say it is not their responsibility to ensure effective care to patients. Clinical leaders are also refusing to interfere with what they saw as operational management activity. They fail to see the harm this is doing."*
>
> **Ward manager**

He concluded that this separation of tasks and duties failed to take account of the fact that whoever was working on the wards to facilitate the clinical agenda had to do it through the staff, and that was the "biggest issue for the management". He added that unless senior managers and clinicians recognise the need for that and ensure there was an ownership of the singularity of approach "I see a serious problem with us actually achieving that clinical agenda, however, good our clinicians are".

There were attempts by managers at communicating the purpose of the change agenda through team building and scenario planning. However some of the examples used in promoting team learning were directly from industry. Consequently, a lot of the participants were left with wondering why they had to go as they complained about the poor determination of the objectives of training or team building day. Some felt it was helpful as a medium for developing an insight to how teams are and what they need to be to become effective. There were activities designed to foster team working which has no bearing at all on the professional activity the hospital was engaged into. Some of the participants were able to get on with others within the team and therefore the exercise has been beneficial in that they provided the opportunity for people to see each other in a different setting. It would be helpful if all involved were able to learn something from the exercise in order to apply it in the work place.

Though useful to many it did not address the real organisational factors which were essential for the effective functioning of the service. Patient care seems to have been excluded from the whole exercise. As one of the participants observed

"It is a wonderful opportunity, it is a shame that we cannot operate as effectively as today. I guess the reason is in the workplace we have patients to deal with and there is where the conflict arises."

9.3.2 Clinical and management structures

The hospital was sectorised to enable ease of management and to bring decision making nearer to patients. All these management units have multi-disciplinary clinical teams and patients were allocated to these teams. Nurses working at clinical level were based on wards under the direct management of a ward manager and had responsibility for co-ordinating the care of a group of patients. Patients were grouped according to needs and so clinical teams had patients for whom they were responsible mixed with patients with similar needs from other teams. The clinical teams were led by a consultant psychiatrist who as the responsible medical officer (RMO) was legally responsible for the care and management of the patient and ensured that other members of the team work together for the benefit of the individual patient. Depending on the needs of the patient or ward, the teams met at least once a week to review the progress of patients.

Clinical managers were responsible for the management of these sectors. Although their titles suggested a degree of involvement in provision of care, the responsibilities of clinical mangers fell within the realm of ensuring the budget was managed and the staffing requirements met. Ward managers too concentrated on the management of human resources and have a low degree of input into direct patient care. All staff except medical practitioners working within a sector or management unit were accountable to the clinical manager. As in all NHS hospitals, the medical director who was a member of the management board for the hospital had responsibility for the management of all doctors. This arrangement claimed by those without clinical background was often a bone of contention between clinical and non-clinical staff, as people without clinically related professional background were not seen as essential in the life of the hospital. This two-tier management arrangement was summed up by a training and development manager as:

"After a major incident in one of the wards, some people were feeling very vulnerable, very fragile and very threatened. I had people turning round to me and saying, you must find it very difficult not being a professional in this organisation. Now I don't know, is it something to do with nurse training that doesn't recognise managerial expertise? There seems to be a big divide between nursing and management and doctor simply do not recognise their usefulness."

Training and development manager

She concluded by saying that the tendency for clinical staff to fall behind the screen of professionalism and clinical judgement was a state of wanting the authority but without the responsibility or accountability. She argued that the two must go hand in hand. Some clinical staff also made almost an identical argument. Senior clinical nurses who do not have any management responsibility for staff but were expected to lead in developing care and move the clinical agenda forward talked of their tasks being made impossible as they did not have the budgetary responsibility to change things.

9.3.3 Culture

Most interviewees, including patients talked about being disempowered and blamed for whatever happened within the hospital. They argued that this prevented any real innovation and appropriate care as intentions could be misinterpreted as working against the "good name of the organisation." One senior nurse summed this up as:

"However nicely you do it, the end result is that you have actually got no power. These things, change only happens slowly, however, hard you implement it. Emotions take a long time to actually catch up with the logic of it, so the logic says we need this, and we need empowerment, but the actual change will take a much more management push."

Senior nurse

She continued that people were still living in the past and not able or not willing to face the facts that the service needed to change. These members of

staff were taking a lot of effort to change as their emotions were damaged. She added that the directors of the hospital have failed to recognise this insisting that the organisation had moved on while in actual fact the hospital had been sitting still for a very long time. Most staff saw the size or responsibility for a budget as the key catalyst for change and saw those who work across the hierarchical line management structures as powerless and lacking the ability to influence change within the organisation. A senior psychologist asserted:

> *"Power is money. Power is pips on the shoulder. Power is how many staff directly report to you. So that's one of the problems, that is we've got this hierarchical and status orientated environment.*
>
> **Clinical psychologist**

He too concluded that people were still living in the past. He argued that even though systems were put in place to make change happen the reality was that staff were still stuck in the past and not willing to make the necessary leap. He blamed this on the fact that there were expectations on people to change but they were not equipped with the knowledge and skills to enable the change. He likened this to what was happening with patients as they were thoroughly assessed, their needs identified but the failure was that nothing was done to help patients realise their hopes and aspirations.

> *"And in between, they'll have all kinds of hurdles along the way which will make people not believe in them and we've done exactly the same with our staff."*
>
> **Clinical psychologist**

There was evidence that the definition of tasks and responsibilities was not made clear to staff or rather the staff did not understand the priorities. This had led to those who should have leadership roles in developing the service failing to grasp the nettle by refusing to see themselves as managers who were independent and working for the best interest of patients.

"They don't see themselves as managers. They don't see themselves as supervisors. They don't necessarily see themselves as leaders, and they want to remain friends with all the people they have been friends with before. Therefore a number of them unfortunately take the line of resistance, and they'd rather be one of the boys or girls, and they don't want to lose that."

Director human resources

The result of this he concluded was that instead of there being leadership, the situation was that key staff were pushing their own agendas through as opposed to taking an overview and providing a clear direction for junior staff and advocating for patients' rights. This had led to lack of involving staff of all grades and professional backgrounds in the clinical agenda effectively. So how were service managers closing the apparent gaps? This question was put to the director of professional development who responded as thus:

"Everything moves back to people going to conferences, people giving clinical papers. Yes, that's all very important, but we're not delivering the agenda because we haven't got basic things in place to deliver and manage it effectively."

Director of professional development

He went on to explained that he had been trying to demonstrate the importance of developing the staff effectiveness base from basics such as identifying the gaps in knowledge and skills and develop a process whereby the responses to meeting the needs of patients, was designed for staff to change their behaviours to ensure the change agenda was met appropriately. He maintained that this had to start from an effective staff review process. This would involve clearer definition of the job for every grade of staff, which should be linked, with the objectives of the hospitals. From that there should be coherent action job descriptions and person specifications all geared towards achieving the organisational goals and more importantly the needs of patients.

9.3.4 Management knowledge and managers

During the course of this study, the pervasive view amongst most of the interviewees, who were mainly from the professions was that managers have not made an impact within the organisation because most of them do not have the management theory nor understand the application of the concepts but were calling themselves managers. This has raised a question for credibility of managers. A senior manager was asked to comment on this view as it seemed not all staff were seen as necessary for the achievement of the care and treatment agenda that the senior managers of the service talked about so frequently. He responded by saying:

> *"I see anybody who has responsibility for other people as requiring management skills, to manage them. I think this organisation seems to think that if you put somebody in a role with the word 'manager' they've automatically got the skills and knowledge, and that's because there is no real recognition of the fact that just as people can't be effective clinically without training and development it is not recognised in the same way for 'managers'. It is assumed because they have got clinical skills they can automatically manage."*
>
> **Clinical manager**

He illustrated this point by drawing from his experience in industry when a well-known company decided to make its best sales people managers. The result was that sales levels fell sharply and some of them struggled to make the management grade. He pointed out that being a good clinician requires different skills and so do managers, adding that was what was happening in the hospital. That some of the best clinicians who were admired for their clinical expertise were put in management positions without first ensuring that they have the skills or knowledge to do the job effectively. These had led to people suffering burn out and were heavily stressed in doing their work properly. He concluded by saying that there was so much anger in the hospital against the management that it is negative to be deemed to be a manager so clinical team leaders do not want to be associated with it.

"They don't want to be called managers because it's a nasty, tacky unpleasant thing to be, where you're seen not to have any integrity and honesty. People don't trust senior managers here."

Clinical manager

This attitude against managers was not helped when they themselves did not work together. A senior manager who was concerned about having to tell me this warned that I should not attribute this to her as she observed that:

"They [senior managers] fight amongst themselves, and all 'these things' are going on, and it devalues managers and it devalues the management processes."

Senior manager

She revealed that she could not even implement measures to correct the imbalance of inadequate preparation of the staff, as she was unable to have the backing from her director. She felt that this was so because the idea had not come from the director himself.

"I think there is a phenomenal agenda. I have put forward a number of proposals, but I have to go through my Director. He doesn't see it the same way as me. I'm arrogant enough to think I am right, but I don't get to talk to the Chief Executive nor the Chairman, I don't get to present things at Boards, and therefore my director takes the things off me. I don't know what's said."

Clinical manager

9.3.5 Knowledge, Skills and Practice

There was a view that budget allocation within the service was not efficient enough to meet neither the training needs of staff nor identification of patients' needs. A clinical manager highlighted this, by saying that some senior managers who have budgetary responsibilities tended to allocate money to meet their own agenda and not that of the corporate entity. The result of this was that there was a lot of ill prepared staff left to deal with very difficult and dangerous situations.

"All these things always need amending, but there are so many different agendas going on in the hospital. So many people interfere in things where they don't have the skills and expertise. It really worries me. You only find out about it by accident."

Clinical manager

This was further elaborated on by a human resources manager who complained that a senior nurse was moving a nursing agenda forward, but as an exclusive function without any thought for the wider implications for ensuring total care to patients within the hospital. Involving patients in care was seen as a major objective of the hospital. This researcher attempted to assess what nurses were doing or thought should be done to ensure that patients contribute to the formulation of their care. A staff nurse was asked to explain her understanding of empowering patients She replied:

"I find the use of transactional analysis gives me new perspectives on care provision. I am finding with this knowledge that I have accepted patients should be happy and I should advocate for them and empower them in the process. Transactional analysis gives us a framework within which my practice has been enriched. I think if we can all find that focus empowering patients will be achieved"

Staff nurse

Unfortunately this nurse was alone in acquiring this new knowledge which had contributed to enlightening her knowledge of the need to involve patients. She maintained that this information could be better co-ordinated and shared if there was a commitment from managers to encourage her in sharing it.

9.3.6 Clinical supervision

Butterworth et al (1992) explained that clinical supervision is a process for developing professional skills to enhance quality of care provision to patients. Alpha defined it as a mandatory or negotiated contractual responsibility for all nursing staff. The processes involved include support, skills development, the maintenance or improvement of standards, and personal development. The service had a high commitment to developing clinical supervision for staff

particularly nurses. The idea was that changes to patient care could be delivered through the umbrella of clinical supervision. However staff accused management of trying to develop it into a managerial tool to assess their competences and managers want it to ensure that the process could be used to implement change management in clinical practice. This divergent viewpoint has made it difficult for trust to be established between managers and staff. During the process of this research the researcher observed that a lot of time had been spent in meetings discussing this issue without any real action. This observation was put to a clinical manager who confirmed this researcher's suspicions:

> *"Because managers were expressing interest in it, staff have decided not to engage in any real discussion towards implementing it. They are threatening industrial action and in situations like this it is much easier not to confront the Prison Officer Association who represents majority of staff here. People here tend to prefer to control rather than enable others."*
>
> **Clinical manager**

He went on to advance the view that inability to implement clinical supervision was impeding effective care to patients as there was no real way to ensure that the quality of nursing care was appropriate and geared towards the needs of patients. She argued that implementing the concept required a lot of management commitment in terms of time and resources allocated to operationalise it. She observed that intransigence to implementing new ideas and meeting needs of patients within the organisation was a problematic area for managers. The same problems beset other contemporary concepts within the NHS in general. Care Programme Approach (DoH 1994) which was introduced by the Department of Health as an approach to unifying the professions in their approach to assessing the needs of the patient became bogged down. Staff complained that it was time consuming and criticised the fact that assessing the needs of patients was only useful if there were adequate resources to be allocated to meet identified needs. Additionally, the researcher also observed that most of the contemporary issues in the health service; patients' charter targets, consulting patients, development of multi-

disciplinary teams and investigation of incidents and complaints have all been incorporated into operational policy manuals and with personnel identified as responsible for ensuring implementation. However their impact on the effectiveness of service provision was very had to pinpoint. This observation was put to a senior clinical nurse who replied:

> *"I am afraid our record for putting all these new issues into practice is rather patchy. We are very good at writing about them though."*
>
> **Senior clinical nurse**

9.3.7 Multi-disciplinary working

The Reed review of services for mentally disordered offenders and others requiring similar services (DoH 1992), recommended in their final report that effective multi-agency and multi-professional working is indispensable for services with so many diverse components. However, they stop short of being prescriptive about the team membership but felt that the composition of the team should be determined locally, and should include representatives of all disciplinary groups both within health and social care settings.

The Clinical Standards Advisory Group (CSAG) which was established in 1991 as an independent source of expert advice to the UK Health Ministers and the NHS on standards of care reported in 1995 (DoH 1995). Its report too identified multi-disciplinary working and audit as one of the key areas which mental health services should pay attention to in order to provide effective care. It recommended that the principles of multi-disciplinary and multi-professional audit should be applied in all agencies providing care for people with severe mental illness.

Commenting on the importance of training for members of the multi-disciplinary team (MDT), the Health of the Nation document Building Bridges, which is a guide for multi-agency working for the care and protection of severely mentally ill people observed that the pre-qualifying training of mental health professionals equips them with many of the skills necessary (DoH

1995a). It however criticised the single discipline focus of that training and concluded that it does not locate the skills in the context of multi-disciplinary team working. The report of the Confidential Inquiry into Homicides and Suicides by Mentally Ill People published in 1996 mirrored this view and recommends that work should be done on improving the functioning of multi-disciplinary teams (Royal College of Psychiatrists 1996). In particular they recommended the following:

1. There is adequate level of staffing, with individual responsibilities in the team being made explicit.
2. The members of the team receive continuing education, some of it involving the whole team.
3. They encourage multi-disciplinary team working and provide training in team working.

Additionally all these reports recommended that patients too should be involved in these meetings and a system to evaluate the team's effectiveness be established. All these key documents identify multi-disciplinary team working as the bedrock for effective care delivery. This section of the research focused on assessing the effectiveness of the teams from the following perspectives.

I. Composition of the team, its stability, leadership and its effectiveness.

II. Adequate level of staffing, with individual responsibilities in the team being made explicit.

III. Whether members of the team receive continuing education and training, some of it involving the whole team.

IV. Assessment of the way members encourages multi-disciplinary working and evidence of training in working as a team.

V. Communication including record keeping and decision-making

VI. Named Nurse – appointment, change of personnel, preparation of the named nurse, role of the named nurse, deputy for the named nurse, relationship with other members of the team, effectiveness of the system and involvement of the whole of the team.

At the time of this study, there were an acute shortage of staff, particularly nurses, psychologists and occupational therapists. Consequently, the membership of the multi-disciplinary clinical teams tended to concentrate on the consultant psychiatrist and nurses based on the ward. The frequency of reviewing the progress of patients was patchy and attendance at these meetings was irregular to say the least. There was no evidence of training and development work geared towards promoting team working. All patients were allocated primary nurses or key workers but they complained that non nursing members of the team do not accord them with the respect they deserve and this has contributed to poor service to patients. A senior clinical nurse summed up the effectiveness of multi-disciplinary working as:

> *"The multi-professional approach to care is an admirable principle, however it is met with difficulty because of different professional groups attitudes towards nursing staff. This most valuable group is often undervalued and left to deal with all basics while other professional groups deal only with the 'higher order activities'. This leads to disunity and barriers, which need to be bridged by closer working and respect for individual's skills. So often work carried out by professionals other than nurses is carried out away from the nursing environment - wards. The principles of* ***patient focused care*** *would go a long way towards improving multi-professional approaches"*
>
> **Senior clinical nurse**

Another thought the principle of multi-disciplinary working has not changed and will not because:

> *"Medics still see nurses as hand maidens".*
>
> **Team leader**

9.3.8 Patients' communication and representation

Traditionally, mentally disordered people express their views about the treatment they were having in or out of hospital through the primary nurse, that is the nurse who is responsible for co-ordinating the care, treatment and management of the patient's stay in hospital. In the community patients were usually allocated key workers who performed a similar role as that of the primary nurse. Patients have access to other members of the clinical team either directly or through the allocated health professional. In the case that they wish to complain about the nature and quality of care they were receiving they can complain directly to their consultant psychiatrist (responsible medical officer) or through any member of the nursing staff at ward level. They could also use the complaints' procedure, which enabled them to pursue their complaint through the system to the chief executive of the hospital and beyond.

In the case of Alpha, all these avenues were available to patients. Additionally they could also complain to the Mental Health Act Commissioners and at the individual hospital level they could raise their complaints with patients' advocates and the patients' council. The patients' council was introduced into the high secure hospitals following an inquiry into allegations that patients did not have a voice to express their views directly to the directors of the service (DoH 1992). The aim of the patients' council was to encourage a higher degree of involvement and act as a medium for patients to express collectively their views on the appropriateness of service provision to the directors of the hospitals. Membership of the council comprised of at least one patient from each of the wards who represented the collective views of patients on that particular ward. Patients' advocates (see below) provide administrative support to the council and the complaints manager co-jointly chaired the meetings with a patient representative. Patients from various diagnostic groups and ability levels from all the wards met and discussed non clinical issues and individual grievances that were of concern to them. The hope by government and indeed managers of these hospitals were that such a group would be a key component in contributing to improving care,

treatment and quality of life for patients within the high secure hospitals. Paradoxically, some nursing staff felt that this forum was designed to further diminish their power base and to weaken their control of the environment and on patients. They complained that the forum had also contributed to disempowering them.

Most of the complaints levelled against the patients' council were about inadequate feedback to other patients. Patients who were non attendees felt that there ought to be increased communication regarding the existence and purpose of the council. They argued that there was a need by patients to "let us know what the council is" and to "circulate what it is doing better." Furthermore, it "needs to be better advertised so people know what it does" so that patients "know exactly what the council can do for them". In addition there was a need to "listen to the patients instead of thinking for them". Others felt that they were not fully aware of the purpose of the council and those who were aware of it felt that it did not represent their views effectively. There were complaints about the tendency of patients with a diagnosis of psychopathic disorder running the council on the basis of their own agendas. This has made it difficult for those with a diagnosis of mental illness to communicate their concerns in an open forum, such as the meetings of the council, which in most cases had numbers of attendees in excess of thirty. Further female patients and those from the minority ethnic groups felt that their needs were not being represented as white male psychopathic disordered patients dominated the group. Additionally, most of the members of the patients' council complained about the response rate and speed in resolving their grievances, particularly those relating to their care and management within the hospital. A member of the council intimated that:

> *"We complained about the amount and the way the meals are served here for over a year but no change. We also asked for visiting for friends [conjugal rights] but we will never get that. No one said we can't but it just doesn't happen."*

Some patients suggested ways in which the contribution of the patients' council could be improved. These ranged from making known their purpose to

all patients rather than the few who were active members to better consultation and liaison between members and other patients whose interests they claimed to represent. Adequate representation was also another area of complaint which patients felt could be improved upon. The argument here was that some of the members of the council represented wards which were not their own and therefore could not contribute effectively to working towards achieving the purpose of the council.

In recognition of the need that patients could be disadvantaged by nature of their distress, social stigma and controlling nature of psychiatric interventions and in response to an inquiry report in 1992, the hospital set up an advocacy network through the Citizens Advice Bureau (DoH1992). The service acts to provide independent and impartial support, representation and information to service users to partially redress the imbalance of power within the service. The advocacy network aims to provide the resources to ensure that patients knowledge of services is increased and their rights to access and free expression of views safeguarded.

Figure 9.5

Workload of the Advocacy Network (1995 - 1996)

Categories	No of Contacts	% of Total for Year	Male	Female
Care and Treatment	52	21%	22	30
Legal and Rights	30	19%	20	10
Patient relational and visiting issues	58	30%	30	28
Discharge Issues	5	4%	3	2
Hotel Services	9	3%	2	7
Staff issues	9	6%	6	3
General Advice	36	16%	17	19

As Figure 9.5 above shows the workload of the Advocacy Network was largely in the areas of patients issues (relationships in the hospital and visiting arrangements), care and treatment problems and issues relating to patients rights in the hospital and the application of the particular part of the mental health act under which the patient may be detained. By far the largest groups of patients who access this service were those diagnosed as psychopathic disorder even though they constitute a smaller proportion of the patient population. Some of the staff within the hospital attributed this phenomenon to the fact that the psychopathic disorder patient is clinically known to be anti-authoritarian and was therefore more liable to complain than other diagnostic groupings. Others argued that this was due to the fact that the psychopathic disordered patient was more likely to articulate their grievances and pursue it with more determination. The observations of the researcher was that mentally ill patients who complain were either assumed to be too mentally disturbed to be believed or they relied on staff to act as an advocate on their behalf. This observation was put to a ward manager who confirmed this observation and added:

> *"It is rather difficult to tell whether what these patients tell you is just a comment or a plea for action. It takes a lot of experience to make the different but staff generally do not understand the request from the patient or they find the complaints procedure too complex and too time consuming to put into gear."*
>
> **Ward manager**

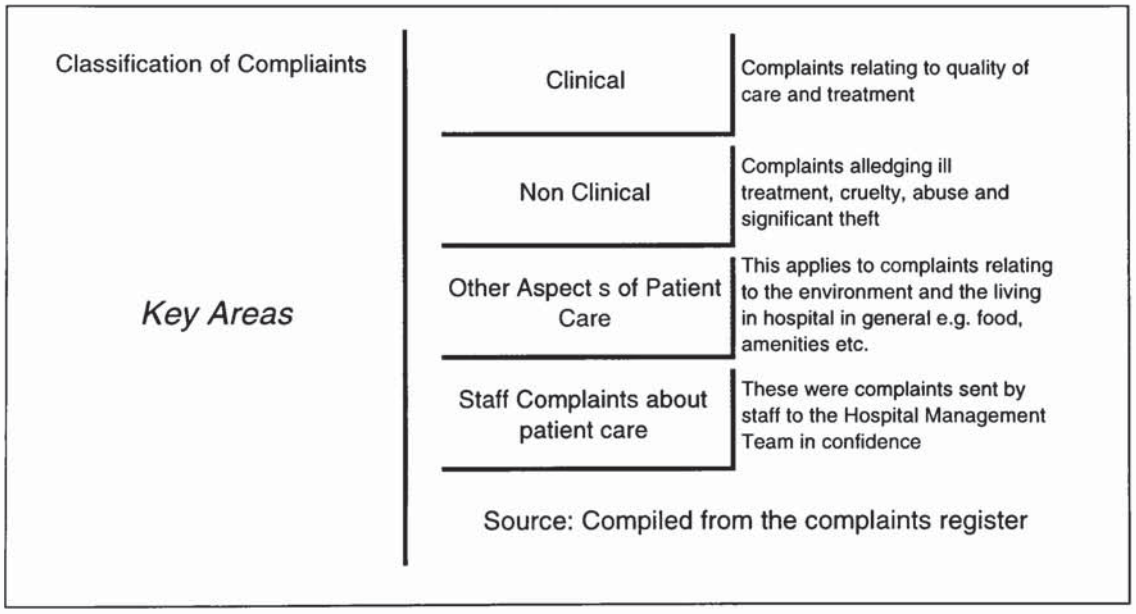
9.3.9 Complaints

To conclude the extent of patient involvement the record of complaints lodged with the hospital by patients was examined. The complaints department has responsibility for collecting, analysing and presenting its findings to the Hospital Advisory Committee, which advises managers on what action to take. During the time of this study, the hospital employed patients' advocates, made management changes and undertook movements of patients to other wards as a result of formation of directorates and made major changes to clinical teams. These issues have a degree of impact and therefore influenced

the number of complaints that the complaints department received. The complaints process was seen as cumbersome, slow and staff who work within the department were insisting that the resources allocated to it was inadequate. Some complaints receive immediate management attention and appropriate actions instituted. Where necessary the complaints department appointed case assessors to help them to investigate complaints received in the department as part of the process.

The complaints register from June to December 1996 was examined by the researcher and found the following, that 62% of all complaints were resolved satisfactorily within twenty working days and about 16% of all complaints were upheld. As Figure 9.6 shows the complaints were grouped into four key areas.

Figure 9.6 Classification of complaints by category



By far the largest number of complaints was about clinical issues. Figure 9.6a below shows that complaints relating to medical and nursing care and treatment formed the largest group. Patients tended to complain also about the care of their properties (61 complaints) and the nature and quality of their living arrangements (29 complaints). The number of patients complaining about the security arrangements was comparatively low (18 complaints) given

that these hospitals were regularly criticised as oppressive. However, this taken in conjunction of the criteria 'deprivation of liberty' (20 complaints) could clearly be seen to be high areas for complaints.

Figure 9.6a Complaints by kind

Period: June - Dec 1996

Grouping of Complaints	Number of incidence
Offence against the person	14
Medical care & services	15
Nursing care & services	132
Other professionals	5
Domestic, living arrangements	29
Finanace & benefits	8
Deprivation of liberty	20
Leave and other absences	7
Catering	5
Administration	15
Patients Vs Patients, e.g. assaults, disagreements	25
Social, Recreational & educational	21
Discrimination	6
Family matters	5
Security	18
Property	61
Other	14

Figure 9.6b: Complaints by originator

Table 9.6b

Originators of Complaints

	% of Total
Patient	48%
Relatives	3%
Solicitor	4%
Staff	8%
Patients' Advocates	33%
Mental Health Act Commissioners	4%

9.3.10 Patients' Comments

One of the main avenues for patients to redress any grievance on group basis is through the patients' council. The Patients' Council was an innovation within the high secure and has been in existence since a government inquiry into allegation of cruelty into one of the high security hospitals (DoH 1992). This was found proven and the hospital was criticised for the lack of involving patients in the day to day decision making process of the hospital. In theory the Council should have representation from all wards within the hospital but in practice only a few handful of patients were actively involved in its deliberations. A patient who was being prepared to be discharged thought the council did not represent their views effectively.

> *"The Patient council only talks about little things. I don't think it sort out problems with treatment and medication problems. They just pass it over to the patient clinical team and they never do anything about it".*

One of the focus groups involved its members who argued that:

"We are too grown up to be told to go to bed at 9 p.m. There are some staff who do not take care of patients, they tell lies. Newer nurses are better than the older ones. Some older ones care for and respect patients, do their job; some are lazy, greedy, careless and seriously cruel. They do not care. They do not tell you what is wrong with you, they just make you take drugs."

A female patient wrote down her thoughts as she found it difficult to concentrate when speaking:

"I am extremely disillusioned by the number of staff who instead of providing a service to us they are manipulative, selfish and arrogant, which perhaps is the way of the world but I find this hard to condone particularly because it affects my mental state. Some staff contribute to making me unsettled. Two days ago I asked one of them if I could make a phone call. He dialled the number and left a message with the recipient of the call and I hate the fact that as a result my privacy is being invaded. He knows I dislike these tactics."

A patient

Another patient who had been admitted due to her difficult behaviour in a local psychiatric hospital expressed dismay about the way staff related to her within the hospital. This female patient was training to become a lawyer and had working experience in the Lord Chancellor's office commented.

"What ceases to amaze me is that staff here have skills to either help you raise your opinions of yourself and they also have the ability to hinder your confidence you have in yourself, for the result that you adopt a mediocre or you underestimate your talents or the fact that you could be an asset to society."

A patient

Another complained about the inefficient use of the policy of twenty-four hour care. The hospital after numerous reports recommending a change in the way care was provided which was on institutional basis, that was such things as a compulsory bed time and wake up time decided to alter this and introduce a more flexible system whereby individual wards were opened all the time. In the past patients were locked up in their rooms to ensure that they were able to wake up early in the morning to start their work programmes. Although there has

been a management decision for this change communicated to all staff, this did not seem to be happening in some areas.

The issue of sharing information with patients in a way that would help their understanding of their illnesses was one that was commented upon by both patients and some of the staff. Nearly all patients interviewed complained about the lack of explanation and inadequacy of information that was given to them. They argued that the priority for staff was that they should be taking prescribed medication but failed to tell them what they were for, how it would help them and what adverse reactions they would have taking these medications. Other patients complained that they were only aware of rules and regulations when someone judged that they were wrong and called for a clearer statement of 'dos and don'ts.' Some of the interviewees argued that they ought to be consulted and expressed the view that staff could not meet their needs effectively without consulting them. Another point of concern to patients particularly from the minority ethnic groups was that they were first thought to be too dangerous before anyone began to develop a care plan for them. This aspect of care had resulted in poor quality of care and the tendency towards exclusion from the mainstream of care provision. This view was developed by one of the patients interviewed as:

> *"If you stand for your right they say you are difficult. So no one talks to you respectfully. If you are quite they say you are a {expletive [lazy]} and nobody care."*
>
> **A patient**

All patients from the minority groups, including Irish patients complained of ill treatment, which they described as a form of discrimination. Although there was documented evidence of ill treatment of patients from the black and minority ethnic communities (Prins 1993), which was also corroborated by some of the staff from both the indigenous and minority groups, the researcher did not experience any direct treatment that could be described as such.

9.3.1 Discussion

In this case study the elements necessary for the development of outcomes measures, that is a partnership between staff and patients had been discussed. A description and a profile relating to the history, purpose, the strategic mission and objectives of Alpha is offered. In addition, the way people and processes were arranged to provide treatment and care to the patient group was also outlined. To complete the dualism between staff and patients that is necessary to develop outcomes measures, patients views as to the degree to which the structures and processes set up to enable effective care and increased quality of care for them was canvassed.

Giddens' dimensions of social structure that is signification, legitimation and domination form a recursive relationship through the modalities of interpretive schemes, norms and power relationships. In the case of signification the way people construe meaning, understand events and draw on their experiences is organised through interpretive schemes. In this context therefore the ontological assumptions made by the researcher from the outset was focused on man's capacity to produce knowledge in this case through communication, that is how people in the organisation acted, communicated with each other and interpreted situations within Alpha. It appeared from what different stakeholders said that this communication was not effective. Managers seemed to be promoting a clinical agenda but it was not quite clear if the interpretation of this desire by staff was that what was needed. Also patients have learned not to communicate for fear that they may be chastised and certainly with the knowledge that they would not be listened to. Empowerment of both staff and patients had not happened, according to interviewees enough to enable the development of working in teams and in partnership. This lack of communication had resulted in suspiciousness of actions by managers, staff and patients and consequently allowing a culture of blame to evolve within the service. Obviously the new language of "clinical agenda" had not taken root within Alpha.

The domain of domination is enacted through the modality of resources and it manifests itself through how power interplay between actors. In Alpha, the physical resources were impressive. The best description of this case study site is that it was designed as a village but with the facilities of a provincial town. Both patients and staff enjoyed these facilities which included training school linked with a local university, a swimming pool, facilities for patients to study up to degree level, a library that was fully computerised and many others. The wards however were not at the same level as the facilities previously described in terms of how they were decorated. At the time of this study there were staff shortages in all professional groups and this was putting pressure on the effectiveness of the various forums within which patients were discussed. It had been discussed how the modality of resources manifests itself through the medium of power, which is both tranformative and relies on the resources that actors call upon to change the activities of others. In the case of Alpha this was identified in different forms. From the managers perspectives they have the power to change the effectiveness of the hospital either through their recruitment and selection policies, their training and development programmes and have the ultimate sanction of dismissal. Staff on the other hand have their professional and trade union organisations to balance unnecessary misuse of sanctions by managers. In addition they can also exercise a very high degree of control on patients through the use of sanctions of sedating medications and seclusion (segregation from others at times of distress).

The final structure element to be examined was signification, which manifests itself through the modality of rules and norms and can be observed in the way rewards and sanctions are exercised. As implied in the paragraph above various actors in this case study do have the means for using different sanctions and indeed reward systems. The managers did use attendance at courses or conferences as reward for hard work and they certainly also used promotion to achieve the same aim. Staff also use a system of good behaviour to reward patients, for example going out on rehabilitation and social trips did not only depend on the mental state of the individual or on the risk the individual might pose while out of the ward or hospital environment

but also the judgement of staff on the compliance of the individual patient. This judgement at times was shown to be flawed on more than one occasion when a "trusted" patient escaped on an escorted trip outside the hospital.

9.4 Duality of structure

Giddens argued that the structure element of signification, domination and legitimation act together to provide patterning that is useful to the way organisations learn and change. He went on to argue that the way people communicate, obtain and exercise power and the sanctions and rewards they use can be observed in the realm of action. The elements of structure and those of the realm of action combine to form duality of structure, which is the best environment to observe the theory of structuration. Further, Giddens identifies a series of basic concepts that are important to the structuration theory. These are as shown in Figure 9.7 below and discussed further to identify the impact they were having on the care of patients in Alpha.

Figure 9.7: Giddens concepts of structuration

All human beings are knowledgeable agents

The study of day to day life is integral to analysis of the reproduction of institutionalised practices

Routine is the predominant form of day to day social activity

The study of context, or the 'contextualities of interaction', is inherent in the investigation of social reproduction

Compiled from Giddens, 1984, p281 - 282

As stated in Figure 9.7 above routines are essential to the enactment of social practice in organisations. Most of the works of organisations are accomplished through repeated patterns of behaviour by an individual or between individuals. Some organisational theorists have defined organisational routines as performance strategies, operational procedures and objective settings. In the NHS and in particular the forensic services these

conceptualisation of organisational routines are applicable. Specifically within this context it could be said to include such organisational activities such as recruitment, training, research and development, audit activity and activities that are related to subject of this study. In the context of a service organisation like the NHS, these routines include all activities that have a meaning to people such as ward rounds, clinical team meetings, assessment, discharge planning et cetera. As discussed earlier and in Chapter 4 Giddens' theory asserts that the practice of the organisation is routinised through the conceptual split between structure and action (Giddens 1993 p4). One view is that people create social interaction or practice and the other being that history, perceptions and rules have a controlling effect on what individuals decide to do. These arguments can be represented within organisations as the existence of self interest seeking individuals who use their resources to achieve situations that improve their interests and oppose practices that could result in making them worse off.

