
THE ALLAN BROOKING TRAVEL FELLOWSHIP

Introduction

The NHS is constantly battling to stabilise its current financial situation. One of the greatest costs to the NHS is agreed to be the 'workforce bill'. In a survey carried out by the 'NHS Confederation'¹ under the leadership of Dr Gill Morgan², 9 % of the 90% respondents to the Confederation survey cited workforce reform as one of the causes of the current deficit and 34% reported that the workforce costs must be reduced.

Whatever was to happen in the future - the current and future NHS workforce had to become more flexible in its roles and also in the way in which patient care was delivered. Many initiatives have been put forward to aid the process of workforce redefinition³ some have demonstrated limited success whilst others have been useful tools to apply to existing problem areas. The task facing the NHS managers of today is not only to secure a constant stream of the very best clinical and non clinical staff but also how to retain and develop the huge talent that already exists. However, one of the major challenges facing the service managers remains - how to motivate the staff to see the change process as being beneficial to all concerned? In a recent statement by Allan Johnson MP⁴ stated that:-

'Doctors, Clinicians and nurses complain that they are fed up with top down instructions and weary of restructuring. They want a focus on outcomes and patients, and less on structures and processes'

furthermore he said:

'this lack of confidence matters because of the impact it has on the operational capacity of the services'

¹ The Confederation is an independent body that brings together NHS statutory organisations

² NHS Confederation June 2006

³ European Working Time Directive, New ways of working, Modernising workforce planning, Changing Workforce Programmes

⁴ Response to House of Commons on the Darzi review of the NHS 4th July 2007

In my current role as the Workforce Lead for Forensic Services my aim was to assist the local forensic service to determine what their 'local workforce' should look like in order to provide the highest quality of care - but within an acceptable and appropriate financial framework.

Centered

Here in the South West an outline business case had been provisionally agreed to build additional capacity in a medium secure unit to support the repatriation of local detainees to their home county for ongoing treatment. This development will require increasing numbers of staff who have the right skills to provide care in this highly complex and challenging setting. It will also require the existing staff to re skill and acquire new competencies to perform their duties – again - all within a very complex financial and environmental framework.

This provided the organisation with a unique opportunity to re-evaluate the current staffing mix and to really unpick historical patterns and ways of working and to be innovative in the design of new 'job' roles whilst enhancing the competencies of those currently in post. The outcome of this work should be the creation of a more flexible workforce that removes outdated demarcations enabling staff to progress and take on new responsibilities at **all** levels and grades within the team.

It soon became evident that one of the major areas to focus on was the nursing staff groups. These staff, generally speaking provide the greatest % of cover during the 24 hour period of patient care and so by default are usually the largest staff group in any healthcare workforce. Rhetorically, these staff commonly express desires to change and enhance their clinical scope of practice but when challenged to do so can sometimes be seen to 'hide' behind professional regulation.

In seeking support from the Allan Brooking Fellowship fund I wished to research aspects of nurse training and development in a country where 'forensic nurses' were taking on expert practitioner roles and working in a 'legally' safe and 'professionally' safe capacity as Forensic Nurse Experts. I also wished to identify the core components of the academic courses which allowed these nurses to gain the skills and competencies in this specialist field and to see how these played out in the context of the multi disciplinary team setting.

In undertaking preliminary searches I was constantly referred to a major University in Pittsburgh, Pennsylvania USA. The University has an international reputation for the quality of its forensic teachings and its acceptance as a leader and innovator in the field of new role development linked to forensic nursing.

My first major point of contact with the University was with one of the Forensic Graduate Programme Directors. With the Departments support a three week programme of observation was arranged for me. The programme included observation of the delivery of one of the academic programmes, the following of a student on a course during one of their practical placements, working alongside a qualified nurse who has set up an individual nurse led service. Working with the Police, Prison and Medical Examiners officers (who are the primary referral source to these services) working in forensic mental health facilities in MH institutions and prisons and finally to meet with Senior Nurse Leads who inform and advice the American Nurses Association on regulation and competence to practice in this specialist field.

