MEETING THE NEEDS OF ADULT MENTALLY DISORDERED OFFENDERS

Thesis Submitted in Partial Fulfilment of the Requirements for the Degree of Doctor of Philosophy by Published Works

Phillip John Vaughan, M.Sc., CQSW., DMS

School of Health and Social Sciences

Middlesex University

April 2003

Text cut off in original

ACKNOWLEDGEMENT

I should like to express my thanks to my tutor Dr John Foster for his advice and support in the preparation of this work.

CONTENTS

Appendices

ABSTRACT

It is essential that those responsible for commissioning special services for mentally disordered offenders (MDOs) take a whole systems approach to the assessment of need and planning of services. National statistics are no substitute for regional and local surveys that collect data on local populations for whom services are being planned.

The results of research carried out under the auspices of The Wessex Consortium supplemented by some earlier community studies have been used to form a robust assessment of need upon which to base a local strategy for managing MDOs.

Ten publications are submitted, representing a number of projects designed to identify the broad area of need of MDOs, ranging from secure hospital care to various aspects of community care. Although there is an extensive literature on MDOs and their needs, most studies concentrate on secure hospital provision and fail to cover the fuller range of services required to provide a more comprehensive response to need.

The submitted works as a whole, represent a unique account of a spectrum of needs of MDOs from a defined geographical area with some contributions having a more generalised importance. While some of the work has been undertaken by others elsewhere, the results are not directly comparable due to methodological differences, different sample groups/populations, etc.

Some of the studies are now being replicated in other parts of the country and the outcome of the research has supported a number of service developments within The Wessex Consortium area and the formation of national policy in respect of forensic psychiatry.

CONTEXT STATEMENT

INTRODUCTION

Most people associate mentally disordered offenders (MDOs) with seriously disturbed behaviour and secure hospital care. Indeed, much publicity and public concern is focused on high profile offences involving mentally disordered individuals, and mental health professionals are likely to see MDOs as the responsibility of the high and medium secure hospitals. However, few people appreciate that individuals detained in secure hospital settings represent only a small and restricted number of those individuals who could be described as MDOs, (Vaughan, 2001).

As at 31st March 2000, the high secure hospitals of Broadmoor, Rampton and Ashworth accommodated a mere 1,300 patients, representing just 4.5% of all NHS psychiatric beds in England, (Department of Health, 2000). A further 1693 beds were provided by NHS medium secure units, and about 175 patients were detained in private mental health nursing homes under court and prison disposals. Additionally, there are a number of individuals within the prison system with serious mental health problems who warrant psychiatric intervention (Singleton et al. 1998) and about 70 are transferred into high secure hospitals each year.

Thus there is a small but significant number of troublesome individuals detained in secure settings. Prins refers to them as 'the people nobody owns' and describes them as the 'unloved, the unlovely and the unlovable', (Prins, 1993 : 4). Community services are not very receptive to this area of work and MDOs are often seen as a breed apart.

However, such views are misplaced. Not only will most patients in specialist settings eventually return to the community but the above figures represent only those at the extreme end of a continuum of challenging and offending behaviour. The number of individuals in the community who could be

described as MDOs far exceeds the number found in secure settings. Indeed there is a large group of service users supported by a variety of agencies that are not regarded as MDOs because their mental health problems or offending behaviour have not been recognised. Many offenders supported by the probation service or serving prison sentences have undetected and/or untreated mental disorders and are, therefore, simply regarded as offenders. Equally, there are those within the mental health system who are regularly violent and commit even quite serious offences without being charged, particularly if this occurs within an in-patient setting.

Such behaviour is commonplace among those with learning disabilities. Disinhibited sexual behaviour and some sexual assaults often fail to come to the attention of the courts as the police, crown prosecution service and professional staff are reluctant to press charges. These incidents are frequently tolerated as within the range of 'expected' undesirable behaviour displayed by such individuals, (Lyall et al. 1995). These people, who have been described as 'the invisible mentally disordered offender' (Vaughan and Badger, 1995) would be officially classed as MDOs if their illness or offending behaviour was responded to more appropriately. If this were to be the case, the number of recognised MDOs in the community would be increased significantly.

It is essential, therefore, that those responsible for commissioning specialist services for this group take a whole systems approach to the assessment of need and planning of services. While it is important to carry out needs assessments for those individuals requiring secure services, it is also crucial to understand the needs and potential demand of those requiring community services.

The literature on the prevalence of offences committed by persons with mental disorder and on the characteristics of the offenders suggests that

regional variation exists regardless of whether the data were gathered in the criminal justice system, general psychiatric services or secure psychiatric services. This variation is to be expected because both criminal behaviour and the incidence of mental disorder are related to demographic characteristics that vary in different populations. National statistics from the study of specific services and agencies with large or undefined catchment areas are of limited use for regional or local planning, (Badger et al. 1999a). Thus with the growing evidence on recognising diversity there is no substitute for regional and local surveys that collect data on the local population for whom services are being planned

In 1992, the Reed Report concluded that future service patterns for MDOs should be informed by regular assessments of both population and individual needs, (Department of Health and Home Office, 1992). Farrar (1996) highlighted the difficulties of predicting and managing the demand for health and social service provision, which required purchasers to undertake a robust assessment of need upon which to base their strategies for the development of services.

The Wessex Consortium

The above issues have been considered by The Wessex Consortium which was formed in 1997 to address the planning needs of mentally disordered offenders. The impetus for its formation arose from national and local concerns about the difficulty of co-ordinating the development of services for MDOs and others with challenging behaviour. It was originally established to encompass the health authority areas of North and Mid Hants, Southampton and South West Hants, Portsmouth and South East Hants, Isle of Wight and Dorset covering a population of 2.5 million, and is now one of 5 specialist commissioning groups for forensic psychiatric services in the South of England.

Accordingly, a whole systems approach has been adopted and the membership now comprises the relevant Strategic Health Authorities, Primary Care Trusts, Social Services Departments, The National Probation Service, H.M. Prison Service, Hampshire Constabulary and clinical representation from local and regional forensic services.

In order for the Consortium to plan and commission services effectively it meets bi-monthly and has commissioned a wide range of needs assessments and surveys to provide sound data on needs, gaps in services and priorities for action. The subsequent information base, ranging from the needs of secure detainees to the ability of community services to support MDOs, has enabled the Consortium to develop and implement a coherent model of joint commissioning across its catchment area.

The submitted works

The publications resulting from the needs assessment exercises together with earlier work by the author are included in the submission for PhD by published works. They form part of a much larger body of published work and have been selected as they are among the most recent and relevant. They cover the need for secure provision and a range of community resources, including the use of community supervision, as well as the views of service users themselves.

Although not originally intended as a subsequent submission for a PhD by published works, they now form a substantive body of related work which meet the requirements for such consideration. The co-authors mentioned in several of the journal research papers have been cited as a courtesy. Their main task was to conduct interviews and collect data. I was totally responsible for the literature reviews, research design, analysis and writing up of the reports. The book, Working with the Mentally Disordered Offender in the Community was co-written with Douglas Badger. This was done by

allocating discrete chapters to each author according to their area of expertise. Accordingly, I was responsible for just over half of the material i.e. chapters two, four, six, eight and most of chapter five.

BACKGROUND, SUMMARY AND CRITICAL REVIEW OF THE SELECTED WORKS

Submission One: A Consortium approach to commissioning services for mentally disordered offenders (Vaughan 1999).

Background

In 1997, The Wessex Consortium had no clear idea of how many individuals in secure care throughout the country were wrongly placed and in need of more appropriate care and treatment in local facilities.

The initial task of identifying the continuum of needs for MDOs therefore was to assess the future security and accommodation needs of those already detained in secure care and ascertain the distribution and shortfall of suitable inpatient and residential facilities to meet them.

Summary of the study

The method used was what Cohen and Eastman (1997) describe as a 'rates-under-treatment' approach i.e. needs assessments carried out on those individuals already known to be in secure care using a specially designed questionnaire [see appendix A(i)]. This provided a priority framework which concentrated on the needs of the MDOs with the most pressing needs in terms of re-location to more suitable local facilities and/or a reduction of funding by the commissioning agencies. The population surveyed was from the large rural areas of Hampshire, Isle of Wight and Dorset and the two urban centres of Southampton and Portsmouth, both of which have significant areas of social deprivation.

A separate mapping exercise was also carried out which sought information on hospital and hostel places catering for people with mental illness and learning disabilities.

The findings revealed a total absence of intensive care beds in North and Mid Hants and no long-term medium or low secure care beds for people with mental illness across the Consortium area. They also showed an almost total lack of any type of provision suitable for people with a combination of learning disability, personality disorder and severe challenging behaviour.

The needs assessments identified two main groups of individuals with unmet needs, i.e. people with mental health problems needing long-term secure care and those with a learning disability and personality disorder causing severe behaviour problems needing long-term and short-term secure care. Additionally, Portsmouth Health Authority had sufficient numbers of people with mental health problems in their short-term low secure unit to warrant the development of a separate long-stay low secure unit and a long-stay 24 hour nursing care hostel for women.

Notwithstanding the above, there was still a need for 'spot-buying' services for small numbers of people with more individual needs, e.g. women, adolescents. The report commented that a supra-consortium approach (the involvement of more than one consortium) to commissioning services for these groups would be welcomed.

The needs assessments also revealed weakness in monitoring extra contractual referral (ECR) placements in some authorities. Thus the study provided a measure of the need of MDOs for local secure provision and structured hostel care together with the inadequacies of local services to meet this need.

Critical review

It is recognised that the methodology used for the needs assessments has it limitations. The 'rates-under-treatment' approach tends to measure only the current utlilisation of services and may represent an incomplete picture of true need. Furthermore, available data on services used may not always be accurate, consistent or up to date. Greater accuracy could be obtained by combining this method with others such as:-

- Social indicator approach which uses secondary data (such as census data, Jarman indices, etc.) to compare similar populations in order to make useful estimates of need and resource allocation.
- Key informant approach where information is obtained from key personnel who are in a position to know the needs and utilisation patterns.
- Community forum approach where members of the community are asked to assess the needs and service patterns usually in the context of a public meeting.

Individually they all have their shortcomings and constraints of time and resources ruled out the opportunity to use a combined approach. Notwithstanding the above it was felt that the shortcomings of the method used were reduced to a minimum as there was sufficient reliable information available within the health authorities to accurately identify individuals in forensic placements. Misplacements within the secure hospitals were identified by the assessment process. Nevertheless it is important to recognise that reliance on this approach alone may not fully highlight or address important areas of need. Individuals, clinicians and managers will all have detailed knowledge of other needy groups of patients and will still be required to encourage purchasers to develop services for them.

It is acknowledged that this work presents only a partial picture of those requiring secure care and that there is a need to take into account the needs of mentally disordered prisoners and the more seriously disturbed and dangerous patients within the general psychiatric population.. However, the group surveyed had the greatest need in terms of re-location and the study provided a clear indication of the immediate requirements for service development.

Finally, the mapping exercise produced a 92% response rate. With the additional cross referencing of returns, checking of registration information and direct enquiry, it was felt that the findings represented a fairly accurate and comprehensive picture of relevant provision within the Consortium area.

In order to complete the understanding of the needs of those detained in secure care, further research was needed to identify the numbers of individuals in prison who needed secure hospital care.

Submission Two: Psychiatric support to mentally disordered offenders within the prison system (Vaughan et al. 1999a)

Background

As well as those individuals being cared for in secure psychiatric settings, it is recognised that there is a further group of people within the prison system whose mental health needs are such that they should be transferred into psychiatric hospital care. Indeed although the actual number of prisoners requiring access to mental health services is not known, research has shown that about 3% of the sentenced population at any one time needs transfer to an NHS psychiatric bed, (Gunn et al. 1991). Additionally, about 8.5% of the remand population is similarly in need of transfer, (Maden et al. 1996). In order that these additional demands on local secure psychiatric services be

included in any future planning requirements, it was felt necessary to extend the original needs assessments to the prison population.

Summary of the study

As it was impractical to survey all 131 prisons in England and Wales, it was decided to concentrate on the secure estate within the Consortium area and on its borders. It was considered that most of the Consortium's prison population would be detained in the 16 prisons so identified.

Prison medical officers and probation officers were asked to identify MDOs within their prisons and an assessment of their needs was carried out by project workers using an interview schedule [see appendix B(i)]. Telephone questionnaires with healthcare staff were used to determine the scope of prison psychiatric facilities and finally Home Office records were examined to ascertain details of Consortium prisoners transferred to and from psychiatric hospital care during 1997.

The findings showed that 21 individuals (43%) assessed by the project workers met the Consortium's MDO criteria. Of these 15 (71%) were felt to be in need of psychiatric hospital care, 9 (43%) of whom required medium secure provision. During 1997, 21 individuals had been transferred to psychiatric hospital care. Ten had been moved to medium secure care and 11 to other hospital settings. Seven of the latter went to hospitals out of area. Conversely, none had been transferred into the Consortium area due to lack of local provision.

The findings also revealed shortcomings in the psychiatric screening process of new receptions and a perceived lack of mental health skills in prison and probation staff. Furthermore, communication and information exchange with outside agencies was found to be poor.

Any planning for future secure psychiatric provision should consider the additional demand for such places from the prison system. Within the prisons, facilities, procedures and staffing in relation to the screening of new receptions, would benefit from some revision. Within the community the training needs of probation officers, in relation to mental health, may need to be reviewed. Finally, a more vigorous and pro-active stance needs to be taken by community agencies to improve liaison in relation to prisoners from their area.

Critical review

Unfortunately, it is difficult to identify the size of the demand with any degree of accuracy. It is not possible to estimate how many of the nominal male population of 7,209 in the prisons surveyed came from the Consortium area. Thus it is not possible to estimate the number of MDOs by extrapolating from the seminal studies of Gunn et al. (1991) and Maden et al., (1996). However, it is most likely that the 67 individuals identified as MDOs by the prison medical officers and probation officers is a significant under-estimation as there were a number of problems in conducting the survey which were impossible to overcome.

