



The Sainsbury Centre

for Mental Health

**FST Project Participants' and their Clinicians' perceptions of the
impact of having access to work opportunities through the
First Step Trust (FST) Project in Broadmoor**

Research Report

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Abstract

The results of this research study indicated that the provision of ‘realistic’ vocational preparation as delivered by the FST project can have a positive impact on individual rehabilitation and preparation for discharge, as perceived by FST project participants themselves and their clinicians. Enabling the renewal of existing skills may be as important as facilitating new skills, both for maintaining engagement in the FST project, and for increasing people’s potential to find work once discharged.

Further research is needed to contribute to our understanding of the effects of work rehabilitation in secure settings. In particular, a larger scale prospective study is required to track individual changes over time, both quantitatively and qualitatively, through the discharge pathway from high security settings to the community.

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Finally, we would like to thank the ward staff across the medium secure units and within Broadmoor Hospital for accommodating us and finding suitable rooms for the interviews.

Terminology

The people in our study had multiple roles and the terminology we have used throughout the report reflects this. In the context of Broadmoor Hospital and the medium secure units, we have referred to people as ‘patients’ and within the FST project as ‘FST project participants’ or ‘workers’. Patients and clinicians who took part in the research are referred to as ‘study participants’ or ‘participants’.



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List of the abbreviations used in the report:

CNM	Clinical Nurse Manager
CPA	Care Programme Approach or Assessment
FST	First Step Trust
LREC	Local Research Ethics Committee
MREC	Multi Research Ethics Committee
MSU	Medium Secure Unit
NIMHE	National Institute for Mental Health in England
RMO	Regional Medical Officer

Foreword

Although the media response to high profile instances of re-offending makes it hard for the general public to accept, many patients in Broadmoor no longer present a danger to the public or themselves and should therefore be working towards discharge. Inevitably this is often a drawn out process and on the way some of the things that sustained individuals on the first stages of their recovery journey get lost - intangible things such as self-belief, self-efficacy and most important of all, the hope of a better life. For many people with mental health problems employment offers all of these and having a job, being valued for what we do, is an important part of recovering life as a normal, contributing citizen.

Unfortunately the barriers to employment are even higher for people in the secure psychiatric system than for others with a history of mental ill health. Discrimination, disempowerment, lack of current skills, lack of self-confidence, no recent track record of employment, no skilled support to help overcome these barriers are the common experience of all too many service users. Those in places like Broadmoor are likely to face even higher levels of stigma and discrimination but in other respects the very nature of the setting means that, potentially at least, more help is on offer.

First Step Trust (FST) has consistently drawn attention to these issues in the best possible way - by trying to do something about them.

This is the second evaluation of their work project in Broadmoor. The first report (Grove and Lockett, 2001) showed that both patients and staff valued their work. This second stage looks at the more challenging question of whether what they do has the potential to contribute to successful discharge pathways via the medium secure system.

The report shows that for many but not all participants the experience of the FST programme remains positive. However it also highlights the lack of specialist employment support available within the medium secure system - another barrier at a point when newly acquired skills, carefully nurtured hopes and burgeoning self confidence are at their most fragile.

The message is clear. People in the secure psychiatric system need to have individual care and discharge plans that include employment and are reviewed and acted on as they move through the system. FST has shown ways in which people's employment ambitions can be nurtured even in unpromising conditions, but their long term aim is to promote greater awareness of what is possible and stimulate ambition within the whole secure system. This small study provides material for the debate that is needed in this neglected aspect, both in terms of investment and investigation, of forensic psychiatry. The report will be of interest to policy makers, commissioners and to all those who work to improve the secure psychiatric system.

Dr Bob Grove, 11th April 2005

Executive Summary

Introduction

The First Step Trust (FST) is a limited liability company with charitable status. It has been operating a work rehabilitation project in Broadmoor High Security Hospital since 1999. An initial, small-scale evaluation of the project, carried out in 2001, clearly showed that both project participants themselves and FST staff working alongside them had observed a range of benefits from participation (Grove and Lockett, 2001).