In the case of Alpha, these routines were numerous. This was due to the nature of the service where certainty of practice activities were few and the tendency was to concentrate mostly on security aspects as oppose to promoting creativity and hence clinical excellence. In enacting social practice, the conceptual split between structure and action manifested itself as the lack of willingness to develop outcomes measures because of the various ways that an information of this nature could be used. The medical director summed this up as:

> *"There is need to measure the effects of people experiencing the forensic services. There is however some medico-legal, socio-political implications for developing such a measure. It is possible that political masters, purchasers and the Home Office under a political system which is not too lenient would seize information and use it to its advantage however dishonourably."*
>
> **Medical director**

Another example of perpetuating self interests could be found in the way there was a dichotomy between the management function and clinical practice. Obviously, staff felt that operating on one side was better than on the other in

so much as ensuring that some benefit might result for them. There was evidence for this identified in this chapter and by the survey of providers when a staff organisation (Prison Officers Association) was identified as the main barrier to the development of clinical practice. This analysis somewhat have taken the routinisation debate away from the contextual issues, for example history or past actions and placing it into the way social practice is recreated through actors making their own choices. This assertion is made due to the fact that there are too few certainties within Alpha, which should have made it easier for staff to follow guidance, but this is not the case at all stages. It seemed the change that is necessary to ensure a degree of control and co-ordination of the activities of individuals was not being adhered to, to encourage the repetitiveness of routines to reduce uncertainties. In short there was no evidence to support some of the precautionary steps taken were effective yet the process still went on. For example all appointments of staff in leadership or management positions underwent psychometric and personality testing and were deemed effective but their practice had not changed to face up to the demands of the new agenda. It seemed too that these self interest groups were pervasive because there was evidence of continuity of resistance to change which was needed to alter the practice agenda to focus on measuring outcomes. It appeared from the experiences of the researcher that new staff too seemed to fall quite easily within this "mainstream" of doing things after a short period of arguing against inaction. Contemporary issues such as clinical supervision appeared to have lost the support of staff because of the part that the routine was playing to ensure that expectations, dependencies and accountabilities were exercised to the advantage of the individual or the groups they belong to. Most of these behaviours could be attributed to the blame culture that interviewees reported and in part by the negative press and criticisms the service receives. This analysis is based on the observations by the way people exercise power within Alpha. According to Giddens' theory of structuration power is defined as having 'transformative capacity' and communicated through the modality of facility which relates to the resources people call upon to change the activities of others. In this context then, the transformative aspects that was mandated from the top of the organisation seemed to be blocked by another, which appeared to have

been organised better, whose rules and habits effectively encrypted in actors mind than that required to change to meet the requirements of service effectiveness demanded by managers.

9.5 Reflections on Alpha

Alpha was a high security hospital facility designed for the care and treatment of mentally disordered offenders and mentally impaired patients who are deemed dangerous, violent or have criminal tendencies. These patients were normally deemed to be an immediate risk to others. Consequently, the physical security of Alpha was considerable, consisting of high perimeter walls, closed circuit cameras, electronic search gadgets, restricted access to wards, double exit doors and many others coupled with controlled movement of patients directed by radio (walkie-talkie) operators characterised by a degree of precision which the military would be proud of.

9.5.1 Description of the service

The service was broadly divided into four distinct functional entities i.e. grouping of patients who have mental illness, psychopathic personality disorder, learning disability and women services. Access to the service was largely from the criminal justice system. Alpha tended to concentrate its activities on the care, treatment and management of the patient within the hospital sector rather than work actively for the discharge of the individual. Although patients were discharged this was often to other health service facilities for further rehabilitation before eventual discharge into the community or back into the prison sector.

9.5.2 Roles and responsibilities

Alpha could be described as a bureaucratic organisation in that its structures were hierarchical and decisions tend to be made at quite a considerable distance away from where it is eventually implemented. This has made it possible for its staff particularly those working closest to the patient to criticise

the remoteness and relevance of policies and decisions. Staff representation (union activity) was prominent and has been cited as one of the main reasons why effective treatment programmes could not be implemented. It appeared that the main driving force behind any kind of activity was the consideration of the security and safety aspect of that undertaking almost to the exclusion of everything else.

There was a clear distinction between clinical and management arrangements in that those who were in management roles play very little part, if any at all in influencing the delivery of treatment to patients. Similarly those who were involved in delivering care played no part in contributing to the decisions relating to the general management of the service. This arrangement was constantly criticised by middle managers and clinical staff as not being conducive to effective management of the service. This in turn has contributed to the overemphasis that is placed on security aspects rather than clinical issues although most people agreed that these two factors were not mutually exclusive. While the service embraced innovation within the wider NHS in policy terms, the change in behaviour that was necessary to advance the clinical agenda did not mirror the proclamations of intent. Alpha by its nature limited its contact with its external stakeholders, the general public, press etc and this has resulted in proliferation of leaks and innuendoes about the effectiveness and competence of its staff and managers within the press almost on a daily basis. Alpha like its sister hospitals was constantly under the public gaze shaped by media reports due to the high profile of some of its patients, a situation that has also contributed to its inward looking nature.

9.5.3 Measuring effectiveness

The service had managed to change the way care was managed by introducing a 24-hour care programme. This was an innovation introduced within the last four years, which enabled patients a 24-hour access to staff and some facilities. Previously patients were locked up in their bedrooms overnight (from 9p.m until 7a.m the next morning). This change in practice was not received favourably by staff as it was alleged that it has contributed to

increasing demands on resources needed to ensure control and safety of both staff and patients. At the time of this research, the service was in the throes of organisational restructuring, which has contributed greatly to the shift in focus from the clinical to the security agenda. Although multi-disciplinary teams exist, their effectiveness has been questioned on the grounds that they fail to work jointly and with a common purpose. While the philosophical and values base of the service was made clear to all the behaviour of key players did not demonstrate any willingness to work together or prioritise the needs of the patient. Alpha's managers do not seem to have achieved the bridge between policy intentions and practice. The functional areas seem to compete against each other in terms of securing resources and there was a lot of animosity against the degree of attention that was given to the psychopathic disorder directorate. The feeling was that because the patients in this directorate complain more and were able to manipulate the system to their advantage, managers of the service acquiesce to their demands readily.

In terms of measuring effectiveness, it seemed that the organisational input into this activity does not show the seriousness of attention it required. While the service had structures in place to deliver an effective clinical agenda, the resources allocated to its evaluation was almost negligible. For example out of a budget of nearly £45 million for the delivery of care and its supporting functions only £19,000 was allocated for audit activity in the year this research was conducted. The professions complained of serious shortcomings in terms of staff numbers, training and the extent of pressure they have to work under. In this study no recognised outcomes measures were in place and no patient satisfaction surveys were made available to or observed by the researcher during the course of this research.

9.5.4 Involving patients in care

The service has established a patient council to enable a collective voice of the patient population to be heard by managers, set an advocacy network to further strengthen the individual voice of the patient. However these two innovations were not generally accepted as representative by most patients

as they did not think that their needs were being met effectively. There was a system of an identified professional who can advocate for the patient but patients too did not see this as being effective. Patients generally complained of not being listened to and that all systems available appeared to be working against their interests.

9.5.5 Strengths and weaknesses

The independent advocacy network financed by the hospital management team but managed by the Citizen's Advice Bureau was an innovation which was unique to Alpha as a forensic sector provider in the country. The Patients' Council too fell under the same category except that they were unique to the high secure sector in general. The strength of staff representation could be seen as important in ensuring personnel friendly policies. The size and diversity of facilities within the hospital provided the best opportunities for the rehabilitation of the mentally disordered offender. Together all these could be deemed to be strengths of Alpha.

However the inability to bridge the policy, theory and practice gap have denied essential development within the service. Equally, the strength of staff organisations and the influence they could exert on the care process have been negative in improving clinical excellence, this coupled with over concentration on security aspects in developing risk assessment tools have also stunted progress. Alpha appeared slow in initiating or adapting to change and weak in consulting and involving patients effectively in their care. It was clear the patient representation structures were ineffective and have contributed to weakening efforts in building partnerships and collaboration to improve quality of care.

CHAPTER TEN

APPLICATION OF THE METHODS - RESULTS (5)

CASE STUDY OMEGA: MEDIUM SECURE UNIT

Background to medium secure units
Introduction and strategic direction – Omega
Realm of action
Duality of structure
Reflections and conclusions

CHAPTER TEN: CASE STUDY OMEGA (MEDIUM SECURE UNIT)

10 Background to medium secure units

Medium Secure Units are NHS facilities that cater for groups of patients whose needs fall between the services offered by local hospitals and high security hospitals. The largest in England and Wales has in-patient capacity of ninety beds and the smallest a mere fifteen beds. The private and the independent *sectors also* provide facilities for the admission and treatment of these groups of patients. These patients because of their difficult, and at times, dangerous behaviour, require security that is not provided in local hospitals, but they do not require the degree of security found in high secure hospitals. These facilities are best suited to admit, assess and treat patients who are not immediate risk to the general public and their security level depends more on the training and vigilance of its staff than on its physical security.

Most of these units started to be opened in the seventies, although their historical account started when a Department of Health working group recommended in February 1961 their establishment (Ministry of Health 1961). They were previously known as regional secure units, that is units within each health region, which would provide treatment under medium secure conditions. None of the proposed units were set up until the Butler Report in 1979 which proposed secure units in each Regional Health Authority area as a matter of urgency (Butler 1979). The revised report of the working party on security in the NHS was published earlier and made similar recommendations, Glancy (1974). The DHSS accepted the recommendation and agreed to fund these units. Although the establishment of these units were agonisingly slow, all Regional Health Authorities (RHA) have a unit or of some sort in operation by 1993. It is estimated that there are about 51 such units in England and Wales with in-patient bed capacity of just under 2000 beds. Initially the management of these units was delegated from the RHA to the local District Health Authorities (DHA) within whose boundary the unit is located. As time evolved

and the changes within the NHS were gathering pace, the model for management and that of care for these units became much more like that in the wider NHS and shifted further away from that which is in place within the high security hospitals. These units were however protected from the initial developmental hiccups (contracting, purchaser/provider-split etc.) that most other hospitals had gone through to prepare for the changes. As in Chapter 9, key elements of Gidden's Structuration Theory was used to assess the effectiveness of the service. The reader is reminded that a full discussion of the structuration theory is provided in Chapter 4 with an earlier application of the theory in Chapter 9 of this thesis.

10.1 Omega - Introduction and strategic direction

Case study Omega is a medium secure unit, which was opened in 1992 to serve a population size of 2.5 million people. It provided assessment, treatment, rehabilitation and after care for mentally disordered offender patients who needed a higher degree of sustained individual attention and security than local psychiatric services could normally provide. The main commissioners of the service were health commissioning agencies (Health Authorities) and prisons within its catchment area. At the time of this case study (March 1997) the unit had 33 in patient beds, a developing outpatient service and three satellite outpatient forensic psychiatric clinics within its area of responsibility. They also operated court liaison services to divert the mentally disordered from custody for treatment and were in the process of negotiating a joint venture with a private prison facility to provide health care within the prison, an innovation that was unique in the country at that time.

The service has managed to acquire a reputation for providing forensic psychiatric service of a high quality and in 1995 was awarded a charter mark; this is a commendation for public services for the quality of their work by the government. Managers were working towards improving the service by increasing the capacity to meet the increasing need that was identified. The NHS Trust, within which the unit is a part, was selected as the preferred health

care partner for the provision of all health care services to a new prison facility. This facility was a joint venture between the NHS and the private sector. The Directorate of Forensic Psychiatry was earmarked to be responsible for co-ordinating the provision of the Trust's services to the new prison which will include the staffing and management of a 44 bedded hospital wing. Discussions were in progress for provision of psychiatric services to other prisons within its catchment area. The service has also developed strong links with local probation and social services. The unit also had a very high degree of integration into the contracting and the provider role within the wider NHS, which it was taking very seriously indeed. Managers of the service have been using the income received for the provision of in-patient services to fund outpatient activity. Their aim therefore was to adopt a differential pricing structure in which separate charges could be made for in-patient and outpatient services in the future. They also admitted patients under extra contractual referrals (ECR), that is patients for whom they do not have a standing contract and were normally not from their catchment area.

10.1.1 Activity and Referral Patterns

Omega has witnessed an increasing number of referrals to the Service since its inception. The sources of referral of outpatients for the period 1st January 1995 to 31st December 1996 is shown in Table 10.1 below. It was forecasted that over the 3-year planning cycle of the service, there would be an increased demand from the criminal justice system. The mental health care needs of clients referred from agencies of the Criminal Justice System are often extremely challenging, with many exhibiting acute problems of mental illness. In order to meet the needs of patients the service has decided to prioritise the following areas.

1. Progress in the expansion of facilities for mentally disordered offenders and others requiring similar services.
2. Development of services in support of the 44-bedded proposed prison
3. Development of psychiatric assessment services for patients who may require secure unit services

4. Academic developments within forensic psychiatry, psychology and nursing

5. Develop a diversion from custody scheme at magistrates' court

The average occupancy rate for the service was about 95% and the average length of stay was 8.3 months and is considerably lower than that in Alpha, which was 8 years. The service's outpatient list had grown from 491 patients in 1992 to over 1,500 in 1996. The cost of care for a patient per day has oscillated from £218 per day in 1993/94, to the peak of £236 for 1994/95 and was at £200 per day (£73,000 per annum) in 1996.

Table 10.1 Outpatient referral sources 1st Jan to 31st Dec. 1996

Referral sources	Number of referrals
Courts	59
Crown Prosecution service	33
Diversion service	27
General practitioners	2
Local psychiatric hospitals	156
Voluntary sector	3
Police	7
Prison health service	426
Probation service	172
Medium secure units	1
Self referrals	2
Social services	40
High secure hospitals	17
Solicitor	478
Total	**1423**

10.1.2 Managing Quality

Omega was the first forensic mental health service to be awarded the government's charter Mark in 1995. This service consistently achieved its quality targets agreed with health authorities and regularly conducted patient satisfaction surveys by its staff and external verifiers. They were also planning

to improve the nature and scope of their user satisfaction surveys to assess the views of patients over a period of time. The service received visits from the Mental Health Act Commissioners (MHAC) and consistently received glowing praises from them. The MHAC is a government established group charged with monitoring the quality of care provided for detained and voluntary patients in hospitals, and restricted patients in the community. During their visits the commissioners monitor the use of seclusion, the number of non-accidental injuries to patients and the number of complaints received. Seclusion is used on rare occasions in this unit and non-accidental injuries to patients were also on the decrease. Comments such as the following were common in their summaries of their visits:

> *"The staff were very helpful and showed a great deal of enthusiasm and expertise resulting in a first class service run by dedicated staff".*
>
> **Mental Health Act Commission comments**

Omega had an active public relations policy, which it aimed to raise public awareness of issues surrounding the care of mentally disordered offender patients. One of their strategic objectives was to continue to generate a significant amount of media coverage with articles being published by staff and patients alike. The services also have good relationship with the local press and had been a subject in a documentary by the BBC television programme, which won a 'Bafta' award in 1995.

10.1.3 Training, Research and Development

Research and audit was accorded a prominent position in the development of the service and the aim was to develop these aspects of healthcare provision on multi-disciplinary basis. During the period of this study there were numerous research and audit projects in progress. There were also plans to conduct multi site projects in order to compare the quality of care provided by the service with similar organisations across the country and in Europe. There were plans also to set up 'Well Men' and Well Women' clinics within the service, focussing on the physical health needs of patients. There was a high degree of emphasis

on the multi-disciplinary and inter agency working which managers of the service identified as practices that were necessary in order to provide an effective service for the patient group. Further there were strong evidence of close working relationships with local services, the high secure hospitals and with the criminal justice system. The experience with engaging the criminal justice system had not been easy, as there was opposition to the principle of bringing health care to the courts and prisons. Building an understanding with local services to take people from the courts too had been difficult as the tendency was that the service was not suitably equipped to deal with this patient group. This in part had prevented a comprehensive development of services for people in the criminal justice system. Had a measure of effectiveness resulted through work with the criminal justice system? A community practitioner explained the process before the intervention of the forensic service as thus:

> *"There was no system by which the court could request a psychiatrist coming* to court *it was perhaps left to the probation service to run around panicking about getting a psychiatric report done. But I am very sceptical about how many times the court will actually ask because of financial implications. So I think people were just remanded to prison even if it was c/ear to everyone in court that they were obviously mentally ill. The view is its up to the prison medical services to sort them out, that is their job, they could do it."*
>
> **Community practitioner**

He went on to outline the difficulties that were inherent in measuring the impact of interventions from health professionals. He concluded by saying that they were using the rate of detection of mental health problems for those who were mentally ill as a measure of their impact.

10.1.4 Objectives of Services

There is a view that forensic mental health services have not as yet matured to be able to identify what they do that effectively meet the needs of patients. A senior manager was asked to comment on this view and to explain what needs

to be done. He explained that psychiatry has attempted to care for mentally disordered offenders under conditions of security but did not believe that the service has been applying the principles of forensic psychiatry or psychiatric nursing in any great degree except in recent years. He thought that it was in the mid 1970s that the special sections of the Royal Colleges of nursing and psychiatrists had emerged and so it is a relatively short space of time to expect a discrete profession of a speciality to emerge. He concluded by saying that:

> *"1 think the development of forensic psychiatry and nursing has been greatly accelerated in those years particularly in the latter years, the last five, but I would assert that forensic psychiatry and forensic nursing is only being applied in a very small number of discrete circumstances at the moment across the whole secure services. I think most secure services are driven by general psychiatric principles and practices and there are pockets of specialisms which are emerging in key areas".*
>
> **Senior practitioner**

Another senior practitioner advanced the view however that forensic mental health as a specialty has been busy in developing and creating its own identity within mental health. He added that there is a belief that forensic services have focused too much on crime and the law and have therefore failed to develop risk assessment and management packages based on the clinical needs of patients.

> *'I would agree that there has been efforts by psychiatry to commit itself to forensic work but I think the mistake that it has made has been its utter pre-occupation with law and psychiatry. Instead of focusing on the needs of patients the focus had been on those people who have committed themselves to an interest in law on one hand and psychiatry on the other. I think we have paid the price because risk assessment and risk management could have been developed if we had a real pre-occupation with the needs of patients in forensic psychiatry we would have far sooner focused in on risk issues that we have today".*
>
> **Senior clinical manager**

Another practitioner except with a different theme pursued this pre-occupation with the law. This time the effectiveness of multi-disciplinary working was questioned:

"I think psychiatry has been pre-occupied with the law and during that preoccupation I think it has resulted in a lost of at least two generations of effort of other disciplines who fell foul or prey to psychiatry's pre-occupation with the law at the expense of caring and I think all it has done is disempower those generations of other professions."

Senior manager

The manager thought however that these professions, particularly nursing have been opened up and empowered in such a way that they can challenge this pre-occupation that psychiatry has got with the law and concentrate peoples minds on the needs of patients. She argued that the only way this paradigm shift could be assured was the continuation of concentrating on interventions that dealt with people's needs. She concluded that the focus on the patient and their needs would shift the dominance of the law and consequently begin to challenge the medical model power base.

Others lamented about the fact that criminology and medicine have dominated forensic psychiatry and doctors have taken over the criminology mantra. The evidence cited for this assertion was that psychiatrists have now been studying for criminology degrees so that they could become experts in this field. This has resulted in forensic mental health being defined as an interface between psychiatry and the criminal justice system. The prevailing view within Omega was that the interface with the criminal justice system and mental health is an interface between professional people who administer care and treatment to the mentally disordered offender and not the interface between psychiatry and the criminal justice system per se. The view that this interface needs to be redefined in order to clarify the inputs and outcomes of this partnership was strongly held within Omega. A senior clinical practitioner concluded this theme thus:

"Now if we can concentrate our minds on this new interface then I think we will secure far more health gain for the whole population and less preoccupation with the law and glamour of working at the interface between the criminal justice system and health".

Ward manager

10.2 Realm of Action

10.2.1 Measuring effectiveness

The need to measure effectiveness of care provision was a constant theme throughout this study. There was a need to strengthen the measures that were being identified and so was that of ensuring that the outcomes could be attributed to the particular intervention. The argument that by clarifying the purpose of forensic services and focusing all efforts on the mental state of the individual, there would be better development of the service and more concentration on developing interventions that work. But would this focus align the service more to general psychiatry and remove the need to develop the forensic service as a specialty on its own right? The answer to this question was provided by one of the managers who asserted that by concentrating on developing risk assessment and its management packages to protect the individual and others the efficacy of the service would be safeguarded.

Asked what the service was doing to develop these comprehensive risk management tools to assure others of the service's effectiveness a senior clinician started by arguing that the measures that forensic services should be measured on needed to be robust. He argued that the present descriptors used to describe the typical model of forensic services were in themselves seriously flawed. The two main models of service provision are parallel to and full integration with mental health services. There was a view in the service that support the standpoint that the terms parallel and integrated emerged out of a psychiatric custom and practice. Because this view did not emerge out of a forensic specific knowledge base there is a degree of confusion. Many practitioners within the service argued that the model for forensic services should be a mixture of both, rather than one or the other.

This viewpoint was further developed by the assertion that every mentally ill person including the mentally disordered offender should have their basic secure and mental health care needs met by the secondary; that is the general mental health services, that where it becomes necessary to curtail freedom of the individual by the use of security then it is better for the forensic services to

be employed. Proponents of this opinion went on to add that while the forensic service is running parallel to the general services during the stay of the patient there should be a considerable degree of integration in terms of sharing skills and support at times of crisis with the general mental health service. A senior practitioner concluded this theme by saying that:

> *"So I think the labels parallel and integrated should be thrown out and we should re-invent some descriptor that more satisfactorily describes how the interface between the secondary (general psychiatry) and tertiary (forensic psychiatry) providers should be developed and should occur."*
>
> **Senior practitioner**

Some practitioners were of the view that measuring outcomes could be achieved through the application of clinical methods such as cognitive behavioural therapy. This method allows concentration on problems and needs whose definition is influenced by the patient and development of intervention tools to ensure that the patient's needs were met effectively. Senior managers and practitioners were of the view that there was evidence that support the fact that patients whose eventual discharge to the community takes the path of the medium secure unit were less likely to re-offend. Consequently, they were certain that their brand of intervention has been instrumental in enabling patients to have a much better opportunity for the future. They indicated that what they were not doing so well as yet was identifying what interventions work and for that matter developing outcomes measures would be the best approach for the service.

On the whole clinical staff believed empowering the patient and their relatives was the best aspect of providing care and treatment. They argued that this aspect of care was essential but what was needed was preparation of the patient in terms of what information and training was given to them. A practitioner cited an example to justify this standpoint.

"The need for providing the best treatment in terms of medication and therapy although very important should be balanced with the impact that patients and carers could bring to the domain of treatment."

Consultant psychiatrist

The viewpoint in the service was that carers and patients should be empowered to take responsibility for their care instead of being passive recipients of what practitioners want to happen to them.

10.2.2 Multi-professional practice

The view expressed above is fundamental to effective multi-disciplinary working. Firstly it was stated that the source of the two models - referred to earlier as parallel and integrated service provision, was coined by product champions who were psychiatrists who by nature strive for clinical freedom and autonomy. That, not only did they want to be different from their colleagues in general psychiatry they wanted to be different from their colleagues from other disciplines within the specialty of forensic mental health, it was alleged. The result of this was that some of them preferred the parallel service whilst others the integrated service ignoring in the process to take the needs of the patient into account. This theme was concluded by the argument that effective multi-professional working would be better served through focus on the needs of patients rather than on the ideology of any dominant practitioner.

"I think that the totality of all services if they are to be designed to meet the needs of mentally disordered offenders who have many and varied career episodes then the service itself has got to be more flexible and interchangeable, and that is only likely to happen if we focus in on quantifying risk of the individual patient and tailor the service around the risk instead of around that perception that is often driven by psychiatrists or forensic psychiatrist."

Senior manager

Had this assessment and understanding of effective multi-disciplinary working improving the way services were being developed within the service? This question was put to a number of practitioners. The prevailing consensus was that the relationship between practitioners and patients within Omega was probably the best in the country. They argued that patients were being treated very much as an individual and from assessment before admission a picture was built about the individual's needs and an allocated practitioner who was best equipped to deal with the issues identified to meet these needs of the patient appointed. The view that the quality of the nursing assessment and the medical formulation of patients' problems were central to delivery of effective care was strongly held within the service. They argued that this focus on quality was not only different from other similar units but also better. One practitioner supported this theme by explaining the process that the nursing assessment before admission was very comprehensive and the medical formulation recorded clearly for others to follow. This process was a planned one which took into account the degree of risk to be taken and the importance of listening to and working with other members of the multi-disciplinary team. There was a view pervasive within the service that the consultant psychiatrists were committed to and support joint working with other professional groups. So does the team's effectiveness depend on the leadership and enlightenment of the consultant psychiatrist? This question was put to a practitioner who responded:

> *"The consultant psychiatrist had their role and responsibilities for the patient enshrined into the Mental Health Act 1983. Until that is changed we have to depend on the willingness of the individual psychiatrist to be accommodating. They can always quote that responsibility if things are not going their way"*
>
> **Senior practitioner**

10.2.3 Involving Patients in Care

The evidence within Omega generally support the focus on multi-disciplinary working. However, this researcher wondered what was the level of engagement in the care process for patients, a process, which was explained

as follows. On admission patients were introduced to the client group as quickly as possible and encouraged to get to know their primary (key) nurses and all members of the multi-disciplinary team responsible for their care and were encouraged to contact them whenever they wish to do so. Asked to comment on what managers and practitioners thought patient might feel about this process, a senior practitioner and manager said:

> *"We have done a patient satisfaction survey from a department perspective, from ex-patients who have left the service and the results of that would suggest that patients are very satisfied with the quality of care and the way that the care is delivered "*
>
> **Consultant psychiatrist**

The motivation for the satisfaction survey referred to above was the desire of managers to assess their effectiveness from the patient perspective and to address issues relating to whether or not practitioners attend when they were asked to by patients. The effectiveness of communications and the extent to which they were being consulted and the flexibility of the staff about their care were also assessed. Other areas assessed were the ability to rearrange appointments without the fear of being chastised, about medication and about the quality of their ongoing care. Asked what in-patients as well as discharged patients would say if asked to comment on the effectiveness of the service a senior clinician observed as follows. He felt that patients would complain about the over-crowded nature of the admissions ward and level of noise within the ward environments. He thought also that patients would feel that there were too many disturbed patients on the wards and that there were too many patients from prisons. He concluded by adding that the service needed to be doing these satisfaction surveys, particularly within the in-patient population to ensure that the care they were providing was meeting the needs of patients effectively.

Closely linked with effectiveness were the problems associated with administration of neuroleptic medication (major tranquillising drugs) in psychiatry. There was evidence that practitioners in the service were aware of

the issues and were tackling the causes. Clinicians were of the view that research findings into use and effect of large doses of these drugs were not being used in practice. The result of this was often the tragic deaths of patients within forensic services (Prins 1994). One clinician quoted the work being undertaken in St Batholomews Hospital in London which was pointing to the fact that there was widespread ignorance about the use of these dangerous drugs in psychiatry as a whole due to their serious side-effects on patients.

A clinician pointed out that there was almost a revolution in pharmacology with many new drugs being licensed here in the UK for treating psychiatric disorders. He maintained that it is important that clinicians keep pace with these developments. He argued that some clinicians have fallen behind and that they would tend to prescribe older drugs, known to have much higher adverse effects on patients. He added that:

> *"I think that there may be many reasons for it, I am not sure that often in our post graduate training programme that we necessarily lay much emphasis on pharmacology as we should. While we are endeavouring to increase our trainees knowledge of psychological and social interventions what we are getting at the end of the day is they end up frequently prescribing drugs and that they forget drugs can actually be dangerous."*
>
> **Consultant psychiatrist**

Asked how this information could be brought to the attention of the busy psychiatrist, he argued that doctors should read the regular bulletins issued to them by the Committee on the Safety of Medicines (CFM). He pointed out the gaps in the information in so far as neuroleptic medications were concerned as the committee often concerns itself with new drugs.

> *"The CFM is more concerned with newer drugs than unexpected side-effects from them, but nevertheless they have a responsibility for the safety of all medicines including drugs like the anti-psychotic drugs that have been here since the mid- 1950s."*
>
> **Consultant psychiatrist**

He maintained that of the 31 editions of its bulletins for doctors the CFM has only once mentioned the potential life threatening danger of an inappropriate use of neuroleptic drugs in emergencies and there has been no mention of the dangers of using high doses despite its association with sudden deaths. In part the CFM was shirking its responsibilities as far as mental health and neuroleptic medications were concerned.

> *"Now that the link between the high doses* or *concentrations in the body of these medications and sudden death is becoming more clear I think it would be useful if they would re-examine the data that they have and maybe if appropriate put out a warning. That gets to every doctor in the country and I think they do take notice of the CFM warning."*
>
> **Consultant psychiatrist**

He expressed despair that whilst the CFM continues to maintain that the main source of information on drugs was the manufacturers product data sheet it did not look as though there would be any changes in practice. There is reluctance to tell doctors what to do, which was shared by the Royal College of Psychiatrists (RCP) even though it too was worried about the number of sudden deaths. This clinician concluded by criticising the inadequacy of interventions by the RCP:

> *"In fact last year it issued a consensus statement setting up some general principles on the use of high dose neuroleptics assimilated after a one-day panel meeting. But some psychiatrists say it does not give enough detailed guidance about handling emergencies."*
>
> **Senior clinician**

The main reason for this criticism has been that the consensus statement issued by the RCP was not prescriptive enough. However, there was an expression of knowledge of the complex nature of the field of the effects of drugs used in mental health and the hope that the statement was a foundation that the future could be built on. The caution however was that unless the mental health profession takes the problem of medication seriously more

patients will die in crisis situations. Without clarity about the risks and better resources the stress of coping with psychiatric emergencies might push those involved in the care of the mentally ill into making the most difficult decisions in the worst possible circumstances. Case study Omega has managed to develop a system that ensured that all professional groups work together by practising under the guiding principle of including even junior medical staff in the experience of learning from the beginning of their training. This was outlined by a senior consultant psychiatrist as:

> *"It allows students to learn how multi-disciplinary teams work. They tract community nurses and to see how they work; they go with consultant psychiatrists to see their patients in their homes."*
>
> **Consultant psychiatrist**

He concluded by stressing that a lot of psychiatry was practised in this way, so it was essential that students saw modem practice. It was also important for students to see patients when they were normal, at home, to take into account the impact of an illness on the family. He cited the case of a man in his fifties, retired on medical grounds because of severe manic depression.

> *"When I took over his care, his wife was at the end of her tether because she wasn't coping. He had two relapses a year for the previous five years. She was asking me to do a frontal lobotomy [*brain surgery*], like 'One flew over the Cuckoo's Nest."*
>
> **Consultant psychiatrist**

He explained further that they were able to empower the carer of this patient through acknowledging the part the wife of this patient could play in that she was the best person if not the expert on the patient's condition. By equipping her with the necessary professional information she needed and the support mechanism at the time of emergency her initial demands and anxiety levels in coping with the illness of her husband subsided and he was able to have the best treatment on offer. This approach also highlighted the importance of the work that the staff of Omega were doing to ensure smooth return of individual

patients back to their families and communities. He concluded by saying that the importance of listening to relevant others was improving their knowledge of the individual patient and the illness they suffer.

> *"We are beginning to see there is perhaps more to disease than just curing the pathology. There is life beyond drugs and surgery...and staff are becoming to discern not only the contribution patients make to their own recovery, but the impact of disability on the family and on life in the society"*
>
> **Consultant psychiatrist**

10.2.4 Sharing knowledge and information

Case study Omega had a reputation for being effective in the way the service operates in involving others in the development of policies, their implementation and their evaluation. Another area of excellence was the view that their model of service provision was more effective in assuring higher standards than most of the services within the country. The researcher made the assumption that all members of staff would be aware of the key elements of their effectiveness. The question of how the service measures its effectiveness was put to a senior clinical staff who was also a member of the management team. She replied:

> *"I do not think I have a wide enough view, I am just a minion in this village pond. I am not involved in a lot of the vital workings. Other people are more involved in the commissioning, purchasing and provider issues. I am too busy with my own bit to get involved."*
>
> **Senior clinical staff**

This view seemed questionable particularly if the service claimed to be inclusive in the way it shared its information then staff, particularly the senior staff ought to be aware of what was happening in the development of the service. This question and assumption when pursued revealed a lot of tensions within the multi-disciplinary team. For example a senior member of the multi-professional staff described the numbers of meeting within the service as excessive. She argued that some of these meetings had no terms of reference

or an agenda and so members did not seem to be sure of its deliberations nor how effective their contributions were. This lack of communications strategy was one of the issues for complaints in terms of effectively working as a team. A senior practitioner summed up this point as thus:

> *I would have thought that was an essential starting point in order that the issues are clarified from the outset.*
>
> **Clinical psychologist**

Asked why she could not change the way things were progressing she stressed the point that senior staff in the service did not think what she was saying was necessary as the service was performing effectively without any written communications strategy. She argued that being persistent would create ill feeling within the unit as the service had managed to obtain itself a countrywide reputation based on the effectiveness of their clinical practice. Another staff member thought that she did not feel able to point out these tensions because she was often criticised for being negative when she questioned how things were being done. When asked what effect this had made on the way she operated within Omega, she said:

> *"Well I think I inevitably end up seeing myself like that because I get so much feedback relating to the way people say they see me. There is a part of me that say if people in the team are being positive, then I must be negative."*
>
> **Head of occupational therapy**

Consequently, she was inclined to change her standpoint not on the basis that her arguments or formulations of a clinical problem for example was flawed or persuaded by the collective views of other team members but rather that she had succumbed to group pressure and have adopted the prevailing mindset. She continued by saying that she had hoped to be able to discuss anything without anyone taking personal offence but this always developed into friction amongst team members. Another staff was asked if this description was familiar. She agreed that this often was the case and likened it to maturity of the team where other practitioners were now demanding that their points of view should be taken into account. Further, she argued that one of the

problems was the reluctance to clarify working relationships, as this would make it more difficult for others to preserve the status quo.