To begin with the response rate to the original requests to identify MDOs in the prisons was poor. Among the non-responders were the community probation teams for all of Dorset who were responsible for prison through-care and after-care. They were unable to take part in the study due to pressure of work and so figures for Dorset residents were derived only from the prison based probation teams and prison medical officers. Although all of the prison probation officers responded, all but 3 gave nil returns. Additionally, although there was a 76% response rate from the prison medical officers only 2 actually identified MDO prisoners. Furthermore, there was no response at all in relation to the female prisons or in respect of a large Young Offenders'

Institution both of which one would expect to have a large psychiatric morbidity amongst its inmates.

The actual number identified is also likely to be an underestimation due to the poor health screening procedures on reception and failure of prison staff to identify mental illness that develops after incarceration. Furthermore, there appeared to be a high incidence of disturbed behaviour due to alcohol and drug problems rather than mental disorder and there was clearly some confusion by prison healthcare staff and probation officers in differentiating the two. Their accuracy rate was 47% and 23% respectively.

Thus although the survey provided a crude indication of demand for psychiatric services it failed to identify a comprehensive picture of need. However, it did indicate a number of service issues relevant to policy and practice.

In order to determine the characteristics of the different levels of security needed locally, further analysis of the data obtained on the patients assessed was required

Submission Three: Developing service specifications (Vaughan 2000)

Background

There is a notable absence of national guidelines for the development of medium and low secure services for people with mental illness and those with learning disabilities. Moreover, there is much confusion over the definitions of these different types of service in relation to both levels of security and short and long stay facilities. The Wessex Consortium was faced with the difficulty of producing robust service specifications when developing new secure services. In order to overcome these problems it was decided that any

service specification should be based on the assessed needs of the patients for whom the new service was to be developed.

Summary of the study

The data collected on patients in the original needs assessment (Vaughan, 1999) were analysed in order to produce a framework on which a variety of specifications could be developed. A 2 x 2 matrix was established to categorise patients with differing needs in terms of security and length of stay. Patients were placed in their appropriate cells within the matrix, thus making it possible to describe the common characteristics of each group of patients providing 4 different inpatient profiles. A similar matrix was then established to describe the service requirements of each group. Each element of a service specification was then applied to the eight different combinations of need i.e. low/medium security, short/long stay, mental illness/learning disability.

A set of sample specifications for secure care provision for people with mental illness and learning disability was produced and published in-house by The Wessex Consortium (Vaughan 1998a, Vaughan, 2002).

Critical review

It is acknowledged that the patient profiles which are shown in figure one were based on a fairly small sample and that if the original needs assessments had been repeated on another group of patients, there may have been some variation in their background and personal characteristics. However, it is likely that this would be minimal. The data gathered closely matched the characteristics of patients with similar needs described by Reed (1977). The secure needs matrix is a rather more subjective description based on the author's own experience. Nevertheless, the inpatient profiles and service

needs were tested in a workshop involving senior forensic service managers and consultant forensic psychiatrists, who endorsed the description given, requiring only minor refinements to the model.

Thus although not an absolute blueprint for medium and low secure unit specifications, the model provides a sound basis on which to develop and tailor specifications to suit individual schemes.

As well as gathering information on those in secure care, further information was needed on the MDOs' route into services through the Criminal Justice System.

FIGURE 1: INPATIENT PROFILES

	Medium Secure	Low Secure
Long stay (> 2 years)	• Majority detained under Part III of MHA 1983 • Serious index offence against the person • Repeated/long term institutional care • Institutionalised group • Poor response/unresponsive to intervention • Enduring mental health/learning disability problems • Continuing dangerousness/risk to self • Would abscond from less secure environment and pose risk to others • Weak community/family links	• Detained under Part II and Part III of MHA 1983 • History of offending/harm to self • Repeated long term institutional care • Institutionalised group • Poor response/unresponsive to intervention • Enduring mental health/learning disability problems • Continuing risk of harm to self and/or others • Would abscond from 'open' ward • Weak community/family links
Short stay (up to 2 years)	• Serious index offence against the person/self-harm • Intermittent institutional care • Acute disturbed behaviour leading to dangerousness/risk to self • Potentially responsive to treatment and rehabilitation • Would abscond from less secure environment and pose risk to others • Recent/active community/family links	• Acute disturbed behaviour leading to assaultive behaviour/self-harm • Intermittent institutional care/involvement with psychiatric/learning disability services • Potentially responsive to treatment and rehabilitation • Would abscond from an 'open' ward • Resent/active community/family links

Submission Four : The working practices of the police in relation to mentally disordered offenders and diversion services (Vaughan et al. 2001)

Background

Although the forgoing needs assessments indicated the number of individuals already in secure hospital care and in prisons who need such care, there are others who are processed by the police, crown prosecution service and the courts who require intervention from forensic services. It was felt desirable, therefore, to understand the size of the problem to measure the likely demand on services from this source.

Although 'diversion schemes' have been established in many parts of the county to identify those in need of health and social care rather than inappropriate prosecution or incarceration in prison, such schemes are patchy and variable in their effectiveness, (Social Services Inspectorate, 1997, Badger et al. 1999b). Crucially diversion schemes are dependent on efficient and effective filter mechanisms applied by the police to identify potential candidates for diversion in the first place. Previous research has revealed shortcomings in the ability of police custody staff in identifying people with mental disorder, particularly if they have less serious conditions, (Gudjonsson et al. 1994). In view of the above, the study focussed on the work of the police in relation to diversion services in Hampshire, the structure of which is illustrated by figure 2.

Figure 2: Bridewells/diversion schemes surveyed

Police stations with bridewell surveyed	Profile of diversion schemes at time of survey
Portsmouth	Established 1995 Staff: Approved social worker Support worker (unqualified) Close working relationship with Drugs and Rehabilitation Team and dual diagnosis worker. Well established and supported service
Southampton	Established in July 1991 Staff: Approved social worker Sole practitioner post although some support from local CMHT. Busy single-handed practice
Basingstoke	Established in 1996 Staff: Approved social worker (RMN) Sole practitioner who also provided a service to 2 other distant bridewells i.e. Andover and Winchester
Aldershot	No scheme in place

Summary of the study

A consecutive sample of individuals detained in cells and not identified by the police as having a mental disorder, were screened for the presence of mental disorder and their suitability for diversion. This was effected by a combination of a simple screening tool [see appendix D(i)] clinical assessment, use of Crown Prosecution Guidelines (Crown Prosecution Service, 1994) and panel assessment. Custody and detention staff were observed and interviewed using a semi-structured interview schedule (see appendix D(ii) to elicit their views and working practices in relation to MDOs. Workers from three different diversion schemes were also observed and interviewed using a semi-structured interview schedule [see appendix D(iii)].

The findings revealed that in bridewells with diversion schemes an average of 7% of detained individuals had mental disorders who were suitable for diversion but were not detected by the police. In the bridewell without a diversion scheme the figure was 14%. Conversely, many individuals without a formal mental disorder were inappropriately referred to diversion schemes.

The effectiveness of screening processes by custody staff was variable. Facilities in the bridewells were not suitable for containing disturbed individuals and two had no CCTV cells. Delays in obtaining mental health assessments caused considerable concern for police officers and prolonged the discomfort of vulnerable individuals. Single post holders in diversion schemes became professionally isolated particularly if located in non-mental health settings. Furthermore, it was found to be unrealistic for one individual to service more than one bridewell, particularly when they were geographically distant from each other.

The report recommended that further preparation and training of custody staff is needed to improve screening procedures. Reception and detention facilities for mentally disordered individuals should be reviewed. Response times from ASWs and psychiatrists would benefit from improvement and an early resolution needs to be found to the debate over identifying a suitable place of

safety for mentally disordered individuals. The appointment of single post holders to diversion schemes who are isolated from mainstream mental health services should be avoided. Finally, it should be acknowledged that single post diversion workers are unable to offer an effective service to more than one bridewell.

Critical review

Unfortunately, the statistical accuracy within the study may not be absolutely accurate due to a slight discrepancy between the statistics gathered manually by the project workers and those recorded on the police computer. As the latter formed the 'official' record of activity, these were the statistics used. Furthermore, as the police computer records did not record details of the outcome of intervention with mentally disordered prisoners, the diversion scheme statistics were used to determine how many were referred to these schemes. The statistics in the report therefore, although probably fairly accurate, are regarded as indicative rather than definitive.

It is acknowledged that the sample of 175 prisoners represented only 15% of the total number arrested by the police during the period of the study. However, it was not practical to trace and follow-up individuals already released or bailed, and time and resources did not allow for a larger sample of individuals detained in cells overnight to be interviewed.

Nevertheless, Hampshire Constabulary co-operated fully in the study and there were no barriers to access to prisoners or custody records. It is considered therefore that the study provided a fairly accurate picture of activity in policy custody suites in relation to mentally disordered offenders.

Mentally disordered offenders diverted to community agencies require a receptive and competent range of services to support them. A better knowledge and understanding of existing community services was required, hence the next submission.

Submission Five: Services for mentally disordered offenders in community teams (Vaughan et al. 2000)

Background

In 1992 the Reed Report (Department of Health/Home Office, 1992) emphasised that MDOs should be cared for, as far as possible, in the community rather that in institutional settings. Of those who are cared for in secure settings only a small minority are detained indefinitely; most eventually return to the community and require intensive after-care and follow-up. Moreover, there are substantially more MDOs in the community who are never admitted to secure institutions but make considerable demands on community services. Unfortunately, the accelerated application of community care principles to this group has outstripped the creation of training opportunities for community staff charged with their support and supervision, (Vaughan and Badger, 1995). Furthermore, recent research carried out by the Social Services Inspectorate, revealed a number of shortcomings in social work support for MDOs in the community, (Department of Health, 1997). It is this situation that led The Wessex Consortium to seek a better understanding of the capacity of its community teams to support MDOs outside of the hospital setting.

Summary of the study

Interviews were held with team leaders to elicit the working practices and responsiveness of teams to this client group using a semi-structured interview schedule [see appendix E(i)]. Additionally, key workers were invited to complete individual questionnaires detailing their proficiency in areas of work related to MDOs. Further information was gathered about their MDO caseloads. [see appendix E(ii)].

The findings revealed a range of organisational styles from close joint agency working to totally separate health and social services teams. For the most part, each client group operated within its own strict boundaries and there was a

general reluctance to work with other client groups. Each group had its own MDOs but often could not meet all of their needs due to limitations within each service. Due to the compartmentalised nature of the services, gaining access to a wider range of skills was difficult. Accordingly many MDOs were denied a comprehensive range of interventions and sometimes received only partial help for their problems.

Perhaps the greatest difficulty was accessing drug and alcohol services as most such teams declined to accept referrals for non-motivated clients. As one of the most common problems faced by MDOs is substance abuse, a major source of expertise was being denied them. There is a clear need for this expertise to be disseminated into mental health teams and in the case of drug misuse into probation teams.

Irrespective of substance abuse issues, a major multi-disciplinary/multi-agency training programme was needed to equip key workers with the skills they need to support MDOs in the community. Each of the 4 types of teams had a range of deficiencies in their skills and knowledge in relation to work with this group. Learning disabilities teams, in particular, appeared to have the greatest challenge in supporting this group as they had the highest proportion of MDOs on their caseloads who also exhibited the highest rates of violence, self-destructive and sexual offending behaviour. However, they had the least amount of reported competencies in working with such behaviour, particularly in the areas of mental illness, personality disorder and offending behaviour including sexual offences. Additionally, support through the Criminal Justice System was sometimes denied them because of the general reluctance to charge and prosecute learning disability clients. Consequently, appropriate interventions were often unavailable, victims' needs ignored and abhorrent behaviour colluded with. Diversion from prosecution in such cases may sometimes be counter-productive.

Probation officers appeared to need training in all aspects of the clinical, organisational and policy aspects of mental health, whereas mental health teams needed input into all matters relating to offending behaviour.

A further major area of weakness in need of rectification was that of links with secure institutions. Both community teams and the institutions themselves claimed neglect and remoteness from each other. Where contact did exist, it was usually on an individual client basis. This is too important an area to leave to the discretion of individual workers and some effort should be made to develop formal methods of communication.

The majority of MDOs in the community were not subject to any special supervisory arrangements. In view of their propensity for further offending and non-compliance with interventions, it would seem that appropriate measures of 'targeted' supervision such as the Supervision Register and Supervised Discharge were not being used to their full advantage. It is recognised that there is considerable ambivalence amongst mental health professionals about the utility of such measures but further consideration could be given to their application to some clients.

In summary, the way in which community services are currently organised does not appear to be very conducive to work with MDOs or others with challenging behaviour. The overall skills in all teams could be increased by additional training but there is little enthusiasm for having a specialist worker in each team. The logical focus for work with this group of clients, would seem to be in joint agency assertive outreach teams, strengthened by considerable input from staff with expertise in drug and alcohol misuse.

Additionally, these teams could be supplemented and supported by district forensic community teams as described by Whittle and Scally (1998). The aim of such teams is to integrate forensic patients into mainstream services thus minimising stigma. Support, education and co-working is provided by the forensic community care team which also provides an active link between secure forensic services and mainstream psychiatry.

Critical review

The survey provided a comprehensive picture of the community mental health, learning disability, probation and drug and alcohol teams in relation to MDOs. However, although 93% of all of the teams were included in the study only 51% of individual team members completed questionnaires about their caseloads and personal competencies. No information from the non-responders is available. It may be that they did not respond because they had no MDOs on the caseloads or that they simply failed to reply. Nevertheless, a total of 9,915 community clients were screened by key workers and 774 MDOs were identified on their caseloads. It is likely, therefore, that there were yet more who were not identified. Notwithstanding the above, the size of the sample was sufficient to provide a realistic picture of MDO supported by community teams.