Week one:

University Placement.

The University has a School of Nursing linked to the Institute of Forensic Science and Law, and is an approved provider of continuing nurse education by the American Nurses Credentialing Centres Commission.

One of the courses reviewed was the Sexual Assault Nurse Examiner (SANE) course. This provides nurses with the skills and training to care for victims of assault (both physical and sexual) by recognising, collecting and preserving evidence, interviewing the patient and linking them to vital community resources to follow them up. This course is taught by experts in the areas of forensics nursing, law enforcement and criminal prosecution. It emphasises the victim advocacy services and reinforces the absolute necessity for the nurse to become a member of the interdisciplinary Sexual Assault Response team allowing them to investigate, provide actual health care and to demonstrate an ability to collect evidence for examination and provide expert witness testimony to prosecution agencies.

The course can be undertaken 'on line' and accessed by students anywhere in the world - in fact whilst I was there army nurses were completing this course who had

recently been deployed to Iraq. The University deals with the issue of practical placements and finds suitable trainers/mentors in the various locations as and when they arise.

Many students are supported from around the world to undertake the course.

The programme has five modules to it and can be undertaken at the individuals own pace. At the end the nurse becomes an accredited Sexual Assault Nurse Examiner.

Week 1 Learning/Action Points:

- Since returning to the UK I have undertaken a mapping exercise to identify what is available here in the UK in terms of forensic education and training.
- Identified the education and training needs of the locality MDTs
- Using the information gained from the University, I have drawn together key managers in A &E, prisons, police custody and the wider forensics units and developed a draft 'menu' of training needs for the qualified and unqualified workforce.
- Using existing University modules have identified what training could and should be tailor made for the UK health market and begun negotiations with the local University provider to see what opportunities there are to take this forward.
- Gained the knowledge to challenge registration authorities as and when the need arises.

Week two

For the following week it was thought appropriate that I follow a past fellow of the course and to see how she has developed a practitioner led service in a dedicated forensic area. It was agreed at this point that I would work with one of the Forensic Nurse Practitioners (FNP) who has a dedicated suite in the Accident and Emergency Department of the local County Hospital, but who is also part funded by the local Police Department and the Medical Examiners office. The FNP and her team are completely independent practitioners and take referrals from police departments, A&E units and the Medical Examiners office. They also deal with individuals who refer themselves to the service. They are a crucial part of the local detective

workforce and part of the funding for the service comes from through the police department budget.

Whilst here I learned how the service had first started and been resourced, how referrals were made to the unit and how she as a nurse overcame the potential conflict in terms of confidentiality of patient information whilst at the same time preserving evidence for the police and prosecutors. I also observed how 'information' was stored and collated, how she performance managed her own unit and how she and her staff maintained their clinical competence. The level of clinical competence was especially important not only to the judiciary but also to the insurance companies who paid for the care and treatment received by their clients.

I experienced whole patient pathway - from the client appearing at the suite, to the actual examination of the patient and the taking of evidence – to the crime laboratories where she handed over the specimens to the crime laboratories technicians for analysis, with the results then being processed and given to the detectives allocated to the case.

Whilst working here I gained a significant amount of knowledge about the nurse's role as an independent practitioner and brought back with me one of the 'evidence kits' they use for their examinations. I have since met with our local police surgeons and health care providers in custody units to show them these as there had been some local debate about what actually constitutes an examination kit and how evidence should be collected and preserved for continuity purposes.

Week 2: Learning /Action Points:

- Through the current partnership forums identify areas where new roles may provide the solutions to some of the more operational working difficulties.
- Through the current local partnership forums negotiated opportunities for jointly funded developments around new roles.

Week 3

During this week I was to work with Forensic Mental Health teams who work primarily in the secure unit setting and correctional facilities. For this I was directed to one of the largest Correctional Penitentiaries in Philadelphia.