With this research project we aimed to provide a systematic examination of personal change, in particular exploring the effects of the FST project on participants' rehabilitation and preparation for discharge. We envisage that the results of this research will feed into the development and delivery of work rehabilitation services within high and medium secure settings and contribute to the development of effective discharge pathways from high security settings into the community.

The aim of the research was to identify the perceived impact of having access to work opportunities through FST on:

1. People who were, at that time, participating in the FST project at Broadmoor
2. People no longer participating in FST who were still at Broadmoor
3. People who had participated in FST at Broadmoor and who had since been discharged from the hospital to a medium secure unit.

Participants for the study were selected through purposeful sampling and data were gathered through in-depth semi-structured interviews with FST project participants and clinicians that they nominated, as well as through examination of clinical notes. Overall, nineteen FST project participants and nine clinicians participated in the study.

The FST Project

FST has developed a model of 'vocational preparation' that they provide across the UK. The FST project at Broadmoor represents the first time this model had been tried in a secure setting.

The model is designed to foster a culture of interdependence within which everyone has something to offer and something to learn. Two vital principles underpin it:

1. The provision of real work i.e. trading commercially with the general public, where the focus is on meeting the customer's need rather than providing traditional rehabilitation and training for its own sake. The emphasis is on tasks, skills and quality service and products
2. People join the workforce not as patients, clients or service users, but as colleagues and equals, sharing the responsibility of making the project work, operating at all levels including management

Results

A staged content analysis was used to analyse the data we gathered. Results related to three key themes:

- The benefits of participation
- The tensions inherent within the project
- Experiences of medium secure units

Benefits of participation

- FST participants from all three groups reported improved confidence, self-esteem and social skills, particularly in terms of communication skills and the ability to take responsibility
- Participants attending the project at the time of the research and those who had been discharged from Broadmoor (Groups 1 and 3) reported gaining new technical skills and renewing or improving their existing skills
- Although a couple of people who had left the project but were still at Broadmoor (Group 2) reported increased technical skills, most in this group focussed on the skills that they felt had been under-utilised or that they were not able to develop at the project
- Participants from Groups 1 and 2 reported a number of clinical benefits from participation such as anger management, learning coping mechanisms to deal with frustrations, a reduction in symptoms and changing attitudes to treatment

Tensions inherent in the project

- Participants from all three groups identified a number of tensions which they felt were inherent within the project and discussed these in relation to their participation:
 - The project's function as 'real work', 'work experience', 'make work' or therapy – only people in Groups 2 and 3 discussed FST as 'make work' or 'therapy'
 - Broadmoor regulations and FST culture – this was a tension highlighted particularly by participants in Group 2
 - The relationship between the project and the clinical teams and the care planning/assessment process – the varying strength of the relationship was discussed by all three groups, with more participants in Group 1 reporting a stronger relationship

Experience of medium secure units

- With the exception of one person, the participants who were in the medium secure units (Group 3) discussed the lack of activity in these units. Some of them thought there were plenty of work opportunities for an FST type project if one could be developed

The clinician interviews supported these findings.

Conclusions and Recommendations

Recommendations are made for the further development of the project, the development of new services and further research.

1. Project development

- The induction of new participants into the FST project is a critical time for identifying people's existing skills and facilitating the use of these skills within the project, or managing expectations if the skills cannot be utilised. We recommend that this become a routine, integral aspect of the induction process
- The induction process is also a time to build an understanding of an individual's reasons for attendance and managing expectations in relation to the project's function and the tensions between 'real work, 'therapy' etc. We recommend that this too becomes a routine, integral aspect of induction
- It is important that the project builds more integrated working with the clinical teams. We recognise the complexities surrounding this, particularly the importance of maintaining the FST ethos and identity. We therefore recommend that FST identifies a way to achieve this and works to secure the resources required as necessary
- We recommend that ongoing negotiations between the hospital and FST are initiated to ensure that existing and new hospital policies and practices do not undermine the project

2. Development of new services

We recommend the development of new services in high and medium secure settings with the following key features:

- Production of a real product or service to sell, where quality is important
- Teamwork approach
- Involve patients in decision making and empower them to take responsibility for running the business
- Use and build on patients' skills and abilities as well as facilitating the development of new skills

3. Further research

Further research is needed to contribute to our understanding of the effects of work rehabilitation in secure settings.