Another limitation of the study is that the accuracy of the self-ratings of competencies by team members, was not verified by an independent research assessment. In doing so, however, the anonymity of the respondents would not have been protected.

Despite these shortcomings, it is felt that the data gathered provided a useful indicator of local circumstances and need for service improvements within The Wessex Consortium area.

An important shortfall of community support revealed by the study was the lack of day care provision. An extension of the study was required to survey the availability of day care services for this group.

Submission Six: Day care for mentally disordered offenders (Vaughan et al. (1999b)

Background

Day care has long been regarded as a mainstay of community based services for the mentally disordered, but historically such development has been patchy and unco-ordinated, (Vaughan 1983a, 1983b, 1985). More recently the provision of day services, especially occupational training has been seen as one of the key areas for development in relation to MDOs, (NHS Confederation, 1997). However, traditional forms of day care are not always appropriate for people with severe mental health problems who are hard to engage with services, (Higgins, 1991). In order to achieve the type of support they require, a range of daytime activity is needed. Day services targeted exclusively at MDOs present a particular challenge as their numbers are relatively small and providing such exclusive services could be very stigmatising. The main challenge, therefore, is for mainstream services to include provision for this client group within their brief.

A community study by Vaughan et al. (2000) revealed that day services and work opportunities were common service shortfalls across all MDO client groups. A further study was conducted to ascertain the range of mainstream day services available to MDOs and to determine their capacity to provide a service for this client group.

Summary of the study

Fifty-one health, social services and voluntary services managers were interviewed representing 85 different facilities using a semi-structured interview schedule [see appendix F(i)].

The findings revealed a diverse and largely un-coordinated range of services. Although not specifically geared toward providing services for MDOs most facilities would accept any client as long as they were stable and compliant.

However, most statutory services would accept referrals only from mental health professionals which tended to exclude many MDOs who fell outside of community mental health and learning disability teams' referral criteria.

General social support, therefore, was easily accessible through the more informal drop-in centres run by voluntary agencies but access to more formal treatments and rehabilitation facilities was more problematic. This was sometimes highlighted in times of crisis.

A more flexible set of referral criteria, with the ability of non-mental health professionals such as probation officers, to put forward needy clients would improve access to specialist interventions. Although voluntary agencies will prioritise certain disadvantaged groups, there is the possible lack of evidence-based expertise. A closer working relationship between mental health professionals and the voluntary sector centres may make expertise from statutory services more acceptable to their clients.

Each NHS Trust and Social Services area would benefit from a co-ordinated approach to the development of day care. An expansion of the clubhouse model of day care would involve attenders in their own rehabilitation and work opportunities. Finally, an extension of opening hours to include evenings and weekends would increase the community support to vulnerable individuals.

Critical review

The study was limited by constraints of time and resources to interviews with day care managers, examination of policies and procedures and informal observation of day care activities. A more detailed picture of the clientele served by each centre could have been obtained by examining the case records of attenders and interviewing the centre users themselves. However, the aim of the study was limited to describing the range, structure and operational mode of day care in Hampshire and the Isle of Wight with a view to clarify its suitability or otherwise for this client group.

A key area of untapped opinion so far was that of MDO service users themselves. This is addressed in the next study.

Submission Seven: An opinion survey of mentally disordered offender service users (Vaughan and Stevenson, 2002)

Background

A needs assessment programme is not complete without seeking the views of those who use the services. Regular feedback from recipients of services is needed if future developments are to be shaped in a way that is acceptable to them. Mentally disordered offenders are a difficult group to engage and monitor in services due to fear and prejudice among providers (Thompson 2000) and lack of motivation and alienation among MDOs themselves, (Repper and Perkins, 1995).

It was felt necessary to canvas the views of this group but finding a suitable sample population was problematic. Although it would have been possible to target the MDOs identified on the caseloads of community teams (Vaughan et al. 2000) this would have excluded those who tend to avoid contact with statutory services. Patients detained in secure psychiatric settings represent a rather specialist sub-group of the most challenging MDOs and would be unlikely to represent the wider MDO population. Furthermore, it is possible that detained patients would have been less inclined to express negative views and they may have felt that this would lead to delays in their discharge or further restrictions on their liberty.

Summary of the study

In view of the large proportion of prisoners who have mental health problems it was decided to select a sample of prisoners with mental disorders from within the prison system. It is known that many in this group do not receive adequate psychiatric or social services in the community, either because such organisations deflect and avoid them or because the offenders themselves shun services, (Sainsbury Centre for Mental Health, 1998). Prisoners, therefore, are likely to have experienced intermittent and perhaps unsatisfactory contact with statutory agencies and formed an ideal target group for this study. Additionally, the proximity of HMP Winchester to The Wessex Consortium offices reduced the logistical problems associated with this project.

Accordingly, 59 male prisoners with mental disorders were randomly selected from the sentenced and remanded prison population of whom 50 were included in the study. They were interviewed using a semi-structured schedule designed to elicit their views about their contact with services before they came into prison. [see appendix G(i)]

The findings revealed that their illness and offending behaviour was not serious enough to warrant the intervention of forensic psychiatric services but their needs were too complex for them to access mainstream community care. As a group they felt vilified and marginalized by many professional workers and were unlikely to seek help themselves. Accordingly, psychiatric intervention was usually determined by a crisis provoked by a psychotic breakdown or suicide attempt

.

Having been stabilised in hospital or prison, after-care and follow-up was not always pursued, which often led to deterioration in mental health and/or offending behaviour followed by further incarceration.

The report concluded therefore that there is a need to broaden the referral criteria of community agencies to avoid excluding MDOs. Rapid and assertive service delivery is required to maintain contact with them. A full

range of therapeutic and practical interventions should be provided rather than just the monitoring of medication and/or court order compliance. CPA documentation should be presented in a simple manner to take into account the literacy problems of many MDOs.

Paradoxically 'enforced' help, through hospital admission and healthcare centre in prison, seemed in many cases to overcome the individual's customary rebellion against such intervention.

Key workers need to maintain contact with their clients during periods of hospitalisation and imprisonment in order to sustain family and community links and facilitate re-engagement with services on discharge or release. More care is required in placing clients in suitable accommodation and more attention needs to be given to helping MDOs claim key benefits such as social security and housing. In particular, these two key agencies need to consider the training needs of frontline counter staff to avoid them alienating 'difficult' claimants by negative attitudes and defensive behaviour.

Workers carrying an authoritarian role should ensure that this is tempered with practical and therapeutic help. Finally, continued training and support is needed for the police to improve their awareness, understanding and management of individuals with mental health problems.

Critical review

It is acknowledged that the requirement to select an interview group from only those prisoners with a known history of mental disorder, produced a biased sample.

Possible under-reporting may limit the validity of the data and there is no way of checking the accuracy of the facts included in the views expressed. Furthermore, although the ethnic mix of the sample is representative of Winchester prison's catchment area, the virtual absence of black prisoners makes it difficult to generalise the findings to the wider prison population.

However, as the aim is identifying the needs of the local MDO population, this is not an issue. It is difficult to compare these results with other mental health service user satisfaction surveys as, unlike this study, the latter usually target those actively involved with services and tend to produce a substantial acquiescent response bias (Ross et al. 1995). Nevertheless, despite these limitations, the views expressed by the respondents may provide a useful insight into the low uptake of some community services by this group.

In order to have a fuller understanding of the wider issues involved in community care for this group the above studies are supplemented by some earlier works by the candidate.

Submission Eight: The Supervision Register : one year on (Vaughan, 1996)

Background

Health Service Guidelines issued on 1st February 1994 required all mental health provider units to establish supervision registers by 1st April 1994 and to have them fully implemented by 1st October 1994, (NHS Management Executive, 1994). The aim of the register was to identify those people with a severe mental illness who may have been at significant risk to themselves or others and ensure that they received appropriate and effective care in the community. However, there was much controversy over the introduction of the register. Considerable doubts were expressed by the Royal College of Psychiatrists about its feasibility and effectiveness (Caldicott, 1994) and by MIND about its lawfulness i.e. that the circular was 'guidance' and therefore not enforceable in law, (MIND, 1994)

Accordingly, the establishment of the registers seemed to have been undertaken without much enthusiasm by mental health professionals and it was thought likely that this would be reflected in a variable pattern of activity. In order to test this hypothesis a study was undertaken to measure the use of the supervision register in the first 12 months of its implementation.

Summary of the study

A postal study was conducted within 4 Regional Health Authorities in the South of England, involving all 90 NHS Trusts with mental health provider units using a specially designed questionnaire [see appendix H(i)] A 72% response rate was achieved. The results showed that the register had been absorbed organisationally but was less accepted professionally. One hundred and nineteen of the 367 consultants in the sample (32%) had no entries on the register at 31st March 1995. The provision of training on its use had a significant effect on compliance although London-based services had marginally less registrations per consultant than their colleagues elsewhere. Very few outside agencies had required access to the register.

The lower number of registrations in London may have been due to services being overwhelmed by the administrative burden imposed by large numbers of vulnerable people who were potentially registerable. If that was the case then the whole purpose of introducing such a measure in areas of highest need would have been defeated.

Critical review

This study was conducted at an early stage of new measures introduced by the Government of the day to combat the perceived poor supervision of those individuals who challenged services. While the figures reveal the number of psychiatrists taking part in the registration scheme, the results may be a more accurate reflection of the efficiency or otherwise of the mental health provider managers in setting up the scheme in their Trusts. Thus the results probably represent the organisational response to the scheme rather than the professional one at this early stage.

In order to test the views of mental health practitioners and their use of the Supervision Register a follow-up study was required.

Submission Nine: Supervision register in practice (Vaughan, 1998b)

Background

The introduction of the supervision register in April 1994 produced a rather jaundiced response from the Royal College of Psychiatrist. It was felt that a mechanism to document a small group of vulnerable patients in the community would have little clinical utility. There were fears that it would prove costly, be time consuming to administer and have an adverse effect on the therapeutic relationship. Furthermore, it was felt that there would be a strong disincentive for consultant psychiatrists to include patients on the register and for other mental health professionals to become keyworkers, (Caldicott, 1994).

A postal survey by Vaughan (1996) 12 months after its introduction showed that although the register had been implemented by the Mental Health Trusts, it was less accepted professionally. To test the latter finding a study was undertaken to determine the views and attitudes of staff using the register and to see whether they felt it was affecting their professional practice.

Summary of the study

A sample of 19 consultant psychiatrists and 28 key workers were interviewed in 10 NHS Trusts covering the rural areas of Wiltshire, Hampshire, Surrey and West Sussex, the urban area of Portsmouth and the London Boroughs of Lewisham and Tower Hamlets using semi-structured interview schedules [see appendices I(i) and I(ii) respectively]. The majority felt that the supervision register was politically motivated and had little effect on their clinical practice. Most felt antagonistic, sharing a view that it was policing by the back door and 'a political ploy'. The number and content of contacts of consultants with patients were said to have been virtually unchanged by the introduction of this scheme with their response being in keeping with clinical need rather than bureaucratic diktat. However, there was a slight increase in indirect patient

activities such as administration and meetings and some key workers were more vigorous in their outreach work.

Most patients did not challenge their registration which may have been the result of the positive way in which the professional presented it e.g. an advantage, in that they were given priority care and treatment. More likely, however, is the fact that most supervision register candidates were among the most damaged and mentally debilitated of the patient group. Their long association with psychiatric services may have desensitised them to what was probably seen as an administrative process. However, it did raise the need to ensure that such individuals are well represented by friends, relatives or advocates in Care Programme Approach meetings. Finally, there was a clear need for greater training for key workers in risk management, together with close supervision to ensure a good service to patients and provide support to staff.

Critical review

The practicalities of time and resources limited the number of consultant psychiatrists who could be invited to take part in the study. Others were excluded on pragmatic grounds, i.e: if they had too few or too many registrations they may not have been using the system judiciously. It was reasoned that those who had no registration may have deliberately avoided using the policy while those with excessive numbers (over 6) may have used it indiscriminately. Furthermore only 53% of the final group agreed to be interviewed. Thus some important contributions may have been missed.

The results represent reported opinion only and there was no verification of statements made by examining patient records to measure any differences in the number of contacts or quality of consultations before and after registration. Neither were patients interviewed to compare their views with that of the consultants and key workers. The survey, therefore, was only as stated viz 'to test the views and attitudes of staff using the register'.

The final work presents a thorough overview of the issues involved in supporting MDOs in the community.

Submission Ten: Working with the mentally disordered offender in the community (Vaughan and Badger, 1995)

Background

At the time that this publication was conceived, there was a dearth of information available for busy practitioners charged with supporting MDOs in the community. Many of the publications available at the time were written by doctors and psychologists who tended to focus on matters related to institutional care. The standard textbooks for social workers, probation officers and community psychiatric nurses made little or no reference to this client group. Furthermore the literature that did exist tended to concentrate on issues raised by the most serious and dramatic cases which were usually far from everyday experience for most practitioners. The majority of MDOs in the community do not fall into such extreme categories and are far more likely to be described as inadequate and vulnerable. Moreover, the existing literature was rather scattered and there was a need to bring together relevant material in a style and format that made it readily available.

Summary of the study

The chapters of the book submitted are:

- Chapter Two deals with the British legal and social policy context and provides some history of the treatment of the mentally disordered offender. This should be helpful to all readers but may have particular relevance for those who are new to this field of work or who are comparing the British system with those found in other countries.
- Chapter Four deals with the assessment of risk and includes a review of the different approaches that have been adopted, including

checklists and reliance on procedures. It also pays attention to the impact of this type of work on the staff involved.