> *"I guess it always the case that status quo prevails because a body of people want the status quo i.e. all the people in power. As a practitioner I am aware of my lack of power and I think it is an awful position to be in. We are perceived to have a fairly high status and so people think we are powerful. The reality is that we have absolutely no power. We do say what we want but no one takes a blind bit of notice."*
>
> **Head of Psychology**

10.2.5 Achieving effectiveness through nursing

Having outlined these shortcomings of the unit, she reminded herself of the fact that the unit was much better than others that she had worked in. She could also understand why staff from elsewhere in the United Kingdom talk about the quality of the service they were providing in Omega. She attributed this to the fact that the nursing contribution was of a very high standard and concluded:

> *"It is probably not the reliability of nurses but it is the way they apply themselves. They have confidence and it seems as if they know they are being taken notice of. It is not like elsewhere where they feel that no one listens to them and so do not care about the work they do."*
>
> ***Psychologist***

Throughout the service and the course of conducting this research non-nursing staff spoke highly of the nursing contribution. Most agreed that nurses themselves feel they were doing very well and consequently they were much more motivated and have a very close therapeutic relationship with patients. Nurses themselves believe that their high level of input could be attributed to the fact that they were well prepared to do their work, listened to in respect of the difficulties they experienced, supported by other members of the team particularly the consultants. A staff nurse summed this up as follows:

"How couldn't we perform? We can articulate our needs well and can convince others on the strength of our argument and not that we know better because we spend more time with the patient. We are involved from the beginning in all aspects of patients' care. With this back-up you just feel you can deal with everything; well almost."

Staff nurse

10.3 Duality of Structure

Case study Omega had a full complement of staff and this had been quoted as one of the key reasons why they were able to tackle most of the challenges that confronted the service. Additionally, there was a high degree of respect within the service for all professional groups, especially nurses have an unparalleled regard from others for the quality and effectiveness of what they were doing. This high regard for nursing staff found favour with most of the patients. Patients spoke highly of their primary nurses (that is nurses who were co-ordinating the work of other professionals) and were happy about the open access and contact they had with members of the disciplinary team. In fact this standard of service provided for patients had demonstrated a degree of dependency on staff of the service. One of the patients summed this up as:

"My doctor is good to me when I am ill. Now I feel better and he said he will get me a flat before I leave the hospital [unit]. The Home Office and the Tribunal [MHRT] agreed for me to leave but I'll wait until my doctor says okay."

A patient

10.3.1 Patient perspectives

As discussed Omega operated a system of care based on an appointed clinical staff usually a nurse whose responsibilities were to organise the care of the patient, be the conduit between other members of the clinical team and the patient in terms of exchanging information and ensuring that the patient had a full explanation of and contributed to the decision making process relating to the care of that individual. This system named "primary nursing" but referred to by patients as "key worker" had been in existence since the service's inception in 1992. Patients were generally complementary about its worth to the care process. They argued that it provided them with a focus for contact in a

process, which was full of many professionals. A patient summed up the usefulness of the process as:

> *"Yes, because I could talk to any of the nurses but they like it better if I talked to the key worker and the key worker writes down what I want to pass on to the clinical team".*

This patient concluded that the key worker system was a good thing and provided the opportunity for the individual nurse to increase their knowledge of the patient for whom they were responsible. She further added that the process also ensured that she got the attention she needed and got involved in the delivery of care. All patients in the focus groups and individually agreed that the system of key worker had been important in involving them in care and had provided them the opportunity to be heard by the clinical teams, especially when the key worker acted as an advocate for them on their treatment needs.

10.3.2 Impressions on staff

All patients who were able to compare Case Study Omega agreed that it was a better place than where they previously were. They asserted that staff explained all aspects of care to them before it was commenced and that they sometimes took part in its evaluation. One patient developed this viewpoint further by adding that:

> *"Other hospitals are just as good but here it is better. In some places staff ask you how you are, and mostly that is all the conversation. But here it is like paradise. Because of the structure, nurses and other staff, the staff make it the best place - they are very good. You can have a beautiful building and beautiful furniture but at the end of the day if they haven't got the staff it means nothing really".*
>
> **Patient**

Another patient expressed the view that although the staff were no angels they excel in their ability to demonstrate their caring nature and the high degree of respect they have for patients, concluding that:

"But here they care, respect, involve me in my care and they encourage me when I am not at my best. I can't get over how genuine they are."

Patient

They were unanimous in declaring that the one thing the unit needed in terms of delivering its objectives was more staff. They complained that due to staff shortages a lot of their rehabilitation activities had to be curtailed when other patients who they recognised as needing the extra input became disturbed. They were of the opinion that this juggling of staff between wards might have contributed to their delayed discharge from hospital and consequently the level of support they needed to live in the community.

10.3.3 Views on specific treatments

During the course of collecting data, some of the patients commented on some treatments they received either within Omega or elsewhere, which they felt contributed to denying them the opportunity to be consulted. One of the comments related to models of treatment that were designed to change behaviour based on rewarding good and positive behaviour. Some of them felt that the administration of such programmes did not take into account the impact other patients behaviour could have on patients who were undergoing these kind of therapies. This view was held by most patients but was summed up succinctly by one as:

"It was all points system - it was very tough and unfair. I was on this ward with youngsters with behavioural problems and because I was ill, if I shout I loose points and I thought it was wrong. I then lost a lot of privileges for not being able to deal with the noise and everything all the time"

Patient

On the whole patients agreed that medication had helped in stabilising their mental disorder but were of the view that these drugs were too powerful and have extreme debilitating side effects. They argued that because of the extensive array of bad side effects they experienced while taking these

medications their normal instinct was to refuse to take them. The following comment was consistent with what patients said about taking prescribed medication.

> *"They tried everything on me, but it didn't work. They had to jab me all the time - it was awful. I used to think they are poisons and refused to take it and I would smash something as a protest and they would hold me and they would jab me and then I became worse and they jab me again."*

Another consistent theme was the administration of electro-convulsive therapy (ECT). This treatment involves the induction of a brief convulsion by passing an electric current through the brain of the patient for the treatment of affective disorders (e.g. depression). This type of treatment is especially indicated for patients who are resistant to active drug treatment. In practice ECT is also used for the treatment of other types of mental disorder. The focus group participants were resolute in denouncing ECT as an inhumane treatment. They complained about being given insufficient information about it and its longer-term implications.

> *I was forced to have ECT [Electro-convulsive therapy] and it was not like having an injection or having tablets and my family and I complained about it. And I know it helped some people but I don't think they should give it until they have the client's permission, however ill they are because it is such a barbaric treatment. I like to fight [campaign] against using ECT.*

Another patient argued that ECT had such a negative reputation that some of the patients she had met in prison did not want to be transferred to hospital for fear of being forced to have the treatment. She added:

> *"I felt I should be punished for what I have done. When I was being asked to come to hospital I did not want to come because I didn't want to have ECT. It is not just what people say but the treatment itself - it is the worst treatment one could ever had and yet I understand mental illness than most people. It is still very abhorrent to me."*

Given the views expressed by the participants on medication and other treatments used in mental health and the link that could exist with mental health problems and offending behaviour, group members were asked to comment on a system being considered by the service in general for the prevention of relapse. The system involved a patient carrying a card that was signed when the patient was well to the effect that should he/she become ill clinical staff could take whatever treatment option necessary to ensure that they receive medication. This could involve having to be injected with medication by force. Patients were of the opinion that they did not wish to relinquish their right to be consulted and so do not agree that a system like this would be to their benefit. They agreed however that they needed to be consulted so that they could be involved in the planning of this very important aspect of care. One of the patients answered after a moment of reflection that:

> *"I'll probably say yes - but I think I need to think about it. We must be asked and everything about it should be made clear. No lies, the truth."*

10.3.4 On index offence

As explained in Chapter 2, most patients who access the forensic mental health services do so as a result of offending behaviour, which in most cases is precipitated by mental illness. In the subject group of this research all patients interviewed have all been charged with an offence (commonly known as index offence) and consequently have been detained under the mental health act. Most of the patients interviewed for this research were adamant in expressing the view that they would have been released had they been dealt with through the prison rather than the hospital system. Their reluctance to be transferred to hospitals was based on the negative stereotypes about mental illness, which was summed up by one of them as follows:

> *"I was really ill at the time and didn't want to move. I thought that because of what I've done, I thought I should stay in prison. When they send me to mental hospital - it was like - something worse to hear about going there. This is because the attitudes people have about mental illness - which is people, think you are a nutter. They do*

not understand that a relative of theirs could become ill. I felt I should do anything rather then go to a mental hospital."

Another patient thought the mention of mental hospital placement made her felt despondent as she thought she was going to be stuck on a ward to "vegetate." However they all agreed that the placement they had was the most appropriate. Their rationale for this line of argument was summed up by one of the focus group members as:

"I am guilty about what I did before coming into hospital. They gave me medication and I got better before I was like a caged animal. When you look back on it, [the offence] it was rather shameful really, but I was screwed up. I know what it means now and I can't just say I was off my head because other people are involved. I apologised but I know that is not the end."

10.3.5 Improving the process of care

Some of them recalled their experiences when they were first admitted to Omega and explained that they were not consulted as much as they would have preferred but agreed that a treatment plan needed to be defined and carried out in order that a degree of control could be exercised over their illness. A patient added:

"When I was on the intensive care unit, I did not have any rights, I could go not out for a walk, I was locked in, when I didn't take my medication I was jabbed, it felt as if I didn't have any rights at all. They probably explained why they had to do that but I can't remember they did. Looking back I could understand it but at the time you just feel so helpless and it seems you've got no rights."

Another patient thought moving from the intensive care unit was a helpful process as she was able to have a lot more space, privacy and less intrusive environment on the rehabilitation ward. She argued that the levels of observation and rigour with which it was applied was too distressing. He continued:

"It is very disconcerting. A lot of patients in here have been to mental hospitals before and so I do not think they would find it as so close

[an environment]. They are used to it but I didn't. But I felt safe as a woman and as a patient because the staff are there to provide a degree of security. It is very disconcerting.

Patients were asked to comment on what could be done to improve the quality of life for them in Omega. Generally they do not feel that there was a adequate space within the unit and complained of the excessive noise made by disturbed patient, particularly on the intensive care unit.

"They were no different from people I saw in the prisons, most of them on remand were mentally ill and very disruptive. For no reasons at all they would start banging on doors and kicking. The wards were noisy, too small and there is nowhere to be quite when the ward is noisy."

Some of them complained about the practice within Omega of transferring patients between the wards based on their clinical need. They accepted however that the practice was useful as it enhanced the opportunities for their rehabilitation. One of the patients added:

"I didn't like it at first. But I got used to it and I found the nurses as good and as kind as those on the intensive care unit. There was more to do and of course I could get regular escorted walks out of the ward in the hospital grounds."

They all agreed however that the practice of introducing patients gradually to their new wards within Omega should be continued although they agreed that it could not be done always particularly when there was an emergency admission.

Overall patients were extremely complementary towards the service. One recalled being dissatisfied on occasions with how her care was being managed but rationalised this situation by arguing that these dissatisfactions were minor disagreements which she thought were unfair at the time. She explained:

"I can't think of anyone who was not pleasant. You get annoyed with people because you disagree. Sometimes I ask to go out with the intention of harming myself but I get refused the permission and of

course I get annoyed because I was prevented. You feel at the time no one was listening."

Another patient described the contribution Omega had made to his life by saying that:

> *"This place only changed my life, my attitudes and made me realise what went wrong, why it went wrong and what I can do to make sure it doesn't happen again. This is not just because of medication alone, it is the steady input you get from psychologists, nurses who, when you want to talk they'll talk and they are so stressed and yet they are always kind and understanding. I am not patronising - don't get me wrong, they are good and a lot of them probably got problems outside but you never see that. I am really glad I came here. They help me and I think most patients would say that. I think it is essential that you have people as supportive as that to get you over a bad period in your own life."*

The way patients described the usefulness of staff with the service raised some issues of attachment in that there would have been a high degree of reliance on staff that would have made it difficult for patients to remain in the community once discharged. This view was put to a discharged patient who argued the contrary by saying:

> *"The longer I stay out the better it would be. I now see my psychiatrist once a week, my social worker twice a week and my community psychiatric nurse also twice a week. And on top of that I know that even in the middle of the night if I have problems I can ring the unit [hospital] and would never be turned away. The good thing about this place is that they still carry on with you, supporting and encouraging you even in the community."*

Another felt that patient relatives should be more involved in the care process but was able to assert that the care that she was given had made it difficult for her to criticise Omega. She summed up her stay in the unit as very useful indeed by saying that:

"If it hadn't been for this place, I couldn't be able to go to College and have two 'A' levels [grades A & B]. Without the help of the Clinic, I mean they pay for the courses, pay for the bus pass, pay for the material and also gave me extra money for the food - they made it really easy for me and that is one of the good things they did to get me back into the community. I left school without no levels at all and they encourage you; they believe in you."

10.4 Reflections on Omega

Omega as many other such facilities in the medium secure sector of the forensic service has a regional catchment area. The service in terms of its patient population was focused on the community with extensive and wide-ranging community facilities supported by a small number of in-patient beds. Managers within the service have largely a professional base and were able to integrate clinical issues competently with organisational imperatives. Unlike Alpha the service was fully integrated into the wider NHS mental health services and has adopted its entire key organisational changes e.g. business planning, contracting, market testing etc. In terms of security, Omega's security seemed to be its staff as it does not have any real external security which any of the patients who was determined to escape could not achieve with little effort. The service admitted patients from a wide range of sources but have estimated that those from the criminal justice system would increase and was in the process of planning to meet the apparent challenge.

As a directorate of a larger NHS Trust, decision making was closer to the patient and patients have spoken positively about their ability to influence these decisions. Training and preparation of staff in achieving the objectives of the organisation seemed to be on uni-professional basis although most of the structures within Omega were multi-professional. In short the professions trained separately but were expected to work within the multi-disciplinary and inter-agency processes; this situation has resulted in tensions within the professions. However it appeared the elements of effective working amongst the professions and agencies were present and were manifested through the level of integration of the structures and policies.

10.4.1 Roles and responsibilities

Omega encourages a high degree of civic activities and regularly engaged itself in activities necessary for the promotion and marketing of the work of the service. The service seems to be responding positively to the expectations of its stakeholders both externally and internally. This observation is based on the level of attention to detail during the delivery of care both in hospital and in the community. There was a very high level of input for patients particularly in the community and preparation of in-patients for discharge into the community. Staff and patients have a high regard for the quality of the service on offer. However there was no evidence of the use of any generic measures of effectiveness although there were some uni-dimensional, condition specific tools. These tools were not used consistently to back up the individual patient focus activity of the service.

In general patients were pleased with the way that Omega discharges its responsibilities. They spoke glowingly about the quality of care they receive and those who were able to make a comparison thought the service was better than any other they have experienced. Patients spoke of being involved in and were able to influence the direction of care. Management responsibilities such as defining the purpose and expectations for the staff group, the philosophy that underpinned practice and the values that drive care provision seemed to be articulated well. Like most NHS hospitals at the time, the focus was clearly on financial management but with a strong tendency towards providing a service, which is beyond criticism.

10.4.2 Measuring effectiveness

In the study, the researcher did not find any measures of effectiveness that is in regular use and have been deemed by all stakeholders as satisfactory. However, the service conducts regular patient satisfaction surveys, which have provided managers and clinicians an impression of what patients within the service felt about the quality of care. While these surveys were often complementary, there were issues that needed to be heeded in order that

managers could provide an effective service. Some of these related to environmental issues such as adequacy of space, privacy and noise levels in the wards, and remoteness of the hospital. Omega was working to redress some of these issues such as their plans for setting up more court liaison schemes, assertive outreach services and increased outpatients' facilities. The service seems to be using comments by statutory watchdogs such as the Mental Health Act Commissioners and Mental Health Act Tribunal commendations or decisions on discharge to measure effectiveness. This practice which is not unique to Omega indicated that the service as a whole was happy to accept external praise but tends to react negatively to criticisms from the same source. Other areas for improvement are multi-professional decision making which have been cited by some members of staff as not inclusive.

10.4.3 Patient Involvement in care

Patients within the sample group of this research agreed that they were consulted and involved in the care process. They spoke of their key workers ability to advocate for them and those preparing to leave Omega also indicated that they work in partnership with staff to identify support mechanisms in the community. It was apparent that patients were satisfied with these arrangements and the staff who were working directly with patients also expressed satisfaction to the effect that they felt they were being listened to. Most of the patients were aware of the nature of their illnesses and the contribution that medication could make to its amelioration. It was clear from what was said by them that they hold very strong views on some types of medication and treatment regimes. It seems patients were empowered through increased knowledge base and actively encouraged to comment on the nature and direction of their care. There was evidence of negotiations between professional staff and patients on what treatment needed to be started and clarification of what is expected of the relevant parties. While power dimensions generally lie with the professional staff and managers, patients expressed satisfaction that they were able to make a choice of the options available to them.

As in the previous case study Giddens' structure elements of signification, domination and legitimation were examined to identify patterning in re-enacting social practice, which is useful to the way organisations learn and change. The reader is reminded that the elements of structure and those of the realm of action combine to form duality of structure, which is the best environment to observe the theory of structuration. To aid this analysis Giddens structuration concepts are used; these are:

- All human beings are knowledgeable agents
- The study of day to day life is integral to analysis of the reproduction of institutionalised practices
- Routine is the predominant form of day to day social activity
- The study of context, or the 'contextualities of interaction', is inherent in the investigation of social reproduction

These concepts were taken into account in assessing the degree to which the enactment of social practice was occurring in Omega. Specifically the following contextual issues were examined; i.e. recruitment, training, research and development, audit activity and activities that are related to the subject of this study as conceptualised. Other related contextual aspects examined related to routines such as ward rounds, clinical team meetings, assessment, discharge planning et cetera. According to structuration theory routinisation occurs through the conceptual split between structure and action (Giddens 1993 p4). The analysis of duality of structure in Omega involve the assessment of the extent to which people create social interaction or practice and how history, perceptions and rules have a controlling effect on what individuals decide to do.

In Omega as in the case of Alpha, these routines were numerous but there was a certain degree of certainty, which was not observed in Alpha. Clearly the focus was on developing staff to meet the needs of patients effectively. This was not done at the expense of security considerations; on the contrary the security aspects were used as a determinant to placing the patient in the best

environment within the service. The need to contribute to developing outcomes measures was embraced more readily in Omega, with clinicians and managers eager to share their knowledge with others. There were evidence to the effect that staff, patients and managers were almost at one in deciding what the objectives were and the methods to take to achieve them. The matrix like management and clinical structure in the organisation has made it possible for agendas to be shared and understood. However the exercise of power was described to be in the hands of the few even though interviewees reported higher degree of inclusion in decision making.

The security in and around Omega was minimal with concentration on the vigilance of staff; consequently the staff and patient ratio was high. Patients who access this service are those who were deemed not to be as dangerous and of immediate risk to the general public if they should escape. The service as a whole was divided into two distinct functional entities i.e. in-patients and outpatients. The placement of patients in the three wards of the in-patient facility depended on the needs of the patients rather than their functional disabilities. This division seemed to be quite effective except for the fact that patients who were disturbed were usually prioritised at the expense of others in terms of allocation of staff. Patients within the focus groups complained about this even though they accepted that the way the service was designed this situation was inevitable; however they called for more staff to prevent this happening on a regular basis. Of note was the apparent lack of union activity on the scale seen in Alpha but this did not appear to have affected relationships between managers and staff adversely. Clinicians were involved in management of the service and were able to experience at first hand the impact of their decisions. Omega has embraced the structural elements of the NHS reforms and was able to use the opportunities inherent to their advantage. For example they took the advantage that the Private Finance Initiative offers to collaborate with the private sector in provision of capital investment while they concentrated on the delivery of clinical services. Omega's extensive external stakeholder base was used regularly to maximise the quality of service provided to patients.

The service appeared to be taking its obligations seriously and in terms of measuring effectiveness, the organisational input into this activity was high. The service contract negotiated with service purchasers was closely examined in terms of assessing its compliance and the cost of care adjusted accordingly. The service also conducted regular patient satisfaction surveys and patients have various ways of commenting on the issues that were of concern to them. What was missing was a forum where patients could have a collective voice in the same lines as those in Alpha. Some patients have complained about the effectiveness of care. During the course of the study a patient from an ethnic minority background complained that he was not always encouraged to discuss his problems. Asked if he had comments to make on the service that could improve the quality of care, he replied but refused to explain his comment:

"This place is very good but it would be nice if they talk to me more"

Omega's, management and clinical leadership was described by both patients and staff as effective. They were positive about assimilating contemporary issues and have taken advantage of it. Training and further education of its staff was a priority and focused on increasing the clinical competence of staff. The service also was an award-winning establishment and has strong reputation on the quality of its services.

The only limitation observed in Omega was the lack of activities for patients, the closeness of the environment leading to complains of lack of privacy by patients and the shift of personnel to meet more pressing needs.

CHAPTER ELEVEN

APPLICATION OF METHODS - RESULTS (6)

COMPARING METHODS (QUESTIONNAIRES & CASE STUDIES)

Survey questionnaires

Comparing the questionnaires
Characteristics of respondents
Views on service provision
Assessing effectiveness
Other comments

Case studies

Comparing the case studies – Alpha and Omega
Signification
Domination
Legitimation
Duality of structure
Conclusion

CHAPTER ELEVEN: COMPARING METHODS: SURVEY QUESTIONNAIRES/CASE STUDIES

11. Introduction

This chapter aims to draw the key findings of the main methods used in data collection by comparing first the two survey questionnaires (provider and purchaser) and the two case studies (high security - Alpha and medium security - Omega). Consequently, this chapter is divided into two sections and addresses in particular the following:

1. To what extent has the findings of the two questionnaires compliment or validate each other.
2. To what extent have the case studies compliment and validate each other.
3. Identify the common themes (1 & 2 above) and state the evidence available that outcomes measurement is a priority for the organisations observed.

11.1 Comparing the questionnaires

This first section of this chapter compares the findings of the two survey questionnaires (providers and purchasers). It uses the key areas of the questionnaires to conclude this analysis with its results listed in Figure 11.1 and fully discussed below. In particular this analysis demonstrates the similarities and dissimilarities by drawing on demographic variables within the sample group as well as drawing comparisons on views on multi-professional and inter-agency working. Further, it identifies the variations in respondents' views on the adequacy of service provision. It also appraises the degree of knowledge of the Reed Review, which was a inter-governmental review of the service and concludes by identifying models of assessing needs and effectiveness tools in use by the service, and highlights some the main themes from the comments of respondents.

Figure 10.1 Case analysis of the survey questionnaires

Dimensions	Providers	Purchasers
Characteristics of respondents		
--Experience	Mainly 5-10yrs	Mainly 1-3yrs
--Disciplinary background	Mainly clinicians	Mainly clinicians
Views on service provision, nationally	Dissatisfied (87.4%)	Dissatisfied (75%)
Comments on the Reed Review	Satisfied (69.3%)	Satisfied (73.8%)
Multi-agency working	Room for improvement (57%)	Promoting the concept (79.7%)
Multi-professional working	Effective working <30%	Promoting the concept
Assessing Effectiveness	44% agree	Evidence based commissioning 50%
--measurement tools)	Uni-dimensional	Uni-dimensional
Other comments	Outcomes measures to be developed	Outcomes measures need to be developed

11.1.1 Characteristics of respondents

In the sample group majority of respondents have a clinical background, with nursing (58%) providing the largest numbers in the provider sample and medicine (32.1%) being the largest professionals for the purchaser group. However there were a sizeable number of respondents from the general management background (26.6%) in the purchaser group but less than 5% from the provider group. These differences in the purchaser group could be attributed to the fact that the commissioning of services for mentally disordered offender was being handled either directly by the director of public health, who is usually a medical practitioner or from the same department but from a different disciplinary background. In the case of experience respondents from the provider group tended to range from 5-10 years while that for the purchaser group was between 1-3 years. These differences here too are probably due to the fact that commissioning forensic services is a new

concept for health authorities. It however did not explain why health authorities were not employing people who had a background in the service to commission services.

11.1.2 Views on service provision

The adequacy of service provision throughout the country was criticised by both groups of respondents; 87.4% from the provider and 75% from the purchaser group were either slightly or very dissatisfied. The reason for this dissatisfaction was given by both groups as the lack of strategic planning of the service. Most respondents were of the view that services should have been co-ordinated at national level rather than be left to individual Trusts to develop. In this criteria there is therefore a convergence of views.

11.1.3 Comments on the Reed Review

Over 90% of all groups were aware of the recommendations of the Reed Review and 69.3% of providers and 73.8% thought that the review team had confronted the issues reasonably well. Although there was a universal support for the teams conclusions some respondents from both groups felt that the 276 recommendations of the group was too many to implement. Another area of contention was that of caring for psychopathic disorder patients, which respondents were of the view that their treatment would have been more cost effective in prison. These views raised the problems of clarification of the objectives of the service, whether it should concentrate on the severely mentally ill or act as a repository for this group of patients whose response to treatment in hospital had not been effective. Over 80% of all respondents supported the six principles of the Reed Review and a further similar percentage agreed that the principles were guiding the development of their services or guiding their commissioning decisions in the case of purchasers. The only criteria that did not receive a high level of support was that to do with location which respondents felt could not be made easily accessible to all patients because of the need to centralise services. This could be due to the fact that the general public tends to object to the siting of secure hospital next

to them and also the very small numbers of patients that require this specialist type of services.

11.1.4 Integrated team working

Multi-professional and inter-agency working was identified as a key component of ensuring effective care to the patient group. Commissioners (80%) were of the view that their purchasing decisions were being influenced by the principles of inter-agency working to some or a very great extent. 53% of providers agreed that further inter-agency working would improve the services they have on offer to the patient group provided there was a focus on joint planning, effective communication, joint education and training, attitudinal changes and a focus on satisfying the needs of the patient based on collaboration. Purchasers too agreed with this viewpoint and explained that there must also be involvement of local services in these specialist services for the concept to be effective.

In the case of multi-disciplinary working, providers were of the view that multi-disciplinary working was only happening at the clinical team interface. 80% of provider respondents felt that increased multi-disciplinary working would increase the quality of care that is provided to patients. While 80% of provider respondents agreed with this, they cautioned that unless more attention was given to effective team working, adequate resources, empowerment of all professionals and increased efforts to promote collaboration the concept would not work. Inter-agency working on the other hand was said not to be effective and would not make any real changes to the present way of working if issues of joint planning at all levels are not put in place.

11.1.5 Assessing Effectiveness (Needs assessment & measurement tools)

67% of provider respondents felt that they were providing effective services to patients, which was of excellent or good quality. However, services were not using any recognised measures of effectiveness according to respondents. It

seemed clinical audit was being practised more frequently than any other form of reviewing effectiveness, although the freedom of the professionals, particularly doctors to exercise their own clinical judgement was overwhelmingly the most frequent form of decision making in terms of determining effectiveness of interventions; this was followed by re-admission rates and rate of re-offending. Health of the Nation Scales (HoNOS) also was frequently cited as being used. Respondents also used psychological measures to measure effectiveness but these measures were uni-dimensional ones. Overall in the service the medium secure sector seems to be the part of the service that appeared to be more concerned with measuring effectiveness of its interventions and services in the community were least likely to use measures of effectiveness. Only 10% of provider respondents were of the view that the tools they were using to measure the effectiveness of services they were offering were measuring those aspects of care they were concentrating on effectively.

On the other hand purchasers have the responsibility of commissioning services that are proven to be effective. However, most of them were of the view that services they were commissioning were not measured as they were not aware of any consistent tool in use by providers. This view was consistent with that of providers in that it confirmed that there were no measures in use in the service. Generally, purchasers tended to use process measures (length of stay etc.) agreed with providers during contract negotiations to measure what they termed effectiveness. While purchasers agreed that the measures they were using were not appropriate, they were of the view that they enabled them to gain an overview of progress, appropriateness of care packages and the present and future plans for improving the effectiveness of service provision.

In the case of assessing future priority areas for development, purchasers were of the view that a consensus approach was needed in other to tackle issues for the future. Some said they had started laying the foundation stones for measuring outcomes by involving providers in agreeing protocols for care. Providers were in agreement that measures for the future should be

developed by taking into consideration the social, psychological, cultural and physical wellbeing of the individual. Some of the key areas for development that were germane to the two sample groups were:

1. The need to clarify the purpose and objectives of the service in terms of the patient group.
2. The need to ensure joint and multi-disciplinary training, and the development of an effective research base.
3. The importance of developing an effective plan for recruitment and retention of staff.
4. The need to extend the scope of use of HoNOS with a view to amending it to meet the needs of the patient group effectively.
5. The importance of developing effective ways of encouraging and involving the patient and his or her carers.

11.1.6 Other comments

There was an acceptance of the importance to develop effectiveness measures that reflect the broad and complex areas of need for the forensic patient and those who care for them. While some from the two sample groups agreed that the development of outcomes measures had been hampered by the focus on process and legal issues, respondents were of the view that more effort should be made in developing these measures. However, some respondents expressed caution in rushing to develop measures. For example the commissioning manager who thought that the focus of her organisation's activity was on building partnerships and consequently asserted that they have neglected work on commissioning services that could be measured was typical of those who were not prioritising this activity. Others thought that the whole system of developing outcomes could be subsumed by the high level of bureaucracy that existed within the service and manifested itself through the degree to which patients had to go through the same assessment process at different levels of security. Most of the comments from the provider staff supported the view that outcomes measures should be developed but an equal number expressed the view that they were conscious of pushing ahead

as outcomes data could be used in different ways and sometimes negatively to demonstrate poor performance. This they cautioned could be one of the reasons why the development of outcomes measures could be slow in the service.

11.2 Comparing the case studies - Alpha and Omega

This section draws on the structural elements of Giddens' structuration theory to compare the similarities and dissimilarities identified during the process of data collection in these two field sites. In this section the structural elements of signification, domination and legitimation form the principal pillars for drawing these comparisons and the process of recreating social practice which is essential for structuration to occur discussed in the domain of duality of structure. A cross case analysis using the theory is presented in Figure 11.2 below.

11.2.1 Signification

Within this domain, issues such as the type of the organisation, its management and clinical structures were examined together with environmental factors that might impact on the effectiveness of the organisation in terms of measuring outcomes measures. Further the way policies, procedures and objectives of the organisation were set was also discussed. Case study Alpha is a large institution and has a wide range of diagnostic groups of patients and facilities for their treatment and rehabilitation. By contrast, Omega is medium size regional service almost the size of a ward in Alpha. Alpha appears to be a bureaucratic organisation, hierarchically structured, communication mainly top down particularly where security consideration were being made. There appeared to be a separation of clinical structures from the managerial structures in that consultant psychiatrist were the leaders of the clinical teams and clinical managers were mainly nurses. This separation made it difficult for clinical managers to challenge bad practice and therefore failing to change practice without the full support of psychiatrists. Omega on the other hand was fully integrated as a

directorate of a NHS Trust and was able to assimilate most of the changes inherent in the NHS reforms in its structures and strategies for care provision. Managers within this environment were clinicians with active caseloads who were familiar with the impacts of their decisions within the clinical arena. This matrix model within Omega has managed to place the patient at the centre of care with staff able to influence direction of care. While Alpha focused its service organisation on the long-term stay of the patient, Omega's attention was mainly on the rehabilitation of the patient and his or her return to the community with support.

11.2.2 Domination

This element of the structuration theory deals with co-ordination and distribution of resources. Alpha as discussed earlier is a large hospital with a budget that compares equally with any Trust in the NHS. It has a range of facilities and staff groups for the care of patients. It has its own training centre that was affiliated to a university for potential preparation of its staff. This investment had not been used beneficially because of problems in releasing staff to attend training sessions. Staff within Alpha seemed to favour training in physical skills in controlling aggressive patients at the expense of developing clinical skills in preventing aggression. Omega however was a complete opposite to Alpha spending a considerable amount of its budget to prepare staff, which was manifested in the degree to which staff, and patients expressed satisfaction with the manner and nature of services on offer. In terms of allocating these services, it seemed Alpha's focus was on balancing its budget. For example at the time of this research, there was a severe shortage of nurses and calls for recruitment of more nurses instead managers decided to increase the opportunities for existing staff to do overtime which was considerably cheaper in financial terms than recruiting new staff. In the wider human resource allocation terms the consequences for implementing this policy on Alpha was that patient care was affected negatively, and manifested itself through increased absence from work and other mistakes that had resulted into accidents, complaints and injuries to staff at work. Omega had high staff/patient ratios and was able to vary their resources to

meet the needs of the patient better. However there were complaints about the allocation of staff to the wards by both patients and staff. This was due to the practice of using existing staff numbers to support wards that have to cope with increased demands leaving other wards' supply short, thereby adversely impacting on the rehabilitation of those patients. This practice even though accepted as an inevitability of health service resource allocation was thought by both staff and patients as not maximising the opportunities for rehabilitating patients.

11.2.3 Legitimation

Legitimation in the context of structuration theory is the domain in which judgements and behaviour necessary to effect social practice are examined. In the case of Alpha, behaviours of managers were not seen as conducive to enabling an environment where mistakes could be made and lessons learned. Managers on the other hand complained about the way the staff organisations undermine their efforts to advance the effectiveness of the hospital. Patients thought that staff were uncaring that their complaints were not investigated and decisions taken to ensure that they did not happen again. Staff in Alpha complained about a 'blame culture' that exists in the hospital preventing them to take any kind of risk in developing therapeutic alliances with patients, that patients were encouraged to complain about them leaving fearful of losing their jobs. In contrast the comments made by both staff and patients on the behaviours and attitudes of all stakeholders within Omega were highly complimentary. There were fewer complaints in Omega by the patient population than in Alpha and fewer disciplinary actions relating to patient care. It could be deduced therefore that there was a higher degree of patients and staff working together in Omega than in Alpha. It could be argued therefore that the pluralism that must be available for the development of outcomes measures was much evident in Omega than in Alpha.