- A larger scale prospective study is required to track individual changes over time through the discharge pathway from high security settings to the community. We recommend that such a study be prioritised for NHS research and development funding and be taken up as a topic of special interest by the NIMHE Mental Health Research Network.

If new services are developed in medium secure settings, as recommended above, research will also be required to evaluate their effects and support their development.

- We recommend that adequate funding for evaluation be made available alongside the development of new vocational services in medium secure settings



1. Introduction

This first section outlines the background to the research study, presents an overview of the relevant literature on employment and mental health, gives a brief explanation of the FST Project at Broadmoor and outlines the environment in which the project operates. We then detail the aims and objectives of the study and explain the conceptual approach behind it.

1.1 Background

The First Step Trust (FST) has been operating a work rehabilitation project in Broadmoor High Security Hospital for over four years. An initial, small scale evaluation of the project carried out in 2001 clearly showed that both project participants themselves and FST staff working alongside them had observed changes in self-confidence, increased practical and social skills; improved communication and ability to interact; and a reduction in symptoms (Grove and Lockett, 2001).

With this research project we aimed to provide a systematic examination of personal change, in particular exploring the effects of the FST project on individual rehabilitation and preparation for discharge.

No previous research had been undertaken into the impact of work opportunities in a high security setting. It was for this reason and because sample sizes were small, that we chose to take a qualitative approach to the study.

We envisage that the results of this research will feed into the development and delivery of work rehabilitation services within high and medium secure settings and contribute to the development of effective discharge pathways from high security settings into the community.

1.2 Overview of literature

A search of the Medline and Psychinfo databases carried out for this study identified a lack of any information relating to work rehabilitation in secure settings. However a considerable body of research does exist on work rehabilitation and mental health in the wider community. This research highlights the importance of providing employment support and work rehabilitation services as part of the recovery process for people who have experienced mental ill health. One of the key characteristics of successful vocational rehabilitation programmes is the integration of vocational expertise within the clinical teams and the processes of clinical management.

1.2.1 The research evidence

Work and mental health

Work is central to the lives and well-being of most people, and is important in maintaining and promoting mental health (Jahoda et al., 1933; Smith, 1985; Warr, 1987). Work provides social identity and status; social contacts and support; a means

of structuring and occupying time; activity and involvement and a sense of personal achievement (Rowland & Perkins, 1988). Quite apart from the money that can be earned, work tells us who we are and enables us to tell others who we are (Galloway, 1991).

While work is important for everyone, it is especially crucial for people who have mental health difficulties. People with such problems are particularly sensitive to the negative effects of unemployment and the loss of structure, purpose and identity that it entails (Bennett, 1970; Anthony et al, 1984; Collis & Ekdawi, 1984). People with mental health difficulties are already excluded as a consequence of their problems – an exclusion that is aggravated by unemployment. Bennett (1975) has characterised work, in contrast to occupational therapy, as the performance of a task within prescribed limits to achieve goals set by others, who judge and reward one thereby linking the individual to society. Without work these links are all too easily lost.

The capacity to work is seen by many who experience mental health difficulties as a yardstick of recovery (Shepherd, 1984; Deegan, 1994). Equally, returning to work significantly reduces the need to use mental health services (Wing and Brown, 1970; McKeown et al., 1992).

Many people who experience mental health difficulties attach a high priority to work: recent studies suggest that as many as 90% of those with ongoing mental health problems wish to go back to work (Grove, 1999; Rinaldi & Hill, 2000, Secker et al., 2001).

What works?

The evidence base covers three broad issues: enabling service users who are out of contact with the labour market to gain and maintain employment; preventing people who are already working and need to use mental health services from losing their job; and ensuring that NHS Trusts and other public sector organisations become exemplar employers of people with mental health problems.

Here we summarise only the evidence concerning people returning to work after a period of absence from the labour market. As noted above, this relates to community rather than high security settings.

Research into what works in enabling people who are out of contact with the labour market to find and keep a job has followed two strands: investigations of client characteristics directed towards questions about 'who is employable' and studies of which models and approaches are most effective. The research literature clearly shows that models and approaches are more important than client characteristics in determining whether people with mental health problems are able to work.