- Chapter Five concentrates on primary and secondary prevention: work that either seeks to prevent those with psychiatric problems from offending or aims to identify those in the criminal justice system whose needs would be better met by the mental health services. The chapter includes case management and divert-to-treatment schemes.
- Chapter Six deals with the traditional forensic patient: those under restriction orders who are leaving hospitals and will be under the care of a social supervisor. The role and statutory responsibilities of the social supervisor are fully described and the whole process from acceptance of the order through transfer to termination is discussed with case material.
- Chapter Eight considers likely developments and emerging trends in the field. The book ends with a return to the needs of the worker and to a review of training needs and provision.

Critical review

Although a useful synthesis and interpretation of the literature, the book suffered from the moratorium on its length by the publishers. Thus some key material was omitted which would have made the coverage of the topic more comprehensive. For example there were a number of sub-groups and topics which would have benefited from coverage e.g. the special issued raised by female offender patients, those with learning disabilities, personality disorder, drug and alcohol misuse, etc. Additionally, with a constantly changing scenario, in terms of policies and legislation for this group, some of the material is now dated and in need of revision.

Summary of submitted works

The overall aim of these ten pieces of work is to present a robust assessment of need upon which to base strategies for the development of services for MDOs from a defined geographical population. Seven of the publications have focussed specifically on various aspects of the continuum of care for this group. The research carried out under the auspices of The Wessex Consortium has been supplemented by the three publications from earlier work on aspects of community care. This has led to a better understanding of the issues involved in planning such services.

As a whole, the works have assisted in the prediction and management of demand for health and social services provision within The Wessex Consortium area. It has also illustrated the value of applied research being closely linked to decision-making around service development.

HOW THE WORKS RELATE TO EACH OTHER

The studies published between 1999 and 2002 were the result of a linked series of projects designed to gain a clear understanding of the needs of MDOs within a defined population, and to ascertain the extent and capacity of services available to meet them. Each project used a common definition of MDO as the criterion for including individuals in the study, which provided consistency across the work undertaken. In only one survey (Vaughan and Stevenson, 2002) was there a slight modification of the definition, which was necessary to cover the parameters of the study in its relationship to mentally disordered prisoners. Subsequently, the completed works formed the basis for a local strategy for the management of MDOs in Hampshire and the Isle of Wight, (Shakespeare, 2000).

The studies published between 1995 and 1998 concentrate on the community aspects of care for MDOs and expand in more detail a number of issues raised in some of the publications referred to above. For example, the book on Working with the Mentally Disordered Offender in the Community (Vaughan and Badger, 1995) provides much more information on the knowledge and practice requirements of community practitioners when supporting this client group. The community study (Vaughan et al. 2000) illustrates how much relevance this book has for all staff working with MDOs in community settings. Finally, the two publications on the use of the Supervision Register (Vaughan 1996, Vaughan 1998b) provide an insight into some of the likely reasons why so few MDOs in the community study (Vaughan et al. 2000) were subject to any 'formal' community supervision.

Thus the ten submissions as a whole form a substantial body of knowledge on the needs of MDOs within Hampshire and the Isle of Wight and the spectrum of services needed to meet them. All of the works are inter-related and cover a common topic. Although most of the studies are focussed on a particular geographical area, many of the findings have resonance with the provision of services throughout the United Kingdom. An additional illustration of the linkage between the studies is shown in figure three.

FIGURE 3: Relationship of submitted works to each other

Spectrum of services required to meet the needs of MDOs	Research publications submitted covering this topic
Prison psychiatric provision	Vaughan et al. (1999a)
Secure hospital care	Vaughan (1999) Vaughan (2000)
Acute hospital care	Vaughan (1999)
Hostel care	Vaughan (1999)
Day care	Vaughan et al. (1999b)
Diversion services/police	Vaughan and Badger (1995) Vaughan et al. (2001)
Community supervision/support	Vaughan (1996) Vaughan (1998b) Vaughan and Badger (1995) Vaughan et al. (2000)
Service user views	Vaughan and Stevenson (2002)

SIGNIFICANCE AND ORIGINAL CONTRIBUTION TO KNOWLEDGE

The importance of a whole systems approach to mapping any mental health service is emphasised by Kennedy, (2002). It is crucial to enlist the co-operation of all agencies likely to be involved in a patient's care pathway to ensure that service boundaries do not create barriers to movement of individuals across different services according to their need. However, although there is an extensive literature on MDOs and their needs, there appears to be a dearth of publications that emphasise the importance of a whole systems approach to assessing their needs. Perhaps the most comprehensive coverage of this area is a focus paper by The NHS Confederation (The NHS Confederation, 1997), which outlines the full range of issues to be addressed when commissioning and providing forensic mental health care. There is little evidence that such an approach to needs assessment has been taken in any particular geographical area. Indeed, most of the current literature concentrates on maximum and medium secure hospitals where most forensic psychiatrists are based. Dabbs and Isherwood (2000) describe attempts by the York NHS Trust to create a psychiatric service for its MDOs who did not require confinement in medium secure settings but who instead needed a range of low secure and community services. However, such plans did not appear to be based on research evidence of need.

Thus the submitted works as a whole represent a unique account of a range of needs of MDOs from a defined geographical area with some contributions having a more generalised importance. While some elements of the work have been undertaken elsewhere, the results are not directly comparable due to methodological differences, population variables, etc.

Secure care needs

A number of needs assessment studies have been carried out which have sought to identify secure placement requirements and have been concerned with population-based needs considerations. Most have adopted slightly

different emphases and have covered different populations to the Wessex Consortium work, which make comparisons difficult. For example, a study by Murray et al., (1994) targeted Special Hospital patients only; Bartlett et al. (1999) excluded patients with learning disabilities; McKenna et al. (1999) limited their study to individuals with a diagnosis of schizophrenia. Most studies exclude assessments of their prison populations and none appear to match needs with existing resources. All are relative to their populations only. Furthermore, the separate prison studies which have been undertaken have identified the prevalence of mentally disordered prisoners generally, rather than describing how many individuals from a given geographical area require transfer into different levels of psychiatric health care. (Gunn et al. 1991, Birmingham et al. 1996, Brook et al. 1996, Singleton et al. 1998).

The only comparable study directly relevant to the population of The Wessex Consortium was carried out by Stevens et al. (1998) which surveyed the care needs of individuals with mental illness and aggression. While covering similar ground to that of the submitted works in respect of those in secure provision, the results are not equivalent due to a number of differences between the studies. The study by Stevens et al. covered a larger geographical area (the old Wessex Region), only two of the three high secure hospitals were included, people with learning disabilities were excluded and prisons were not directly surveyed. While, therefore, studies of discrete populations and their need for secure psychiatric care have been conducted by a number of researchers, none directly replicate the submitted works on this area of need.

Police and diversion schemes

Most of the research relating to diversion of MDOs from the criminal justice system has been focussed on court diversion schemes and there is a comparative scarcity of papers on diversion at the point of arrest, (James, 1999). A generalised account of the police and MDOs is given by Bean (1999) which covers many of the important issues of police competency in identifying mentally disordered detainees. However, the paper concentrates

mainly on Section 136 of the Mental Health Act 1983 and is more of a review article than an analysis of primary data.

A few key studies have been carried out on police screening of MDOs and diversion at the point of arrest but none equate to the submitted work on the subject. An early study by Wix (1994) which evaluated the effectiveness of a police diversion scheme relied on observation of detainees during the booking-in process in the custody suite to identify potentially mentally disordered individuals, or responded to referrals from the police. Similarly a study by Robertson et al., (1996) of all detainees arrested in seven London police stations relied on observational methods to determine the presence of obvious mental illness. Only 1.2% were regarded as seriously mentally ill. As no effort was made to screen detainees by interview, it is likely that their findings were an under-estimation of the true numbers of mentally disordered people passing through the cells. Those individuals who are not floridly disturbed or fail to volunteer information about their background are likely to have been missed.

By the same token a survey of 4,300 custody records in a London police station by Revolving Doors (1994) found indications of major mental health problems in 1.6% of all detainees, but is likely to be an underestimation for the same reasons as given above. More recently Riordan et al. (2000) examined the efficacy of diversion at the point of arrest for a group of individuals between 16 – 93 years but only evaluated those referred to the diversion scheme by the police.

In the learning disability field a number of studies have concentrated on the interaction with the police and the Criminal Justice System. For example, Lyall et al. (1995) reported on three linked studies which investigated the extent to which people with learning disabilities were engaged in offending behaviour in the Cambridge Health District which were designed to inform service development. They found that twelve (4.4%) of the people arrested had a mild or moderate learning disability and that seven (2%) of 318 adults living in a residential placement for adults with learning disabilities were

interviewed by the police for an alleged offence. However, although some received a prison sentence, none were referred to diversion services due to lack of established links between the criminal justice system and other services and the influence of 'protective' attitudes of staff. Thus although identified as vulnerable individuals, their reasons for non-diversion contrasted with the findings of the submitted work where detainees were not diverted because they were not identified by the police as mentally disordered in the first place.

Furthermore, following a comprehensive literature search, Barron et al. (2002) concluded that offenders with intellectual disability often received inadequate services as a result of poor identification through the Criminal Justice System and that research into effective treatments is rudimentary.

The method used in the submission on this topic, involved screening interviews with a sample of detainees who had not been identified by the police as having a mental disorder and comparisons were made between bridewells with and without diversion schemes. This approach does not appear to have been replicated elsewhere and certainly no work on the subject has previously been carried out in Hampshire. It is likely therefore to have produced a much more accurate picture of the number of individuals with mental disorder passing through police cells.

Community care

Much of the research on MDOs in the community has been carried out in the USA and has focussed on the effectiveness of different models of service delivery e.g. outpatient care, partial hospitalisation, assertive outreach, etc. A similar approach to the published works was used by Nuehring and Raybin (1988), in that a key informant questionnaire survey of criminal justice professionals, mental health and forensic professionals and social service agency representatives was carried out in the Miami area of Florida, to determine the feasibility of community-based care for MDOs. However, this

was an attitudinal study rather that one designed to measure quantity of demand on services and ability of individuals to meet need. In any event, it is notoriously difficult to compare studies from overseas as definitions of MDOs are relative and culturally determined.

In this country, publications relating to the delivery of community services for this group tend to be review or descriptive articles rather than an analysis of primary data (Whittle and Scally 1998, Snowden et al. 1999) or arguments for a style of work and range of knowledge required when working with MDOs, (Prins, 1970, 1990). In relation to learning disabilities Lindsay (2002a) reviewed eleven articles that reported on all aspects of offending and intellectual disabilities which highlighted issues of epidemiology, vulnerability, assessment of the offence and intervention. Additionally Holland et al. (2002) proposed that two broad groups of people with learning disabilities can be identified i.e. firstly those with a combination of significant intellectual impairment coupled with social disadvantage and mental ill-health and secondly, those already known to intellectual services where 'challenging' behaviour has become regarded as 'offending' behaviour. Furthermore, Hayes (1996) has highlighted the importance of service providers having a working knowledge of the Criminal Justice System and a clear idea of their role in relation to the client group, especially during police interviews.

While the above studies have not replicated the submitted work, certain elements of the submitted work have been addressed by other authors. Hudson et al. (1993) looked at the training needs of probation officers and social workers in this field as did the Social Service Inspectorate, (1997). Furthermore, Mason and Murphy (2002a) conducted one of the first systematic investigations into the prevalence of people with intellectual disabilities in the English probation service and described the characteristics of such probationers. They concluded that a significant minority of probationers have an intellectual disability or similar needs. A further study by the same authors (2002b) identified 7% of probationers with intellectual disabilities from a sample of ninety people on probation in south-east England. These studies make clear the ramifications for the probation service in having to

supervise a group of clients whose support needs may require additional expertise and resources. However, there was no comparison with mentally disordered offenders supported by other types of community teams.

Other review articles have examined the characteristics of people with learning disabilities who offend. For example, O'Brien (2002) reviewed research findings concerning individuals with so called 'dual diagnosis' i.e. intellectual disability with an added psychiatric disorder and gave high priority to research questions concerning the nature and psychopathology among offenders with intellectual disability. Additionally, Winter et al. (1997) investigated factors contributing to suspected offending behaviour by adults with a history of learning disability taken into custody at a Cambridge police station. They found that the offending group shared many social characteristics with the general offending population. However, neither of these studies linked the findings to the skills mix required of community learning disability teams.

More specifically Lindsay (2002b) reviewed the literature in relation to the characteristics of sex offenders with learning disabilities and found disparate results due to the different variables used in collecting the data. Lindsay et al. (2002) carried out an audit of a service for sex offenders with intellectual disabilities aimed at maintaining their community placements. However, the study focussed on the effectiveness of the service rather than the qualities of the staff and in neither of these studies was there a comparison with other client groups.

As part of its review of care for people with severe mental illness who are hard to engage with services, The Sainsbury Centre for Mental Health (1998) attempted to define the group, estimate its size and describe its main needs. However few studies appear to have been made of all of the MDO population in a defined population area. Perhaps the most comparable study is that by Murphy and Fernando, (1999). Their study surveyed mental health and learning disability teams in two boroughs in Kent to determine numbers and descriptions of people with challenging behaviour supported by their teams.

Although similar results were obtained to those in the submitted works, the study did not include probation or drug and alcohol teams, nor did it include day care services.

At the time of writing the submitted work of Working with the mentally disordered offender in the community (Vaughan and Badger, 1995), the literature on the subject was disparate and rather obtuse. Most publications were concentrated on clinical, legal and institutional issues rather than community care. At that time the most comprehensive coverage of MDOs was by Bluglass et al. (1990) although only eight of the 1405 pages were devoted to the probation service and very little else to social work or community care. The publication by Herbst and Gunn (1991) did reflect the move to care in the community for this client group and Section 5 was devoted to that topic. However, it is largely descriptive and ideological rather than instructive. A publication by Norris (1984) was the only British publication to concentrate exclusively on community supervision and after-care of the conditionally discharged patient. However, it offers no guidance to workers involved with patients who are not from high secure hospitals and who form the bulk of MDOs in the community. The only writer at the time who provided any guidance for community supervisors was Prins, (1986). However, his coverage of the topic mostly concentrated on the more extreme end of the criminal/mental illness spectrum.