Figure 11.1 Cross Case Analysis using Giddens' Structuration Theory

Elements of structuration	Case Study Alpha	Case Study Omega
Signification (Communication of meaning) Type of organisation Organisational structures Management Clinical Environmental factors Flow of communication Setting objectives	Not fully integrated into the NHS. Managed by a hospital board and commissions services from a national board. Hierarchical management structures separate from clinical structures even at ward level. Organisational concentration on security at the apparent expense of developing clinical skills. Distance between patients and staff too wide as there was no obvious therapeutic alliances and common to all patients. Flow of communication is top down, objectives towards long term stay of patients. Patient group potentially more dangerous with long term and complex needs.	Fully integrated into the NHS as a directorate of an NHS Trust and commissions services from Health Authorities. Managers are clinicians who have an active clinical caseload. Structures are integrated and the patient is clearly a key component. Security mainly on staff knowledge of the patient propensity to violence and response to treatment. Two-way communication with staff and patients expressing satisfaction with the process. Objectives are on discharge of the patient into the community as soon as possible. Deals with patients who are not immediate risk to others
Domination (Exercise of power) Resources Authoritative: Co-ordination of resources	Large budget. Could benefit from economies of scale. Few express satisfaction on managing people effectively. Staff complained of not being well prepared for the tasks.	Small and managing to achieve a lot in developing the service under tight budgetary controls. High satisfaction rate amongst staff on management style, opportunity for training and inclusion in development and delivery of service objectives.
Allocative: Fairness in allocation	High level of focus on financial management Few staff working excessive overtime Dissatisfaction among directorates on the way resources were allocated. Complains of education and development of staff neglected at the expense of income generation by concentrating on selling outside	Focus on quality and developing clinical excellence. High staff / patient ratios. Some dissatisfaction on the practice of shifting resources which favoured the acute wards. Opportunities for training and staff development, concentration were on training own staff.

Elements of structuration	Case Study Alpha	Case Study Omega
Legitimation (Evaluation of judgement)	**Complains of the existence of a 'blame culture' preventing initiative and flexibility of practice.** **Patients complained of repressive rules and regulations, and uncaring staff.** **Managers blame inflexible staff organisations for refusing to change.** **Dissatisfaction with the direction of the service which was towards empowering patients and increased therapy** **High volume of complaints from both staff and patients. High level of disciplinary actions taken.**	**Focus on empowering patients and staff.** **High levels of satisfaction with rules and regulations.** **Relationships between unions and managers are good and directed at facilitating increased performance.** **High degree of satisfaction with the rehabilitative and community oriented approach.** **Low volume of complaints, high satisfaction rates and few disciplinary actions taken..**
Duality of Structure		
Communications	**Strong and clear intentions but weak on delivering objectives.**	**Clear intentions, structures and effective**
Process activity	**Comprehensive facilities, low usage**	**High uptake of services in and outside hospital**
Assimilation of contemporary issues	**Slow in adapting.**	**Quick in adopting new concepts and working with them effectively.**
Training, development and research.	**Low level activity although structures exist.**	**High in investing for the future, research activity exists and finding used to change practice.**
Managing staff	**Low satisfaction and confidence in managers.**	**High satisfaction and more confidence in managers**
Multi- disciplinary working	**Low satisfaction levels**	**High satisfaction levels**
Multi-agency working	**Low level activity due to the direction of service which is towards hospital care**	**High level of activity, community focused**
Managing patient expectations and needs	**Slow in the development of measures for the assessment of patients needs**	**No recognised measures of need in operation but patients talked positively of being listened to.**

Duality of Structure...continued		
Degree of involvement of patients in care	**Advocacy structures in place but not readily available. Complaints about its effectiveness from both patients and staff.**	**'Key worker' functions as an advocate. High levels of satisfaction about the system. Developments relating to empowerment and building partnerships in care evident.**
Patients' experiences and satisfaction	**Low due to suspicion of genuineness of intent**	**High.**
Complaints and their management	**Low satisfaction from both staff and patients**	**Satisfaction with management.**
Use of measures of outcomes	**Non in existence. Focus on developing a clinical agenda is meeting with some resistance.**	**Non in general use. Evidence of willingness and steps to start using one available.**
Risk assessment and management	**Focus on group basis. Slow movement towards individual definition of risk.**	**Defined and applied individually.**
Balance of power	**Appears to be in the hands of the few. Senior managers were said to have too much power but managers feel they were being prevented by the threat of industrial action.**	**Responsibilities made clear. General acceptance of roles but there is a degree of disquiet about medical dominance.**
Supervision	**Low with suspicion of intent**	**Degree of informal supervision and support**
Degree of implementation and evaluation activity	**Low**	**Medium pace activity level**
Preparedness for undertaking work on developing outcomes measures	**Low. Whilst there is activity in developing a programme for clinical effectiveness the pluralism that is needed to develop outcomes measures is not obvious**	**Medium to high. Better chances of developing measures that take into account the expressed needs of patients.**

11.2.4 Duality of Structure

In enacting social practice, structuration theory proposes the belief that communication of meaning and the following of the rules and moral norms are essential components. Equally is the degree to which people can make a different to the organisational life of their services however small that contribution. The arena in which this activity is observed is the duality of structure, which becomes evident when structure and human action are joined together creating 'patterning' practices over time and space. As Figure 11.2 shows the domain of duality of structure examined key conceptual aspects of outcomes measures in comparing the way 'patterning' occurs in these two field sites. In the case of Alpha communication of intent was observed to be clear but there was a weakness in that the objectives were not achieved, while on the other hand Omega's action in practice was clearly towards realising their goals. Alpha due to its size should be able to benefit from maximising their resources achieving economies of scale in the process but the reality was that the take up of these services were low with difficulties in assimilating contemporary ideas. Omega was a reverse of this and appeared to be achieving its objectives to the satisfaction of most of its stakeholders. In both cases there were no evidence of using effectiveness measures that measure the totality of care. However there were steps and structures within both organisations charged with examining its feasibility. The intention to work towards the development of outcomes measures was stronger in Omega. Nevertheless measures of effectiveness which are condition specific and uni-dimensional were not in general use in both organisations.

11.2.5 Conclusion

The main conclusion that could be drawn from this comparison is that the two survey questionnaires complement each other with each group of respondents insisting on a national approach to developing outcomes measures. In the case of the case studies the findings discussed in this chapter are similar except for the following differences:

1. Omega was the better of the two field sites in terms of integration into the NHS

2. Management and clinical structures were hierarchical in Alpha while in Omega these structures were a lot more organic

3. Patients in Alpha were seen as more dangerous with much more complex needs than those in Omega

4. Both patients and staff were more likely to complain about the fairness of distribution of resources in Alpha than in Omega.

5. Omega was observed to be better at matching its policy intentions with action

6. The pluralism of approach that needs to be present for duality of action (enactment of social practice) to occur was more evident in Omega

Despite these dissimilarities the overwhelming intention by managers, professional staff and patients was to work towards the development of outcomes measures. However the urgency of need was more evident in Omega than in Alpha and could be attributed to the type of regulation imposed nationally and locally in the field sites. While the survey question demonstrated the willingness of the service to work towards outcomes measures, the evidence from the case studies supported this desire at organisational level. It is clear from the evidence that the service as whole was not using any effectiveness measures on a regular basis although it appeared that some parts of the service were using some sort of measures but were certain that these measures were not measuring the totality of care.

CHAPTER TWELVE

APPLICATION OF THE METHODS - RESULTS (7)

Consensus Building Conference

Introduction
Background to consensus building in the NHS
Defining the terms
The nature and process of consensus conferences
Planning for the conference
The trawl of the field
The conference
Conclusions

CHAPTER TWELVE CONSENSUS BUILDING CONFERENCE

12. Introduction

In this chapter the answers to the remaining research questions are discussed. The findings so far collected is summarised (see chapter 13) and the manner in which it was presented to a group of practitioners in a consensus building conference is discussed here. Chapter One sets out the objectives of this research, which included the collection of the views of key stakeholders, and to present it to a representative group of these stakeholders to identify what needs to be prioritised in terms of developing outcomes measures. The goal therefore of the consensus conference approach was to clarify the key issues and narrow the gap between current knowledge and practice on topics with sufficient base of scientific data to make expert scrutiny feasible. The consensus building conference was seen as a very important component of the research methodology as it provided the best environment within which to discuss the findings of the research, ensuring that as many practitioners as possible are involved in deciding the priorities for the future and as another means of disseminating the results of this research.

This chapter begins by explaining the origins of consensus conferences, its use in the NHS and identified the main types. It continues by discussing the usefulness and the limitations of the method as a research tool and attempted to discuss the need for its use in the field of the research. Further a survey conducted at the closing stages of the research (October 1997) to increase the knowledge base of the prevalence of effectiveness measures in the service is also discussed. This survey referred to as the 'Trawl of the Field' was targeted at senior practitioners or their representatives and is discussed in some depth in this chapter. Finally, this chapter concludes by listing the areas identified as a priority as a result of the consensus building conference and discusses some of the measures that needs to be undertaken to raise the awareness of measuring outcomes within the forensic mental health sector.

12.1 Background to consensus building in the NHS

The Oxford English dictionary traces the origin of the word 'consensus' to the Latin 'consentire', meaning 'to feel together' as opposed to 'census' which indicates enumerative activity. However, this fundamental difference is often a source of conflict between expectations and realistic goals of consensus guidelines (Fallen 1995). Consensus development conferences originally began in the United States in the 1970s (Vang 1986 p 65). The format discussed below was imported into Europe and had been practised extensively in Sweden, Denmark and the United Kingdom (Kings Fund 1987).

The enterprise culture of the National Health Service, together with the competition introduced into the service by the internal market had brought the consensus that existed before the reform of the 1980s a step nearer to extinction. Hewison (1995) observed that the Conservative government of 1979 failed to restore that consensus because they had entered office convinced that the failure of the effectiveness of the public sector could be linked with consensus management. He went on to quote Mrs Thatcher as saying, when attacked by her predecessor, Mr Heath about her abrasive approach in respect of consensus management that:

> *"... to me, consensus seems to be the process of abandoning all beliefs, principles, values and policies in search of something in which no one believes, but to which no one objects; the process of avoiding the very issues that have to be solved, merely because you cannot get agreement on the way ahead. What great cause would have been fought and won under the banner "I stand for consensus."*
>
> ***Hewison 1995 p209-210***

Hewison concluded paradoxically that, the Thatcher government sought to build a "new beginning" that was conditioned by the sense of the disorder and decay that marked the seventies. This "new beginning" created the principles that underpin the reforms in the NHS, which involves consultation albeit on a very small scale. However, clinical staff in the NHS continued to develop team working which is strongly based on consensus; although intra Trust or Hospital collaboration had waned somewhat considerably.

12.2 Defining the terms

Consensus building can be defined as a process whereby a decision is reached through the participation and contribution of members of a team to resolve an organisational or clinical problem. This process of decision making had been prevalent in the NHS prior to the management reforms of the service (Griffiths 1989). Even though this approach has all but disappeared in the management of the service, its use for changing service provision has increased. Professional staff have continued to use this approach to set clinical standards and to agree on how these standards can be implemented. Taking decisions in uncertain situations has led to high use of the consensus methods in the health service.

According to Goodman (1995) there are a variety of group judgement methods to resolve issues in health care. These include meta-analysis, and group judgement methods such as consensus conferences, which are an attempt to bring diverse elements of information together for synthesis. Jones et al (1995 p376) defined consensus and consensus methods as another means of dealing with conflicting scientific information. In recent times the clinical perspective has been shaped by the move towards measuring outcomes in health care. Meta-analysis refers to a retrospective investigation in which data from known studies of a particular clinical issue are gathered, evaluated and quantified. Begg (1996 p1299) drew the distinction that it differs from traditional narrative reviews, in that there is a commitment to scientific principles in assembling and analysing the data, via protocol-driven library searches and data abstraction, in addition to the formalism of statistical analysis. In making the contrast between meta-analysis and traditional narrative reviews, Begg asserted that narrative reviews can often produce partisan perspectives, due to the selectivity of the material presented (ibid). The application of meta-analysis is best at gleaning more information from existing data by pooling the results of many smaller studies and applying one or more statistical techniques. Meta-analysis has been in operation within the health sector since 1904 (Sacks et al 1996).

In the case of consensus methods, the three most popular used in healthcare are the Delphi Process, the Nominal Group Technique (also known as the expert panel) and the consensus development conference (CDC).

12.2.1 Delphi technique

The Delphi process takes its name from the ancient Greek Delphic oracle's skills of interpretation and foresight. It is a highly specialised application of the nominal group technique for developing forecasts and trends based on the collective opinion of knowledgeable experts; the delphi method in practice is further described later in this chapter. The technique has been used widely in health research (Pill 1971; Rowe et al 1991, Kitzinger 1994), education and training (Crotty 1993; Elder & Andrew 1992), priorities and information (Moscovice et al 1988; Oranga et al 1993) and in developing nursing and clinical practice (Mobily et al 1993). The Delphi method enables a large group of experts to be contacted cheaply by mail or by involving the participants in resolving inconsistencies and any ambiguities in wording of the questions. An adaptation of the Delphi method and the Nominal Group Technique will be used to develop consensus statements in this research and is therefore discussed fully later in this chapter.

12.2.2 Nominal group technique

The Nominal Group Technique uses a highly structured meeting to gather information on a given topic. It consists of two rounds in which a small groups of experts rate and re-rate a series of items or questions (Jones et al 1995). An expert on the topic or a credible non-expert facilitates the group meeting. This method was developed in the 1960s, and had been applied to problems in social services, education, government and industry (Fink et al 1984). Within health, this technique has been used to examine the appropriateness of clinical interventions (Hunter et al 1994), education and training (Battles et al 1989) practice development (Justice et al 1990) and for identifying measures for clinical trials (Felson 1993).

12.2.3 Consensus development conference (CDC)

The CDC is often organised through defined programmes, for example the Kings Fund and the National Institutes of Health in the United States, and requires a vast array of resources (Stocking 1985; Ferguson 1996; Stocking et al 1991). This approach, which is widely practised world wide, was developed in the United States by the Office of

Medical Applications of Research at the National Institutes of Health. Within it, discussions are held in public and led by experts in the field being investigated. The experts present their evidence to a consensus panel made up of practitioners from a broad range of backgrounds that listens to the evidence and prepare answers to a set of questions about the technology or procedure. There are two models within this approach, scientific peer review and the judicial models.

The scientific peer review model, which is the favoured method in the United States of America, comprises representation from user perspectives and experts who are known not to have any biases on the technology or procedure but are knowledgeable about the subject. The questions asked are restricted to scientific issues as well as the need for further research.

The judicial model as pioneered in the United Kingdom by the King's Fund, has a panel whose members are not experts and are not exclusively medical practitioners but have no user representatives. It also considers the economic impact and its implications for the wider (NHS) services provision if that particular procedure is to be recommended. Stocking (1985: p713) argued that, in spite of the focus on finding economic implications for the procedure, the main task of the panel is to consider procedure or the techniques' scientific merits.

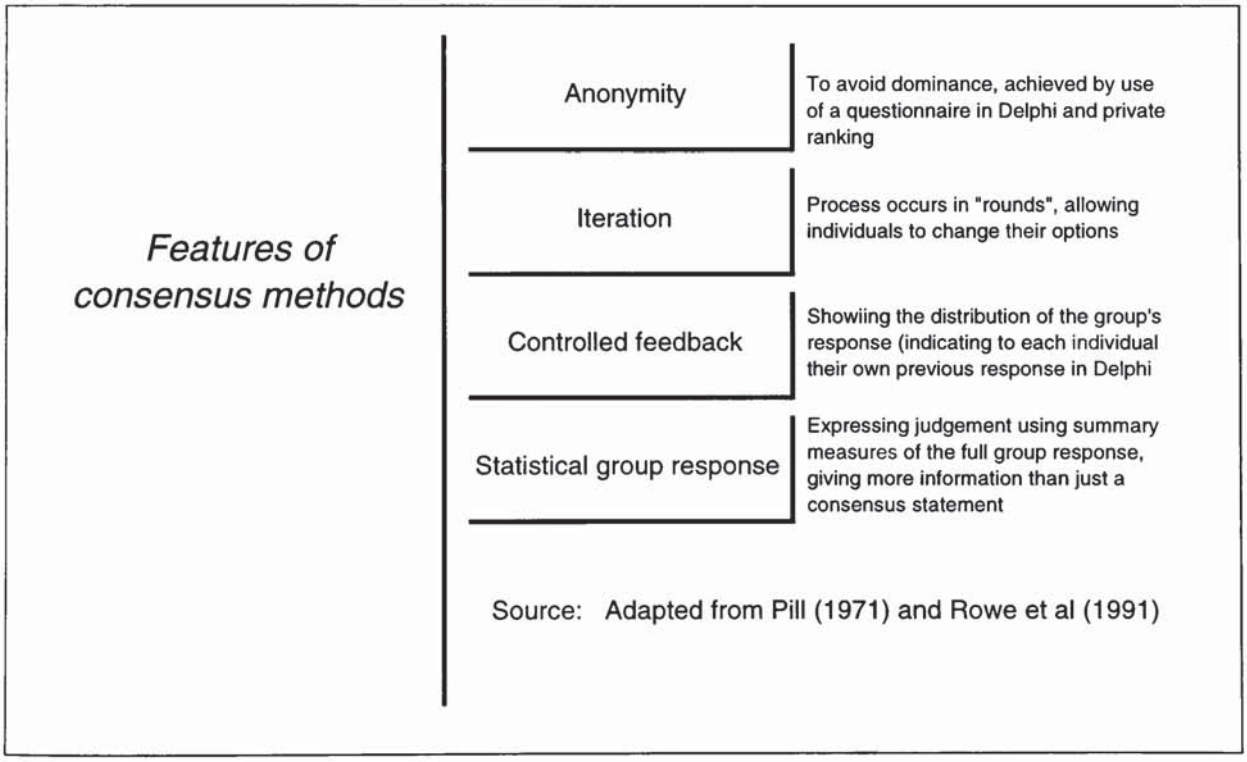
12.3 The nature and process of consensus conferences

The key features of consensus conferences are that they help health care stakeholders to take a new technology and assess its applicability to various aspects of care provision. Basically, a panel from a broad range of backgrounds, listen to evidence presented by experts and views from participants and prepare answers to a set of questions about the technology, practice or the procedure. The adoption of the consensus method enables an assessment of the extent of agreement (consensus measurement) and to resolve disagreement (consensus development) on a given health care issue, using a group approach to decision making. Gowan (1993) supported the group process for building consensus contending that the body of knowledge concerning group consensus building and decision processes is a rich one,

and provides alternative structured approaches which are intended to increase the efficiency and effectiveness of this group activity.

Consensus conferences provide the environment within which agreements and disagreements could be discussed. As shown in Figure 12.1, the nature of it ensures that the method selected for this research will encourage debate without undue pressure on individual participants as decisions made are undertaken concurrently. The richness of the information derived from the conference is assured as participants have the opportunity to change their minds in the light of further information and after considering the wider group decision. This method of seeking group decision-making will provide more information as to the extent of agreement and the degree of consensus reached.

Figure 12.1: Key Features – Consensus Methods



In Figure 12.1 above, anonymity in developing consensus is achieved through different stages of the process with an opportunity for the individual to rank responses without any group pressure. This process is particularly helped when a questionnaire is used when the Delphi process is being used and by private ranking when the nominal group

technique is used. The next step in the process to ensure a consensus is through a stage by stage approach to the development of the statements. This is known as iteration, and can provide the individual the opportunity of matching their responses against that from other respondents, in addition to changing their minds in view of what others have said. There is also a controlled feedback so that information that is given is relevant in enabling participants to make decisions on informed bases. The process is completed by applying to it a degree of statistical analysis, thus providing participants more information than just that a consensus is reached.

12.3.1 Usefulness of consensus conferences

Consensus methods allow a wider range of study types to be considered and are used to resolve differences and conflicts in scientific evidence (Jones et al 1995). However the usefulness of consensus development conferences has been questioned on the grounds of their reliability, ability to change practice and cost effectiveness (Zaleski 1992 p 1390, Lomas 1991 p41-65). Lomas 1991 reported that consensus statements have not influence what he thought was its purpose; to effect change for the better in clinical practice during a review of its use in hypertension. He reported on a review of what he termed nineteen "methodologically credible" studies of the impacts of consensus recommendations and found that the great majority has no significant impact except for six studies who had contributed in changing behaviour moderately. He pointed out that only three amongst this group had contributed to changing clinical practice in a major way. In the United States, Kosecoff et al (1987) reviewed twelve recommendations from four NIH consensus conferences and found that compliance with the recommendations range from 57% in the first twelve months after the conference and 52% at 12 - 24 months thereafter. They further found the rate of change before the conference did not rise dramatically, therefore concluding that the conference did not exert any positive impact. The main findings of their study is summarised as follows:

I. Consensus conferences should focus on those areas that truly needed improvement
II. Greater impact would require active follow-up at national and local level
III. The greatest inducement to change was provided by local leadership

Clearly Lomas and Kosecoff et al (ibid) are of the view that the main purpose of the consensus conference is to promote change in behaviour and that failure to do so means the conference has been ineffective.

However its use in developing clinical and service guidelines are highly recommended and frequently used in the health service (Grootensdorf et al 1988; p554 and Hill et al 1984 p1190-1194). Hill et al (1984) reported high levels of awareness (62%), 82% familiarity with the recommendations but only 18% change in practice behaviour and 17% reported usage of the recommendations in every day practice. Self report questionnaires were administered six weeks before and one year after the conference and show that questionnaires sent 6 weeks before the conference revealed a 66% of clinicians were already practising in the manner congruent with 9 out of 10 recommendations. They concluded that the consensus statements codified current practice and that failure to change practice indicated once again that much appropriate change had preceded publication of the recommendations.

Johnsson (1988) studied the impact of consensus conferences based on the Consensus Development Conference in Sweden and found very high rates of awareness (94%), professed knowledge (99%) of the recommendations with 10% saying they had changed practice. However 83% stated there has been no change in practice behaviour although many made the comment that the consensus statements reflected their previous practice before the publication of the recommendations. However there was the agreement that production of the guidelines provides an authoritative codification of current best practice as a guide to practitioners and opinion leaders. Johnson (ibid) consequently concluded that if change is to be the major objective for consensus conferences, then the topics chosen should be those where change is thought to be desirable. The experience reported from the Netherlands is more positive than of the countries mentioned here. One of the more successful studies reported by Lomas (ibid) is from the Netherlands and quoted the authors of the study as saying that their positive results are due to the fact that their process originated from health professionals committed to quality assurance, rather than adopting the American model of National Institute of Health Studies, which the Dutch perceived as originating from technology assessment (Casparie 1987). Chalmers (1995 p37-40) reviewed the impact of consensus conferences in Europe, United

Kingdom and North America and concluded that, the main value of the consensus statements was not to effect rapid and substantial change in practice but rather that it provided an authority for best practice. Chalmers, further advanced the view that guidelines or consensus statements can further help to set the scene to facilitate change towards more rational and better care. He cautioned though that if the object of the statements is to promote change in practice, the statements have to be embedded in a more comprehensive programme. This could include follow-up to ensure implementation and a raft of measures to overcome barriers that could stem from fear of litigation, patient-centred factors, and local institutional procedures or from economic disincentives and brevity.

Additionally, Durand-Zaleski et al (1992), found the usefulness of consensus statements in institutions that are homogeneous in terms of case-mix (diagnostic related groups) and practice patterns, and who can best develop statements and frequently issue re-statement of any recommendations until consensus is achieved. Gowan et al (1993) found it useful in evaluating competing research and development of information systems project proposals, and for evaluating a group of personnel in order to take selection or promotion actions. The King's Fund ran series of consensus development conferences in the 1980s and found the process useful in developing guidelines for practitioners in various aspects of health care (King's Fund Forum 1987. Its application is best where there are no unanimity of opinion. The consensus development conference model in practice in North America has been seen as an innovation through technology assessment and is therefore thought of as a process designed to regulate practice (Chalmers 1995 p39). The model practised in Europe and in particular in the Netherlands has been developed by clinicians and was designed to illuminate practice. This view is supported by Hill et al (1991), who argued that clinicians perceived the North American model as biased towards the sponsors of the conference. They concluded that, "the clinicians seem to be aware of the sponsors' intent to produce a document that meets the sponsors need to communicate a particular message about how medicine ought to be practised'. They recommended that a test of post-test adherence to the recommendations of guidance and consensus conferences are:

I. Pre-test practice congruent with recommendations

II. The standing of the conference sponsors (professional bodies such as the royal colleges were preferred to government agencies)

These reviews show that the main values of practice guidelines developed as a result of consensus conferences are that they do not produce rapid and substantial change in practice. On the contrary, they consistently show that, their best impact is at the time when practice is evolving rapidly, a timely production of guidelines provides an authoritative codification of current best practice. In this way they reflect and reinforce the changing nature of practice rather than promote change. It is possible that the initiative could also influence government policy in allocation of health care resources and influence the targeting of research programmes. However if the intention is to produce a substantial change in practice, the production of the statements need to be developed as part of a more comprehensive programme.

12.3.2 Building consensus in forensic psychiatry: The need

Why is consensus so important within the healthcare sector in general and, forensic psychiatry in particular? The specialty of forensic psychiatry is one of the most diverse sectors of the health service in terms of casemix, although there are similar diagnostic groupings. Its link is firmly rooted in the application of many aspects of the law within the practice of psychiatry. Users of the service have a common denominator, which relates to their behaviour and mental disorder. The provision of the service at whatever level in terms of debility requires joint working with practitioners within relevant agencies.

There is a strong call by policy makers, general public and other stakeholders that the service must develop effective measures of service provision as the medium secure sector continues to grow. New methods of service provision are being developed and most of it are being restricted for general dissemination as more and more of these services become increasingly integrated within the NHS service commissioning mechanisms, and consequently suffering from its ramifications of secrecy.

Another aspect to consider is the rapidly escalating knowledge in mental health services about mental disorder, which is based on the perspectives of various disciplines within the field. There is therefore more knowledge available than any one profession, discipline or individual could understand, synthesise and use. On this assertion the individual practitioner is limited in scope and depth of knowledge needed to satisfy the needs of the patient effectively. With this limitation on time to learn all the facts, it is increasingly hard to take the additional time needed to think critically about all the principles of knowledge. Perrin et al (1984 p 323) put this assertion into context by arguing that creativity, critical thinking and problem solving skills are at risk, adding that education as a process would be sacrificed for learning the facts of training to acquire skills if consensus is driven from within the multi-disciplinary team.

Over recent years, community mental health care appears to be dealing more with severely mentally ill people (Dean et al 1993). The present focus on primary health is a real and perceived challenge to professionals in that sector of health care provision (Department of Health 1996 & 1997). Traditionally, forensic psychiatric care is practised in institutions. Consequently the skills needed are concentrated within these hospitals. As the service moves towards the community increasingly, the need for these skills to be transferred or cultivated and nurtured in the community is acutely necessary. Thus, consensus statements or guidelines that are simple, explicit and evidence based can only help healthcare practitioners to keep abreast of an ever-changing field of knowledge.

The development of guidelines can also help to provide confidence and direction in management decisions that have the approval of key players who are experts and are known nationally and internationally for their work in the field of forensic psychiatry. Finally, because the recommendations are applicable to the sector as a whole, the guidelines and recommendations will be decided taking into account the various priorities that are confronting the sector.

12.4 Planning for the conference

It has been discussed how consensus development conferences can improve quality of care by issuing practice guidelines that are based on evidence and agreement, and

are focused on a given evidence, practice or procedure. The method that is best to meet the aims of this research and the objectives of the sponsor of the conference was the Delphi and to some extent the expert panel processes. The Delphi process takes its name from the Delphic oracle's skills of interpretation and foresight. The technique has been used widely in the health service research (Crotty 1993; McGlynn et al 1990; Bellamy et al 1991; Moscovice et al 1988). For the purposes of this research the process proceeds in a series of rounds as shown in Figure 12.2 below. The pre conference preparations involved negotiations with potential sponsors and possible participants whose views were canvassed during the course of this research. Key stakeholders in the effectiveness of the service were asked to comment on the necessity and feasibility of this type of conference. Having achieved the general political acceptance for the conference, the next step was to identify the most appropriate sponsor of the conference. The High Security Psychiatric Services Commissioning Board (HSPSCB) was selected as it offers the best overview of the multi-agency nature of service provision and because of its national focus on the care of mentally disordered offenders.

The HSPSCB has responsibility for commissioning high security psychiatric services at national level. Its main remit is to integrate the high security hospitals into the National Health Service in terms of purchasing and assessment of the need for that level of service provision. It acts as the conduit for gathering the thoughts of other health authorities in England and Wales on service needs for the patient group. Its Director is responsible to ministers through the Chief Executive of the National Health Service. The Director of Clinical Strategy of the HSPSCB agreed to make a budget available to finance the conference. The following protocols were agreed to meet both the needs of the research and that of the sponsor (HSPSCB). These were that invitations should be sent to:

I. All chief executives who have responsibility for provision of services for mentally disordered offenders at all levels

II. Directors of clinical services within forensic psychiatric provider units

III. Health authorities and GP Fundholders who are involved in purchasing forensic services

IV. Personnel from the prison service

V. Government officers from the Department of Health and Home Office

VI. Service users and appropriate user representative groups

VII. That any other practitioner who wishes to attend should be nominated by their respective service directors

VIII. An expert multi-disciplinary group be set up to decide on the statements to be put to participants at the conference

At the same time of agreeing the guiding protocols for the conduct of the conference, the aims and objectives were also agreed. The aims and objectives of the conference were those of this research but were adopted by the core planing as that of the conference.

12.4.1 Aims and objectives of the conference

The question to be asked is this, why aim for consensus in the way the health service is organised and delivered? Jones et al (1995 p376) provided the rationale that because health service providers face the problem of trying to make decisions in situations where there is insufficient information and also where there is an overload of (often contradictory) information. The best example of this in the forensic sector is the way treatment, care and management of psychopathic disordered patients has failed to attract general acceptance on the best environment – hospital or prison, the suitability for treatment and the best method for treatment while the patient is within the hospital sector. While statistical methods such as meta-analysis have been used to summarise and to resolve inconsistencies in study findings, consensus methods provide another means of synthesising the information where there is very little published information.

Consensus conferences also allow a wider range of study types to be considered than is usual in statistical reviews and at the same time providing a greater role for qualitative assessment of evidence. The overall aim of using the consensus method in this research was to determine the extent to which key stakeholders practitioners - professionals and managers, service commissioners, users and carers agree about

the use of outcomes measures in forensic psychiatry. Secondly, to increase the awareness of this type of research and to update the findings of the research to ensure participants were in possession of the facts. In order to update the finding a Trawl of the Field was carried out and its results are discussed later on in this chapter. The specific objectives of the conference were as follows:

I. To present the findings of the research to a consensus development conference in order to seek agreement on key areas to develop measures.

II. To set an agenda for the development of effectiveness measures in forensic practice

III. To establish a network of practitioners, willing to work with promoting outcomes measurement.

IV. To agree on key areas to prioritise and to develop into measures of outcomes

V. To disseminate the findings of the research.

12.4.2 The process

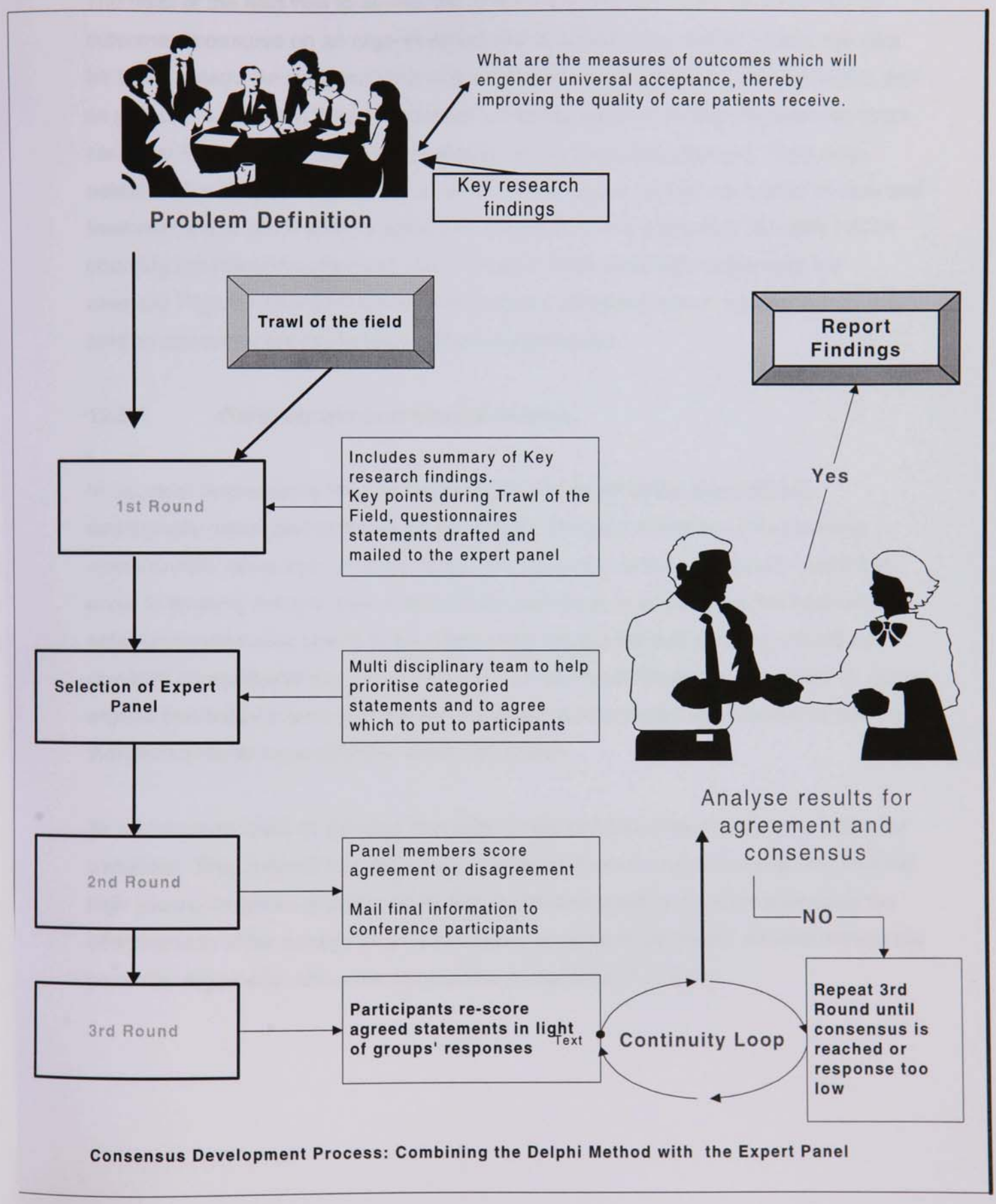
The process adopted is shown diagrammatically in Figure 12.2. The core planning team comprises the Director of Clinical strategy and Research and Development Manager of the High Secure Psychiatric Services Commissioning Board (HSPSCB) of the Department of Health, and the researcher. It was agreed within the core planning team that Stockton Press which is a subsidiary of Macmillan Publishing Group should be approached with a view to raising the profile of the conference. The Commissioning Board agreed with the researcher, who is also the editor of their journal, Psychiatric Care that an edition should be devoted to publishing selected articles on clinical effectiveness in addition to providing advertising space in the journal for the conference. It was decided to publish the relevant publication of the journal to coincide with the conference and to make the journal available to all participants as a means of adding to their knowledge base. Others joined members of the core planning team at the later stages of the conference planning process to form the expert panel.