Studies of 'employability' indicate that client characteristics have very little impact on vocational outcomes (Grove, B. & Membrey, H. 2001). Most studies show no relationship between employment outcomes and diagnosis, severity of impairment and social skills. There is no consensus about how specific symptoms affect work performance, and while there is a relationship between hospitalisation history and work outcomes, the direction of causality is not clear. Employment history is a robust

predictor of work outcomes, but motivation and self-efficacy appear to be more important. Wanting to work, and believing that you can, is the best predictor of work outcomes. In this context the extent to which mental health services promote confidence in relation to work is likely to be critical (Rinaldi & Hill, 2000).

Research into models and approaches clearly shows that segregated sheltered workshops are relatively poor at enabling people to return to open employment (Crowther et al, 2001). Despite their intention to help increase people's confidence and skills and thus enable them to move on to employment, there is evidence that they often confirm a person's belief that they would not be able to manage in open employment and move-on rates have been universally poor (Pozner et al 1996; Grove, 1999, 2000).

There is strong evidence in favour of 'supported employment', especially the Individual Placement and Support (IPS) model developed in the US (Becker & Drake, 1993; Drake and Becker, 1996) over other approaches such as sheltered workshops and clubhouses (Crowther et al., 2001). The features which research suggests are most likely to enable people to gain and retain open employment are:

1. Vocational rehabilitation is a central and integral component of the work of mental health teams rather than a separate service. Front-line staff need to have a vocational orientation and there must be vocational expertise within teams if success is to be achieved.
2. A primary goal of open employment in integrated settings – 'real work' rather than pre-vocational or sheltered work experiences.
3. Rapid job-search and minimal pre-vocational training. Supporting people to develop work skills on the job is more effective than preparation in a sheltered environment.
4. Initial and continuing assessment and adjustment. Getting into work is not an end in itself but part of an ongoing process, and it may be necessary for a person to try a number of different jobs before they find one in which they are successful.
5. Time-unlimited support and workplace interventions, including reasonable adjustments under the DDA, to enable people to retain employment.
6. Attention to users' preferences and choices rather than providers' judgements about the sort of job that is appropriate. If you help someone to get a job they want they are more likely to stick to it.

A number of studies indicate that around 58% of people with serious ongoing mental health problems engaged in programmes with these characteristics are able to gain and retain employment: a marked contrast to the 12% who are at present in employment. Randomised controlled trials clearly suggest that supported employment is more effective than sheltered work at helping people with severe mental health problems to obtain and keep competitive employment (Crowther et al, 2001).

The evidence in relation to the FST Broadmoor project

There is no body of literature that evaluates interventions for preparing people in high and medium secure settings for employment on discharge. In the case of Broadmoor, where the average stay is 6.5 years¹, there is no immediate prospect of employment for

¹ 30th June 2005

any of the patients, since when they leave Broadmoor they will mostly go to another secure setting. Place and train interventions, such as the IPS model, are therefore not an option, nor are intermediate solutions such as work experience in an open setting or even volunteering in the community. The only option therefore to keep patients in touch with the idea of themselves as productive and potentially employable citizens has to be a version of sheltered work. The FST programme takes "realism" to the limits possible within Broadmoor by importing business activities with customers on the outside and fostering a culture in which patients take responsibility for as much of the business process as possible, including initiation, product design, marketing, production deadlines, budgeting and quality control. Within the FST "bubble" patients also share responsibility for team management and effectiveness. The extent to which this is beneficial, acceptable to participants and likely to lead to the creation of discharge pathways resulting in employment is the subject of this study.

1.3 Overview of First Step Trust (Berkshire)

The First Step Trust is a limited liability company with charitable status. It was set up in 1994 to provide opportunities for people with mental health problems and other disabilities or disadvantages across the country to move towards open employment and to challenge some of the prevalent attitudes about disability.