Thus the book provided new knowledge in the overall subject area of MDOs. It identified and synthesised knowledge from experience in different fields and different disciplines which was previously not available or accessible. It provided new knowledge on key perspectives and provided a basis for professional education and training. Subsequently there have been a number of publications around this topic. A series of publications have been produced from the nursing perspective. (Robinson and Kettles, 2000; Challoner and Coffey, 2000; Dale, et al. 2001). A sociological perspective on MDOs has been produced by Mason and Mercer (1999), and Webb and Harris (1999) have edited a volume as a tribute to Professor Herschel Prins. A chapter on people with learning disabilities who offend has been contributed by Murphy

and Mason (1999) in an edited volume entitled Psychiatric and Behaviour Disorders in Developmental Disabilities and Mental Retardation. More recently Alec Buchanan (2002) has edited a title on, Care of the mentally disordered offender in the community. However, although the topic has been updated and expanded in many of these publications, they do not duplicate the submitted work. Many draw upon the North American experience of working with MDOs which is not always transferable, while others focus mostly on nursing interventions. Yet others address issues not covered by the submitted work, which remains a significant addition to the literature.

Supervision Register

The submitted work on the use of the Supervision Register one year after its implementation appears to have been the first piece of published work on this topic. By the time the second submitted work on the topic was published (Vaughan, 1998b), the subject had attracted other researchers who published around the same time. However, the contemporary publications did not cover the ground in a comparable manner.

Godin and Scanlon (1997) carried out interviews with thirteen community psychiatric nurses to examine their attitudes towards supervision and changes to the way in which care was organised and developed. The study was limited by the low number of a single discipline and was limited to one area. A study by Lowe-Ponsford et al. (1998) used questionnaires to test the views of consultant psychiatrists to the Supervision Register, which produced similar results to that of Vaughan (1998b) but was again restricted to one discipline from a limited area. Goldstaw and Salib (1998) gathered statistical details for England and Wales on the use of the Supervision Register but did not explain how this was done. They also surveyed practitioners in North Cheshire about their attitudes to being key workers but again did not explain how this was carried out. Furthermore, the survey was limited to just seven practitioners. The inadequate detail of the study makes it difficult to compare with other work. A more rigorous study of the key workers attitudes to the Supervision

Register was carried out by Nolan et al. (1998) in one mental health trust but was limited to nurses only.

The two most comprehensive studies which covered similar ground to the submitted works and produced similar results, were both published some time afterwards, (Bindman et al. 1999, 2000). For example, Bindman et al. (1999), used the results of a questionnaire of key informants into the use of the Care Programme Approach (CPA) and Supervision Register (SR) to compare them with the data from Health Authorities using the Mental Illness Needs Index as a measure of population need. Wide variations in the application of the CPA and SR were not explained in variations of population need and revealed inconsistent use of the CPA and SR as a method of prioritising services. In the follow-up study (Bindman et al. 2000), Responsible Medical Officers completed questionnaires and key workers were interviewed, which showed similar doubts of mental health professionals about the Supervision Register to those obtained in the submitted work.

MDO service user views

Publications on satisfaction surveys of MDO service users are somewhat scanty and tend to be dominated by studies of inpatients of secure hospital settings, (Vartiainen, et al. 1995, Morrison et al. 1996, Russell and Kettles, 1996, Huckle, 1997, Ford et al. 1999, McIntyre 1999). One of the few studies of a similar non-institutionalised group of patients is by Jones and Mason (2002) who interviewed individuals subject to Section 136 Mental Health Act 1983, to determine their perceived quality of care and the disparity between police interactions and those of mental health professionals. However, they included only two of the eleven types of services and professionals covered in the submitted work on this topic, (Vaughan and Stevenson, 2000).

A study of user views of people with intellectual disabilities and challenging behaviour who had committed criminal offences, or were at risk of offending was carried out by Murphy et al. (1996). A similar Likert-type scale to that used in the submitted work on this topic was used to determine their views on

their previous contact with different professions in their earlier treatment setting and on the activities engaged in. However, as well as being a substantially different client group, the study focussed on their experience in one particular specialised hospital unit in contrast to the more general experience of the prisoners in the submitted work.

The only other study that seems to approach the same area is by Rose et al. (1998) who surveyed 58 mental health clients on the top tier of the Care Programme Approach, 73% of whom had had some contact with the police. These were individuals who were being supported by community services, unlike those in the submitted work but who reported similar shortcomings, particularly in respect of housing.

Thus no directly comparable work on the issues covered in the submitted work on service users appears to be available.

Outcome of the research

The research has been well received by local commissioners who have used the results to support a number of service developments e.g:

- Development of a multi-million pound long-stay, medium-secure service which opened in May 2002.
- Commissioning plans for the development of a long-stay, low-secure service due to open in December 2004.
- Revision of joint working practices between health and social services on the Isle of Wight.
- Improved training for community staff working with MDOs.
- Improved training for police custody staff.
- Further developments in the provision of psychiatric advice to magistrates' courts, (Austin et al. 2003).

Submissions one and five have been quoted extensively by the National Institute for Mental Health in England (2003a) in their review of research

evidence supporting its Cases for Change publication. Submissions two and nine were also cited in the bibliography of research publications consulted (2003b).

Material from submission ten was drawn upon by the Health Advisory Service when setting its standards for MDOs, (Health Advisory Service 2000,1999). Submission ten has also become the course text book for an MA module on 'Working with Mentally Disordered Offenders in the Community' at the University of Reading.

Finally, the methodologies of some of the research projects have been requested for replication elsewhere in the country, i.e.

Submission one : East Anglia

Submission five : North Wales

THE EQUIVALENCE OF THE PUBLISHED WORKS TO A PhD BY THE CONVENTIONAL (THESIS) ROUTE

The total length of the publications submitted is 80,000 words, which is the normal length of a PhD thesis. They also cover a period of seven years which is roughly equivalent to the time taken to complete a PhD by the normal route on a part-time basis.

All of the research papers are shorter versions of much longer and fuller reports. They have all been published by mainstream professional journals and validated by academic referees. The book received similar academic scrutiny before publication and subsequently received very positive reviews, viz:

> "Before reading this book myself, I decided to conduct a little market research study. I gave this book to the social worker and CPN that work in my forensic psychiatry service. I received rave reviews! They thought that this should now be the standard book for all practitioners involved in the community care of mentally disordered offenders. I am sure that this is so".
>
> "In summary, if you are a psychiatrist who works in this field, consider buying this book even though you are not the target audience. It deserves a place in every psychiatric library, if there are any copies left after it is purchased (as it should be) by social workers, probation officers and nursing practitioners, their managers and teachers".
>
> P. R. Snowden
> Consultant Forensic Psychiatrist
> Psychiatric Bulletin (1995) 19, 717

> ".....Vaughan and Badger's impressive book contains everything you could wish to know about community care legislation in a manageable format."
>
> "Reading the book made me realise I had a number of patients on my caseload who were offenders but who were not recognised as such – those the authors term 'patients whose offences are officially ignored'. The book is relevant not just to those working with patients from special hospitals or on probation orders but to all mental health, criminal justice and social service workers".

"...this book offers a valuable contribution to the art of balancing risk against therapeutic gain".

Tony Gillam, B.A., RMN
Community Psychiatric Nurse
Nursing Times (1995) 13th June, 53

"This book occupies a useful gap in the current literature, supporting more traditional texts, but also stands alone as being a useful handbook for those directly involved".

Colin York
Senior Lecturer, Occupational Therapy
South Bank University
British Journal of Occupational Therapy (1995) 58(5) 218

The publication of the service user survey (Vaughan and Stevenson, 2002) has attracted the attention of the editor of the Prison Service Journal who has described the article as "... a particularly elegant, accessible piece of research", and who wishes to reproduce the article in a future edition of the Prison Service Journal (George, 2003).

The findings from the reports have been positively received locally resulting in numerous presentations. Papers on the findings have also been presented at a number of conferences viz:

- NHS Executive South and West Regional Conference on MDOs Taunton 10.12.97
- Gatehouse Conference on 'Strategies for the future of secure provision'. York 29.4.98
- Harrogate Management Centre, 'Re-integration of MDOs' London 13.12.2000
- 3rd International Forensic Mental Health Conference, 'Creating seamless services in forensic psychiatry'. University of Central Lancashire. 4th – 6th June 2001. (2 papers presented).

The relevant literature on the topic has been reviewed and evaluated and the research has enlarged and consolidated my knowledge on the subject.

The focus of the research has been clear and has been adhered to without straying into non-related areas. This has resulted in a series of tasks which have led to a progressive reduction of uncertainty related to the needs of MDOs within a defined geographical area much of which can be generalised to a wider audience particularly from the community focussed activity.

The findings also indicate the potential for further research into the needs of more specific groups such as women and those with discrete clinical conditions, e.g. personality disorder. Furthermore, they have clear links into the need for multi-agency/multi-disciplinary training.

Finally all of the findings have been 'tested' by presentations to numerous mental health and forensic clinicians, managers, planners and policy makers who have used the result on which to base the development of future services.

AN ACCOUNT AND CRITIQUE OF THE RESEARCH METHODOLOGIES USED IN THIS RESEARCH

The works submitted consist of basic descriptive research using a combination of methods i.e. questionnaires, interviewing, participant observation and written sources.

Questionnaires

Postal questionnaires were used to gather information in three studies. In submission one, a survey form was sent to all Consultant Forensic Psychiatrists in high secure hospitals and the local medium secure unit. Due to the time pressure of completing the study, the validity and reliability of the questionnaire was not tested beforehand. Nevertheless, it had been adapted from a document previously used by commissioners to gather similar information on a routine basis and was seen and commented on by senior managers and clinicians. The questionnaires used in the other studies were piloted beforehand.

The use of a fairly simple questionnaire to measure need rather than reliance on a sophisticated validated assessment tool may be seen as a weakness in the research method. However, Bartlett et al. (1996) have argued that a simple questionnaire administered to Responsible Medical Officers (RMOs) represents the safest and most cost-efficient way of assessing the treatment and security needs of special hospital patients. This assertion is based on the assumption that special hospital RMOs will consistently make more conservative judgements about onward placements. Given the expense and time-scales involved in more complex research based assessment of need, this may be the most realistic way of collecting such data. Bartlett et al. (1996) sum it up by describing the two approaches as 'ideal world' assessments and 'real world' assessments.

None of the studies attracted a 100% response rate which of course always raises the question of the significance of any missing data. It may be that the

non-responders felt they had nothing to contribute, overlooked or simply ignored the questionnaire. Furthermore, in each study the returns were not verified from an independent source and the views of the respondents had to be accepted on face value.

Interviewing

Interviews were used in seven of the works submitted. Most involved the use of semi-structured interview schedules together with clinical assessments. Again sophisticated and validated assessment tools were not used due to the reasons given above. Additionally, although there is the danger that clinical assessments alone may be rather subjective, note is taken of a study to assess the mental health needs and services for young offenders by Nicoy et al. (2000). They used a sophisticated screening process to differentiate young people in a variety of residential establishments who had been deemed by staff to have a mental problem and compared then with a group not so identified. After a subsequent clinical assessment they concluded that, "....the screen was invalid as a predictor of psychiatric disorder in the various population groups we studied.... We might just as well have taken a sample of the various establishments included and studied their needs without the trouble of administering the screen questionnaire", (p.248).

Thus it was that in the three surveys where a clinically reasoned judgement was required, the methodology was sufficiently robust given that an actual diagnosis was not required. Nevertheless, in submission four, individual clinical judgements were matched against The Code for Crown Prosecutors (Crown Prosecution Service, 1994) and were reviewed by a research panel to achieve consistency between the two interviewers.

Inevitably the use of interviews in the submitted works was limited to sample populations ranging from 15% - 93%. There may have been some under-reporting particularly where individuals were asked to give details of their background or professional practice. In others, their subjective views could not be tested or verified. Answers may also be affected by other factors. For

example in submission eight, interviews were held with consultant psychiatrists and key workers of patients on the Supervision Register. Their views about the impact of the Supervision Register could be biased either negatively by the general sensitivity to the policy or positively to justify their own role in including such patients on their caseloads. However, their views were matched by subsequent equivalent research by Bindman et al. (2000).

Nevertheless, the reliability of the interviews that were conducted was not routinely addressed. If done again the following methods could be used to address this point.

In submission two, given more time and resources, all prisoners from the Consortium area, whether deemed by the probation officers and prison medical officers as mentally disordered offenders or not, could have been assessed by the project workers. This would have produced a more comprehensive and consistent assessment of the MDO population from the Consortium area. Alternatively, those who were interviewed in the study could have been interviewed separately by both project workers in order to obtain inter-interviewer reliability data. However, apart from the logistical problems, it may have been difficult to explain to prisoners why a second interview was necessary without implying that their initial responses had somehow been inadequate.

In submission four, the validity of the findings identifying those who were missed by the police as suitable for diversion could be improved by the use of a scoring system by the panel in the final assessment. A comparison of the scores would provide a more concrete measure of inter-rate reliability.

Finally, in submission six, additional separate interviews could be held with some of the deputy day care managers which would provide a comparative set of data to that obtained from the day care managers themselves.

Participant Observation

This method formed a small element in the submitted works two and four. In both cases the observers were 'free' and direct. Both of the research workers involved had previous experience within the prison system and police cells and so were able to distinguish between 'normal' behaviour and that which might have been staged for their benefit.