The members of the expert panel were selected through recommendation from their professional organisations and were known to be involved in developing innovation in the way patients are care for in their own organisations. The members of the expert group included a patient representative, a director of nursing, consultant forensic psychiatrist, a representative from the Social Services Inspectorate, a facilitator of clinical audit in a high secure hospital, a head occupational therapist, two clinical psychologists, head of professional development, including the core planning team.

Special care was taken to balance the representation on the basis of regional, disciplinary, levels of security and service orientation. Members of the Expert Panel were presented with the general findings of this research and the summary of a trawl of the service on issues of concern on measuring outcomes. Members then defined the problems and questions to be discussed at the conference (see Figure 12.2 below) and the decision was made to focus on eight key areas (see Figure 12.4 below).

The mixture of the Expert Panel and the Delphi process was adopted because while it allowed the expert panel members to select the topics, there was the opportunity for a much larger group involvement in the selection of areas to prioritise, having been informed of the facts available and as such, the method has the best potential for its outcomes being implemented.

Figure 12.2 Flowchart depicting the Consensus Development Process



Consensus Development Process: Combining the Delphi Method with the Expert Panel

12.5 The trawl of the field

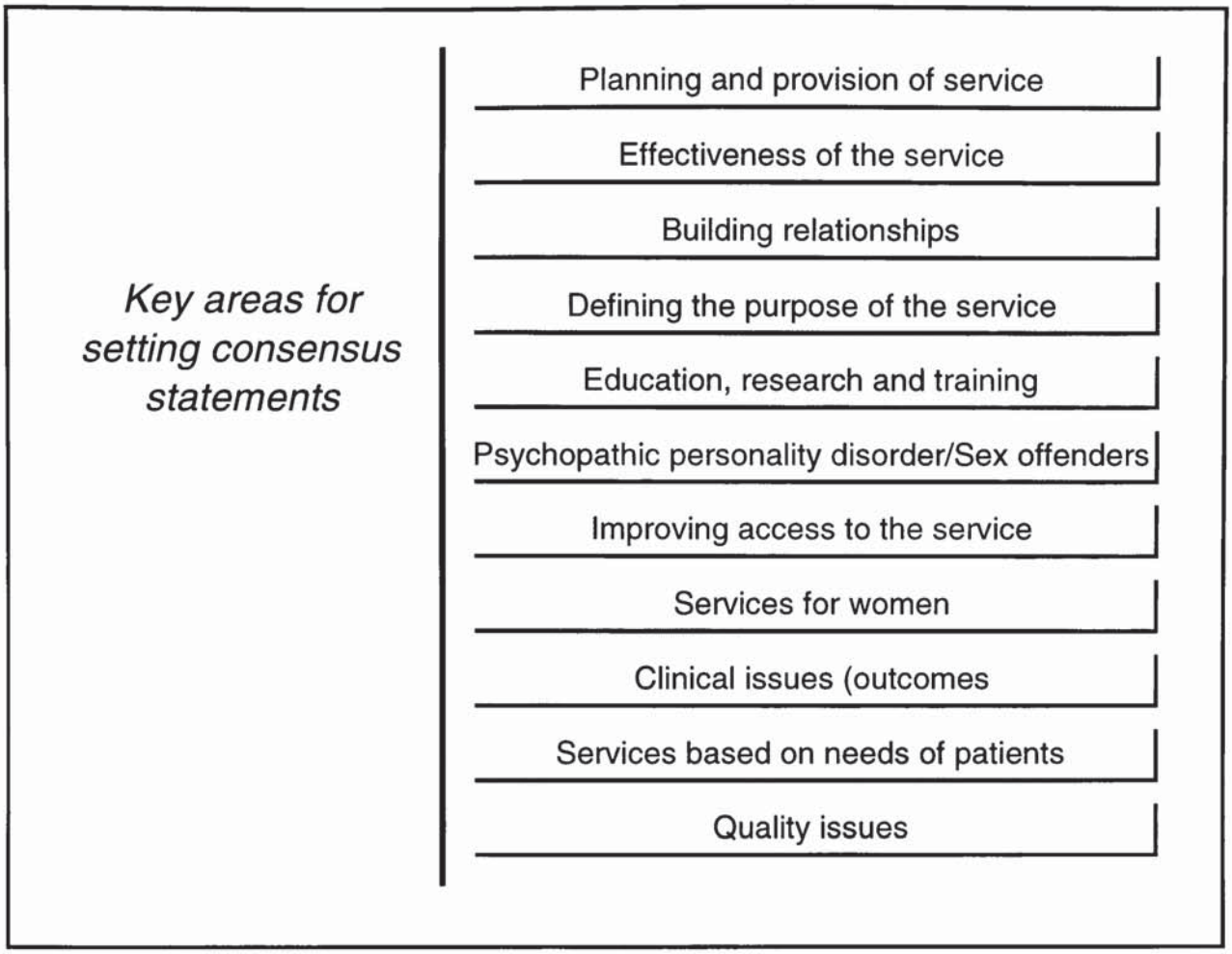
The trawl of the field was to access the level of commitment to the development of outcomes measures on an organisational and strategic basis and to update the data for the research. An invitation form was sent to all service directors and managers and as part of the invitation they were asked to identify areas of concern to them for which consensus statements could be developed and to state their reasons. They were asked deliberately not to limit the areas to clinical issues so that the totality of care and treatment areas could also be reflected. The focus of the analysis of this was not on counting but rather on what was said. However there were 300 statements for analysis. Figure 12.3 below shows the summary of the key areas and the rest of this section described the justification of the selected areas.

12.5.1 Planning and provision of service

In all, most respondents felt that the service ought to be better planned and strategically developed because MDOs require stringent follow up. This planning would enable some form of on going care in the community for those who need it in order to properly monitor their mental health and provide a safety net for them and a safer environment for others in the community. Others felt that services should be provided comprehensively and on the basis of the Reed Principles (Appendix 1). Some argued that better planning of the service would lead to better assessment of need and therefore a much more effective service provision.

All respondents were of the view that setting national consensus guidelines would be beneficial. They argued that this would help bring down the cost of placement into the high secure hospitals and provide Health Authorities a benchmark for assessing the effectiveness of the service they commission. A national statement will also reduce the perennial arguments about the appropriate placement of patients.

Figure 12.3 Trawl of the service
Key areas



12.5.2 Effectiveness of the service

The effectiveness of the service was also of concern. Respondents generally felt that the influence of the Prison Officers Association (staff association) was stymieing developments in the high secure hospitals. This they argued was not helped either by the sometimes rigid application by some professionals of the concept that "past behaviour is the best predictor of future behaviour" when decisions were being made on effectiveness of care. The explanation for this point of view was that while practitioners continue to maintain the status quo the need to be involved in the development of effective risk assessment and management packages will be lost. Others complained about the poor facilities for the practice of forensic care and maintained that they were not conducive to effective practice. Some felt that the development of outcomes measures and the evaluation of effectiveness needed to

focus on specific treatment regimes for defined groups of patients and their needs. A pre-requisite for this would be for patients to be grouped appropriately in level/type of provision according to assessed needs and treatment objectives. This they argued should be made taking into account the need for physical security and not use treatment as that security.

12.5.3 Building relationships

Concentration on developing effective partnerships and meaningful collaboration to facilitate ease of movement within the service was seen as another area that consensus statements could be developed. Some respondents reported instances when patients were discharged back to specialist provision without prior negotiation with the local health authority. Others forecasted that because there will be more small size services the need to plan the service on parallel basis to general mental health services was an ineffective option to pursue. They advanced the view that integrated services were the best method of provision and so there was a need to develop effective working agreements. Others thought building this partnership would be helped if money follow the patient when they left high secure hospitals, which was not happening.

The need to open up the service more in terms of sharing information was cited as one of the most important issues to seek agreement for. Supporters for sharing of information were of the view that because thorough assessment of risk is reliant on the quality of information received from variety of sources agreement on what information to be shared would be helpful. They contended that 'confidentiality' at times was being used to obstruct the sharing of information across professional groups and can inhibit a multi-disciplinary approach to managing risk. A further concern was the 'power' of Responsible Medical Officers who, at times, use the argument that 'it is they who will appear at the Coroners' Court', to counter other staff's requests to be included in the decision making process. Others also feel there should be further debate about the balance between the patient's needs and public protection issues.

12.5.4 Defining the purpose of the service

There were calls for defining the purpose of the service, as these seems to be lost when there is concentration on the protection of the public or others at whatever cost, they argued. Equally, there were concerns for the clarification of treatability, this concept is applicable to people diagnosed as suffering from personality disorder. This aspect of care, that is the concept of treatability plagues the admission process to both high and medium secure provision, as patients who are diagnosed as such normally ends up being rejected by clinicians. The one who makes the decision and what should happen to people who are regarded as dangerous following assessment but untreatable should therefore be clarified. Others argued that this clarification was needed to ensure that people who are difficult to manage are not dumped onto the forensic services.

12.5.5 Education and training

Education and training of both patients and staff was seen as an area to prioritise. Respondents argued that further adult education is suffering because of the withdrawal of funding that was being accessed by mentally disordered people. Poor training or lack of appropriate training of staff within the criminal justice system, non forensic settings particularly where juveniles are do militate against early detection of mental illness, appropriate referral leading to inadequate and untimely interventions. These issues in addition to the general difficulties relating to national demographical changes need to be resolved to ensure the future of the viability of the service is assured.

12.5.6 Psychopathic personality disorder and sex offenders

Another area identified was that of effective care for people diagnosed as suffering from psychopathic personality disorder. There were calls for agreeing on a conceptual framework for the effective assessment, treatment and long term management of people who have the condition. Others questioned the continuing need for the mental health services' input. The point here was whether these patients should be treated in hospital or receive prison sentences. The call for this clarification seemed to be coming

from the stigmatisation and the pejorative labelling of such conditions as untreatable and yet provide the most disturbing behaviour if left unattended. The numbers for these patients are small and yet this patient group consumes most of the resources that are allocated to the services. Respondents argued that the Reed Review did not shed much light on how best to deal with this problem. These patients block beds in the forensic services and cause untold management problems.

In the context of prioritising specific diagnostic groups, some responders were concerned about the management of mentally disordered sex offenders. They argued that public antipathy and the lack of appropriate long term safeguards within Mental Health Act 1983 for this group and their carers meant that their care and the protection of the general public was being compromised. They called for a national consensus to resolve the problem.

12.5.7 Improving access the service

Others called for a much more co-ordinated approach in arranging access to the service. They argued that there was a need for co-ordinated and agreed approach between agencies at time of discharge or entry to the various levels of service provision. Some of the respondents were of the view that there should be consensus guidelines about the range of aftercare provided to ensure quality of service that meets the needs of individuals.

Another aspect that impacted on access to or from the service was the nature of its funding. Funding of the service tend to concentrate on beds and hospitals where high levels of experience and skills still existed. In community settings little specialist resources were available to contain and manage risk in less restrictive environments. As a consequence, discharged patients failed due to lack of appropriate support. This often leads to difficulties in moving patients who have been identified as a serious risk, before they commit an offence.

12.5.8 Services for Women

Provision for gender specific care within secure units should be a priority and so should mixed gender units or wards, which were no longer acceptable under the terms of the Patients' Charter (DoH 1996). Mixed wards are seen by many as actively detrimental to the aims of therapeutic care, others drew on their own experiences to argue that where single gender accommodation and care has been provided improved results and patients satisfaction have resulted. On the whole most respondents were of the opinion that many of these women have a history of sexual and/or physical abuse and being a small minority amongst a male offender population could be counter-therapeutic, they argued.

12.5.9 Clinical Issues (Outcomes)

Clinical issues were also identified as areas where consensus statements could be developed. Specifically the care and control of very disturbed and/or violent patients using therapeutic methods needed to be clarified. There were calls for common language in assessing and managing risk, in particular the development of assessment forms. Others thought that the clarification of the roles of the responsible medical officer and public expectations of the service should be targeted and resolved. Also there should be increase in the provision of psychological therapies to all patients. The problems relating to adequacy of service provision could be reduced by involving non-psychology based professionals into providing therapy. Others thought that the over prescription of powerful neuroleptic medications and punitive use of control and restraint methods were issues that were counter productive and detrimental to effective care. They believe consensus statements could be used to develop alternative methods of using traditional controls that bring benefits to the patient while providing safety and security to others. There was a general view that statements that concentrate on multi-disciplinary identification of needs of patients and developing appropriate services should to be developed.

12.5.10 Quality Issues

Improving quality standards and developing research and accepting its impact on the effectiveness of the service was seen as an area for development. In terms of quality respondents were of the view that provision of a safe (physically and psychologically) environment for service users must be a priority and so was adding value to their quality of life. Others felt that the balance between security and therapy needed to be in favour of what is best to meet the needs of the individual patient.

Many respondents thought that one of the main objectives of secure services must be to achieve therapeutic outcomes from both users and public perspectives including enabling patients to lead more valued "ordinary" lives and to assure public safety. They argued further that this means that the quality of the service on offer should be of the highest order. Further some advanced the view that this focus was needed to encourage effective and motivated staff to pursue the therapeutic vision, and to eradicate the "blame culture" that limits the scope of forensic clinical work to "warehousing of patients". These areas needed to be dealt with to reassure the general public. One respondent summed up this view as "until we are certain that the care on offer produces the desired outcome we cannot assure ourselves and the public that we know what we are doing."

Figure 12.4 further lists the issues of concern to respondents that could be developed for possible future measures. This time the issues are classified in the classical Donebedian classification of quality, that is issues of Structure (inputs), Process and Outcomes.

Figure 12.4 Trawl of the field - Classification of Issues of Concern

Input Issues: Planning and Provision

Provision of seamless services, determined strategically at national level with the patient the focus for planning.

Develop contracting and commissioning to reduce substantially the competition, uncertainties of HA purchasing of all forensic services in the future.

Clarification of the future of the maximum security hospitals and the way this impact on beds.

Effective plans to enable joint appointments (high and medium security level).

Joint funding between the Department of Health and Home Office for diversion and treatment within Criminal justice system.

Seamless services for offenders with learning disability.

Better integration with local services

Removal of the Prison Officers Association from the high secure hospitals

Improve training for those who are dealing with forensic (patients) issues in the community

Improve recruitment, training and retention of all staff.

Develop conceptual framework for effective assessment, treatment and long term management of Psychopathic Disordered patients and clarify the responsibilities of all sectors of mental health services.

Provision for gender specific care within secure units. A policy document highlighting the needs of women users.

Develop appropriate standards of advice, which is given when a unit assesses that a patient does not fit into the eligibility criteria identified for a particular unit but who still requires a secure placement elsewhere.

Improve services for the mentally ill within the prison service, others who are diverted get better treatment in the health service.

Clearer guidelines on effective use of resources (high security, MSU, long term facilities, local and primary care).

Process Issues: Managing Efficiency

Better involvement of purchasers

Clarification of the future of the maximum security services

Better management and collaboration between all sectors of the service (health, social and criminal justice system).

Better provision of information on beds availability (medium security) at the national level.

The Prison Officers Association is a reactionary and anti-therapeutic influence

Clarification of objectives, patient needs, preparation for discharge and role and function of all service components.

Creation of 24 hour diversion systems

Clearly defined search policy

Define treatability, the forensic patient in the community and clarify the position on patients who are assessed as dangerous but untreatable.

Outreach and aftercare services for MDO patients appear patchy and inconsistent; particularly in relation to flexible, community-based residential facilities.

There is no national psychiatric assessment form for mentally disordered persons at the point of arrest in police stations

Lack of attention to mental health needs of sentenced prisoners particularly when they are due to be released.

Involvement of catchment area services in a joint admissions and discharges panel

Management of mentally disordered sex offenders

Outcome Issues: Measuring Outcomes of Interventions

Discharge/entry planning between different services

The audit of the arrangement for patients discharged from secure inpatient services and the appropriateness of local service provision when compared to need.

Develop therapeutic methods to manage disturbed or violent patients

The range and quality of psychological therapies available to MDO patients is too low. The development of training programmes and career structures to enable non-psychologists to contribute to these services should be explored.

Develop clearer language for risk assessment involving its management (Multi-agency involvement, Role of Responsible Medical Officer, Patient's needs v Public Perception)

Develop a formalised 'peer review' structures to manage difficult cases.

Should reduction in offending be the sole criterion for outcome success?

How to improve the quality and impact of research into what is quality care for MDOs particularly on transfer from high to medium security.

Provision of a safe (physically and psychologically) environment for service users.

Achievement of positive outcomes in terms of MDO quality of life, independent living and public safety (re-offending)

Facilitating cultural change within general forensic services - having a therapeutic use of security - rather than security per -se

Outcome evaluation of forensic patients treated in all settings

Needs-led care, highly personalised. I sense that this must be better developed, using a multidisciplinary approach

There is not enough emphasis to measure assessment of need. The view is taken of individual cases in short-term and based upon their behaviour at that time.

The role of professional organisations and staff representative groups to enable or impede the development of appropriate and effective measures

The expert panel of service commissioners, providers and users of the service have acted as a validation panel to re-examine the findings of the research and the results

of the trawl of the service, in order to select areas for developing and setting consensus statements (see Figure 12.2). In considering the overall aim of the research and that of the conference the following key aspects were taken into account.

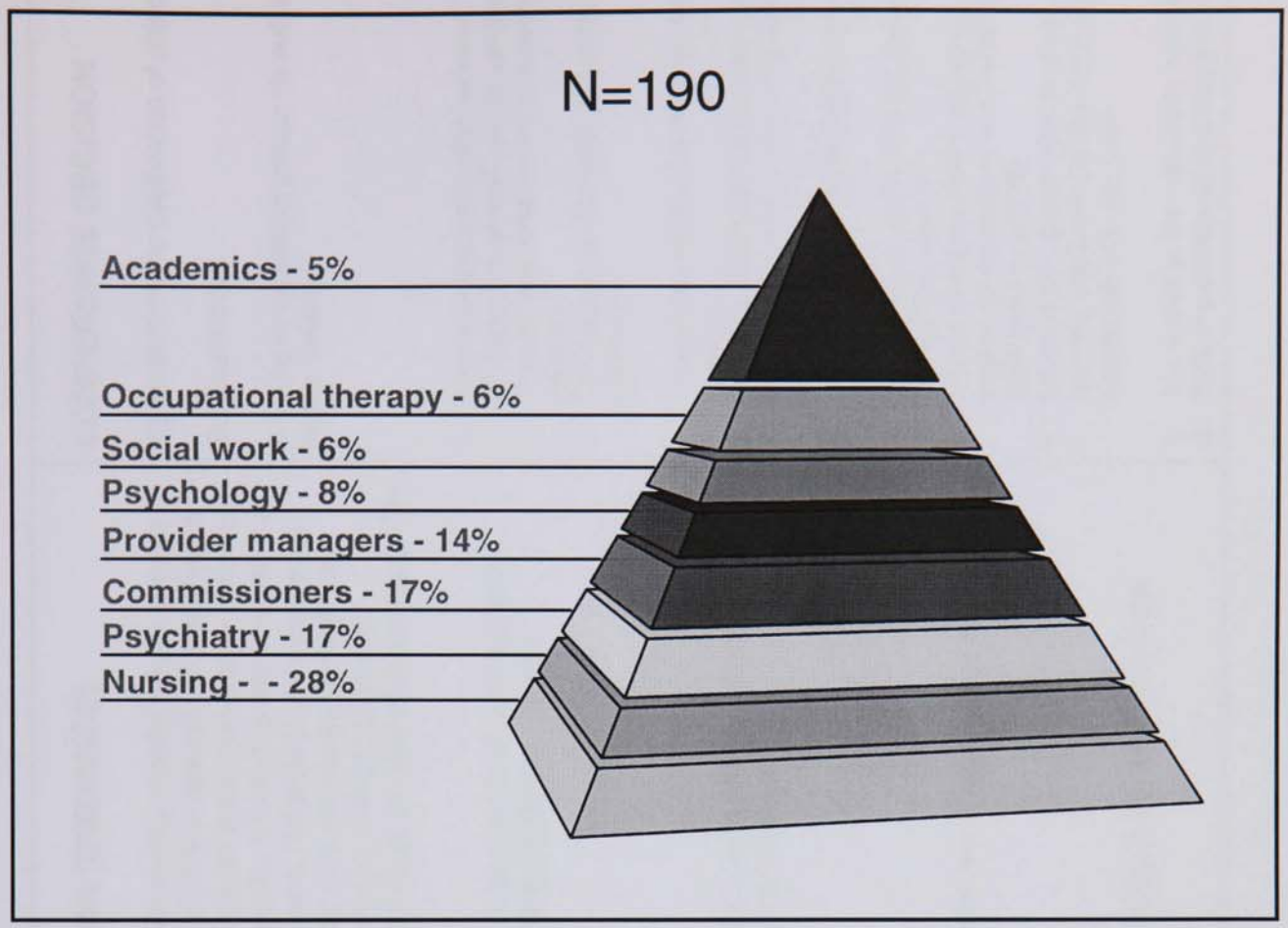
These were setting clear objectives for the exercise, appropriate selection of participants, previous realisation of synthesis of the pre-existing information and the definition of the degree of agreement which leads to the consensus and in evaluation of its impact. In addition to the information arising from the research, the panel members were asked to comment on wider issues such as, how the findings of the research could be disseminated, ways in which the findings could be incorporated into planning the care of patients and the impact of political and how legislative and regulatory considerations can have on the implementation of the findings. The shared view that has emerged is summarised in Figure 12.6 below, which also shows the decisions made by conference participants.

Participants for the conference came from all sectors of the service (high, medium, low security and the community), government officials, commissioners of the service and from various geographical locations throughout the country. Due to the nature of the service, patient representation by those who are actively receiving in-patient care was thought to have the potential of creating too much controversy. Consequently, ex-users some of whom were engaged in research were thought to be the best option available as they would be able to provide a perspective that is near enough representative. The participants of the conference were invited in collaboration with the HSPSCB of the National Health Service Executive (NHSE) of the Department of Health. Invitations were also sent to health service clinical staff (doctors, nurses, psychologists, occupational therapists, social workers) their managers and commissioning staff.

12.6 The Conference

The consensus development conference was held on the 12th November 1997, fully funded by the High Security Psychiatric Services Commissioning Board (HSPSCB) and free to all participants. Figure 12.5 shows the skill mix of the one hundred and ninety practitioners who attended the conference.

Figure 12.5 Skill mix of participants



This together with the careful selection of the members of the expert group was an attempt to ensure that the field sees the final outcome of the conference as credible. As Figure 12.5 shows the conference was attended by representatives of all practitioner groups, their place of work reflected the environments within which the practice of forensic mental health takes place and included representatives from professional, user, and government departments. The involvement of key stakeholders was seen as the best medium for assuring credibility and appropriateness of the consensus statements.

Figure 12.7 Consensus areas

AREAS FOR CONSENSUS BUILDING	EXTRA INFORMATION (GUIDANCE)	CONFERENCE DECISION
Define the objectives of the forensic mental health services	"Treating MDOs in a high quality mental health service (with an agreed definition of the service). This implies a wide range of settings including the community, criminal justice system and hospitals. It includes consideration of the views of commissioners, the public and patients. It also includes consideration of clinical (including risk management), social, ethical, cultural, physical, psychological issues and those of cost-effectiveness." Do you agree?	Agreement on the clarification of objectives 90% agreement 10% felt some patient groups do not need health facilities
Developing seamless clinical services	Define and identify the components of an integrated range of services, focusing on clinical aspects	1. Improve communication between professional groups and at service levels 2. Greater and effective involvement of patients 3. Development of clinical outcomes measures
	What outcomes measures could be used to monitor the effectiveness of this type of service?	1. Learn from inquiry reports and change practice 2. Increase clinical and treatment activity 3. Increase promotion and marketing of activity 4. Develop clearer career pathways for staff
Recruitment and retention of the best staff	What should be done to improve recruitment and retention?	1. Increase flow and exchange within and outside the service 2. Career and succession planning 3. Higher concentration on clinical rather than security activity 4. Develop the clinical effectiveness agenda and promote interventions backed up with evidence
Health of the Nation Outcomes Scales (HoNOS)	Identify outcomes measures to be used to assess success rate	1. It is a start to the outcomes agenda 2. 70% of participants feel that it is not

		appropriate because it is over concentrated on professionally defined measures and clinical outcomes only 3. Develop one for forensic psychiatry
	What are the benefits of using HoNOS? Should it be adapted for forensic practice? If not appropriate what are the alternatives	1 Increase effective communication, clarification of roles and breakdown of barriers 2 Focus of care is on the patient *3* Remove power base of a single professional group
Multi-disciplinary and inter-agency working	Define and clarify the components of multi-disciplinary and inter-agency working	1. Commitment to and general use of the Care Programme Approach 2. Regular audit of communication and member experiences 3. Full participation of patients 4. Reduction in concentration of perceived power base
	How would you like the effectiveness of this to be measured	1 Effective multi-disciplinary assessment of treatment goals 2 Patient input into determining the treatment plan 3 Identify an appropriate tool to measure benefits
Assessment of patients' needs	Identify the best method(s) to use to meet patients needs effectively	1. Care Programme Approach (CPA) if applied effectively
	Identify the best needs assessment tool in existence for use in forensic mental health	1. CPA but further research into its reliability, relevance and promotion is needed
	How could the appropriateness of this tool be improved to be used for assessing the needs of patients?	1. Give more information to patients on which to enable them make decisions 2. Training in advocacy 3. Commitment to meeting identified needs

Involving patients and other users in care	Identify the key components in the process for involving patients and others in care	1. Develop measures of effectiveness 2. Measure patients' experiences over time 3. Share information with relevant others
	How could the effectiveness of this process be measured?	1. Improvement in effectiveness of care 2. Informed staff able to engage patients in care 3. Increased recruitment into the service
Research, training and education for development	Discuss and identify the contribution research, education and training could make to improving service delivery	1. Establish a broad base for research skills 2. Multi-disciplinary learning 3. Integrate learning with general mental health
	What should be the main focus for development for:	
	Research, training and education	• Increased flow and exchange of communications within and outside the service • Improve effectiveness of care • Informed staff able to engage patients in care

12.6.1 Programme of activity

The conference programme was designed to provide an overview as well as practical discussion groups to ensure that debate and ideas were not lost. Consequently, there were two plenary and two workshop sessions. During the first session of the plenary session, the aims of the conference were set out by the Strategy Director of the HSPSCB. The practical issues impeding the development of outcomes within a high secure setting were set out by a chief executive of one of the hospitals. The Royal College of Psychiatrists' perspective was discussed by their representative and the research data collected by the researcher was also presented to delegates. This session was followed by workshop sessions. Participants were put into groups with great attention being paid to matching people to their preferred groups as far as possible. Each of the workshops have leaders who were members of the Expert Panel. This approach was seen as the best option as the panel members were closely involved in the development of the project and would be in the position to guide and also explain the areas chosen for consensus building. Feedback at the end of the day was that the foresight shown in organising the conference and the quality of the information available to delegates was invaluable in bringing outcomes measurement to the top of the agenda for the service.

12.6.2 Conclusions

It has been argued in this chapter that the impact of consensus statements had not contributed greatly to changing clinical practice. Some writers had advanced the view that consensus statements were developed to change practice and so their impact should be measured by considering the change in behaviour form the outset. This conference has shown that the true measure of the impact of guidelines will require more that an assessment of the level of awareness of the guidelines or the knowledge of the recommendations in assessing its impact. To guard against any apathy in developing outcomes measures, the director of strategy of the HSPSCB agreed to prioritise outcomes measures in their research programme. The main findings of the conference are further discussed in Chapter 13.

PART SIX

CHAPTER THIRTEEN

Discussion of the findings of the research

Introduction
Conclusions from the review of the literature
The Rapid Appraisal Method
Emerged conceptual themes
The surveys
Contextual aspects of the research – Access
Managing problems relating to access
The case studies
Consensus building conference
Lessons learned from applying the methods
Models for improvement
Detail findings

Chapter Thirteen: Discussion of the findings of the research

13. Introduction

This chapter discusses the main findings of the research, its implications for future development of outcomes measures within the forensic service and the need for outcomes research in the future. It also discusses some of the difficulties or the lack of them encountered and the lessons learned during the process of the research. In general the purpose of research is to explore or explain a phenomenon. It is important that the what and how the phenomenon is to be explained or explored is clearly outlined. The way through which the "how" or the process, or the "what" or the content are to be explained depends on the methods chosen. In this research a multi method approach to data collection was employed in order that the phenomena to be explored could be examined thoroughly and in a progressive but consistent manner. In brief the methodological approach started with the review of the literature and the application of the Rapid Appraisal Method. Lessons learnt during this early stage helped in designing the survey questionnaires to explore among many other issues the degree to which the service was using or preparing for the development and introduction of outcomes measures.

The two case studies were designed to confirm what was learnt from the aforementioned methods and used Giddens' structuration theory to explain the duality of action between managers, staff and patients that were favourable for developing outcomes measures. In Chapter 11 a comparison of the two case study field sites was discussed. This comparison revealed that Omega (a medium secure unit) appeared to be better organised in co-ordinating the three key elements of structuration theory enabling patterning of social practices to occur. This duality of action is important in that it provides the basis for developing dialogue necessary for work on measuring outcomes that meets the needs of all stakeholders. Building on this foundation this report will also demonstrate the importance of this partnership by

describing models for change grounded in the data collected from this research. The reader is reminded that the theoretical framework underpinning this research including an analysis to identify key stakeholders of forensic mental health practice and methods used are described in detail in chapters 4 and 5 and are listed in Figure 13.1 below:

Figure 13.1 Theoretical framework & Methods

- Theoretical framework
  - Giddens Structuration Theory
- Methods used
  - Stakeholder analysis
  - Rapid appraisal
  - Survey questionnaires
  - Interviews
  - Case studies
  - Consensus building conference
  - Action Research Approach

Overall Hemerneutical approach to data collection

13.1 Conclusions from the review of the literature

The review of the literature was thematically arranged in order to approach this task in a systematic way. The following key areas were identified and discussed.

1. Identification of a definition for health and its implication for measuring outcomes
2. The key elements of the effectiveness policy framework of the NHS
3. Classification of effectiveness measures
4. Experiences from elsewhere on measuring patients (subjective) outcomes
5. Problems associated with measuring outcomes and a discussion of implications for forensic mental health

The evidence in the literature shows that most commentators tend to define health in a positive way and rely on World Health Organisation's definition of health (WHO 1947). The implication for this is that it does not allow the sufferer to express a view, which could influence the way the treatment plan is drawn and implemented. It is known also that patients do define health differently from that of practitioners and are able to report that they are feeling well although it may be known that they are suffering from a chronic and debilitating disease or illness. On the other hand someone with no identifiable medical condition could complain of not feeling well. The implication of this for forensic services is immense, particularly because of the chronicity and long term nature of mental disorder. This said, the importance of preparing patients and staff to seek the views of patients and their carers and including these views together with that from the professionals in developing the treatment plan was clearly identified in the literature. The health policy of various governments since the inception of the NHS had been to secure through the resources available the greatest possible improvement in the physical and mental health of the people. However there are variations in the way people are treated that are not fully explained by population characteristics. Consequently the need to improve the effectiveness of the NHS became a government priority (DoH 1993 and 1995 and 1997). The main elements of this policy are to monitor the effectiveness of the service by attributing the health gain to the intervention and the acceptance that clinical intervention alone is not the only one determinant of a positive health outcome.

A classification of the measures in use in the NHS identified disease or condition specific measures as the most likely measures of effectiveness and revealed that the most widely used measure in the mental health field is the Health of the Nation Outcomes Scales (see chapter 2). This measure is clearly a condition specific one but appeared to have found favour with the professional staff in the absence of any suitable one. However it too failed to canvass the views of the individual patient and relies on the perceived observations of the professional staff. Clearly the lack of involving the patient in measuring effectiveness is evident across all sectors of the NHS and mental health is no exception, and yet this is where effort needs to be

concentrated on in developing outcomes measures. Most of the problems associated with measuring outcomes depend on the methods adopted in identifying the measures and the need to be able to attribute the health gain with the particular intervention. In the mental health sector these issues together with the debilitating effect of mental illness in terms of retaining insight have made it difficult to identify reliable measures. There is also the prominence and preference of randomised controlled trials as the 'gold standard' method of research in the health service, which may not favour the views of patients as reliable measures (see chapter 4). The issues relating to methodology and to insight of the individual patient posed serious questions for the research in so much as the best methods to use was concerned. In order to ensure that the best possible methods are selected for the research, a rapid appraisal method was used to identify the key elements of measuring outcomes and to test the readiness of the service.

13.2 The Rapid Appraisal Method

The Rapid Appraisal Method (R.A.M) was used as an exploratory tool and together with the review of the literature relating to outcomes measures the researcher was able to achieve the following:

1. Identify the gaps in the literature in respect of measuring outcomes in forensic the service.
2. Conceptualise the research question to enable a methodological approach to the data collection.
3. Develop a framework for identifying stakeholders of the service and made choices relating to who or which groups of stakeholders to be targeted.