In 1999, FST carried out a scoping project within Broadmoor Hospital and from this developed the FST (Berkshire) project. The project is designed to maintain a culture of interdependence within which everyone has something to offer and something to learn. The FST model works from two vital principles:

1. The provision of real work i.e. trading commercially with the general public, where the focus is on meeting the customer's need rather than providing traditional rehabilitation and training for its own sake. The emphasis is on tasks, skills and quality service and products
2. People join the workforce not as patients, clients or service users, but as colleagues and equals, sharing the responsibility of making the project work, operating at all levels including management

The FST projects ensure that people with mental health problems and other disadvantages hold keys to buildings, run the accounts, drive the works vans, have authority as managers to run their sections, carry out estimates for work and take on contracts. Within Broadmoor Hospital, FST have continued this ethos, as far as possible, within the security rules and regulations.

The projects generate substantial income through the commercial activities of the workforce. This protects the rights of the workforce and ensures that the long-term security of the projects is a shared responsibility for all.

The FST project in Broadmoor consists of 6 business units:

- Textiles (clothing alterations and soft furnishings)
- Carpentry/Woodwork
- Office (including Project finance and desktop publishing)
- T-shirt design and printing

- Card & Craft
- Estates (litter picking, gardening and fence painting).

Patients - referred to in other contexts as 'FST project participants' or 'workers' - work in the unit of their choice but must display the flexibility to work in other areas as per the business needs. Each unit has a participant appointed as Section Manager who receives a higher rate of pay than other workers. (Although due to new regulations across the hospital from April 2005, this will change so that all workers will receive the same hourly rate).

FST within Broadmoor aims to:

- Improve participant confidence, motivation and self-esteem
- Extend participants' abilities to assume individual and collective responsibility for fulfilling work tasks
- Provide opportunities for collective and individual decision-making within the constraints of the secure environment
- Offer a rehabilitation regime that enables participants to move beyond traditional work skills and into situations more like the labour market they will encounter on discharge.

Over the past four years, over 100 patients at Broadmoor have been part of the project, with individuals participating anywhere from three months to three years.

Since the Broadmoor Hospital segregation policy was introduced in May 2002, men attend on Tuesdays, Thursdays and Fridays and women attend on Mondays and Wednesdays. Participants can attend half or full day sessions.

Patients are referred to FST in a number of ways. They can refer themselves, either by asking a member of the ward staff to contact the project or by asking a current member of the workforce (other patients) to request an application form, or the occupational therapist or another member of the clinical team may request an application form on behalf of the patient.

1.4 Running the FST model within a high security setting

The regulations of a high security environment have quite distinct effects on the operation of work rehabilitation services. These effects are worth outlining for readers who may be unfamiliar with the high security context. The list below gives an indication of the complexities of operating the FST model within this setting, particularly the impact on the length of time patients can actually 'work' on FST business, the levels of empowerment possible and the staffing levels required to run the project efficiently and safely on a day-to-day basis.

- Escort procedures mean that start times are later and finish times earlier than ideal. In effect morning and afternoon sessions are reduced to 2.5 hours each (a maximum of 3 hours if escort arrangements run to schedule). The escort procedures also affect the number and gender of FST staff needed (and the required number can change depending on the time of year and how dark it is

outside). Furthermore, patients have to be back on their ward at certain times or they will miss their meal.

- Security regulations mean that all patients are scanned on entering and leaving the project and at least 25% are searched. This takes a good fifteen minutes at the start and end of each session.
- Policies around tool handling mean that there has to be a full tool check at the start and end of each session and at any time when a patient may leave the area in the meantime. Anytime a tool is wanted, patients have to ask a member of staff who holds tool cupboard keys. The staff member then must open the cupboard and allocate the tool against a patient's name. At any one time only a limited number of tools are allowed out.
- The telephone and fax machine have to be in a locked cupboard as security regulations mean that only staff can use these.
- In terms of postal monitoring, all mail has to be checked before it goes out.
- At any time, all staff must have line of sight with each other and all patients must be within line of sight.
- A member of staff must be in the office (where the computers are located) at all times – if they have to leave, the patients must leave too.
- The spot-checks and “no patient movement” rules mean an entire day's work can be lost whilst the Control Room manages a variety of situations, including checking numbers in the hospital or managing an incident within hospital.