Within the prison system the culture is strong and dominant and is likely to have been little influenced by the presence of the research workers, who were there ostensibly to interview prisoners and only incidentally to observe the prison regime. Their presence in the police cells may have been a little more influential in affecting the way in which police personnel dealt with detainees, although their daily appearance over a number of weeks would have seen their influence diminish as time passed.

Written Sources

Several of the submissions used additional written sources of information to supplement their investigations. These included an examination of written policies and protocols in relation to community and day care services. In the prisons, health care records were scrutinised and custody records seen in police custody suites. However, in both of these latter cases little was added to the information already gathered due to the inadequacies of the records kept. Submission two also involved the examination of Home Office records for transferred prisoners.

The relevant literature was reviewed for each submission and a major review of the literature was undertaken for submission ten. Making comparisons and drawing examples from other countries was difficult due to the differing cultural influences on the definitions of mentally disordered offenders and the different legal and psychiatric systems in place. Priority, therefore, was given to studies based in the U.K.

LIMITATIONS OF THE RESEARCH

Apart from the methodological shortcomings described above there are a number of limitations to the research.

Time/resources

There have been the constraints of lack of time and resources which have influenced the usefulness of the submitted works viz:

- The research has been carried out from a health organisation base rather than an academic institution. Accordingly the work has lacked the benefit of any academic supervision which may have improved the rigour of the methodologies used.
- Similarly a lack of statistical support led to a modest use of statistical analysis and some studies would warrant a further examination of the interaction of variables.
- I was under considerable pressure of time to reach deadlines in presenting results which precluded a more leisurely analysis of data before moving on to the next project. Since 1997 I have been working on a 12 month renewable contract and did not have the security to extend each project.
- Most of the published works have been the results of relatively small projects and have concentrated on a defined geographical population. Many of the results cannot be generalised to the wider forensic community.

Screening tools

It is argued by Shaw (2002) that needs assessment for MDOs is different from that used in the general psychiatric population in that there needs to be a different emphasis on certain domains such as co-morbid personality disorder,

substance abuse and offending behaviour, security needs and sometimes consideration of a political dimension.

Sophisticated screening tools were not used for the reasons given above (ideal world research v. real world research) and also because Health Authorities need to use the most cost-effective method of obtaining data, given the expense and time-scales involved in more complex research-based assessment of need. The needs assessments have also been unable to benefit from an additional specialist assessment tool currently being developed. A forensic version of the Camberwell Assessment of Needs (CANFOR) is currently under development and is likely to be published later in 2003, (Thomas, 2003).

Lack of comprehensiveness

Although the research has provided a sound knowledge base on which to develop services, it has not been comprehensive. The Reed Report (Department of Health/Home Office, 1992) identified a number of groups of MDOs who have special or differing needs, i.e:

- People with brain injury
- People who are deaf or hearing impaired
- Substance misusers
- Sex offenders with mental health care needs
- Suicide prevention
- Children and adolescents
- Young people with learning disabilities or autism
- Elderly people
- Women
- Homeless mentally disordered offenders
- Prisoners
- People from black and ethnic minority groups

While the submitted works were not intended to include the elderly or children and adolescents, many of these specialist groups have yet to be researched. Of particular importance is the need to address the issues around providing forensic services for women and individuals with personality disorder. In both of these cases, strategies have recently been published by the Government which will heavily influence the development and style of services for these groups (Department of Health, 2002; National Institute for Mental Health for England, 2003c). Only when all of these sub-groups are covered can more individually tailored services and interventions be developed.

'Shelf-life' of research

A major shortcoming of research of this type is that the results have a limited 'shelf-life'. The needs of any patient group are likely to be a 'moving target' and in need of constant updating. For example, the patient group identified in 1998 as needing a long stay medium secure placement, was replaced by a largely different group of patients when the new unit was opened in 2002. Thus the research was able to identify a broad area of need but the individual patient needs were constantly changing due to the variance in their clinical state, changing social circumstances and the emergence of new services and interventions. Indeed the subsequent development of services as a result of the needs assessments immediately alters the balance between needs and resources available to meet them.

Accordingly, the research presented can quickly become dated and needs a rolling programme of updating to remain current. Similarly, the literature which is reviewed in submission ten, has been overtaken by the emergence of new policies and legislation and is in need of revision.

However, a positive aspect of this type of approach is how far this research evidence is used. Thus it is important for the researcher to be actively engaged with the planning and development process.

REVIEW OF DEVELOPMENT AS A RESEARCHER

I first became interested in research in 1977 while undertaking an M.Sc. in Mental Health at the University of Leeds. The taught part of the course included a research module on research methods and the degree was awarded partly on the submission of a research dissertation. The award of the Diploma in Management Studies in 1989 also included the submission of a research dissertation.

Subsequently during my career, first as a mental health practitioner and then as a mental health manager, I continued 'learning on the job' by including research activities in my work in a variety of settings. I have published a number of research studies, review papers and a book on Suicide Prevention, which have not been included in the submitted works. (See complete list of published works in appendix 'K').

During this time, I have had an ongoing association with the University of Reading as a visiting lecturer and latterly as a member of their Mentally Disordered Offender Research Group. In 1996, in recognition of my contribution to the University I was appointed as an Honorary Research Fellow and this was renewed in 1999 and 2002.

From 1997, my research activities have accelerated significantly as this has been part of a requirement of my post of Project Manager for The Wessex Consortium. Initially, strict time limits were imposed on each project and I did not have the authority or confidence to challenge this. However, as time has passed I have seen how such constraints can sometimes compromise the rigour of the research and now have the confidence to resist demands to complete projects within unrealistic time scales.

As an example, in 1998 I was asked to undertake a survey of adolescents requiring secure care in the whole of the area covered by the old South West Regional Health Authority, within a timescale of less than four months. Due to the requirement to produce a report to a planning committee on a certain

date, there was no time for adequate preparation, testing of the survey questionnaire, analysis of data, etc. As a result, I produced a 'quick and dirty' piece of work which was rushed and inadequate. While accepted by the committee, I felt embarrassed by the result and did not write it up for publication.

Subsequently, I have resisted being rushed into any projects without the time to ensure that they have been thoroughly prepared and properly implemented within a realistic time frame. My more concentrated research activity in the last few years has enabled me to improve my competence and become more confident in this role. This is illustrated by a recent comment from the editor of the British Journal of Learning Disabilities in respect of a forthcoming research publication (Vaughan, in print):

> "I am returning your paper with referees comments and annotated typescripts. Both referees recommend publication of the paper with only minor amendments and these are clearly listed. This is quite rare – you should feel pleased."
>
> Dr Jan Walmsby
> Co-editor
> British Journal of Learning Disabilities
> 23rd October 2002

In light of my experience and publications, I have been asked to comment on some national developments in relation to MDOs viz:

- Systematic Review of International Literature on the Epidemiology of Mentally Disordered Offenders. NHS Centre for Reviews and Dissemination, (Badger et al. 1999b).
- Therapeutic Community Effectiveness : a Systematic International Review of Therapeutic Community Treatment for People with Personality Disorders and Mentally Disordered Offenders. NHS Centre for Reviews and Dissemination, (Lees, et al. 1999).
- Health Advisory Service programme for developing quality standards in medium secure units (2002 – 2003).

However, I hope that my competence as a researcher will continue to improve with further experience and exposure to new techniques and applications.

REFERENCES

(including references by the candidate not included in the submitted works)

AUSTIN, C., LE FEUVRE, M., O'GRADY, J., SWYER, B. and VAUGHAN, P. (2003). Improving psychiatric information for magistrates' courts. **Justice of the Peace** 167 1 and 2, 6-7 (11th January).

BADGER, D., WOODWARD, M., WILLIAMS, P and VAUGHAN, P.J. (1999a) Planning to meet the needs of mentally disordered offenders : in the United Kingdom. **Psychiatric Services** 50, 12 1624-1627.

BADGER, D., NURSTEN, J., WILLIAMS, P.. and WOODWARD, M. (1999b). **Systematic review of the international literature on the epidemiology of mentally disordered offenders.** Report CRD15 University of York Centre for Reviews and Dissemination/University of Reading.

BARRON, P., HASSIOTIS, A. and BANES, J. (2002). Offenders with intellectual disability : the size of the problem and therapeutic outcomes. **Journal of Intellectual Disability Research** 46 (6) 454-463.

BARTLETT. A., COHEN, A., BACKHOUSE, A., HIGHET, N. and EASTMAN, N. (1996). Security needs of South West Thames Special Hospital patients : 1992 and 1993. No way out? **Journal of Forensic Psychiatry** 7, 256-70.

BEAN, P. (1999). The police and the mentally disordered in the community 38-52 in D. Webb and R. Harris (editors). **Mentally Disordered Offender – Managing people nobody owns**. London: Routledge.

BINDMAN, J., BECK, A., GLOVER, G., THORNICROFT, G., KNAPP, M., LEESE, M. and SZMUKLER, G. (1999). Evaluating mental health policy in England : care programme approach and supervision registers. **British Journal of Psychiatry** 175, 327-330.

BINDMAN, J., BECK, A., GLOVER, G., THORNICROFT, G., KNAPP, M., LEESE, M. and SZMUKLER, G. (2000). Psychiatric patients at greatest risk and in greater need : impact of the Supervision Register policy. **British Journal of Psychiatry**. 177, 33-37.

BIRMINGHAM, L., MASON, D. and GRUBIN, D. (1996). Prevalence of mental disorder in remand prisons: consecutive case study. **British Medical Journal** 313, 1521-1524 (14th December).

BLUGLASS, R., BOWDEN, P. and WALKER, N. (editors) (1990). **Principles and Practice of Forensic Psychiatry**, Edinburgh: Churchill Livingstone.

BROOKE, D., TAYLOR, C., GUNN, J., and MADEN, A. (1996). Point prevalence of mental disorder in unconvicted male prisoners in England and Wales. **British Medical Journal** 313, 1524-1527.

BUCHANAN, A. (editor) (2002). **Care of the mentally disordered offender in the community**. Oxford: Oxford University Press.

CALDICOTT, F. (1994). Supervision Register : the college's response. **Psychiatric Bulletin** 18, 385-388.

CROWN PROSECUTION SERVICE (1994). **The Code for Crown Prosecutors**. London : The Crown Prosecution Service.

CHALONER, C. and COFFEY, M. (editors) (2000). **Forensic Mental Health Nursing : Current Approaches**. Oxford: Blackwell Science Ltd.

COHEN, A., and EASTMAN, N. (1997). Needs assessments for mentally disordered offenders and others requiring similar services : Theoretical issues and a methodological framework. **British Journal of Psychiatry**, 171, 412-16.

DABBS, H.J. and ISHERWOOD, J. (2000). Bridging the gap : service developments in forensic psychiatric rehabilitation at district level. **Journal of Forensic Psychiatry**, 11, 1, 198-205.

DALE, C., THOMPSON, T and WOODS, P. (editors) (2001). **Forensic mental health : issues in practice.** Edinburgh : Baillière Tindall in association with Royal College of Nursing.

DEPARTMENT OF HEALTH (1997). **Services for mentally disordered offenders in the community : an inspection report**. London : Department of Health.

DEPARTMENT OF HEALTH (2000). Inpatients formally detained in hospitals under the Mental Health Act 1983 and other legislation. England: 1989-1990 to 1999-2000. **National Statistical Bulletin 2000/19** London: Department of Health.

DEPARTMENT OF HEALTH (2002). **Women's Mental Health : Into the Mainstream. Strategic development of mental health care for women.** London: Department of Health Publications.

DEPARTMENT OF HEALTH/HOME OFFICE (1992). **Review of health and social services for mentally disordered offenders and others requiring similar services**. Final summary report Cmnd 2088. London: HMSO.

FARRAR, M. (1996). Government policy on mentally disordered offenders and its implementation. **Journal of Mental Health**. 5(5) 465-74.

FORD, K., SWEENEY, J. and FARRINGTON, A. (1999). User views of a regional secure unit – findings from a patient satisfaction survey. **International Journal of Psychiatric Nursing Research**, 5, 1, 526-41.

GEORGE, C. (2003). **Personal Communication**.

GODIN, P. and SCANLON, C. (1997). Supervision and control : a community psychiatric nursing experience. **Journal of Mental Health**, 6, 1, 75-84.

GOLDSTRAW, D. and SALIB, E. (1998). The Supervision Register : another exercise in paperwork that does not work. **Psychiatric Care**, 5, 1, 26-29.

GUDJONSSON, G., CLARE, E.I., RUTTER, S., and PEARCE, J. (1994). Persons at risk during interview in police custody : the identification of vulnerabilities. RCCJ Research Study No. 12. **Home Office Research Bulletin**, 35, 31-2.

GUNN, J., MADDEN, A. and SWINTON, M. (1991). **Mentally Disordered Prisoners**. London: Home Office.

HAYES, S. (1996). Recent Research on Offenders with Learning Disabilities. **Tizard Learning Disability Review**. 1, 3, 7-15.

HEALTH ADVISORY SERVICE 2000 (1999). **Standards for Mentally Disordered Offenders**. London: Health Advisory Service/Brighton: Pavilion Publishing (Brighton) Ltd.

HERBST, K.R. and GUNN, J. (editors) (1991). **The Mentally Disordered Offender**, Oxford. Butterworth-Heinemann Ltd.

HIGGINS, J. (1991). The mentally disordered offender in the community. In Katia R. Herbst and John Gunn (editors). **The Mentally Disordered Offender**. Oxford: Butterworth – Heinemann Ltd., 171-185.

HOLLAND, T., CLARE, I.C.H. and MUKHOPADHYAY, T. (2002). Prevalence of 'criminal offending' by men and women with intellectual disabilities and the characteristics of 'offenders' : implications for research and service development. **Journal of Intellectual Disability Research**, 46 (Suppl. 1) 6-20.

HUCKLE, P.L. (1997). The use of patient satisfaction surveys in forensic psychiatric settings. **Psychiatric Care**, 4, 5, 230-233.