The advantages of using the R.A.M were twofold. In the first instance it provided the researcher with the opportunity of bringing to the attention of various stakeholders the intention to undertake this kind of research and to identify those that might be willing to co-operate with the research particularly the selection of possible case study sites. Secondly, by involving the field during the initial stages, it ensured that the areas to explore during the

applications of other methods were identified and generated by the potential sample population. It was clear that they need to consult patients was a primary consideration for most interviewees at this stage and so was the need to conduct a scoping exercise to identify what was happening in the field in terms of measuring effectiveness.

13.2.1 Emerged conceptual themes

Another important issue for the research was the way the research problem was conceptualised. The conceptualisation of outcomes has the following important implications. First, clinical outcomes are characteristics of patients. This is to say that whatever the source of the information, clinical outcomes involved assessment of the person undergoing treatment. Thus emphasising that the unit of analysis in clinical outcome research is the patient. Secondly, clinical outcomes should be measured over time and not a one off endeavour. This assertion is again supported by Cook and Campbell (1979) who argued that post test only research designs - those that assess the patient only at the termination of treatment - are invalid for inferring causality. The main principles emerging from this conceptual background were:

1. The measure of health gain needs to be multi-dimensional and developed in a way to capture the patient's point of view.
2. The developments of such measures need to take into account strategies necessary for the prevention of relapse and maximising rehabilitation.
3. The measurement of health outcomes needs to shift from objective measures towards inclusion of subjective ones.
4. Effective risk assessment is the cornerstone to effective outcomes measurement in forensic psychiatry.

Lyons et al (1997 p27) commenting on the problems of attribution argued that measuring outcomes at the end of treatment might not fully capture observed changes in the clinical status of the individual patient. They went on and warned that there is enormous risk that historical and maturity factors may contaminate any attribution of end-of-treatment clinical status to treatment

effects. Thirdly, in measuring clinical outcomes changes must be attributable to interventions. This implies that there is a cause and effect relationship between the treatment and the outcome. This in effect makes the service delivery as an agent of change. Information collected from these exercises provided a robust base for developing a framework particularly the choice of questions to explore in the survey questionnaires and further contributed in conceptualising the research problem (Figure 13.2).

Figure 13.2: Conceptualising the research problem

Multi-disciplinary and inter-agency working,
Patients involvement in their own care,
Environmental factors,
Effective communications
Flow of communication,
Standard setting and bench marking,
Degree of advocacy, empowerment, partnership & subsidiarity,
Comprehensiveness of use
Process activity: - access adequacy of service provision and throughput.
Managing patient expectations and needs
Needs assessment
Patients' experiences and satisfaction
Training, development and research.
Degree of assimilation of contemporary issues,
Complaints and their management
Balance of power
Risk management,
Managing diversity.

This data was collated to enable the way the key variables of the research could be identified and measured during the course of the research.

13.3 The Survey Questionnaires

The survey questionnaires were designed to canvass the views of both providers and purchasers (see Chapters 7, 8 & 12). The overwhelming view from both groups was that outcomes measures should be developed and they seemed to have agreed on the key areas for which measures should be developed. The conclusions drawn from this method was that:

1. The inter-governmental review of the service in 1992 was judged to be relevant for the development of the service.

2. Respondents however criticised the lack of coherence in planning the service due to excessive decentralisation.

3. Multi-disciplinary and inter-agency working was the one most consistent model of delivery care to patients.

4. Promotion of effective working depends on focusing all efforts on satisfying the identified needs of patients.

5. While measuring effectiveness of the service was a priority for all respondents in terms of the benefits it could bring in terms of improving the quality of the service no measures were identified which was in regular use.

6. There was a consistent expression of the view that the purpose and objectives of the service was too unclear particularly where the care and management of people who are diagnosed as suffering psychopathic personality disorder.

7. There is acute sensitivity relating to collecting data about outcomes measures due to suspiciousness about the use of the information gathered.

Further detailed findings of the survey questionnaires are listed further in this chapter. In the case of sensitivity that related to collection of data, this raised questions for the research in terms of what methods to adopt and how reliable were the information gathered. In the case of reliability of the information, the consistency of the views amongst various stakeholders led the researcher to have faith in the reliability of the data. The problems relating to access were dealt with below and were taken into account in designing the case studies, focus groups of patients and the consensus building conference.

13.4 Contextual aspects of the research: Access

Access to the service and indeed to respondents was problematic. Some of this may be due to the nature of the service or the reluctance of respondents to comment on effectiveness of their individual services for fear of recrimination. Some of the problems discovered during the course of the research discussed here and comparisons drawn between the nature of this research and access for researchers in general who undertake research within the service. A senior clinical staff who was sent a pilot questionnaire for comments on its design and scope with the suggestion that it could be completed as a "dry run" sent a note after completing the questionnaire saying:

> *"I hope this is mega confidential as my life within this hospital won't be worth living. I know you will protect my confidentiality but I am just worried".*
>
> **Senior clinical nurse**

In another instance, a commissioning director was so sceptical of the source, why the research was being undertaken and concerned about what its anticipated use would be that she wanted a face to face meeting before completing the questionnaire. This view was expressed even though agreement was sought and granted by the Chief Executive of the Health Authority concerned. A patient who has spent over twenty years in the service initially refused to be interviewed because:

> *"They never listen to me. It don't matter what I say. Why should I talk to you when nothing is going to change".*
>
> **Patient**

Another patient thought it unwise to talk to the researcher about what his expectations were because he could not reassure himself sufficiently that the "authorities" would not take adverse actions against him. A consultant forensic psychiatrist refused to allow any of his patients to be involved in the study even though approval by the research and ethics committee had been

granted and explanatory notes sent to all doctors and managers about the purpose of the research. In the wider context Macmillan (1996), reported that a researcher who was conducting research on whether or not disturbed patients should be excluded from social contact with others was vilified, victimised and the family put under such stress that he has lost the will to pursue his research interests within the speciality. These and many other examples provided the backdrop for the research in addition to the official hoops and hurdles that needed to be negotiated in the course of any research study.

This is not to say that there was no acceptance for the research. On the contrary a discharged patient make a round trip journey of over two hundred miles to be interviewed, when she heard that the researcher was asking to know about patients' experiences of the service. A senior staff member of one of the case study sites welcomed the research with great enthusiasm, because "it is long overdue". These and many more examples can be cited throughout the stages of this research, sometimes with very strong views for and against the need to conduct this type of research. This ambivalent expression of views was accepted as the real concerns of all stakeholders of the service. So why is this type of research within forensic mental health so contentious?

Part of this question can be answered by examining the nature of the service's contribution to the health of the nation. The service caters for the most dangerous but vulnerable individuals within psychiatry. The public, the press, politicians and policy makers all have a stake in the way the service functions and each of these have a view, often very strong on the way patients should be treated and cared for within the service. The therapy and security dimensions transcend all aspects of the service, sometimes at the very opposite ends of the same continuum and needed to be considered at all times. These structural issues influence the way the *service is perceived both* inwardly and externally to the service and invariably influenced the way this research was designed and data collection managed, which was cautiously.

It was clear from the outset that researching the outcomes of interventions within the service is a sensitive undertaking. The question of how to research sensitive subjects cropped into mind on more than one occasion. According to Lee and Renzetti (1993 p5), the threatening character of the research and its potential consequences for both the researched and the researcher suggests that a sensitive topic may be under study. Sieber and Stanley (1988) defined "socially sensitive research" as studies which there are potential consequences or implications, either directly for the participants in the research or for the class of individuals represented by the research. This definition is rather broad and could be taken as including action research and could be construed as being synonymous with researching controversial topics. However there is substance and a degree of applicability to this study in considering the definition offered by Lee and Renzetti:

> "a *sensitive topic is one that potentially poses for those involved a substantial threat, the emergence of which renders problematic for the researcher and/or the researched the collection, holding, and/or dissemination of the research data" (Lee et al 1993 p5)*

This definition seen in conjunction with Goyder's (1987) hypothesis that different social groups attribute different meanings to requests for participation in research demonstrates that a study seen as threatening by one group, could be thought as innocuous by another. It is therefore important that research in the sector is seen as such and considered within the context of the topic being studied.

Lee and Renzetti (ibid) further suggested possible areas in which research is more likely to be threatening than others did and these include:

I. where research intrudes into the private sphere or delves into some deeply -personal experience

II. where the study is concerned with deviance or social control

III. where it impinges on the vested interests of powerful persons or the exercise -of coercion or domination

IV. where it deals with things sacred to those being studied that they do not wish- profaned

13.4.1 Managing problems relating to access

The key overriding aspect of this research was that it impinged on the vested interests of persons and has the potential to identify methods employed by provider and purchaser staff in determining the effectiveness of service provision. This information may help clarify how the service caters for its patients, either through therapeutic alliances or through exercise of coercion and domination. However the context of this research was that of suspiciousness and therefore raises questions as to the validity of its conclusions. The following factors were considered in the process of presenting information that is both valid and unbiased.

1. The involvement of a wide range of subjects in data collection to ensure that the findings could be generalised.

2. The importance of maximising the scope of the research and minimisation of the need of the accusation that non-responders might not share the same characteristics as responders, particularly for the questionnaires.

3. Development of an assurance process based on confirmation of findings from application of each method to the next.

4. Verification of what was said with documentary evident particularly during the course of conducting interviews for the case study method.

5. Involvement of managers of the case study field-sites to comment on the findings.

6. The use of the expert panel as a validating group to assess the relevance of the research findings during the application of the consensus building conference method.

7. The use of the expert panel to review the findings of the research and the use of the participants to select the key areas for future development of outcomes.

Having clarified what the key responses were within the service on measuring outcomes of interventions and identified the problems relating to access, the stage was therefore set for the next step on the rung of the research process ladder. This stage related to finding out what the service was doing in practice to measure the phenomena under study and also to assess the readiness of the service.

13.5 The Case studies

Information derived through analysis of the R.A.M and the survey questionnaires provided strong base for the next stage of the research process. This stage related to the application of the case study method to two organisations (see Chapters 9, 10 &11). Here, Giddens structuration theory was used to aid data collection and interpretation of the findings. Further the main concepts of outcomes measures developed as a result of the literature search and the use of the Rapid Appraisal Method were also assessed to provide meaning to the various aspects of interaction of stakeholders. The main focus for this part of the research process was to confirm the findings of the questionnaires in terms of the regularity of the use of outcomes measures and to what extent were these organisations prepared to meet the change in behaviour necessary for developing outcomes measures. The main findings of the application of the case study method were discussed below by use of the elements of Giddens' structuration theory (i.e. Signification, Domination and Legitimation). The overriding issue isolated by the use of this method was that the type of organisation, its size and the extent to which staff and patients were empowered to be creative on the part of staff and be actively involved in the formulation and evaluation of care in respect of patients is essential in developing partnerships. It appeared that the larger and bureaucratic the organisation the more difficult it would be for developing outcomes measures. The flow of communication in the large institutions is best described as 'top down' and have been instrumental in developing bottlenecks of resistance whilst in the smaller units the flow of communication was both ways. The larger institutions in the service are best described as high security hospitals and the smaller ones known as medium secure units.

Another aspect of note is the culture within these organisations. In the high secure hospitals it was described as a culture of blame. This 'blame culture' as it was dubbed by staff was cited as the one factor that was impeding progress and responsible for de-skilling staff and ensuring that the transformation of the care process and integration of these hospitals within the NHS was slowed down almost completely. On the other hand smaller size units particularly the case study site was described by both its patients and staff as forward looking and actively empowering both staff and patients to contribute to the development of the service and of the individual care of patients. Morale at the time of this research amongst the staff group in Omega (medium secure) was higher than that in Alpha (high secure) and consequently the degree of involving patients in the care process was much more prevalent than in the former. It is perhaps possible that the size and the fact that Omega is fully integrated into the NHS and much more opened to scrutiny by external verifiers that its development and way of working was more flexible than that observed in Alpha. It was clear that staff in Omega work more closely with patients in achieving their expectations than in Alpha and have reported a higher satisfaction with their work. The influence of staff associations particularly the Prison Officers Association (POA) which was the predominant association within Alpha was deemed to be working against effective working for the benefit of patients. The POA was seen as obstructing all efforts made by managers to change practice and to liberalise the regime of the high security hospitals. Alpha as one of the high security hospitals in the country suffer from this and have been singled out as one of the main reasons that work on outcomes measures might not succeed as such activity could be seen as empowering patients at the expense of staff.

In the case of measuring outcomes (effectiveness) which is the central concern of this research, there were organisational strategies and established structures for clinical effectiveness developmental work. In both instances there was no evidence of a concerted effort to develop or use measures that took into account the expressed views of patients. While Omega reported conducting periodic patients' satisfaction surveys their usefulness could be

criticised because of the time lapse between them. Alpha on the other hand had not conducted this type of study in its very long and chequered history, and patients have complained a lot about the lack of consultation and in some cases dialogue between them and staff on their living conditions and the quality of their care. As Figure 11.1 shows Omega appeared to be prepared better to work towards the achievement of the variables under which they were assessed and therefore better placed to work towards developing and possible use of outcomes measures. In the case of Alpha, both staff and patients would need training in developing therapeutic alliances, building partnerships and establishing trust before any real attempt could be made of developing outcomes measures that could be said to have included the expressed needs of patients.

One of the objectives of this research was to identify areas where further developmental work could be undertaken on outcomes measures provided there were no reliable measures available and in regular use in the service. As discussed earlier in this chapter the Health of the Nation outcomes Scales (HoNOS) was the only measure that was identified as being used in the service. This raises issues for the measuring of outcomes given the focus of the measure, which is on the manifestation of clinical sign and symptoms of the patient as observed by raters. This research has found that if appropriate measures of outcomes are to be developed it must take into account a broader focus than just concentrating on clinical aspects. The appropriateness of HoNOS must be assessed. Given the views expressed already relating to the inappropriateness of this measure the researcher decided to canvass the views of the wider service on the usefulness of HoNOS and many other areas for future development. The consensus building conference was thought to be the most appropriate method for meeting the objectives of this stage of the research.

13.6 Consensus building conference

The choice of the consensus building conference was to enable as many stakeholders of the service to discuss the findings of the research, to identify areas for future development, as a means of disseminating the conclusions of the research and to plan for the future. The findings of the research was presented to a multi-disciplinary panel including representatives patient groups, Department of Health, Social Services Inspectorate and the Home Office who selected the following areas as a priority (see chapter 12).

1. Definition and clarification of the objectives of the service.
2. Development of a seamless (comprehensive) clinical services across all sectors of the service.
3. Ways of improving recruitment and retention of best staff.
4. To assess and agree on the adoption of the HoNOS as a measure of outcomes for the service
5. Develop the best methods for multi-disciplinary and inter-agency working
6. Development the best approach to assessing the needs of patients and their involvement in care
7. Identify the research, training and education needs of the service

Majority of the 190 conference attendees agreed with the conclusions of the findings of the research discussed and agreed that the key areas listed above should be prioritised in terms of further research. However, 70% of attendees rejected HoNOS as a measure of outcomes because of its concentration on professionally and clinically defined outcomes (Figure 11.1). This was anticipated given the knowledge derived by the researcher from the data collected for the research. HoNOS was selected, as a measure by the panel of experts from the field who thought it could be adapted to suit the needs of the forensic mental health patients, clearly it did not meet the needs of those who have been using it sufficiently. The need therefore to develop a measure that is relevant to the needs of all stakeholders is therefore very important.

Another area of contention where consensus was reached but lacked an agreement was the clarification of the objectives of the service. While all attendees agreed that there should be clarification and agreed with the suggested definition they felt that the definition offered was an all inclusive definition (see Figure 11.1); 10% of attendees thought that there were some patients for whom the services of health care practitioners should not be made available to. The patient group in question was those patients diagnosed as having a personality psychopathic disorder. The general view was that these patients were untreatable and so should receive rehabilitation within the criminal justice system if they offend. This viewpoint has a lot of support from professionals because psychopathic disorder is legally and not clinically defined. Consequently, no real medical treatment is available for the treatment of the condition. The view therefore was that caring for these patients in the forensic sector was not the best cost effective approach.

13.7 Lessons learned from applying the methods

The main difficulty in applying all the methods was the need to be sure to obtain the right information at the right time, thereby making it unnecessary for second visits or interviews. This was due to the sensitivity that surrounds the research topic and the desire of the researcher to limit the chance of refusal to co-operate with the study. As a result of this a tape recorder was used where it is permissible and contemporaneous notes taken where permission for the use of tape recorders have been refused. However this has put a lot of pressure in terms of time and accuracy of recording and transcription, and interpretation of the interview minutes. In the case of questionnaires the need to transcribe before analysis was obviously not needed as this process was shortened by the use of computer packages. Clearly, the use of the survey questionnaire method was more convenient and much more precise in terms of analysis however the information derived from the use of the qualitative methods provided a much richer and fuller picture of the behaviour of subjects under study. The initial use of the Rapid Appraisal Method has contributed to grounding the study within the service and therefore establishing the political acceptance for the research from the outset.

The theoretical framework that underpins the design of the research process was helpful in that it enabled the researcher to organise and interpret data derived from the research. While the structuration theory helped in attaining this level of organisation particularly with data from the focus groups and interviews during the application of case study method, stakeholder analysis was useful in identifying what groups to target in terms of data collection. The framework was also useful in integrating the results into a comprehensible framework, leading to the development of a model based on what is known about the research area; which is discussed next.

13.7.1 Model for improving care

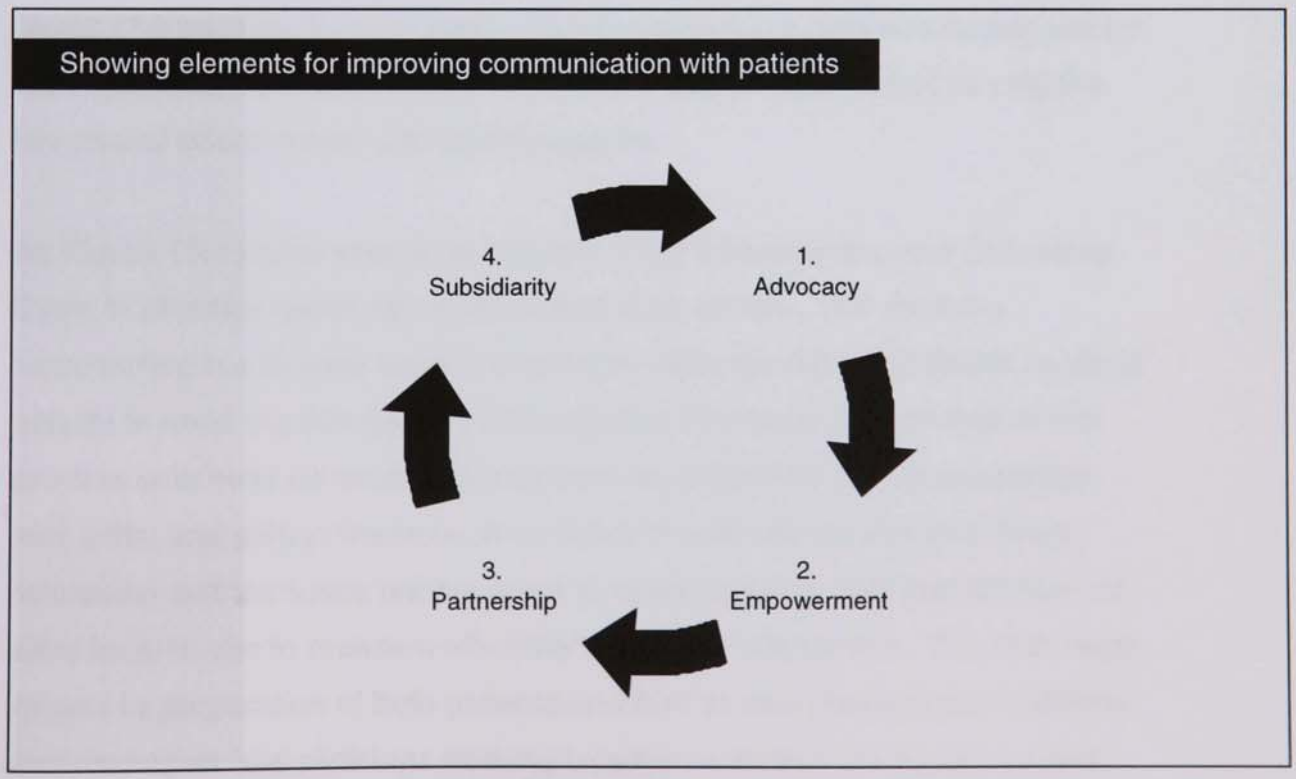
The general assumption that could be drawn about this research is that in general the mentally disordered offender patient has not benefited substantially from the opportunity to input into decisions relating to their care. It has been discussed how patients particularly those in Alpha complained about the lack of being included in decisions but expressed a great deal of suspicion and mistrust about any effort that could help redress the imbalance. This raises issues for training and education for both patients and staff in the best way of developing a process that could help in addressing these issues and the assertion that:

> **If the focus of care delivery is on identifying the needs of the patient, better co-ordinated and communications improved, the quality and standard of care would be better.**

In order to test the relevance of this assertion, a conceptual model has been developed based on observations and discussions undertaken during the course of the research. This model has emerged, as a result of the need to ensure the conceptual shift that is required to involve the patient in care effectively. It represents a process through which choice in treatment approaches is exercised, starting from the point where the individual has no information to the stage where there is sufficient information to enable the patient to work on partnership bases with professionals.

The model has four key elements - advocacy, empowerment, partnership and subsidiarity (Figure 13.3). The advocacy stage provides for the staff to express the views of the patient where the individual is unable to articulate their own views. The empowerment stage evolves when staff are able to provide the patient with sufficient information for them to be able to represent themselves effectively. When the patient and staff are able to negotiate and debate the needs of the individual, taking into account his or her wishes then the stage of partnership is reached. Subsidiarity is defined here as giving back willingly what one cannot cope with in the care process. For example, if a patient were to say to a clinician I am unable to make a decision on an aspect of care because of one reason or the other, then that decision is made on his or her behalf. This is done until such time that the patient is able to assume control again. Subsidiarity is therefore "reverse delegation". At the heart of the effectiveness of the model is the need to improve communications with both patients and staff in clarifying what is possible and what is not.

Figure 13.3: Model for Care



This model focuses on what the service needs to do to improve the quality of care to patients. This is essential in outcomes work as supported by the data from this research, in that it provides the framework from which the confidence of patients in any genuine attempt to improve practice could be embedded. The standpoint is that if the lines and content of all communications is clear to all then patients would be able to take part in initiatives designed to improve their experiences of the forensic services.

On the wider scale the change strategy necessary for the development of effective outcomes measures that are acceptable to all stakeholders has been highlighted by this research. The need to encourage the participation of the patient through training was discussed above. The next aspect is to identify what the service as a whole need to do to ensure that the findings of the research and the commitment to further work in the service to develop the measures is not lost. In building on what is known since the completion of data collection the importance of identifying suitable solutions to specific problems has been central in the researcher's mind. Most commentators on the research so far have asked for a recommended process to ensure that the clinical effectiveness agenda within the NHS takes into account the many facets of outcomes measurement. Consequently a process was developed by the researcher that takes into account the evidence based practice initiative, the clinical effectiveness and quality agenda.

As Figure 13.4 below shows the fulcrum of the Effectiveness and Outcomes Cycle is effective needs assessment and audit activity. This model is represented in a circular fashion in order to allow services at different levels of activity to enter the process at various points. The main components of this process is to build on what evidence there is in terms of clinical knowledge and skills, and policy intentions in conjunction with key service and clinical measures and formulate priority areas to tackle together with identification of what tools to use to measure effectiveness of the intervention. The next stage relates to preparation of both patients and staff to own the particular initiative and managers and clinicians working together to involve the patient so that each stakeholder's role and input is clarified. Assessment of needs of the

patient (normative, expressed, comparative and felt need or want) together with audit of performance of the organisation or the ward is then conducted. Decisions are then made taking into account other influencing factors such as financial and resources implications of the identified activity. As a whole systems approach this model ensures that there is adequate testing and re-testing of any initiative to ensure that the effectiveness of the change programme is secured. It is important to note that the success of this process depends as much on measurement and adequacy of input and process issues as those of outcome. As Figure 13.4 shows that outcomes measurement tool could be developed by incorporating a wide and varied selection of other relevant tools.

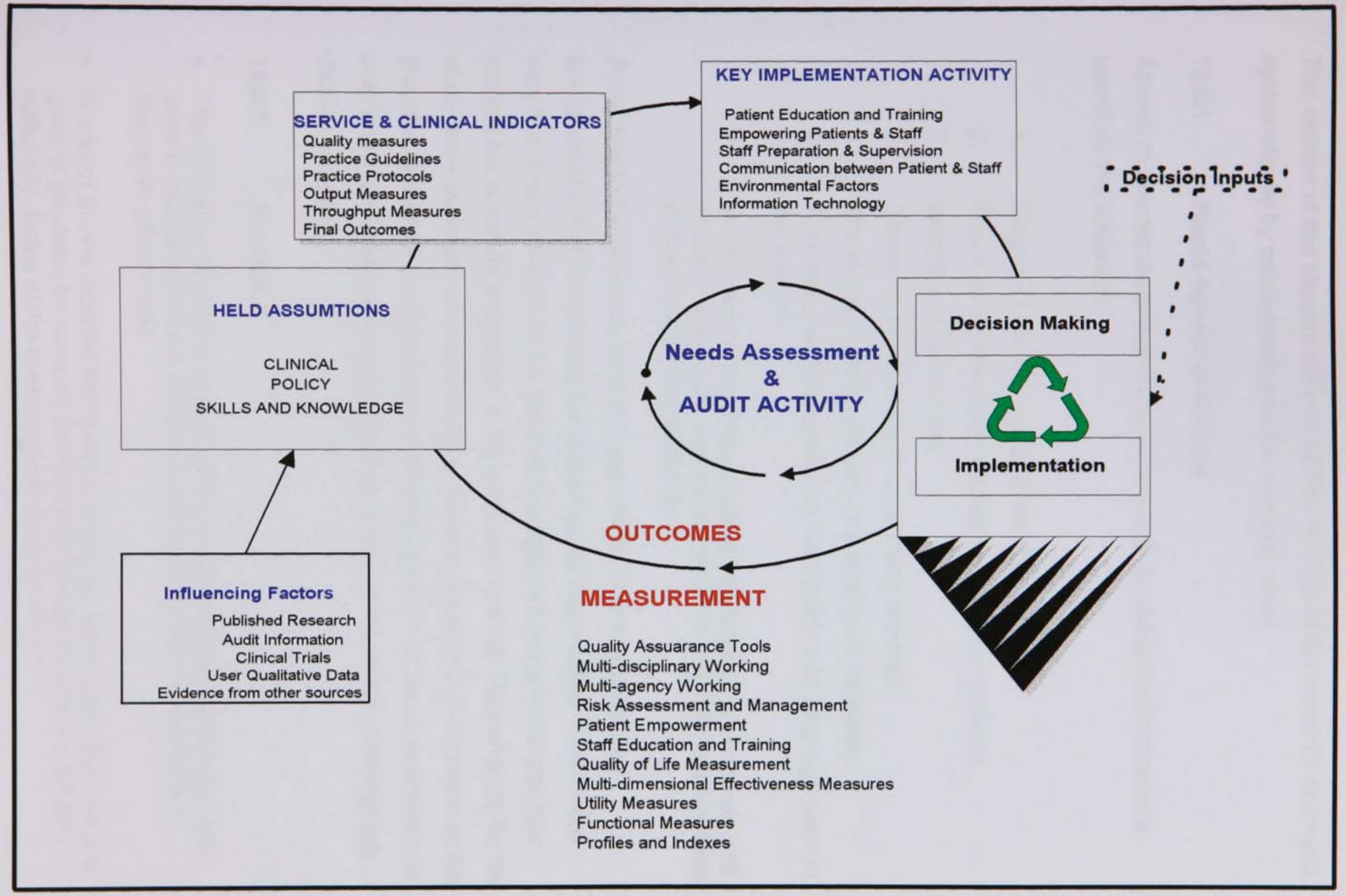


Figure 13.4: Effectiveness & Outcomes Cycle

13.8 Detail findings

This section of this chapter will now list the findings of the research arranged systematically by concentrating on the methods used.

13.8.1 Rapid Appraisal Method

Assess the readiness of high security hospitals to measure effectiveness based on the following:

1. Degree of training available for staff
2. Focus on psychopathic disorder and women patients
3. Identify measure of risk
4. Degree to which patients were being involved
5. Promotion of advocacy and empowerment initiatives
6. Simplifying and standardising information and language used in the service
7. Involvement of the Royal Colleges in developing outcomes and common languages and involve patients and other stakeholders in developing these language.

According to the research most of respondents have a professional background with nursing being the largest group represented. There were very few respondents from the general management group in the provider sample but a greater proportion in the purchaser sample. Respondents for the study were experienced practitioners of forensic psychiatry (5-10 years on the provider side while purchasers were relatively junior in terms of experience in purchasing services for the patient group. Some of the specific findings are discussed below.

13.8.2 Providers

- The difficulties relating to precise definition, classification and language used in mental health are likely to make developments of outcomes measures problematic.
- A total of 87.4% reported being either slightly or very dissatisfied with the general provision for services for mentally disordered offender patients nationally. Some of the reasons given were as follows:

1. Inadequacy of services due to no strategic planning.

2. Poor preparation for patients being discharged from the high secure hospitals.

3. Feelings of insecurity amongst the staff group and lack of therapeutic alliances between staff and patients.

4. Overemphasis on security and at the expense of effective therapeutic preparation for patients

5. There is evidence of suspiciousness amongst the professions leading to poor development multi-disciplinary approach to working.

- 80% of provider respondents reported that the inter-governmental review of the service (Reed Review) in 1992 & 1994 dealt with the issues confronting the service very well or reasonably well.

- Respondents agreed overwhelmingly that all sectors of the service should be developed on the basis of the Reed principles.

- However fewer numbers agreed that their individual services were being developed based on these principles.

- Less than 50% of respondents agreed that their services were working at all levels to foster multi-disciplinary working.

- Over 60% of respondents agreed that increased multi-disciplinary working would improve the quality of the services and care of patients based on the following:

    1. Joint training and removal of all legal barriers and increased efforts to promote team working.

    2. Increased and better management of resources.

    3. Greater collaboration between all sectors of the service and efforts to build partnerships with services and agencies.

    4. Development of independent and proactive advocacy and empowerment of patients and staff.

- Collaboration between services is only happening at patient and clinical team level in terms of inter-agency working. Senior level contacts are not so effective.

- While 52% of respondents agreed that increased inter-agency working would improve quality of care a similar number did not agree that it would happen under present arrangements. Some of which are:

1. Lack of joint planning and effective communication between services and agencies

2. Entrenched attitudes relating to protecting the status quo.

3. Lack of basic understanding of what each area could provide.

4. Lack of focus on and the satisfaction of needs of patients through joint funding.

- Less than 50% of respondents thought that they were providing effective services to patients.

- 52% of respondents thought that their services were good at achieving its objectives and a further 18% thought that they were providing excellent services.

- Respondents were of the view that the measures of effectiveness they were using were not appropriate and useful.

- No measures of outcomes were isolated in this research. The best form of clinical decision making in terms of measuring effectiveness of care is as follows in order of importance and regularity of use:

  1. Clinical professional impression
  2. Clinical audit
  3. Medical audit
  4. Specific measures
  5. Re-admission rates
  6. Psychological measures
  7. Recidivism rates
  8. HoNOS (Health of the Nation Outcomes Scales)
  9. Medical Outcomes Survey SF36

- The following areas were identified by provider respondents as essential areas to be developed into outcomes measures.

  1. Clinical outcomes
  2. Quality of life issues
  3. Development of effective risk assessment and management packages
  4. Better assessment and management of risk
  5. Improved resources management - recruitment & retention)
  6. Improved and effective methods of involving patients
  7. Better training and supervision of staff
  8. Better focus on identifying and satisfying needs of patients
  9. Improved multi-disciplinary and inter-agency working
  10. Identification of better systems for assessing patients satisfaction
  11. Better and effective ways of preventing relapse and reducing public risk
  12. Better prediction of violence and its management

13. Better services for psychopathic disorder and women patients

All these changes need to happen and should take into account the following dimensions of clinical, social, psychological, cultural and physical wellbeing of patients.

13.8.3 Purchasers

- 89% were dissatisfied with service provision in terms of its configuration, planning and integration into the NHS. Some of the reasons are as follows:

  1. Disincentives for Health Authorities (purchasers) to encourage transfers from high security hospital where they do not pay for treatment.

  2. Poor resources for treatment and management of psychopathic disordered and women patients

- Only 70% of respondents agreed that their purchasing intentions were being guided by the principles in the Department of Health executive letter EL(93)68.

- Collaboration in assessing needs is patchy in the medium secure sector and almost non-existent in the high security sector.

- 38% of purchasers said they were not consulted when care programmes were being planned for patients in the high security hospitals. 25% were not involved at all in planning care programmes for patients in the medium secure sector.

- Only 13.1% agreed that they were investing their resources in interventions that were known to be effective and where outcomes could be systematically monitored in accordance with EL(94)55.

- 78.3% of respondents agreed with the conclusions of the Reed Review but criticised the inner city focus of the review and the arrangements for the care of psychopathic disordered and women patients.

- Only 16% agreed that they knew services they were purchasing was effective conversely 25% did not know whether these services were effective or not.

- Purchasers were using a wide range of untested subjective instruments to measure effectiveness of service provision. Some of these were based on the reputation of the service while others on the occurrence of critical incidents.

- Purchasers also reported that HoNOS was being used but agreed that the measures they were using were not effective and in some cases appropriate. They called for:

  1. Replacement of the present system with better measures of outcomes
  2. Development of objective and reliable assessment tools
  3. Improvement of the quality of the service through increased research activity
  4. Increased sharing of information and involvement of others in evaluation of the effectiveness of the service
  5. Increased use of clinical outcomes measures
  6. Better education and training for staff
  7. Better attempt at improving after care and reduction in re-admission and re-offending rates
  8. Focus on the needs of patients
  9. Increased use of HoNOS

- While the High Security Psychiatric Services Commissioning Board (HSPSCB) was focusing on the needs of the psychopathic disorder patient, other service commissioners were prioritising the seriously mentally ill patients.