1.5 The research question

The question we wished to explore was whether the provision of ‘realistic’ vocational preparation as delivered by the FST project has a positive effect on participant rehabilitation and preparation for discharge, and contributes to the development of a discharge pathway into less secure settings and ultimately into the community.

1.6 Research aim and objectives

The aim of the study was to identify the perceived impact of having access to work opportunities through FST on:


1. People who were participating in FST in Broadmoor
2. People no longer participating in FST who were still at Broadmoor
3. People who participated in FST at Broadmoor and who have since been discharged from the hospital to the community or to a medium secure unit.

The objectives of the study were to:

1. Identify perceived benefits for participants
2. Identify the reasons why some participants leave the project while others remain involved, or drop out and return.
3. Explore whether there is a relationship between a participants' patterns of involvement and an individual's rehabilitation and preparation for discharge.
4. Assess the need for and value of continuing work opportunities in the discharge pathway after Broadmoor.

1.7 The report

This report is structured in six further sections. The next section describes the methods used to carry out the research, including the ethical issues and considerations we took into account prior to gathering the data. Section 3 provides a profile of the people who took part in the study, followed by information about the data collection process. Section 4 presents the results, which are then discussed in Section 5. The conclusions we have drawn from our results are set out in Section 6, where we also make recommendations for developing policy and practice in this area.



2. Methodology and Research Design

2.1 Overview of methodology

The study was retrospective in design because within the time and resources available to us it was not feasible to carry out a prospective study observing and tracking changes over time.

The size of sample it was possible to obtain precluded a statistical analysis. A qualitative approach was therefore required and perceived outcomes were assessed through in-depth interviews with project participants and their clinicians, and from an analysis of clinical notes where they were available.

The intention was to recruit three groups of eight people to the study: those people still working with the FST project; people still in Broadmoor who had worked with the project but left; and people who had worked with the project and had been discharged from Broadmoor to a medium secure unit.

Where participants gave consent we also wished to obtain the views of a clinician of their choice and to examine their clinical notes for evidence of the impact of the FST project.

2.2 Data collection

Semi-structured interviews were chosen as the primary data collection method and schedules were designed to guide interviews with project participants and clinicians.

The interviews were carried out over a six-month period between April and September 2004.

The interview schedule for project participants covered:

- Their involvement in the project e.g. likes and dislikes, types of activities, perceived benefits of attending
- Attendance levels - start date, number of sessions per week, timing and reasons behind any breaks
- Initial aspirations – why they got involved in FST, what they hoped to gain from attending
- Future aspirations
- Involvement in decision making within the project, including level of responsibility
- Their observations of any changes in themselves resulting from their involvement in FST and any observations from people around them
- The relationship between FST and their clinical team and Broadmoor Hospital more widely
- The timing and content of work progress reviews
- Date of and reasons for leaving the project (if applicable).

The interview schedule for clinicians covered:

- Their understanding of the FST project
- Their initial and future aspirations for the participant relating to their attendance at the project
- Their knowledge and awareness of the person's role in decision-making and level of responsibility
- The benefits of participation and any observations about the person relating to their participation in FST
- How they view the FST project
- The relationship between the ward and the FST project.

In order to maximise the richness of the data obtained, participants' permission to tape record the interviews was sought, with detailed note taking as an alternative where permission was refused.

The clinical notes of project participants who gave consent for these to be used were examined to ascertain whether any benefits or problems attributed to involvement with the FST project had been observed and recorded by ward staff or other members of the clinical team. They also enabled the research team to consider the relationship between the FST project and the care planning and assessment process.

2.3 Ethics and governance approval

Since two-thirds of the participants we wished to recruit were still at Broadmoor hospital, approval from the Broadmoor Local Research Ethics Committee (LREC) was required. This process took several months but approval was given at the end of January 2004.

Because people discharged from Broadmoor could be anywhere in the country, we also needed to gain Multi-centre Research Ethics Committee (MREC) approval. This was granted in December 2003 with 'no local investigator' status, meaning that further LREC approval from the NHS Trusts where the medium secure units were located was not required.