HUDSON, B.L., CULLEN, R. and ROBERTS, C. (1993). **Training for work with mentally disordered offenders : report of a study of the training needs of probation officers and social workers.** London: Central Council for Education and Training in Social Work.

JAMES, D. (1999). Court diversion at 10 years : can it work, does it work and has it a future? **Journal of Forensic Psychiatry**, 10, 3, 507-524.

JONES, S.L. and MASON, T. (2002). Quality of treatment following police detention of mentally disordered offenders. **Journal of Psychiatric and Mental Health Nursing**. 9, 1, 73-80.

KENNEDY, H.G. (2002). Therapeutic uses of security : mapping forensic mental health services by stratifying risk. **Advances in Psychiatric Treatment**, 8, 433-443.

LEES, J., MANNING, N. and RAWLINGS, B. (1999). **Therapeutic Community Effectiveness : A Systematic International Review of Therapeutic Community Treatment for People with Personality Disorder and Mentally Disordered Offenders.** Report CRD 17, University of York Centre for Reviews and Dissemination/University of Nottingham.

LINDSAY, W. R. (2002a). Integration of recent reviews on offenders with intellectual disabilities. **Journal of Applied Research in Intellectual Disabilities**. 15, 2, 111-119.

LINDSAY, W. R. (2000b). Research and literature on sex offenders with intellectual and developmental disabilities. **Journal of Intellectual Disability Research**, 46 (Suppl. 1) 74 – 85.

LINDSAY, W.R., SMITH, A.H.W., LAW, J., QUINN, K., ANDERSON, A., SMITH, A., OVEREND, T. and ALLAN, R. (2002). A treatment service for sex offenders and abusers with intellectual disability : characteristics of referrals and evaluation. **Journal of Applied Research in Intellectual Disabilities**, 15, 2, 166 -174.

LOWE-PONSFORD, F.L., WOOLSTON, P. and LINDESAY, J. (1998). Consultant Psychiatrists views on the Supervision Register. **Psychiatric Bulletin**, 22, 7, 409-411.

LYALL, I., HOLLAND, A.J. and COLLINS, S. (1995). Offending by adults with learning disabilities : identifying needs in one health district. **Mental Handicap Research**. 8 (2) 99-109.

MADEN, A., TAYLOR, C.J.A., BROOKE, D. and GUNN, J. (1996). **Mental Disorder in Remand Prisons**. London: Home Office.

MASON, T. and MERCER, D. (1999). **A sociology of the mentally disordered offender.** Harlow: Pearson Education Ltd.

MASON, J. and MURPHY, G. (2002a). People with intellectual disabilities on probation : an initial study. **Journal of Community and Applied Social Psychology.** 12, 44-55.

MASON, J. and MURPHY, G. (2002b). Intellectual disability amongst people on probation : prevalence and outcome. **Journal of Intellectual Disability Research**, 46, 3, 230-238.

McINTYRE, B., (1999). Placement and community support needs of patients in a medium secure unit. **Mental Health and Learning Disabilities Care**. 2, 11, 379-382.

McKENNA, J., SHAW, J., PORCEDDU, K., GANLEY, A., SKAIFFE, K. and DAVENPORT, S. (1999). 'Long stay medium secure patients' in Special Hospital. **Journal of Forensic Psychiatry**. 10, 2, 333-342.

MIND (1994). **MIND's response to the Department of Health's Guidance on Supervision Registers and on Hospital Discharge** London: MIND.

MORRISON, P., BURNARD, P., and PHILIPS, C. (1996). Patient satisfaction in a forensic unit. **Journal of Mental Health** 5, 369-377.

MURPHY, G.H., ESTIEN, D. and CLARE, I.C.H. (1996). Services for people with mild intellectual disabilities and challenging behaviour : service-user views. **Journal of Applied Research in Intellectual Disabilities**. 9, 3, 256-283.

MURPHY, G. and FERNANDO, S. (1999). Services for people with challenging behaviour and mental health needs at risk of offending. **Tizard Learning Disability Review**, 4, 3, 31-39.

MURPHY, G. and MASON, J. (1999). People with developmental disabilities who offend, in Nick Bouras (editor). **Psychiatric and Behavioural Disorders in Developmental Disabilities and Mental Retardation**. Cambridge, Cambridge University Press.

MURRAY, K., RUDGE, S., LACK, S. and DOLAN, R. (1994). How many high security beds are needed? Implications from an audit of one region's Special Hospital patients. **Journal of Forensic Psychiatry**, 5, 3, 487-499.

NATIONAL INSTITUTE FOR MENTAL HEALTH IN ENGLAND (2003a). **Cases for Change : Forensic Mental Health Services**. Leeds: Department of Health.

NATIONAL INSTITUTE FOR MENTAL HEALTH IN ENGLAND (2003b). **Cases for Change: Introduction**. Leeds: Department of Health.

NATIONAL INSTITUTE FOR MENTAL HEALTH IN ENGLAND (2003c). Personality disorder: no longer a diagnosis of exclusion. **Policy implementation guidance for the development of services for people with personality disorder.** Leeds: Department of Health.

NHS MANAGEMENT EXECUTIVE (1994). **Introduction of Supervision Register for mentally ill people from 1st April 1994**. HSG (94) 5.

NICOL, R., STRETCH, D., WHITNEY, I., JONES, K., GARFIELD, P., TURNER, K and STANON, B. (2000). Mental health needs and services for severely troubled and troubling young people including young offenders in an NHS Region. **Journal of Adolescence**, 23, 243-261.

NOLAN, P. OYEBODE, F. and LIBURD, M. (1998). A survey of patients placed on the Supervision Register in a Mental Health Trust. **International Journal of Nursing Studies**, 35, 1-2, 65-71.

NORRIS, M. (1984). **Integration of Special Hospital patients into the Community.** Aldershot: Gower Publishing Ltd.

NUEHRING, E.M. and RAYBIN, L. (1988). Mentally ill offenders in community based programmes : attitudes of service providers. **Journal of Offender Counselling Services and Rehabilitation.** 11 (1) Fal-Win 19-37.

O'BRIEN, G. (2002). Dual diagnosis in offenders with intellectual disability : setting research priority : a review of research findings concerning psychiatric disorder (excluding personality disorder) among offenders with intellectual disability. **Journal of Intellectual Disability Research**, 46 (Suppl. 1) 21–30.

PRINS, H. (1975). A danger to themselves and to others : social workers and potentially dangerous clients. **British Journal of Social Work**, 5 (3) 297-309.

PRINS, H. (1986). **Dangerous Behaviour, the Law and Mental Disorder**, London : Tavistock Publications.

PRINS, H. (1990). The supervision of potentially dangerous offender-patients in England and Wales. **International Journal of Offender Therapy and Comparative Criminology.** 34 (3) 213-221.

PRINS, H. (1993). Offender-patients : the people nobody owns. In: Watson W. and Grounds, A. (eds). **The mentally disordered offender in an era of community care.** Cambridge: Cambridge University Press.

REED, J. (1997). The needs for longer-term psychiatric care in medium or low security. **Criminal Behaviour and Mental Health** 7, 201-212.

REPPER, J. and PERKINS, R. (1995). The deserving and the undeserving : selectivity and progress in community care services. **Journal of Mental Health**, 4, 483-493.

REVOLVING DOORS (1994). **The management of people with mental health problems by the Paddington Police.** London: Revolving Doors Agency.

RIORDAN, S., WIX, S., KENNY-HEBERT, J. and HUMPHREYS, M. (2000). Diversion at the point of arrest : mentally disordered people and contact with the police. **Journal of Forensic Psychiatry** 11, 3, 683-690.

ROBERTSON, G., PEARSON, R. and GIBB, R. (1996). The entry of mentally disordered people to the criminal justice system. **British Journal of Psychiatry** 169, 172-180.

ROBINSON, D., and KETTLES, A. (editors) (2000). **Forensic Nursing and Multi-disciplinary care of the Mentally Disordered Offender**, London: Jessica Kingsley Publishers.

ROSE, D., FORD, R., LINDLEY, P., GAWITH, L. and THE KEW MENTAL HEALTH MONITORING USERS' GROUP (1998). **In our experience : user focused monitoring of mental health services in Kensington, Chelsea and Westminster Health Authority**. London: The Sainsbury Centre for Mental Health.

ROSS, C.K., STEWARD, C.A., and SINACORE, J.M. (1995). A Comparative study of seven measures of patient satisfaction. **Medical Care** 33, 392-406.

RUSSELL, J.H., and KETTLES, A.M. (1996). User views of a forensic service. **Psychiatric Care** 3, 3, 98-104.

SAINSBURY CENTRE FOR MENTAL HEALTH (1998). **Keys to Engagement: review of care for people with severe mental illness who are hard to engage with services**. London: The Sainsbury Centre for Mental Health.

SHAKESPEARE, R. (2000). **A strategy for the management of mentally disordered offenders.** Unpublished Report of The Wessex Consortium.

SHAW, J. (2002). Needs assessments for mentally disordered offenders is different. **Journal of Forensic Psychiatry** 13, 1, 14-17.

SINGLETON, N., MELTZER, H., and GATWARD, R. (1998) **Psychiatric Morbidity in Prisoners**. London: The Stationary Office.

SNOWDEN, P., McKENNA, J., and JASPER, A. (1999). Management of Conditionally discharged patients and others who present similar risks in the community : integrated or parallel? **Journal of Forensic Psychiatry** 10, 3, 583-596.

SOCIAL SERVICES INSPECTORATE (1997). **Services for mentally disordered offenders in the community : An inspection report.** London: Department of Health.

STEVENS, A., GOODER, P. and DREY, N. (1998). Care needs of people with mental illness and aggression. **Psychiatric Bulletin**, 22, 36-11.

THE NHS CONFEDERATION (1997). **No bars against care : policy proposals for the treatment and care of mentally disordered offenders**. Birmingham : The NHS Confederation.

THOMAS, S. (2003). **Personal Communication**.

THOMPSON, A. (2000). Falling through the gap. **Community Care**, 30th March 20 – 21.

VARTIAINEN, H., VUORIO, O., HALONEN, P. and HAKOLA, P., (1995). The patients' opinions about curative factors in involuntary treatment. **Acta Psychiatrica Scandinavica**. 91, 3, 163-166.

VAUGHAN, P.J. (1983a). The disordered development of day care in psychiatry. **Health Trends**, 15, 4, 91-94.

VAUGHAN, P.J. (1983b). Day care or confusion? **The Bulletin of the Royal College or Psychiatrists**. 7, 10, 184-185.

VAUGHAN, P.J. (1985). Developments in psychiatric day care. **British Journal of Psychiatry**, 147, 1-4.

VAUGHAN, P.J. (1996). The Supervision Register : one year on. **Psychiatric Bulletin**, 20, 143-145.

VAUGHAN, P.J. (1998a). **Sample specifications for secure care provision for people with mental illness and learning disabilities**. Winchester: The Wessex Consortium.

VAUGHAN, P.J. (1998b). Supervision Register in Practice. **Psychiatric Bulletin**, 22, 412-415.

VAUGHAN, P.J. (1999). A consortium approach to community services for mentally disordered offenders. **Journal of Forensic Psychiatry**, 10, 3, 553-566.

VAUGHAN, P.J. (2000). Developing service specifications for secure provision. **The British Journal of Forensic Practice**, 2, 2, 13-18.

VAUGHAN, P.J. (2001). Mentally Disordered Offenders : Everyone's Responsibility. **The British Journal of Forensic Practice**, 3, 4, 16-21.

VAUGHAN, P.J. (2002). **Sample specifications for secure care provision of people with mental illness and learning disabilities** : Winchester: The Wessex Consortium, 2nd edition.

VAUGHAN, P.J. (in print). The secure care needs of individuals with learning disability and severe challenging behaviour. **British Journal of Learning Disabilities.**

VAUGHAN, P.J. and BADGER, D. (1995). **Working with the mentally disordered offender in the community.** London: Chapman and Hall.

VAUGHAN, P.J. KELLY, M. and PULLEN, N. (1999a). Psychiatric support to mentally disordered offenders within the prison system. **Probation Journal** 46, 2, 106-112.

VAUGHAN, P.J., KELLY, M. and PULLEN, N. (1999b). Day care for mentally disordered offenders. **The British Journal of Forensic Practice**. 1, 4, 9-16.

VAUGHAN, P.J., KELLY, M. and PULLEN, N. (2001). The working practices of the police in relation to mentally disordered offenders and diversion services. **Medicine, Science and the Law**, 41, 1, 13-20.

VAUGHAN, P.J. PULLEN, N. and KELLY, M. (2000). Services for mentally disordered offenders in community teams. **The Journal of Forensic Psychiatry.** 11, 3, 571-586.

VAUGHAN, P.J. and STEVENSON, S. (2002). An opinion survey of mentally disordered offender service users, **The British Journal of Forensic Practice**, 4, 3, 11-20.

WEBB, D. and HARRIS, R. (editors) (1999). **Mentally Disordered Offenders : managing people nobody owns.** London: Routledge.

WHITTLE, M.C. and SCALLY, M.D. (1998). Model of Forensic Psychiatric Community Care. **Psychiatric Bulletin**. 22 (12) 748-50.

WINTER, N., HOLLAND, A.J. and COLLINS, S. (1997). Factors predisposing to suspected offending by adults with self-reported learning disabilities. **Psychological Medicine**, 27, 595-607.

WIX, S. (1994). Keeping an eye on the straight and narrow : diversion of mentally disordered offenders at the point of arrest. **Psychiatric Care**, 1, 102-104.