13.8.4 Case Study: Alpha

- There was obvious discordant between managers and clinical staff on what the organisational focus of attention should be.

- There were complaints regarding the limit of knowledge and skills of managers and the apparent refusal by managers to contribute to the clinical agenda.

- There was a lack of trust and suspicion amongst managers and among the senior management group itself.

- Interviewees complained about the existence of a 'blame culture' resulting in lack of innovation in practice and effective care for patients.

- There is evidence of 'burn out' amongst all staff groups as they were clearly complaining that they were being asked to do things they were not prepared for to undertake.

- Staff complained of incessant change within an organisation described as hierarchical where power was perceived to be concentrated in the hands of the few.

- Evidence existed to support the view that tasks and responsibilities were not understood leading to those in leadership position working against the corporate good as they continue to work to their own personal agendas.

- Lack of success in changing staff attitudes to embrace a change agenda that prioritised patients and their needs.

- Most interviewees agreed that the primary function of the organisation was to enhance the clinical agenda but there is a lack of understanding that management functions were essential in achieving this.

- There was evidence to the effect that there was a training and skills gap amongst the staff and this has implications for effective and quality care and management.

- The cohesion in developing effective multi-disciplinary working was absent resulting into conflicting priorities for patients.

- Clinical supervision of staff was seen as another management and not as an enabling tool. There were problems in its full implementation.

- Staff shortages amongst the multi-professional group, lack of commitment in promoting the concept of team working and concentration of power around one professional group have contributed to preventing the development of effective multi-disciplinary teams.

- The introduction of the Patients' Council was seen as an innovative addition to promoting patient involvement. It was however seen as ineffective in representing patients views across all spectrum of care.

- Members of the Council complained that management did not respond to their requests. Staff, particularly nurses felt that the advent of the patients' council has contributed to reducing their status within the organisation.

- The Advocacy Network established by the hospital in conjunction with the Citizens' Advice Bureau was not seen as entirely independent as it tended to negotiate complaints instead of advocating for patients.

- Most of the complaints received by the Complaints Department were made by patients with primary diagnosis of psychopathic disorder.

- Staff found it difficult to understand the gravity of complaints made by mentally ill patients and found the complaints procedure too complex and too time consuming to engage on behalf of these patients.

- The Complaints Department complained of shortages of staff resulting in slowing down of the process given the volume of complaints received.

- Complaints relating to care and treatment, property, living arrangements, security and deprivation of liberty were the most frequently made by patients.

- 48% of all complaints were made by patients themselves with complaints made on their behalf by patients advocates (32.7%) in second place.

- Patients complained of cruelty, being goaded by staff, not consulted and only made aware of rules when someone decided they have broken them.

- Patients from ethnic minority groups complained of being thought of primarily dangerous even before any assessment. They complained that the quality of their care plans was adversely affected leading to poor quality of care.

- They further complained that they do not receive information about their illness.

- Patients complained of being forced to take medication even though it could be seen to be affecting them badly and not allowed to negotiate what works for them.

- Patients complained of discrimination on the grounds of race, ethnicity and disability.

- There were concerns for the development of outcomes measures because of the fear of possible misuse of the data collected.

13.8.5 Case study: Omega

- The effectiveness of multi-professional working was being adversely affected by relationship tensions between members.

- Staff were not completely satisfied that decisions being made were completely multi-disciplinarily determined.

- Patients expressed very high degree of satisfaction relating to their experiences of the service.

- Patients were involved and encouraged to contribute to the shaping of their treatment plans and their evaluation.

- Staff regularly negotiate with patients on what treatment to undertake based on sharing information with patients.

- However they complained of not being able to take full advantage of the rehabilitation opportunities on offer to them due to staff shortages.

- They also complained about the various models of care and treatment approaches, which they said was either injurious or unfair to them.

- Patients singled out the use of electro-convulsive and behavioural therapies as brutal and unfair respectively.

- It is possible some of the patients in the prison system may be influenced in seeking psychiatric help for fear of being transferred to hospital where they are concerned these treatments could be forced on them.

- Patients were reluctant to forego their right to be consulted even if their wellbeing was compromised at the time when they lost insight due to exarcebation of their condition.

- Patients complained of lack of space, privacy, excessive noise and intrusive environment

- Omega's focus for care provision is towards the community and developing alliances and partnerships to support these structures.

- Omega's resources into caring for discharged patients to live successfully in the community are extremely high.

- Managers have clinical responsibilities, which could be a factor in helping to integrate clinical and organisational imperatives competently.

- Integration within the NHS appeared to have benefited Omega in the way the service was developing its services.

- Security appeared to be focused on accurate identification of patients' needs and vigilance of staff.

- Although most of the organisational structures within the service were multi-disciplinary, training remained uni-professionally determined, it is possible that this may be affecting effective team working.

- No multi-dimensional outcomes measures was identified in use in the service.

13.8.6 Consensus building conference

A consensus building approach was needed for the development of outcomes measures because of the paucity of accurate data in informing practice effectiveness within the service. It provided the best medium through which information could be shared and decisions made for future development of outcomes. The specific findings of the application of this method are as follows:

- There is convergence of findings between this research and the survey that was conducted to further inform the conference planning team.

- An agenda was established for the future development of outcomes measures, leading to the achievement of all the objectives of the conference.

- The Delphi and the Expert Panel methods were effective in achieving a consensus.
- A consensus was achieved in identifying key areas for future development; thereby achieving a major objective of the research.

- There was a strong acceptance within the service that outcomes measures should be developed.

13.8.7 Conclusions

In this chapter the findings of this research in terms of the application of methods chosen for data collection has been discussed and the main findings listed. It shows that there is a high degree of willingness within the service for the development of outcomes measures but there is a reluctance for this to happen as the feeling was that data from effectiveness measures could be used deleteriously. This fear coupled with the reluctance of some of the subjects to collaborate with the research raises issues that must be taken into account by researchers and others.

CHAPTER FOURTEEN

CONCLUSIONS AND RECOMMENDATIONS

Introduction
Issues relating to methodology
Accessing the sector
The research questions
Contribution to knowledge
Outcomes research and measures: The future
Recommendations
Final remarks

CHAPTER FOURTEEN: CONCLUSIONS AND RECOMMENDATIONS

14. Introduction

This chapter pulls together the final strands of the research. It discusses the background issues of measuring outcomes in the forensic sector and identifies some of the methodological implications for conducting such a research. It further appraises the extent to which the findings of the research could be generalised, discusses its contribution to knowledge, provides answers to the principal research questions and makes comments on the need to develop outcomes measures. In order to update the reader, the aim of the research and the process of data collection are restated here (see chapters one, four and five). The research was conducted:

- Firstly, to assess the types of outcomes measures, their effectiveness and extent of use within forensic mental health services.
- Secondly, to draw the views of key stakeholders together to reach a consensus of opinion on key areas of practice in order to develop outcomes measures.

In order to ensure a degree of rigour to the findings, an action research (multi-method) approach was adopted for data collection and analysis. A combination of methods included rapid appraisal, survey questionnaires, structured individual interviews, focus groups, organisational case studies and a consensus building conference within an overall framework of an hermeneutical approach. This research has highlighted a plethora of issues, the implications for practice are therefore diverse and complex.

14.1 Forensic mental health and outcomes

This research has shown that most current measures of outcome used in the NHS either comprises of output indicators, morbidity or mortality statistics. In their current state these measures are arguably too crude to be of value in the measurement of effective forensic mental health care. This view is based on

the experience of the researcher during the fieldwork (see chapters nine and ten) and as a clinician where the conditions for treatment are chronic, with small changes occurring over long periods. The nature of the disorder under treatment - mental disorder is also a major problem. Nevertheless, if performance review is to attain any scientific credibility, clinical outcome measurements are an important requirement and development work should be promoted within the forensic services.

In 1992, the review of services for mentally disordered offenders and others requiring similar services (Reed 1992) stressed the importance of performance management in terms of making effective use of resources. The review team concluded:

> *'Performance indicators on services for mentally disordered offenders should be developed and piloted'.*
>
> **(DoH 1992 p. 35)**

Although the review team detailed some of the areas in which outcome measures could be developed, the developmental work necessary was not undertaken. This was due to a plethora of reasons, amongst which was the lack of resources in terms of staff and finance to develop these measures.

The most important issue in the study of treatment evaluation in mental health is its effectiveness, and the need to assess effectiveness of interventions is crucial to outcomes research. However, the review of the literature shows that there are difficulties that are inherent in the search for effective evaluation of treatment interventions. Some of the main difficulties are the classification of the disorder itself which is associated with diagnostic inaccuracies, self limiting nature of some of the disorders, the chronicity of many conditions and the general vagueness of defining the illness (Jenkinson 1994; Gournay 1997 and Mirin 1991).

Secondly, the definition of what treatment is needs to be resolved. According to Brooks (1991) the tendency is to define treatment on the observed signs and symptoms of the practitioner rather than those identified by the sufferer.

Therapy therefore becomes what the professional does to the individual, irrespective of that professional's expertise or knowledge.

Thirdly, the field of psychiatry is seen as an indiscreet science which lacks the rigour that can be applied to the natural sciences and therefore does not have the precision of conclusions these sciences have in defining and consequently prescribing an effective care.

The final factor which casts a shadow over outcomes research is the way the study is designed and its goals specified. Outcomes research is conducted in the social worlds of actors and therefore the intrusiveness of cultures, values and norms is bound to confound the scientific design of the study.

14.1.2 Action Research and Hemerneutics as a methodological approach.

The choice of action research and hemerneutics as overall approaches in conducting this research is therefore appropriate in capturing the cultures, values and experiences of actors and stakeholders.

Action research works at engaging the research population in formulating solutions to identified problems, therefore enabling the researcher to become a facilitator in the process of investigating people's interpretation of their situations and developing negotiation and ownership, and reaching a consensus. Stringer (1996) proposed four key stages of action research, these are setting the stage, looking, thinking and acting. To explain these terms: **look** relates to the view that participants should be involved in defining and describing the problem to be investigated and its context. **Think** relates to analysing and interpretation of the situation in order to develop an understanding and **act** means formulation of solutions to the problem.

To set the stage for this research, stakeholders were identified from the outset and a positive climate of interaction established by building on the researcher's own networking and facilitation skills. The Rapid Appraisal

method was useful in involving participants in developing a consensus on what to study who to involve and how it could be done. This approach enabled the researcher not to be seen as closely associated with any particular stakeholder group. Next, the particular views and experiences of individual stakeholder groups were clarified by the researcher and agreed with the groups before revealing data to other stakeholders in the final stage of the research, i.e. consensus building conference. In effect the thinking stage of the process was achieved by organising the consensus conference. The final stage of action research i.e. acting resulted when consensus was reached on the areas to be developed into outcome measures.

In explaining how the interpretation of text occurs, Ricoeur (1981) argues that it is unnecessary to refer to the author's intentions, the text's originally intended audience, or the text's originating culture. A document typically becomes separated from its author, its originally intended audience, and its originating culture whereupon we can say that the text has taken on a life of its own; the Bible is an example of such a text. It means something to the reader irrespective of their lack of knowledge of the authors, its original audiences or originating cultures.

There are five concepts that are central to hemerneutics: distanciation, autonomisation, social construction, and enactment. Distanciation refers to the separation, in time and distance, that occurs between a text and its author, its originally intended audience, and or its originating culture and society. Autonomisation refers to the text's taking on a life of its own despite the distanciation. Appropriation denotes that the interpretation is to make one's own what was initially alien as it actualises the meaning of the text for the present reader (Bolan 1991 p445). To stress the importance of this, Bolan adds that the intended meaning of the text is not essentially the presumed intention of the author but rather what the text means for whoever complies with its injunction. Thus the meaning of a text can refer, but is not restricted, to what it means to its author or what the author had in mind. This is known as the text's non-ostensive reference - or what could be termed its already existing social construction, reality or world, which the meaning of the text is a

manifestation or artefact of (Ricoeur 1981). Enactment refers to an environment, which is constituted by the actions of independent human actors.

The starting point for this research was the empirical findings in both practice and research that concentration on involving the patient in care can improve the quality of care and practice to various actors in the forensic field. However knowing this fact is not the same as knowing how to involve the patient in care. In this thesis, an interpretation of how this could be achieved was discussed. In achieving this richness of text and experiences of actors the main elements of hemerneutics i.e. distanciation, autonomisation, social construction and enactment has occurred. These relate to the confidentiality that is accorded to respondents, the potential of the text to be read within a context other than that for which it was originally intended and the essential part played by participants of the research. There are also further methodological problems that make measuring outcomes almost impossible.

14.2 Issues relating to methodology

The role that the choice of the most appropriate methods can play in researching outcomes measures in the forensic mental health sector is critical. It is debatable to assert the view that the scientific method - that is holding down variables while changing only one - is the best technique to adopt. This is because the bulk of this type of research is about people and the way they experience their world therefore controlled studies may be difficult to operationalise. It has emerged from this study that by just increasing the sample size may not help nor is applying systematic review technique to series of flawed research is assuring validity and reliability. What is needed is increased precision and better techniques in addressing the following:

1. Better accuracy in diagnosing mental disorder
2. Improved definition of therapy (interventions)
3. Better techniques in defining the needs of patients and treatment goals

4. Increasing the role the patient could play in identifying the interventions that work.

This study employed a multi method approach to collecting and analysing data focusing on selecting the most appropriate method for collecting data to the problem under investigation and thus achieving a high degree of triangulation of findings. Reality, meaning and behaviour were analysed from the subjects' perspective which allowed the researcher to go beyond the 'official' description given during the application of the survey questionnaires and to develop a richer and more provocative account of events in peoples' lives in the context of measuring outcomes. While the choice of methods was a strength of the research, the researcher as a single individual in conducting the research is a limitation. Measuring outcomes is a complex undertaking and requires the same degree of research design and of resources. However in this research this major weakness was managed by the systematic approach of the research and of involving representatives of the service as a whole.

Another limitation was the length of time the researcher was able to stay in Omega (medium secure unit) during the implementation of the case study method. The richness of the data could have been enhanced had this been as long as that in Alpha (high security hospital). However the participant/observer role of the researcher could be said to have influenced the responses of respondents, particularly that of patients.

14.3 Accessing the sector

A major aspect of outcomes research within the forensic mental health service is the degree of co-operation with the researcher in terms of gaining access to subjects and to services. Barnes (1977), argued that it is possible for a social scientist to find that gaining access to the people he/she may wish to study could be as difficult and lengthy a process as gaining financial support for the work. He argued that a rationale for refusal of access to other researchers had been that the researcher may be an uninitiated member of the

organisation, who lacked the qualifications essential for access to the secrets and if qualified, cannot be trusted nor not to pass on the secrets to the unqualified world at large through his or her publications.

In the case of this research, the researcher found that access to subjects, that is patients and staff had been restricted by the nature of the research. Research into effectiveness of a service which, is regularly criticised for its poor responses to meeting patients needs appropriately is bound to raise anxieties. The higher degree of attention attached to confidentiality of information and the media attention patients attract also poses extra problems for researchers. Although there was a high level of response rates for the survey questionnaires, much higher return rates were anticipated particularly when the aim of the research was to develop a consensus of approach in developing an effectiveness measure.

However access to the case study sites was not too difficult on the whole and most of the hiccups had been ironed out through assurances and reassurances on the nature of data being collected and what its final use was to be. As previously discussed in this thesis, patients too were sceptical about the final outcomes of the research. Consequently, contacts with patients had been largely unrestricted after initial hurdles had been cleared. The consensus building conference too had been very well attended and the extra information asked for from participants had been readily provided (See Chapter 12). It is the belief of the researcher that this success had been achieved due to the general inclusiveness of the research design, which has enabled key stakeholders of the service to be consulted prior to and during the research process. The personal prominence of the researcher also helped a great deal in securing this acceptance for the research.

On the other hand researchers who enter this field as "strangers" may find it difficult to enjoy the same level of collaboration. This in part is due to the culture of secrecy in sharing information, which was often dressed up as protecting patients' confidentiality and the natural tendency of the service to protect its integrity against these "strangers". Consideration will now be given

to assessing the degree to which the core questions posed by the research as identified in chapter one of the thesis were answered.

14.4 The research questions

14.4.1 Question one.

How do organisations determine what constitute effective and appropriate service?

The key methods used in data collection, i.e. the surveys and the case studies both demonstrated that the present way of assessing effectiveness is a mixed bag of subjective, process oriented, condition specific mostly psychological measures. Most of the respondents to this research were using re-admission, recidivism, levels of aggressive behaviour by patients, subjective clinical impression and many other process-oriented tools to measure effectiveness. Most of these were assessment tools and appeared to be repeated on many occasions at various stages of the care process. For example, it was not uncommon to find a patient assessed with a particular instrument in a high security hospital for the same instrument to be used on the same patient in a medium secure sector often within months of the patient being transferred there. This in a way demonstrated the extent of suspiciousness within the service and could be interpreted as reflecting lack of confidence in the reliability of the measures or the competence of those who were administering them. While the use of medication to treat acute stages of mental illness and control of residual symptoms during the chronic stage was the predominant method, the assessment of effectiveness tended to be on clinical impression of the individual practitioner. In this study the use of clinical subjective impression usually formed over many years of training and experience by the practitioner was pervasive within all sectors of the service.

In examining the degree to which measures of effectiveness were prevalent in the service the medium secure sector tended to be the area that was more likely to use these measures. This was followed by the high security hospitals, the low secure sector and the area that is most likely not to use any of these

measures was the community. The low occurrence of use of these measures is particularly worrying and more so for the community given the unpredictability of the behaviours exhibited by the mentally disordered (Avon Health Authority 1996; Ritchie 1992). In terms of assessing the effectiveness of knowledge and skill base of staff, responses from the high security sector was that there was a lack of investment in training. On the other hand most staff responses demonstrated that they were not willing to embrace the concept of supervision which could have identified their needs in a more co-ordinated fashion. In the medium secure sector there was the view that training ought to be jointly developed to ensure a common approach to solving clinical and organisational problems. On the whole provider and purchaser staff were able to identify investment in training as the best legacy for effective practice.

14.4.2 Question two

What are the main effectiveness measures in use in the service and to what extent do staff who use them agree that they measure the totality of care?

While the majority of respondents agreed that their individual services were providing services that were effective, no recognised measures of effectiveness were identified. They also revealed that they did not have confidence in the measures they were using to assess this effectiveness. Some of the reasons they cited for this were that some of them were process based and easily attainable, some were said to be politically biased, poor in involving patients and too subjective. Some of the recognised measures in use were Health of the Nation Outcomes Scales (see chapter three), medical and clinical audit, psychological and condition specific measures. Others were the reports from service regulating bodies such as the Mental Health Act Commission, the Mental Health Review Tribunal, the Home Office's assessment of dangerousness, length of stay or re-admission rate of the patient.

Commissioners too were not using any effectiveness measures even though there is a government directive demanding that they should only invest in services that have been shown to be effective (DoH 1994 (EL (94) 55). They were using measures such as reputation of the service in achieving its objectives, annual contractual review meetings, financial resources management and other observable activities such as evidence of undertaking research. There was general agreement that present measures in the service were inappropriate, as they do not measure the totality of service provision.

14.4.3 Question three

What is the level of satisfaction/dissatisfaction with the present system of care delivery from the perspectives of patients, providers and commissioners?

There was dissatisfaction with the national strategic approach to the development of the service by both the provider and purchaser groups. While a large majority agreed that the inter-governmental review (Reed Review - DoH 1992 & 94) of the service was right to make the recommendations it made for the development of the service, they expressed an equal measure of dissatisfaction at the lack of co-ordination at the national level and the commitment by local managers in developing the service. Commissioners were further critical of the apparent inner city focus of the Reed Review while providers were disappointed at the slow pace of development leading to patients being left untreated within the prison service. There were criticisms of the lack of investment for services in the community in terms of providing treatment and care for those who may be in need but have not as yet committed a misdemeanour.

Patients too expressed a mixture of emotions in so far as effectiveness of the service was concerned. They complained about the level of medication they have to take with its debilitating side effects, the lack of respect accorded them and the exclusion they experienced in wanting to be consulted and involved in the development of their treatment plans. However patients within

the medium sector and in the community were generally pleased with the quality of the service they were receiving.

14.4.4 Question four

To what extent are behaviours consistent in promoting pluralism in the way services and care intentions are communicated to patients and staff?

In Giddens' structuration theory, duality of structure relates to the state when structure elements of signification, domination and legitimation are joined together with action to produce 'patterning' across time and space. In choosing this theory to collect and interpret the data the focus of the study was placed on the behaviours of actors within these organisations examined rather than on the organisations per se. In the case of the case study of a high security hospital (Alpha and discussed in full in chapter nine) it was obvious that the pluralism that must be developed between staff, managers and patients before outcomes measures could evolve was not evident.

The research revealed widespread dissatisfaction with the workload, its content and the effectiveness of staff in meeting the requirements effectively. For example staff complained of not being trained for the type of work they were being asked to do and that their managers were too ready to criticise them. They complained of the existence of a 'blame culture' in the organisation, which was inhibiting creativity. Managers also complained of the reluctance of staff to be committed to taking an active part in the evolving improvement of the clinical agenda. They further complained that the staff organisations were working against them in improving the quality of care for patients. Patients on the other hand did not feel they were considered at all in the way services were being planned, implemented and evaluated. They complained that all the structures of care delivery were working against their best interests. There was evidence that managers and clinical staff lack the sharing of the common goal of the organisation and are therefore working against each other. Patients were suspicious of the motives of staff in terms of

promoting the principles of working in partnership and consequently making it difficult to develop outcomes measures.

On the other hand evidence from the medium secure sector (Omega discussed in chapter ten), was much more encouraging. Patients expressed the view that they were encouraged to take part in the development of their care plans and felt that their views were taken into account. They however complained about the way services were being managed in terms of deployment of staff at the time of disturbed behaviour and the lack of space and privacy within this type of facilities. While staff in Omega (medium secure unit) agreed that they were prepared well in order to face their responsibilities effectively, staff in Alpha (high security hospital) were in agreement that they were not prepared well for the tasks they were asked to perform and there was very little evidence that people were working in tandem towards achievement of the corporate objectives.

This discussion taken in conjunction with analysis in the previous chapters, the conclusion that Omega was better placed to realise the duality of structure and thereby promoting the development of outcomes measures is well supported by the data. Alpha on the other hand has many of its staff working towards improving the alliance necessary to achieving the duality of structure but were experiencing a lot of problems on the way.

14.4.5 Question five

What are the expectations of patients before and during their progress through the service?

Most patients agreed that they were acutely ill when they accessed the respective services in the hospital sector, they were therefore not completely able to have insight into the effectiveness of the service. However, those in the high security hospital maintained that they expected to be treated as patients and given treatment for their conditions. Some of them expected the medium secure sector to be as indifferent to their needs as the high security

sector. They were however surprised to find very high levels of commitment to meet their needs and to ensure that they were able to live as normal a life as possible in the community. Most of them expected to be consulted and where there was evidence that this is going on they wanted this to be maintained and improved upon. They wanted people to advocate for them and to do so on their behalf where they are unable to do so for themselves.

On the other hand they expressed the view that they expected to be 'forced' to receive treatment that they consider to be unpleasant and as a result of this most of them were not looking forward to care in the sector. However, they maintained that most of their experiences within the medium secure sector was positive while on the whole patients who have used the high security hospitals in the past and those currently within these hospitals complained of cruelty of the staff, lack of respect for them, lack of being involved in planning care and not being listened to. It is perhaps right to assert therefore that the experiences of these patients in the high security hospital would affect the way they respond to the measures designed to involve them in developing outcomes measures.

14.4.6 Question six

How could a consensus of views and priorities be obtained to facilitate the development of outcomes measures?

The answer to this question can be found in the way that the research was developed step by step using the decisions from the application of one method to build on the next. For example, the Rapid Appraisal Method together with the review of the literature informed the choice and selection of subsequent methodological approaches. By focusing on an inclusive approach to data collection, that is consulting key stakeholders of care by adopting a multi-method approach to data collection, the expressed views and observed behaviours of these stakeholders were collected and common themes identified.

The use of the expert panel as another validating forum and the staging of the

consensus building conference were all designed to strengthen this strategy. It was demonstrated as a result of the use of the consensus building conference method that the methods chosen to work towards attaining this consensus was the right ones as key areas for future work in terms of developing outcomes were agreed. It shows also that a consensual approach based on developing partnerships between the researcher and the researched was effective in achieving the key objectives of the research and helped to overcome some of the potential barriers resulting from the perceived sensitivity and secrecy.

14.4.7 Question seven

What are the areas identified through the consensus building process for future development?

The main outcome of the research was that key areas to be developed as outcomes measures were identified having achieved consensus that met the needs of most of the stakeholders. In this case this key objective was therefore achieved. The research project went further by securing further support and commitment to funding for the future research into the areas identified as listed below and discussed in Chapter 12.

1. Define the objectives of the forensic mental health services
2. Developing seamless clinical services
3. Recruitment and retention of the best staff
4. Health of the Nation Outcomes Scales (HoNOS)
5. Multi-disciplinary and inter-agency working
6. Assessment of patients' needs
7. Involving patients and other users in care
8. Increase activity on research, training and education for development

14.4.8 Question eight

What are the implications for the development of outcomes measures following this research?

This research is the most comprehensive of its kind in the forensic mental health sector. It is also unique in terms of some of the methods used in data collection, for example the Rapid Appraisal Method and application of Giddens' structuration theory in assessing the preparedness of the service for developing outcomes measures. It therefore has contributed to shaping the direction of future developments of outcomes measures and has helped to raise the awareness of the value of this type of research in the service both at national level and in particular in those areas where the case studies were undertaken. Therefore the implications of the research are twofold:

1. It has contributed to setting the agenda for future conduct of outcomes research.
2. It has contributed to the development of national policy.

In the case of assessing its measure in shaping the future research agenda into outcomes measures, this is demonstrated in two ways. In the first instance the acceptance and co-operation of subjects and their managers in the research has shown the readiness of the field to improve upon the present state of identifying what the constituents of quality care are in the service.

Secondly the patronage of the consensus building conference was a landmark event in that it was the first time that a representative sample of key stakeholders of the service have come together to deliberate upon the usefulness of measuring outcomes and have actually agreed on the priorities for the future. The need to involve the professional bodies, clinicians and patients in the development of these priorities was crucial in that their support for this research and for future ones is essential. Patients need to have confidence in the measures developed and the only way to achieve that confidence is by actively encouraging them through the concepts of

citizenship and involving them in the development of care within and outside the service.

In considering the extent of clinician acceptance, their enabling role cannot be overlooked. For the measures to be developed and operationalised their co-operation must be gained, as they would be the key group of practitioners who could either progress or hinder its effectiveness. The part that the professional groups could play in advancing this venture is the most important component in the jigsaw. This research has identified evidence to the effect that consensus statements developed by professional bodies are seen as less contentious and less biased than those developed within other programmes. Chalmers (1995) found that where these statements were developed voluntarily by the clinicians through their professional bodies the implementation rate was higher than when they see it as an initiative to regulate their performance.

This discussion raises issues for the process adopted in the development of the consensus statements for this research. The first point to make is that relating to sponsorship. The High Security Psychiatric Services Commissioning Board (HSPSCB) sponsored the conference and could be seen as running its own agenda particularly if their role as a government institution, research funding body and as a purchaser of services is analysed. Clearly there are issues relating to conflict of interests. This position was considered before the initial approach was made to them and the decision was taken to involve the professional bodies and clinicians from the field in planning the conference and therefore reducing any criticism on that front.

The next point to consider in terms of the implications of the research is that of its contribution to policy development. It is the view of the researcher that change within the service, that is on improving quality and planning for and developing effective services could only happen if this is confronted on various fronts. The new clinical governance agenda, the focus on quality and the measurement of patients' experiences contained in the *White Paper, The New NHS Modern, Dependable* have further propelled the need to measure

outcomes onto the agenda of the NHS as a whole (DoH 1997 and 1998). The establishment of the External Reference Group to develop a National Service Framework for mental health is seen as a medium where standardisation of service development and its delivery could be assured. The researcher believes that the conclusions drawn from the consensus building conference have already been fed into the work of this body by the HSPSCB.

Further, the work of the National Institute of Clinical Effectiveness (an innovation triggered by the White Paper) would also serve to increase the importance and the urgency to develop outcomes measures that can measure effectiveness of interventions. The nature of the present health service agenda which is focusing on quality and measuring patients' experiences is also providing a much needed impetus for improving the measurement of outcomes within the forensic mental health sector.

14.5 Contribution to knowledge

This research is the first of its kind within the forensic mental health sector and as piece of fundamental research it has contributed to knowledge in two distinct ways. The first is its uniqueness in its particular findings (see Chapter 13) and the contribution it has made to the literature on outcomes measures within the health service and the public sector in general.

In the case of the particular findings of the research, it has made a substantial and original contribution to the knowledge within the NHS and in particular in the forensic mental health sector. In particular the survey of views on the applicability of the recommendations of inter-governmental review of the service (DoH 1992) was unique in that this research was the first of its kind.

The application of Giddens structuration theory to the subject of outcomes measurement is original within the forensic service. In this case the research has contributed to the wider social science knowledge base. The use of this theory has been instrumental in organising and interpreting the data derived from the application of the case study methods. It made it possible for the

researcher to integrate and understand the sheer volume of data collected from applying the case study methodology.

The research has also made a contribution to the broader literature relating to the public sector measurement of effectiveness and outcomes measurement. For example, the new agenda for measuring effectiveness, which is concentrating on assessing the experiences of patients within the health service, is a notable one. It shows that a lot of work needs to be done before patients accept the genuineness of intention within the forensic sector.

In the case of the public sector management literature, this research has added to the discussion about the importance of clearly identifying stakeholders of services when attempting to measure outcomes of interventions. While this illumination will help the forensic sector it has the potential of providing managers in the wider public sector with evidence in applying the stakeholder principle from the forensic mental health perspective.

The demonstration of the value of the multi-method approach used in studying this research problem is also an important contribution to the management knowledge base. This is not to reinforce any aspect of the uniqueness of the methodology but rather that it shows that the triangulation of methods from both the quantitative and qualitative paradigms have been useful and practicable.

14.6 Outcomes research and measures: the future

Although the researcher found that there were anxieties relating to the conduct of outcomes research, there has been overwhelming support for the research. Engaging the commitment of clinical staff, managers and commissioners of health care in promoting the development of outcome measures is a key finding of this research. Many conflicting reasons were given. Some of these were related to the developmental nature of outcomes measures, and the view that measuring outcomes will not alone bring about improvement in care delivery and the insistence that clinical judgement and

randomised controlled trials are the best option for determining effectiveness of practice. A senior consultant forensic psychiatrist summed up this dilemma by arguing the very diverse ways outcome measures could be used by saying that:

> *"There is need to measure the effects of people experiencing the forensic services. There is however some medico-legal, socio-political implications for developing such a measure. It is possible that political masters and the Home Office under a political system which is not too lenient would seize information and use it to its advantage however dishonourably."*

Clearly there are other important issues for measuring outcomes, some of these identified in this research are:

I. Problems relating to definition and understanding of the measures, and what to select as the most appropriate measures.

II. Lack of involvement patients in the process of developing outcomes

III. The wariness of clinicians about the possibility of data being used comparatively and the fear that outcomes measures are a political move within an unclear agenda

IV. There is general acknowledgement for the need to measure effectiveness of care but there was a lack of enthusiasm to co-ordinate such activity amongst the multi-disciplinary team, providers and purchasers, and across agencies to set the objectives and define common measures.

V. Despite the gains in patient centred approach to care within the wider NHS, effectiveness measures within forensic mental health remained provider focused and professionally dominated.

VI. There was no evidence of general usage of any effectiveness measures that are designed to assess the impact of care that takes into account the perceptions of the service user.

Majority of patients in the forensic mental health services are there due to the fact that they have committed a crime or exhibiting an anti-social act as a result of their mental ill health. The debate about recidivism and outcomes measures is a problematic one particularly when attempting to measure effectiveness of care. A consultant psychiatrist highlighted this problem as:

"It is possible that recidivism is not a true guide for effectiveness of care. Cos people who may have been habitual offenders and have been admitted to hospital because of the nature of the index offence may have returned to the community after treatment and continue with the offending behaviour".

Another point of note is that the measurement of outcomes has been established on the service improvement agenda of the forensic services. For example the High Security Psychiatric Commissioning Board has identified it as one of the main areas to fund for further research following the consensus conference. Its commitment as a major service commissioner is necessary to extend the initial work undertaken by the researcher.

14.7 Recommendations

14.7.1 Introduction

This research was about identifying the use of outcomes measures and building enough consensus amongst key stakeholders of the service to identify areas to prioritise for future development of outcomes measures. The survey questionnaire identified the Health of the Nation Outcomes Scales as the only effectiveness measures in use in the service. Although some of the hospitals and units were using it, practitioners generally believed that the instrument was not applicable to the forensic service. The following recommendations are based on the information derived from this research:

14.7.2 Developing new measures

Recommendation one:

In view of this revelation above the service needs to develop new measures and so would need to prioritise research. Some of the areas within which this research could be commissioned are:

- Clarification of the purpose and objectives of the forensic services in terms of the patient group and the knowledge and skills of staff to meet the needs of patients effectively

- The main components of a comprehensive, seamless and integrated forensic mental health services.

- The key elements of recruiting, motivating and preparing staff to meet the changing needs of patients.

- Identification of the best practice model that would promote multi-disciplinary and multi-agency working.

- The best ways of consulting and involving patients in the care process and service improvement programmes.

- Examine whether or not the way patients needs is presently conceptualised is not conducive to involving patients identifying their needs effectively.

- Identify ways and means of applying evidence in practice to improve the quality of care.

14.7.2 Building consensus

Recommendation two

The evidence from this research is overwhelmingly that there is a need to develop outcomes measures through the consensus building process. Lomas (1991) argued that consensus statements are more likely to be implemented if the practitioners rather than an organisation is seen by the professionals to be imposing the statements issue the statements. The High Security Psychiatric Commissioning Board as a commissioning agency could be seen as such. It is therefore recommended that:

- The Royal Colleges should come together to develop an agenda for further research which is needed for the development of outcomes measures.