The study also needed research governance approval from the West London Mental Health NHS Trust within which Broadmoor Hospital is located and from each NHS Trust to which people had been discharged. In some cases this involved obtaining an honorary contract for which a Criminal Records Bureau (CRB) check, occupational health clearance and references were required.

In total the process of obtaining ethical and research governance approvals took 12 months.

2.4 Sampling

Once the necessary approvals were obtained, staff at the FST project were asked to draw up a sampling frame of everyone who had used the project, stratified according to the three groups of participants we wished to recruit to the study. All project

participants were given FST reference numbers and the sampling frame was therefore anonymous when it was sent to the research team.

Purposeful sampling designed to obtain as representative a sample as possible was then undertaken by the research team. Within each of the three categories set out above, attempts were made to ensure the following variables were encompassed:

- Gender
- Ethnicity
- Age
- Length of time in Broadmoor and the FST project
- Level of responsibility in FST project
- Diagnosis.

2.5 Access to project participants

Initial contact with people still participating in FST (Group 1) was made by FST project staff², who provided potential participants with written information about the study from the research team. Permission was sought from those who expressed interest in taking part and completed the consent form, to pass on their name to the research team. No further contact was made with those who did not wish to be involved. Arrangements were made with those who wished to participate to carry out an interview at a mutually convenient time on the their ward. Contact information for the clinician that the participant nominated to be interviewed was also obtained. Clinicians were contacted through a letter and information sheet, followed up by a phone call.

Contact was made with people still in the hospital but no longer with FST (Group 2) via their clinical nurse manager (CNM), who gave them an information sheet inviting their participation and an enclosed consent form. All CNMs from each ward in the hospital received information about the research project and a talk about the research by the FST Manager prior to any patients being contacted. This meant that they were in a position to answers questions from patients and other staff as they arose. The researcher then contacted the CNM or the patient's primary nurse to ascertain whether the patient had given consent. Where consent was not granted the research team made no further contact. Where consent was granted the research team arranged a mutually convenient time to carry out an interview on the ward. At the same time the name and contact details were taken for the clinician nominated by the participant. Nominated clinicians were contacted through a letter and information sheet followed up with a phone call as above.

Initial contact with former participants discharged to a medium secure unit (Group 3) was made by a member of their current clinical team, either their Regional Medical Officer (RMO) or their primary nurse. Recruitment followed the same procedure as that described above. (See appendix 1 for the information sheets, consent forms and letters).

² FST staff were also provided with an information sheet explaining the research project and had direct access to the research team to ask any further questions

Recruitment of participants continued until the required sample sizes had been achieved or the timescale for recruitment exceeded. As noted earlier, we had intended to interview eight people from each group, but time constraints, particularly the time it took to follow up contacts and negotiate access to the medium secure units, meant that we were only able to interview seven people in Group 2 and four in Group 3.

2.6 Data analysis

We used the following staged content analysis procedure to compare and contrast outcomes within and across the study samples:

1. Key themes were identified and compared for each individual from the project participant and clinician interviews and from the clinical notes. In line with quality criteria for qualitative research, the three data sources were not used to verify or disconfirm each other. Instead, the aim was to understand how contradictions between data sources made sense in the contexts in which the data were produced.
2. Themes identified in relation to each individual were compared and contrasted for the three sample groups. Explanations for similarities and differences within sample groups were considered in relation to the background variables, such as age, gender, length of time at FST etc. as identified in the sampling frame.
3. Finally, themes were compared across the three sample groups, taking into account the relationship between perceived outcomes, patterns of FST service use and individual background variables.

2.7 Data storage - protecting confidentiality and anonymity

All participants were allocated a numerical code to ensure that interview notes and tape recordings were anonymous.

During the study, electronic versions of interview transcripts were kept in password-protected files. The original tapes and paper versions of the transcripts were stored in locked filing cabinets. Only the principal researcher and academic supervisor had access to the tapes and transcripts. Information that might identify participants was stored separately from the transcripts under similar secure conditions.

Following completion of the study, tapes were wiped clean immediately. Electronic versions of the transcripts were transferred to CD and stored with the paper versions in locked cabinets at SCM for six months, and then archived for five years at the Sainsbury Centre secure lockers at Abbot Datastore. Security measures here include security patrols, intruder and fire alarms and CCTV on a 24 hour basis. After this period all data will be destroyed.