This Correctional Institution is about 31 miles west of the city of Philadelphia and was built in 1929 and is still Pennsylvania's largest maximum security prison holding approximately 3,500 prisoners. The prison is on a site of some 1,730 acres, and has a prison farm and a 62 acre prison compound within 30 foot walls observed by 9 manned watch towers. Each wing has 400 cells on it and these are patrolled by prison officers on horseback with loaded shot guns. Other cell blocks include a 40 cell security unit known as the BAU (Behaviour Adjustment Unit) and an RHU (Restricted Housing Unit) and a death row. (Executions have ceased on site over the last five years and inmates are transferred to another state facility for this final act to be undertaken) The prison has recently opened another RHU (Restricted Housing Unit). These are basically prisons within the prisons, and house about 300 prisoners in total. The prisoners here are only allowed one hour a day for exercise, and remain confined to their cells for the other 23 hours of the day. They receive three meals a day and are permitted 'shower visits' occasionally. The prisoners in RHU are only allowed one visitor a month.

The regime is harsh and thoroughly unpleasant and its aim is basically to **make** the prisoner behave in a manner the prison staff wishes them to behave in. I was shocked to learn that the majority of these prisoners are in fact seriously mentally ill prisoners who have become a discipline problem and are therefore segregated for management purposes. Few have any access to educational, recreational or vocational activities as these are earned by displaying 'good behaviour'. Radios and TVs are not allowed and only certain books are allowed on the unit. They are allowed the bare minimum of personal possessions- usually only toiletries. The unit has no access to mental health trained personnel and they are only referred to a Dr if any condition becomes significantly worse.

The prison has only a 28 bedded infirmary for the whole of the prison population and until recently prisoners with specific mental health issues were not provided with any additional support or treatment.

More recently Mental Health Services have become involved with the Health Care services. The unit has a 10 bedded ward off the main infirmary site and it takes the most severely mentally ill patients but only for a maximum of two weeks. These patients are then transferred back to the wings where nurses administer their medications to them alongside the other prisoners on the wings. The patients have no access to therapies at all and none are provided. Those with learning difficulties are also placed within the main prison estate and are probably the most vulnerable group of prisoners on the site without any additional support or protection. One gentleman whilst I was there was being kept in the mental health unit for safety reasons as he had been repeatedly burned and apart from him being admitted to the segregation unit there was actually no other place that was safe for him. The prisoners/patients roam aimlessly around the small unit and are dressed in bright green uniforms to identify them as MH patients. The whole experience left me with a feeling of utter desperation.

Week 3 : Learning /Action Points:

- Upon my return I sent the Director a comprehensive programme of therapeutic interventions and treatments that are routinely provided within forensic and other MH units in the UK and could easily be adopted in his units.
- The Director has used this information to underpin a review of the service he is currently providing - highlighting deficits in terms of provision.

For the second part of my placement I went to a city detention centre to observe how prisoners were assessed and decisions made once they entered the custody system on where they should be held. For this I went to a City Jail in Maryland.

This locality is now described as the one of the most violent states in America. For my work placements I was given set times to be dropped off at the gate of the prison then an armed guard would collect me to take me into the jail. I believed this was because of the jail itself but was later to find out it was to stop me being hurt on the streets around the jail. The area around the jail looked like an old bomb site, houses were boarded up and falling down, some had huge sections of the house missing, there was rubble and litter everywhere and they were still being lived in. It is an area of abject poverty, with high levels of gun crime related to drugs and alcohol. There is also a huge unmet need in terms of mental health provision in this state and so along with other dependency issues the felony rates are astronomical.

Part of this prison dates back to 1803, and is known to be one of the oldest pretrial detention facilities in the country. In parts the façade is crumbling and the facilities inside leave a great deal to be desired. Most years they admit in the range of 43,456 people and at any time of the year the prison can and does take in the region of 2,500 inmates. Of these approximately 2000 are awaiting trial.