14.7.3 Learning from within the service

Recommendation three

This research shows that there is more activity within the medium secure sector for measuring effectiveness than there is in the high security hospitals and in the community. It was clear that the medium secure sector operates a model of service provision based on achieving effectiveness. This model would help to improve the quality of the service as a whole. It is therefore recommended that:

- There should be increased integration, active programmes of exchange of staff, sharing of information and of practice between all sectors of the service. In particular the high security hospitals would need to implement lessons learnt from these initiatives.

14.7.4 Increasing the body of research evidence

Recommendation four

The problems relating to access to researchers was identified as a possible obstacle to the improvement of quality of service. Research activity needs to be increased so that service and practice decisions are made on informed basis. This is the bedrock upon which evidence based practice is formed. There is a need to expand research activity in the service to shape much needed development of the service. It is recommended that:

- More staff from various disciplinary backgrounds should be trained in the use research
- Researchers from the service should form alliances with researchers from outside the service and conduct joint programmes in order to increase the exchange of knowledge and skills.
- Managers should ensure that the environment for conducting research and its application is encouraged and assured.

- Service managers should increase the prominence of researchers in their profile and their influence in the decision making process within the service.

14.7.5 Increasing the role of service commissioners

Recommendation five:

Service commissioners have a very important role to play in measuring outcomes of interventions. Their statutory obligations were defined by the government in terms of assessing patients' need and assuring effectiveness of interventions. Commissioners were of the view that they were not involved sufficiently in assessing the effectiveness of the service. Given that the results of the questionnaires show that the experience of staff within Health Authorities is not that extensive in terms of commissioning services for the patient group the future for what the service can do effectively is not very clear. The recommendation here is that:

- Health Authorities should invest in activity which will increase the knowledge base of their existing staff or make attempts to recruit appropriately trained and experienced staff.

14.7.6 Involving users in care

Recommendation six

Much has been said about the need to empower patients to enable them to contribute effectively to their care. This research has developed a model for enabling this. It must also be taken into account that patients are not going to get involved readily and so there should be a gradual but persistent approach to building this partnership for care. There was evidence in this research that support the fact that where patients were involved in care its quality becomes better. It is recommended that:

- A process of involving patients in care is developed by all services and its effectiveness evaluated regularly.

14.8 Final remarks

One of the greatest concerns for any researcher is the need to know the extent to which the findings of the research undertaken could be generalised to the main population from which the sample was selected. In short, the researcher needs to know if the sample group selected is representative of the whole and can the findings be replicated. In this case the concerns of the researcher are issues of reliability and validity.

This research adopted a multi-method approach to data collection, analysis and interpretation. In the case of each of the methods the findings were checked against the next to ensure a greater degree of consistency. This triangulation of methods was designed to ensure the validity of the findings of the research. In the case of the questionnaire this was achieved by review of the literature, the conclusions drawn from applying the Rapid Appraisal Method and the fact that the questionnaire was piloted.

The case studies also confirmed what was known from the previous methods and the second survey undertaken to update information for the consensus conference (see chapter 12) also identified the same concerns as did the main research. As a result of this the researcher contends that the key criterion of internal validity has been amply achieved.

In order to ensure external validity, that is the generalisability of the research findings, the researcher adopted a system of checks and balances to achieve this criterion. For example, two case studies were conducted and the reports checked and agreed with the respective service leaders, the expert panel which was presented with the findings during the planning of the consensus conference (see chapter 12), and the presentation to the consensus conference delegates all helped in assuring a high degree of confidence in the findings. This has therefore demonstrated the achievement of that other criterion of validity; ecological validity.

In respect of the survey questionnaires, out of a total of 350 questionnaires 234 (68%) were returned. The scope of the survey involved all the health authorities with responsibility for commissioning forensic mental health services, provider staff of all disciplines and a further survey to inform the consensus conference. The generalisation test in this is based on the sample size which is enough to give a margin of error of not more than $\pm$ 7%.

This study employs an action research approach, involving the use of various methods both from the qualitative and quantitative paradigms. The researcher believes that the scientific rigour and validity of this approach lies in the use of triangulated research methods. The methods used in this research involved field applications designed to inform the researcher of the experiences of participants through series of meetings to identify what needed to be done, survey questionnaires to determine the profile of outcomes measures in the service and finally culminating in the consensus conference to set future priorities. The study therefore has established a link between qualitative and quantitative data confirming the findings of each method through triangulation, developed an analysis rich in detail and turning ideas round and providing fresh insights. Attention shall now turn to the hypothetical prediction of the research, which was that:

> **Achieving consensus on priorities to develop as outcomes measures is a problematic undertaking and will not be achieved given the diversity of stakeholder needs and interests.**

This hypothetical standpoint was based on observations of the researcher prior to the start of the research. It transpired that this viewpoint was not confirmed as a consensus was reached for areas to prioritise for future development of outcomes measures.

Finally, this research concludes by drawing on the broad research question, which was answered in some detail but returned to here. It is clear from the research that no broad based measures of outcomes were identified. However there were uni-dimensional and condition specific measures but

none of these too was being used regularly. So to what extent has the research question stated below been answered?

> **What interventions of health, social, psychological and cultural in nature have been shown to be effective in measuring or influencing outcomes of care, and how could the unidentified areas be developed to achieve consensus for implementation?**

The consensus conference yielded eight key areas for future development and with an agenda for future promotion and conduct of outcomes research. It was clear from the research that although interventions were used on many occasions to manage the mental state presentation of the patient no consistent method of measuring outcomes was identified.

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Appendices

Survey of providers' views
Survey of purchasers' views
Case study schedule
Conference programme

APPENDIX 1

SURVEY OF PROVIDERS' VIEWS

Cover Letter

Dear

The effectiveness of care for mentally disordered offenders and others requiring similar services (MDOs)

As you will be aware, increasing attention is being given to how to assess the effectiveness of mental health services. As part of this, attention is being given to developing and testing "OUTCOME MEASURES". This questionnaire is designed to obtain your views on the ways in which outcome measurements could be developed for mentally disordered offenders and others requiring similar services.

This **CONFIDENTIAL** survey is designed to canvass the views of professional and managerial staff working in the service on how they feel the outcomes of the service provided to patients should be measured. I will be very grateful if you could help in this research by answering the questions in this booklet.

For many questions you simply need to tick the box that corresponds with your views and so it should not take too long. The results of the survey will help to ensure that the measures used in the future reflect the views of professional and managerial staff working in the service.

Please return the completed questionnaire in the enclosed FREEPOST envelope as soon as possible before the end of August 1995. There is no need to put a stamp on it. You can be assured that the information provided is completely confidential. As you will see, the survey is anonymous and there is no need for you to put your name on the questionnaire. Should you need to discuss any aspect of this survey, please do not hesitate to contact me on telephone number below:

0121 359 3611 Ext. 4605

THANK YOU VERY MUCH FOR YOUR TIME AND HELP. IT IS GREATLY APPRECIATED.

Please return the completed questionnaire in the enclosed FREEPOST envelope to:

David K Sallah
Doctoral Programme - Research
Aston Business School
Aston University
Aston Triangle
Birmingham B4 7ET

1. YEARS OF EXPERIENCE

(a) First of all could you tell me how long you have been involved with the care of mentally disordered offender patients and others requiring similar services, (MDOs)?

Less than a year	1 - 3 yrs	3 - 5 years	5 - 10 yrs	10 - 15 years	Over 15 years
☐	☐	☐	☐	☐	☐

2. YOUR PLACE OF WORK

(a) Which of the following categories best describes your place of work? (You may tick more than one.)

High Security	Medium Security	Minimum Security	Community
☐	☐	☐	☐

3. YOUR VIEWS ON SERVICE PROVISION NATIONALLY.

(a) Overall how satisfied are you with the effectiveness of service provision nationally for the MDO patient group?

Very satisfied	Quite satisfied	Slightly dissatisfied	Very dissatisfied	Don't know
☐	☐	☐	☐	☐

(b) Why is that? (Please state)

4. THE REED REVIEW

(a) Are you aware of the Department of Health & Home Office review of services for this patient group commonly known as the REED REVIEW?

YES ☐ → (b)

No ☐ → Please go to question (4c)

(b) **If yes, how well do you think the review has dealt with the key issues relating to service provision for the patient group?**

Very well	Reasonably well	Poorly	Very poorly	Don't know
☐	☐	☐	☐	☐

(c) The Reed Review sets out six key principles, which should guide service development. These are listed (i-vi) below. (Select each of the principles and tick the box that best corresponds with your views on each occasion.)

To what extent do you agree that services for your patients should be provided.....

		Agree totally	Agree partly	Disagree	Don't know
(i)	With regard to the quality of care and proper attention to the needs of individuals?	☐	☐	☐	☐
(ii)	As far as possible, in the community rather than in institutional setting?	☐	☐	☐	☐
(iii)	Under conditions of no greater security than is justified by the degree of danger they present to themselves or to others?	☐	☐	☐	☐
(iv)	In such a way as to maximise rehabilitation and their chances of sustaining an independent life?	☐	☐	☐	☐
(v)	As near as possible to their own families if they have them?	☐	☐	☐	☐

(vi)	With respect for patients' citizen rights as in-patients?	☐	☐	☐	☐

(d) To what extent is each of the "Reed Review Principles" already guiding the development of your service?

(Select each of the principles and tick the box that best corresponds with your views on each occasion)

		Agree totally	Agree partly	Disagree	Don't know
i)	With regard to the quality of care and proper attention to the needs of individuals?	☐	☐	☐	☐
iii)	As far as possible, in the community rather than in institutional setting?	☐	☐	☐	☐
iii)	Under conditions of no greater security than is justified by the degree of danger they present to themselves or to others?	☐	☐	☐	☐
iv)	In such a way as to maximise rehabilitation and their chances of sustaining an independent life?	☐	☐	☐	☐
v.)	As near as possible to their own families if they have them?	☐	☐	☐	☐
vi)	With respect for patients' citizen rights as in-patients?	☐	☐	☐	☐

5. MULTI-PROFESSIONAL WORKING

a. The Reed Review recommended that services should be provided on a multi-professional basis. To what extent do you do you consider your service already does this?

(Select each of the levels and tick the box that best corresponds with your views on each occasion)

		To a very great extent	To some extent	To a very limited extent	Not at all	Don't know
(i)	At all levels	☐	☐	☐	☐	☐
(ii)	At service level	☐	☐	☐	☐	☐
(iii)	Clinical Team level	☐	☐	☐	☐	☐

(iv) At patient level ☐ ☐ ☐ ☐ ☐

(b) To what extent do you believe ***multi-professional working*** has already contributed to improving the quality of the services your organisation provides?

To a very great extent	To some extent	To a very limited extent	Not at all	Don't know
☐	☐	☐	☐	☐

(c) To what extent do you believe greater ***multi-professional working*** could contribute to improving the way you provide services to your users in the future?

To a very great extent	To some extent	To a very limited extent	Not at all	Don't know
☐	☐	☐	☐	☐

(d) What further changes (if any) would you most like to see in improving the multi-professional approaches to care? **(Please comment)**

6. INTER-AGENCY COLLABORATION

(a) The Reed Review, further recommended that services should be provided on ***inter - agency*** basis. To what extent do you consider your service already does this? (Select each of the levels and tick the box that best corresponds with your views on each occasion)

	To a very great extent	To some extent	To a very limited extent	Not at all	Don't know
(i) At all levels	☐	☐	☐	☐	☐
(ii) At service level	☐	☐	☐	☐	☐
(iii) Clinical Team level	☐	☐	☐	☐	☐
(iv) At patient level	☐	☐	☐	☐	☐

(b) To what extent do you believe ***inter-agency working*** has already contributed to improving the quality of services your organisation provides?

To a very great extent	To some extent	To a very limited extent	Not at all	Don't know
☐	☐	☐	☐	☐

(c) To what extent do you believe greater ***inter-agency collaboration*** could contribute to improving the way you provide service to your users in the future?

To a very great extent	To some extent	To a very limited extent	Not at all	Don't know
☐	☐	☐	☐	☐

(d) What further changes (if any) would you most like to see in improving the inter-agency approaches to care? **(Please comment)**

7. MEASURING EFFECTIVENESS OF CARE

(a) To what extent do you believe your organisation provides effective and appropriate care to mentally disordered offenders?

To a very great extent	To some extent	To a very limited extent	Not at all	Don't know
☐	☐	☐	☐	☐

(b) How would you rate your service, ***in relation to other similar services nationally*** in achieving its aims and objectives for patient care effectively?

Excellent	Good	Average	Not too bad	Poor	Very poor
☐	☐	☐	☐	☐	☐

(c) Please state below ***effectiveness of care measures*** presently in use in your service and answer questions (d-h) below for each of the measures you have listed.

Please list the changes Measure(s)	Do you think this measure is appropriate?		What do you consider are the main strengths of this measure?	What do you consider are the main weaknesses or limitations of this measure?	Do you consider this should be refined or measure?		What would you most like to see?
	Yes	No			Yes	No	
Measure 1	☐	☐			☐	☐	
Measure 2	☐	☐			☐	☐	
Measure 3	☐	☐			☐	☐	
Measure 4	☐	☐			☐	☐	

(d) How often do you use each of the following to measure effectiveness of care for your patients? **(Please add comments where appropriate)**

		Always	Sometimes	Rarely	Never	Comments
(i)	Health of the Nation Scales	☐	☐	☐	☐	
(ii)	Medical Outcomes Centre SF 36	☐	☐	☐	☐	
(iii)	Subjective Clinical Impression of Change	☐	☐	☐	☐	
(iv)	Recidivism or re-offending rate.	☐	☐	☐	☐	
(v)	Re-hospitalisation	☐	☐	☐	☐	
(vi)	Psychological measures e.g. MMPI	☐	☐	☐	☐	
(vii)	Condition Specific Measures. e.g. Beck's Depression Inventory	☐	☐	☐	☐	
(viii)	Medical Audit	☐	☐	☐	☐	
(ix)	Clinical Audit	☐	☐	☐	☐	

(x) Others **(Please state)**

(e) To what extent do you think the measurement tools you use measure the full range of benefits patients can have from using your service?

To a very great extent	To some extent	To a very limited extent	Not at all	Don't know
☐	☐	☐	☐	☐

(f) What do you consider are the most important aspects of care to measure?
(Please state below)

8. Your Background.

Finally, so that I can compare the views of different groups of people could you please tell me:-

(a) Which one of the following which describes your professional or disciplinary background.

General Management	☐	Occupational therapy	☐
Medicine	☐	Psychology	☐
Nursing	☐	Social work	☐

Other (Please state).....

(b) Please state your job title.....

(c) Please state your grade.....

(d) Which of the following categories do you feel best describes your ethnic origin?

White British	☐	Black African	☐
White European Union	☐	Black Caribbean	☐
White other.....		**Black other.....**	
Bangladeshi	☐	Chinese	☐
Pakistani	☐	Indian	☐

Other Asian.....

(e) What is your gender? (Please tick appropriate box)

Male	☐	Female	☐

9 ANY OTHER COMMENTS

If there are any other comments on measuring outcomes of care to MDOs you would like to make please write them below.

(f) Please tick box if you require a summary of the survey's findings. ☐
(Write your name and address below)

THANK YOU ONCE AGAIN FOR YOUR HELP.

Please return the completed questionnaire in the enclosed FREEPOST envelop.

APPENDIX 2

SURVEY OF PURCHASERS' VIEWS

YEARS OF EXPERIENCE

a) First of all could you tell me how long you have been involved with the care of mentally disorder offender patients and others requiring similar services, (MDOs)

Less than a year 1-3yrs 3-5yrs 5-10yrs 10-15yrs Over 15 yrs

b) Secondly, how long have you been involved with purchasing the care of MDOs

Less than a year 1-3yrs 3-5yrs 5-10yrs 10-15yrs Over 15 yrs

2. YOUR PLACE OF WORK

a) Which of the following categories best describes your place of work?

High security psychiatric Commissioning board | National Health Service Executive | NHS regional office | Health Authority

3. YOUR VIEWS ON SERVICE PROVISION, NATIONALLY

a) Overall, how satisfied are you with the effectiveness of service provision nationally for the MDO patient group?

Very satisfied | Quite satisfied | Slightly dissatisfied | Very Dissatisfied | Don't know

b) Why is that? (please state)

4. ASSESSING THE NEED

a). The EL(93)68 recommends that Regions (NHSE Offices) should ensure that there is a regular assessment of needs of their residents for secure provision and of the non-secure hospital needs of MDOs, updated annually. To what extent are your purchasing plans influenced by this?

To a very great Extent | To some extent | To a very limited extent | Not at all | Don't know

High security hospitals

b). At what stage are you or your nominee involved in compiling a care programme for patients from your region in special hospitals?

Before admission to hospital	Early part of admission	Later part of admission	Pre-discharge case conference	Not at all

c) Which of the following agencies are involved in compiling care programmes for patients in special hospitals?

Health Authorities	Provider Units	Social services departments	Housing departments

Medium secure units

c) At what stage are you or your nominees involved in compiling a care programme for patients from your region in medium secure units?

Before admission to hospital	Early part of admission	Later part of admission	Pre-discharge case conference	Not at all

e) Which of the following agencies are involved in compiling care programmes for patients in special hospitals?

Health Authorities	Provider Units	Social services departments	Housing departments

f). The Priorities and planning guidance for the NHS: 1995\96 (EL(94)55) recommends an investment of resources in interventions which are known to be effective and where outcomes can be systematically monitored , and reduce investment in interventions shown to be less effective.

To a very great Extent	To some extent	To a very limited extent	Not at all	Don't know

5. THE REED REVIEW

a) Are you aware of the Department of Health and Home Office review of services for mentally disordered offenders commonly known as the REED REVIEW?

Yes No

b) If yes, how well do you think the review has dealt with the key issues relating to service provision for the patient group?

	Very well	Reasonably well	Poorly	Very poorly	Don't know

c) Please explain your answer

d) The Reed Review sets out six key principles, which should guide service development. To what extent do you agree that services you purchase for patients should be provided.....

	Agree totally	Agree partly	Disagree	Don't know
i. With regard to the quality of care and proper attention to the needs of individuals?				
ii. As far as possible, in the community rather than in institutional setting?				
iii Under conditions of no greater security than is justified by the degree of danger they present to themselves or to others?				
iv. In such a way as to maximise rehabilitation and their chances of sustaining an independent life?				
v. As near as possible to their own or families if they have them?				
vi. With respect for patients' citizen rights as in-patients?				

e) To what extent do you agree that each of the "REED REVIEW PRICIPLES" listed (i-vi) below already is guiding your purchasing decisions?

	Agree totally	Agree partly	Disagree	Don't know
i. With regard to the quality of care and proper attention to the needs of individuals?				
ii. As far as possible, in the community rather than in institutional setting?				
iii Under conditions of no greater security than is justified by the degree of danger they present to themselves or to others?				
iv. In such a way as to maximise rehabilitation and their chances of sustaining an independent life?				
v. As near as possible to their own or families if they have them?				
vi. With respect for patients' citizen rights as in-patients?				

f) The REED REVIEW further recommended that services should be provided on inter-agency basis. To what extent do you consider services you commission for your patients does this?

To a very great extent	To some extent	Not very much	Not at all	Don't know

6. MEASURING EFFECTIVENES OF CARE

a) To what extent do you agree that services you purchase for MDOs are effective?

To a very great extent	To some extent	Not very much	Not at all	Don't know

b) How do you assess the effectiveness of care you commission for patients? Please state below

c) Do you consider this measure effective? Yes No

d) What do you consider are the main strengths of this measure? Please state below.

e) What do you consider are the main weaknesses or limitations? Please state below.

f) Do you consider this measure should be refined or modified?

Yes No

g) What changes would you most like to see? Please state below.

h) Are you aware of any effectiveness measures providers of service you purchase? Please state.

7. PRIORITISING EFFECTIVENESS MEASURES

a) To what extent is OUTCOME MEASURE a priority in deciding the type of services you purchase/commission for patients.

To a very great extent	To some extent	Not very much	Not at all	Don't know

8. YOUR BACKGROUND

a) Please tick one of the following, which describes your professional or disciplinary background.

General Management
Medicine
Nursing
Occupational Therapy
Psychology
Social Work
Other. Please state.....

b) Please state your job title.....

d) Please state your grade.....

d) Which one of the following categories do you feel best describes your ethnic origin?

Black African	White British
Black Caribbean	White European Union
Black other.....	White other.....
Bangladeshi	
Chinese	
Pakistani	
Indian	
Other Asian	

What is your gender?

Male Female

10. ANY OTHER COMMENTS

If there are any other comments on the care of mentally disordered offenders you would like to make, please write them below

IF YOU WOULD LIKE A SUMMARY OF THE SURVEY'S FINDINGS WRITE YOUR NAME AND ADDRESS BELOW.

Thank you once again for your help.

Please return the completed questionnaire in the enclosed FREEPOST envelop.

APPENDIX 3

CASE STUDY SCHEDULE

Case Study Schedule **Developing Outcome Measures for Forensic Psychiatric Care** **Name of Organisation**

Framework	Summary (key findings)	Examples (if possible)

Part A: Introduction

A1 Description of the service

When established
Level of security
Location
Size of the organisation
Catchment area
Capital costs
Degree of integration in NHS
Diagnostic groups
Accessing the service
Sources of admissions
Organisational structures

A2 Profile of the service

Length of stay
Number of admissions
Outputs - discharges
- Re-admissions
No of wards
Inputs - Resources
Total number of patients
Cost per case/average
Number of staff (C,M,S)
Staff costs
Training and preparation of staff

Framework	Summary (key findings)	Examples (if possible)

Part B: Roles & Activities

B1 Overview

Main roles in respect of
- representation (NHS,staff, pts)
- Service provision
- Resource management

Relationships
- External
- Internal (Pts, Staff)
- Civic activities

* All over past 3yrs.

B2 Key issues & achievements

Key service policy changes
- NHS reforms
- Reed review
- Special Hosp. Serv. Auth.
- Criminal Justice Act

Range of issues tackled
Some achievements
Impact on the service
Service responses

For each probe:

Effect on staff
Patients
External relationships

Framework	Summary (key findings)	Examples (if possible)

Part B: Roles & Activities Cont.

B3 Service integration

Multi-disciplinary working
Inter-agency working
Other relevant organisations
Roles of patients
Probe - Involvement in care planning
- In assessment
- In evaluation
- In decision-making

Contemporary issues

Probe - Reed Review
- Clinical audit
- Research activity
- Evidence based practice
- Clinical supervision

B4 Philosophy of care

Mission statement
Service objectives
Service values
Methods for implementation
Probe - inclusion in Business plan
- Degree of assimilation
- Methods for checks

Framework	Summary (key findings)	Examples (if possible)

Part C: Effectiveness Measures

C1 Clinical effectiveness

Uni-dimensional measures
Multi-dimensional measures
Multi-professional decision - making.
Roles of patients

For each of above probe
- Regularity of use
- Appropriateness
- Effectiveness
- Level of satisfaction
- How evaluated

Probe role of
- Home Office
- Commissioning Board
- Other Commissioners
- Mental Health Act Commissioners
- Mental Health Act Tribunal

Assess degree of acceptance as a measure of effectiveness by service providers.

Framework	Summary (key findings)	Examples (if possible)

Part D: Patient involvement in provision of care

D1 Advocacy

Identify advocates.
Identify Key worker.
Assess the relationship between the two.
Degree of representation.
Influence of risk assessment.
Influence of security.
Degree of consultation with the patient.

For each of above probe
- Influence within care process of advocate
- Assess patient's knowledge of
  - Representative
  - Is the patient satisfied
  - Is the advocate satisfied

Framework	Summary (key findings)	Examples (if possible)

Part D: Patient involvement in provision of care

D2 Empowerment

Identify degree of consultation
Extent of information given on
- Illness
- Acceptable behaviour
- Degree of self-expression
- Why things are done in a certain way

The way power is exercised
Perceptions of power base

For each of above probe
- Influence within care process of patient
- Is the patient satisfied
- Is there a means for redress
- Assess degree of consultation

Framework	Summary (key findings)	Examples (if possible)

Part D: Patient involvement in provision of care

D3 Partnership

Identify degree of consultation
Extent of Information given on
- Illness
- Acceptable behaviour
- Degree of self expression of needs & wants.

Use of Sanctions - Patients
- Staff

Balance of power base

For each of above probe
- Influence within care process of patient
- Is the patient satisfied
- Is there a means for redress
- Assess degree of consultation

Framework	Summary (key findings)	Examples (if possible)

Part D: Patient involvement in provision of care

D4 Subsidiarity

- Identify degree of balance in consultation and delegation.
- Extent of information given on
  - Illness
  - Acceptable behaviour
  - Degree of self expression of needs & wants.
  - Freedom of action - Patients
    - Staff

Balance of power base

For each of above probe
- Influence within care process of patient
- Is the patient satisfied
- Is there a means for redress
- Assess degree of consultation

Framework	Summary (key findings)	Examples (if possible)

Part E: Strengths, Weaknesses and Potential for development

Perspectives (Staff, Patients & Managers) and the degree to which they are characteristics of the case study.

E1 Strengths & Weaknesses

Service innovations
Service successes
How are these successes judged by:
- Patients
- Staff
- Management

E2 Opportunities and Problems

Including where appropriate the plans of the case study organisation on

- Ability to initiate change
- Ability to respond to change
- Consultation with patients
- Structures for patient - Representation
- Improving collaboration
- Degree of autonomy

APPENDIX 4

CONFERENCE PROGRAMME

"Multi-disciplinary consensus conference in forensic mental health - quality and outcomes"

12 November 1997
Great Western Hotel, Praed Street, London W2

This one day multidisciplinary conference aims to bring together professionals from all disciplines involved in forensic mental health care delivery - from mental health managers and clinical personnel of provider units, service users, purchasers and policy makers and including colleagues in the criminal justice system - to debate and agree the best way forward in developing quality of life and outcome measures for use in forensic psychiatry.

8.45	Coffee and Registration
	Chair - Dr Dilys Jones (HSPSCB, Department of Health
9.30am	Opening Remarks (Dr Dilys Jones)
9.35am	"Quality and Outcomes: The National Perspective" Dr Sheila Adam (HSD, Department of Health)
9.45am	"Outcomes in Forensic Mental Health" Dr Kim Fraser (Newcastle City Health NHS Trust)
10.05am	"Forensic Mental Health Services and Outcomes Research" Mr David Sallah (Aston University)
10.25am	"Outcomes from a Provider's Perspective" Dr Hilary Hodge (Ashworth Hospital Authority)
10.45am	Coffee
11.15am	**WORKSHOP ONE**
12.15pm	Lunch
1.15pm	Feedback from WORKSHOP ONE and explanation of next taks Dr Dilys Jones
1.55pm	**WORKSHOP TWO**
1.55pm	Tea
3.25pm	Feedback from WORKSOP TWO
4.00pm	Plenary Session
4.30pm	Summary of Day (Dr Dilys Jones)
4.35pm	Closing Remarks (Mr Ray Rowden)

Morning Workshop

Briefing Notes

Defining Objectives

"Treating MDOs in a high quality mental health service (with an agreed definition of the service). This implies a wide range of settings including the community, criminal justice system and hospitals. It includes consideration of the views of commissioners, public and patients. It also includes consideration of clinical (including risk management), social, ethical, cultural, physical, psychological issues and those of cost effectiveness".

In this workshop you are requested as the leader of your group to secure consensus or agreement on the best definition for forensic mental health service. Please note the definition agreed by the expert panel at our meeting in October is reproduced above. If after discussion, there is a need to offer another definition then you must steer your group to achieve this taking into account the key areas in the original definition.

Where there is no consensus, you must vote on the issue(s) of contention and record the result (numbers for/numbers against). Please remember you do not have a vote as the facilitator of the group.

Task One
Before the start of your discussion, you must remind your group to complete, without consultation with others, the Consensus Statement Form, stating the degree to which they agree with the original statement.

Before you proceed to task two, remind your group to record the group's decision on the Consensus Statement Form. Remind them to keep the form until after the afternoon session whereupon they should hand it over during the last plenary session when requested.

Task Two
Whatever the definition adopted by your group, your next task is to identify outcomes (intended results of any intervention). Please concentrate on effectiveness rather than process issues. For example the turnover of patients being treated is a process issue while the number of patients treated as in-patients or discharged and living in the community with a **high degree of satisfaction** with their treatment is an effectiveness (outcome) issue.

Task Three
For each of the outcomes identified in Task Two, identify the way they should be measured at strategic, operational and patient contact level.

- **Please record here any agreements you made through voting.**

1. Agree ☐ Disagree ☐

2. Agree ☐ Disagree ☐

Afternoon Workshops

(A) A seamless service - clinical aspects

The aim in this workshop is for you to lead your group to define and identify the components of a comprehensive (seamless) service based on clinical issues only. The aim here too is to secure agreement through voting.

Task One
Define what a seamless service is and identify its components.
Encourage your group to indicate how the effectiveness of a seamless service can be measured. Please record all the identified measures on this form.

Task Two
Please record the three most important effectiveness measures on the acetate provided.

Please write below all the measures identified by your group and record the number of those who agree/disagree in the appropriate box.

The measures	Number Agree	Number Disagree
1.	☐	☐
2.	☐	☐
3.	☐	☐
4.	☐	☐
5.	☐	☐

(B) Service planning and management including recruitment and retention

In this workshop you are asked to consider how well the service should be planned and managed. It might be helpful to identify the main component and then discuss them individually. Please include recruitment and retention of staff in this discussion. The aim here too is to secure agreement through voting.

Task One
Encourage your group to indicate what the key outcome measures are and how these can be measured. Please record all the identified measures on this form.

Task Two
Please record the three most important effectiveness measures on the acetate provided.

Please write below all the measures identified by your group and record the number of those who agree/disagree in the appropriate box.

The measures	Number Agree	Number Disagree
1.	☐	☐
2.	☐	☐
3.	☐	☐
4.	☐	☐
5.	☐	☐

(C) Service planning and management including recruitment and retention

In this workshop you are asked to consider how well the service should be planned and managed. It might be helpful to identify the main component and then discuss them individually. Please include recruitment and retention of staff in this discussion. The aim here too is to secure agreement through voting.

Task One
Encourage your group to indicate what the key outcome measures are and how these can be measured. Please record all the identified measures on this form.

Task Two
Please record the three most important effectiveness measures on the acetate provided.

Please write below all the measures identified by your group and record the number of those who agree/disagree in the appropriate box.

The measures	Number Agree	Number Disagree
1.	☐	☐
2.	☐	☐
3.	☐	☐
4.	☐	☐
5.	☐	☐

(D) HoNOS - modification for MDOs

Explain HoNOS and its purpose in order to establish a baseline for your group. Ask the group if HoNOS as it stands can be used in forensic mental health. Record the number of those who agree/disagree below:

Number agreeing ☐ **Number disagreeing** ☐

Task One
Discuss why HoNOS is not suitable for use in the service in its present form. Please record the reasons and proceed by asking what should be done to make it suitable for use. Please record the group's decision below, working always to secure agreement through voting if necessary.

Task Two
Please write down the decisions of the group on the acetate provided.

Please write below all the changes identified by your group and record the number of those who agree/disagree in the appropriate box.

The measures	Number Agree	Number Disagree
1.	☐	☐
2.	☐	☐
3.	☐	☐
4.	☐	☐
5.	☐	☐

(E) Effective multi-disciplinary working

Task One
Secure a definition for "effective multi-disciplinary working". If there is no consensus you can progress the discussion on by voting. Please record your definition and the result of your subsequent voting below.

Your group's definition

Degree of agreement	Total agree	Total disagree
	☐	☐

Task Two
Discuss and agree (voting) the key effectiveness measures below:

The measures	Number Agree	Number Disagree
1.	☐	☐
2.	☐	☐
3.	☐	☐
4.	☐	☐
5.	☐	☐

Task Three
Select three most important measures and write them down on the acetate provided.

(F) Effective inter-agency working

Task One
Secure a definition for "effective inter-agency working". If there is no consensus you can progress the discussion on by voting. Please record your definition and the result of your subsequent voting below.

Your group's definition

Degree of agreement	Total agree	Total disagree
	☐	☐

Task Two
Discuss and agree (voting) the key effectiveness measures below:

The measures	Number Agree	Number Disagree
1.	☐	☐
2.	☐	☐
3.	☐	☐
4.	☐	☐
5.	☐	☐

Task Three
Select three most important measures and write them down on the acetate provided.

(G) Needs assessment

Secure a definition for "needs assessment". If there is no consensus you can progress the discussion on by voting. Please record your definition and the result of your subsequent voting below.

Your group's definition

Degree of agreement	Total agree	Total disagree
	☐	☐

Task Two
Discuss and agree (voting) the key effectiveness measures below:

The measures	Number Agree	Number Disagree
1.	☐	☐
2.	☐	☐
3.	☐	☐
4.	☐	☐
5.	☐	☐

Task Three
Select three most important measures and write them down on the acetate provided.

(H) Gaining the views of carers, users and users' dependent(s)

The aim of this workshop is to identify and agree a suitable way of involving patients and other service users, and to their satisfaction in the process of developing outcomes and improving the quality of care they receive.

Task One
Discuss in your group the stage at which patients should be involved in developing outcomes

Write your decision for this task below:

Task Two
Identify the methods that can be used to involve patients in developing outcome measures and write them down below:

The methods	Number Agree	Number Disagree
1.	☐	☐
2.	☐	☐
3.	☐	☐
4.	☐	☐
5.	☐	☐
7.	☐	☐
8.	☐	☐

Task Three
Identify and write down below the effectiveness measures that can be used to ensure that patients are involved in their care.

Task Four
Select three most important measures and write them down on the acetate provided.

(I) Research, training and education strategies to underpin service development for MDOs

In this workshop you are asked to discuss the contribution research, education and training should make to improve service and clinical outcomes. Please lead your group to consider the three issues separately.

Task One
Identify what should be done to increase the impact of the following:

- Education

1.
2.
3.

- Training

1.
2.
3.

- Research

1.
2.
3.

Task Two
What are the effectiveness measures for these objectives

- Education

1.
2.
3.

- Training

1.
2.
3.

- Research

1.
2.
3.