APPENDICES

SUPERVISION REGISTER INTERVIEW SCHEDULE

PART ONE

CONSULTANTS

---

1. What are your feelings about the introduction of the Supervision Register?

   Positive **Neutral** **Mixed** **Negative**

2. What are your view about this process being called the "Supervision Register"?

3. What do you think about the categorisation of risk into categories A B and C? (show card)

   Cat. A

   Cat. B

   Cat C

4. In general what has been the reaction of patients to being put on the Register?

5. Do you tell patients that they are being put on the Register?

Never **Rarely** **Often** **Always**

6. Are they involved in the discussion about why they are being put on the Register?

Never **Rarely** **Often** **Always**

7. Is there an information leaflet for patients?

Yes **No** **Don't know**

8. Does inclusion on the Register have any effect on the therapeutic input of the patient?

Yes **No** **Don't know**
(If yes, give details)

9. Does inclusion on the Register have any affect on the frequency of contact you have as a consultant?

Yes **No** **Don't know**
(If yes, give details)

10. Does inclusion on the Register have any effect on the frequency of contact of other professionals involved in their care?

Yes **No** **Don't know**

(If yes, give details)

11. Has the implementation of the Supervision Register increased the amount of time you have to spend on paperwork?

Yes **No** **Don't know**

11a. If yes, how much time per week? < 1/2 hr (specify).....
1/2hr - 1 hrs
1hr - 2 hrs
>2 hrs (specify).....

12. Has the implementation of the Supervision Register increased the amount of time you have to spend in meetings?

Yes **No** **Don't know**

12a. If yes, how much time per week? < 1/2 hr (specify).....
1/2hr - 1 hrs
1hr - 2 hrs
>2 hrs (specify).....

13. Has the implementation of the Supervision Register produced any extra resources for this group of patients?

Yes **No** **Don't know**

(If yes, give examples

14. What is the trigger mechanism for you to consider using the Supervision Register? (show card)

Routinely considered at each CPA meeting	☐
Rely on key worker to alert me to risk	☐
Response to incident or sudden deterioration	☐
Other (specify)	☐

15. How often is a patient on the Supervision Register reviewed?

< Monthly	☐
Monthly	☐
2 Monthly	☐
3 Monthly	☐
> 3 Monthly	☐
As required	☐

16. Is the review of someone on the Supervision Register carried out as part of a CPA meeting?

Never **Rarely** **Often** **Always**

17. Does the review frequency differ to those patients not on the Supervision Register?

More frequent **Less frequent** **Same** **Don't know**

18. Are patients files highlighted in any way to indicate that they are on the Supervision Register?

Yes **No** **Don't know**

19. In your experience has inclusion on the Register caused patients any difficulty in being registered with a G.P?

Yes **No** **Don't know**

20. What would you say are the main advantages of the Supervision Register?

21. What would you say are the main disadvantages of the Supervisor Register?

22. Would you like to make any other comments about the Supervision Register?

SUPERVISION REGISTER INTERVIEW SCHEDULE

PART TWO

KEY WORKERS

---

1. What is your profession?

2. What is your grade?

3. What qualifications do you have?

4. Since qualification, how many years experience have you had in mental health?

5. What are your feelings about the introduction of the Supervision Register?

   Positive **Neutral** **Negative**

6. What are your views about this process being called the "Supervision Register"?

7. What do you think about the categorisation of risk into categories A. B & C? (show card)

Cat. A

Cat. B

Cat. C

8. What is the criteria for becoming a key worker for someone on the Supervision Register in your team?

9. How many patients on your caseload are on the Supervision Register?

10. What does it feel like to be a key worker for someone on the Supervision Register?

11. Does inclusion on the Register have any effect on your therapeutic input to the patient?

Yes **No.** **Don't Know**

(If yes, give details)

12. Does inclusion on the Register have any effect on the frequency of your contact as a key worker?

13. Has the implementation of the Supervision Register increased the amount of time you have to spend in meetings?

Yes No Don't know

13a. If yes, how much time per week?

< 1/2 hour	☐	(specify).....
1/2 hr - 1 hours	☐	
1 hr - 2 hours	☐	
> 2 hours	☐	(specify).....

14. Has the implementation of the Supervision Reigster increased the amount of time you have to spend on paperwork?

Yes No Don't know

14a. If yes, how much time per week?

< 1/2 hour	☐	(specify).....
1/2 hr - 1 hours	☐	
1 hr - 2 hours	☐	
> 2 hours	☐	(specify).....

15. Is there an information leaflet for patients?

Yes No Don't know

16 Have you had any specific training on the management of suicide risk?

Yes No Don't know

16a. If yes, how many hours training?
(Estimate in hours at 7 hours per day). ..... hours.

17. Have you had any specific training on assessing the risk of violence?

Yes No Don't know

17a. If yes, how many hours training?
(Estimate in hours at 7 hours per day). ..... hours.

18. Could you give me a thumb nail sketch of a patient who falls into risk category A?

18a. Can you describe in detail the events surrounding his/her last suicide attempt?

18b. What events could lead to a similar situation developing in the future?

18c. What are you doing to prevent the future risk of suicide?

19. Could you give me a thumb nail sketch of a patient who falls into risk category B?

19a. Can you describe in some detail the events surrounding his/her last violent episode.

19b. What events could lead to a similar situation developing in the future?

19c. What are you doing to prevent the future risk of violence?

20. Could you give me a thumb nail sketch of a patient who falls into risk category C?

20a. Can you describe in some detail the events surrounding his/her last episode of severe self neglect?

20b. What events could lead to a similar situation developing in the future?

20c. What are you doing to prevent the future risk of severe self neglect?

21. If somebody is on the Supervision Register, is there always someone they can contact at any time of the day or night?

Yes No Don't know
(If yes, describe system)

22 If any other worker had to intervene in your absence for someone who is on the Register, would there be any way of them knowing that the patient was on the Register?

Yes No Don't know
(If yes, describe system)

23. Can you describe the clinical supervision you have in relation to your overall caseload?

24. Can you describe the clinical supervision you have in relation to those patients who are on the Supervision Register?

25. What would you say are the main advantages of the Supervision Register?

26. What would you say are the main disadvantages of the Supervision Register?

27. Would you like to make any other comments about the Supervision Register?

SUBMISSION TEN

Vaughan, P.J. and Badger, D. (1995). **Working with the mentally disordered offender in the community.** London: Chapman and Hall.

ISBN : 0 412 56740 7

(contained in separate pocket on back cover of binding).

FULL LIST OF PUBLICATIONS BY THE CANDIDATE

BOOKS AND CONTRIBUTION TO BOOKS

(1981) 'Women and Broadmoor: Treatment and Control in a Special Hospital' in Bridget Hutter and Gillian Williams (Editors) **Controlling Women: The Normal and the Deviant.** Croom Helm (with Colin Rowett).

(1985) **Suicide Prevention: A working guide to recognition and prevention** - PEPAR Publications.

(1995) **Working with the Mentally Disordered Offender in the Community** – London: Chapman & Hall (with Douglas Badger).

(1995) **Suicide Prevention: A Working Guide to Recognition and Prevention** - PEPAR publications. 2nd (revised) edition.

ARTICLES

(1979) 'The key to the growth of social work in Broadmoor'. **Health and Social Service Journal.** 1 89, 4636, 384-386.

(1979) 'An evaluation of short-term hostel care for severely mentally handicapped children' - **Apex** 7, 3, 76-78.

(1980) 'The increasing burden of care experienced by staff in hostels accommodating the severely mentally handicapped' - **Apex** 8, 1, 13, 14 and 25

(1980) 'Letters and visits to long-stay Broadmoor patients'. **British Journal of Social Work** 10, 471-481.

(1980) 'Special hospital patients have relatives too...' **MIND OUT** 26, 16-18

(1983) 'Keeping people out of hospital'. **Community Care** 461, 18-19.

(1983) 'Day care or confusion?'. **The Bulletin of the Royal College of Psychiatrists** 7, 10, 184-185.

(1983) 'The differing role of the social worker in the special hospital/penal setting'. **Prison Service Journal.** No. 50 new series. April, 17-19 (with Charles Fortt).

(1983) 'The disordered development of day care in psychiatry'. **Health Trends** 15, 4, 91-94.

(1984) 'Steps towards suicide' **Community Care** 26th July, 14-16.

(1985) 'Occupational or therapy in psychiatric day care?' **British Journal of Occupational Therapy**, 48, 6, 169-171 (with Mary Prechner).

(1985) 'Developments in psychiatric day care'. **British Journal of Psychiatry** 147, 1-4.

(1986) 'A structured approach to psychiatric day care. **British Journal of Occupational Therapy,** 49, 1, 10-12 (with Mary Prechner). (Translated into Dutch and reprinted in **Flemish Journal of Occupational Therapy).**

(1986) 'Joint projects : A question of balance'. **The Health Service Journal,** 25th September, 1260-1261.

(1988) 'Management of the compulsory psychiatric admission'. **Community Psychiatry**, 1, 1, 5-6.

(1989) 'Matrix management : managing together'. **Insight**, 11th April, 12-14.

(1989) 'A new kind of team'. **Community Care,** 14th September, 14-15.

(1991) 'Rules of engagement : Key factors in the successful management of inter-agency projects'. **Health Services Management**, 87, 3,126-128.

(1996) 'The supervision register : one year on'. **Psychiatric Bulletin**, 20, 143-145.

(1996) 'Screen test'. **The Health Service Journal**, 31st October, 31.

(1998) 'Supervision register in practice'. **Psychiatric Bulletin**, 22, 412-415.

(1998) Patient access to psychiatric assessment reports. **Psychiatric Care**, 5(6), 225-227 (with M. Slaney).

(1999) Psychiatric support to mentally disordered offenders within the prison system. **Probation Journal,** 46, 2, 106-112 (with M. Kelly and N. Pullen).

(1999) A Consortium approach to commissioning services for mentally disordered offenders. **Journal of Forensic Psychiatry.** 10, 3, 553-566

(1999) Planning to meet the needs of mentally disordered offenders : in the United Kingdom. **Psychiatric Services, 50, 12, 1624-1627** (with D. Badger, M. Woodward and P. Williams).

(1999) Day care for Mentally Disordered Offenders. **The British Journal of Forensic Practice**. 1, 4, 9-16 (with M. Kelly and N. Pullen).

(2000) Developing service specifications for secure provision. **The British Journal of Forensic Practice,** 2, 2, 13-18.

(2000) Services for mentally disordered offenders in community psychiatric teams. **Journal of Forensic Psychiatry.** 11, 3, 571-586 (with N. Pullen and M. Kelly).

(2001) The working practices of the police in relation to mentally disordered offenders and diversion services. **Medicine, Science and the Law,** 41, 1, 13-20. (with M. Kelly and N. Pullen).

(2001) Mentally Disordered Offenders : Everyone's Responsibility. **The British Journal of Forensic Practice**. 3, 4, 16-21.

(2002) An opinion survey of mentally disordered offender service users. **The British Journal of Forensic Practice.** 4, 3, 11-20 (with Susan Stevenson).

(2003) Improving psychiatric information for Magistrates' Courts, **Justice of the Peace** 167, 6- 7, 11th January (with Christine Austin, Mary Le Feuvre, John O'Grady and Barbara Swyer)

(In print) Secure care and treatment needs of individuals with learning disabilities and severe challenging behaviour, **British Journal of Learning Disabilities**

MINOR PUBLICATIONS

(1982) 'Multi-disciplinary joint care group'. Heatherwood Day Unit. **Community Occupational Therapists. Seminar for Heads and Seniors. Conference proceedings** 3rd - 5th March. College of Occupational Therapists, (with Mary Prechner and Barbara Perry).

(1983) 'The need for academic practitioners'. **Social Work Education**, 2, 2, 18-19. (Edited version of longer article).

(1983) 'Help offered not forced' (letter to the editor). **Community Care**, 469, 9.

(1991) 'Joint mental health service at Bucknell House and Coley Clinic'. **A Reading Medical Newspaper.** Issue xiii.

(1998) **Sample specifications for secure care provision for people with mental illness and learning disabilities**. Winchester, The Wessex Consortium. ISBN: 0 9534001 0 7

(2001) **Sample specifications for secure care provision for people with mental illness and learning disabilities**. Winchester. The Wessex Consortium 2nd (revised) edition. ISBN: 0 9534001 1 5

Appendix 'L'

GLOSSARY

Bridewell : a police station with a custody suite i.e. cells to detain individuals overnight.

Challenging Behaviour: used in respect of people with learning disability or other mental disorders who exhibit behavioural disturbance through assaultive, aggressive or destructive behaviour and/or irresponsible conduct.

Diversion Scheme: a service which enables a mentally disordered offender (or alleged offender) to receive care and treatment from services other than those provided by the criminal justice system. In practice, the term is most often applied when this happens at or just before a court appearance but could also apply to diverting people from police stations or remand prisons.

Extra Contractual Referral (ECR) : the practice of referring patients to a provider who is not already contracted to provide a service for commissioners. Usually this applies when local providers are unable to meet demand, either because of lack of expertise or no bed being available. Also referred to as 'Out of Area Treatments' (OATs).

Intensive Care Beds: for use with individuals who are acutely disturbed and/or suicidal and who require intensive nursing and medical care in a special unit within or attached to a 'normal' acute setting. There may be a degree of physical security by the use of locked doors or by the use of above average staff ratios.

Learning Disabilities: term adopted for 'mental handicap'. Applies to people with a state of arrested or incomplete development of mind which includes significant disabilities of intelligence and social functioning. Includes

mentally impaired and *severely mentally impaired* people within the terms of the Mental Health Act 1983.

Personality Disorder: personality disorder includes many different disorders ranging from histrionic personality to anti-social personality disorder (often referred to a psychopathic disorder). It is anti-social personality disorder that is most relevant to the works submitted.

Whole Systems Approach : an approach to service planning which takes into account the full range of facilities and agencies required to provide a comprehensive range of services as opposed to concentrating on individual aspects of provision, e.g. secure care, health care, etc.