Of these 2500 inmates, there were approximately 125 juveniles ranging in age from 15 to 17 (including a handful of female juveniles) who were charged as adults, and approximately 500 women. These inmates are housed in 5 separate buildings: the Men's Detention Centre, the Wyatt Building, the Annex Building, the Jail Industries Building, and the Women's Detention Centre.

Inmate housing includes single cells, double cells and dormitories. The facility also has modular educational facilities and space for drug treatment programmes – notice that I referred only to the space to undertake these activities as opposed to the actual running of any educational programmes.

Male inmates with chronic mental illnesses are housed in the Special Needs Unit (SNU). Other inmates with mental illness, both male and female, are housed in Inpatient Mental Health Units (IMHU). Those with serious medical illnesses are temporarily housed at the infirmary, which for the women is inside the Women's Detention Centre. The men's infirmary is located within the Metropolitan Transition Centre (MTC), which is a regional facility located nearby, serving four other Maryland state correctional facilities as well as Baltimore City jail.

This prison takes an average of 600 prisoners on a Friday and Saturday night alone – as much as possible the prison has to be 'emptied' on a Thursday ready for this onslaught and as I witnessed - often the gym floor has to be used to accommodate all the prisoners.

Once admitted to the detention centre the patient **should** be immediately examined by an Emergency Medical Technician ...they decide if the person is fit enough to actually be in the detention centre or if they should go to a hospital. Once the person has been seen by the EMT and is authorised to enter the detention system then they **should** be examined by a nurse practitioner or Doctor to establish their fitness to be detained.

At this point a full physical and mental health assessment **should** be undertaken. The outcome of this assessment also determines where they will be placed in the prison setting. As you can imagine many of the patients arrive at the detention centre still intoxicated or under the influence of drugs and/or drink some are severely mentally ill and have little insight into what is happening to them and others have pre existing medical conditions that require observation. What I witnessed was a system of overwhelming proportions. Sometime there is no EMT on duty and so a police officer will determine if they can be admitted to the detention centre, notes show that often the patient was not assessed on admission nor has been assessed some days into their detention. Many reports exist about the levels of care and treatment in this centre and few report any improvements on a year by year basis. Deaths in the centre are not uncommon.

I can only report that this is the worst environment that I have ever witnessed or observed in terms of human behaviours and human rights. The environment can only be described as volatile and vile. It appeared to me that the inmates had no rights at all, that the prison is constantly overwhelmed in terms of sheer numbers and that there are just not enough staff to cover the service. Some of the coping mechanisms are draconian and I felt desperate for all parties working and detained there on a day to day basis.

On one of the mental health assessment wards where severely disturbed patients were housed I witnessed probably the worst type of patient care I have ever seen. The patients do not wear clothes instead they are stripped and wear what appear to be radiographer type heavy padded aprons. They are bare footed and handcuffed at all times. When they are moved they are shackled at the feet and are transferred with four armed guards. The temperature on the ward area is kept at a constant high temperature and the patients are often heavily sedated. Once they have been assessed they are then found a placement pending either a court appearance OR if they have come from court and are sentenced then they may well await transfer to a State Facility. They are placed in 6 bedded ward areas and there is no consideration given to racial mix, gang mix, ethnicity or any other diversity issue. Both the patients and staff are in this very dangerous environment with the minimum of support. It was reported and I was given access to reports that show that on some occasions inmates have been purposely housed together because they have a 'score to settle' guards turn a blind eye to this behaviour and some serious woundings have taken

place. A report published by the Assistant Attorney General recently pointed out that this practice even though it had been highlighted in many previous investigations was still taking place and had not ceased to happen.

Far from finding examples were the UK can learn from these areas I was appalled at the lack of resources and access to services these 'patients' have. These patients have few rights and often find themselves incarcerated in the criminal justice system inappropriately because they do not have access to MH treatments and support.

By remaining in the prison system they may well become stabilised on the correct medication but these patients are not given any other supportive therapies' or other interventions. In fact in this detention centre if they are seen by any qualified practitioner and medicated then that in itself is deemed a success. The incidence of reoffending is therefore very high once released.

Today, more than 2 million people, or nearly one out of every 100 adults, is sitting in a jail or prison in the United States - an incarceration rate unprecedented in U.S. history. The US Justice Department estimates that 16 % of individuals currently incarcerated in US prisons and jails suffer from a **severe** psychiatric condition such as schizophrenia, bipolar disorder or major depressions. The majority of the rest had some lesser degree of mental incapacity and /or other dependency related issues. Among the indirect costs of mental illness to society the 2001 Surgeon Generals Report estimates that \$4 billion annually is lost in productivity for incarcerated mentally ill Americans.

It has long been a subject of research and is therefore now widely believed that the criminal justice system is most often utilised to deal with the behaviour of people with untreated psychiatric problems. What it demonstrated to me though was that for most mentally disordered offender's things only became worse once they were incarcerated. It was reported by the Department of Justice survey in 2001 that 60% of prisoners with severe mental health illness in jail and 40% of those in state prisons received no treatment at all.

Inmates with schizophrenia fared significantly worse than their fellow prisoners in every way it was reported. They are refused their right to work, the greatest majority stay locked up for considerable amounts of time - not just days but weeks, and the

ability to obtain release is well documented as being very limited. Half of the mentally ill persons in prisons for violent crimes are repeat offenders it was found.

What I really could not believe when I undertook further investigation was that out of the 1,320 state facilities and 264 private facilities in operation since June 2000 – that not **all** screen inmates for mental health problems or provide treatment. Nearly 70% of the facilities housing state prison inmates reported that as a matter of policy they screen inmate intakes: 65% conduct psychiatric assessments, 51% provide 24 hr mental health care, 71% provide therapy by trained MH staff, 73% distribute psychotropic medications and 66% help released inmates to obtain community MH services. As a consequence there remains a huge unmet need here - with consequences such as high prison populations, high crime rates and high reoffending rates. It can easily be understood (but not accepted) how the option of incarceration is more easily resourced than providing treatments and therapies to prevent the problems occurring in the first place.

Week 3: Learning /Action Points

- Celebrate the successes of the UK system, highlight just how much is achieved by the NHS in each locality.

Conclusion

The experience and the opportunities I have been given through the Fellowship have been enormous. It was a journey of many sorts, it was a journey of knowledge gathering and knowledge giving and it was also a personal journey where I was challenged by what I saw and how I reacted to it.

My visit allowed me to see the power of a ‘money led service’ rather than a ‘patient led service’. In the University large sums of money were donated by local benefactors and so an excellent quality of teaching and training was available - leading to the outturn of highly skilled and competent practitioners. At the other end of the spectrum where there was little money or resources targeted at it - I witnessed the complete antipathy of this. I saw very little evidence of planned or coordinated work being undertaken and I saw a workforce who were not completely skilled to perform duties in this specialty and had little opportunity to develop new skills or provide a higher level of care.

Here in the UK we are experiencing a period of unprecedented change in mental health services. In the last five years, a wealth of evidence has emerged about which practices are effective and which are not.

In the Department of Health's own words *'There is a growing recognition that "one size doesn't fit all" and that national standards need to support a mix of local services to meet a diversity of local need'*

The Government also recognises the need to better co-ordinate activity across traditional boundaries, and work in partnership with front-line staff, voluntary, community and business sectors, as well as service users. Staff must meet the therapeutic needs of patients whilst addressing legal, security and public safety issues but I believe that new roles could and should be developed to support the whole process of recovery for these patients. Carrying out research in forensic mental health has been particularly challenging and without the support of the Fellowship it would have been even more difficult to achieve.

I would like to thank the Trustees for having given me this unique opportunity.

Chrissy Aspinall
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