2.8 Presentation of data

In order to preserve anonymity, when data are presented in the following section the person concerned is referred to by a code relating to the three study groups (1a, 1b, 1c, 2a, 2b, 2c, 3a, 3b etc.) so the reader can assess the range of data presented.

Where quotes are taken from the interview transcripts, they are indented in the text. Where project participant and clinician perceptions are cited from the researcher's notes, these are indented and italicised.



3. Study Participants and Process

3.1 Overview of the section

This section provides a profile of the people who took part in the study, followed by information about the data collection process.

3.2 The people who took part in the research

Overall we interviewed a good cross-section of people, with study participants coming from different age, gender and ethnic groups with varying lengths of time at Broadmoor and within the FST project.

The representation of participants interviewed was in line with the overall profile of all participants who have attended the First Step Trust project, with the exception of a slight under representation of women in our sample.

At the time of our study, a total of thirteen FST participants had taken on the role of Section Manager since the project started. We interviewed six of these Section Managers either whilst they were in the role or after they had left it.

The profile of each group is summarised below, for more detail please refer to Appendix 3 at the end of this report, which provides a profile of::

- The FST participants who were part of the research project
- All the people who have participated in FST since the project was established
- All people in Broadmoor hospital.

3.2.1 Group 1

Group 1 comprised six men and two women. These participants ranged in age from 33 to 63. In terms of ethnicity, two of the men described themselves as Black British while the other six participants described themselves as White British. The participants' admission to Broadmoor dated from 1990, most having been admitted between 1993 and 1996. One more recently admitted participant (1999) had been with the FST project for the longest time period (34 months).

With the exception of one woman (1f) who had had breaks in her attendance, participants attended the FST project regularly. Their length of time with FST ranged from 10 to 34 months, with seven of the eight people involved for over a year. Of the group, one woman and one man were Section Managers when we interviewed them. A second man had been a Section Manager, but had recently stepped down from the role.

Seven of the eight participants gave permission for us to look at their clinical notes. However, two people's records were unavailable and five sets of notes were therefore examined.

All eight participants nominated a clinician to be interviewed. One clinician declined to be interviewed, one sat in on the participant's interview at the participant's request and two were unable to schedule a face to face interview in the time available. Instead, questionnaires were sent to these two clinicians on two occasions but no response was obtained.

3.2.2 Group 2

This group comprised two women and five men aged between 25 and 57. One man described himself as Black British, while the other six participants described themselves as White British. Their admissions to Broadmoor had taken place from 1992, the majority having been admitted between 1996 and 1998.

Group 2 participants had attended the FST project for between three and 37 months, with four people attending for less than 12 months. Four of the participants attended the project consistently, with the other three having a number of breaks in their attendance. Two of the men had been Section Managers during their time at the project.

All seven participants nominated a clinician to be interviewed. One clinician could not be interviewed as they only worked nights, another clinician was no longer in touch with the participant and a third was unable to schedule a face-to-face interview in the time available. Four clinicians were therefore interviewed.

3.2.3 Group 3

This group comprised three men and one woman. One of the men described himself as Black British, with the other three participants describing themselves as White British. Two of the participants had been in Broadmoor since 1990, while the other two had been admitted prior to 1990. Two of the participants had been discharged from Broadmoor in the summer of 2003 and two in March 2004.

These participants' lengths of time with the FST project ranged from 13 to 27 months. The female participant and one of the men had attended consistently. The other man had been suspended from the project for two months, while the third man's attendance had been inconsistent. Only one participant had attended until discharge, the others having given up attending between six and ten months prior to discharge.

On reflection it became apparent that the clinical staff involved with these participants in the medium secure units would be unable to comment on the impact of the project except through reference to participants' clinical notes. For this reason, extensive examination of clinical notes was substituted for clinician interviews. Three of the four participants gave permission for us to look at their notes and there were no problems in doing so.

3.3 The data collection process

For the majority of the participants interviewed, the interview itself was the first and last time the researcher met with the individual. This in itself meant that participants were talking to a stranger. Time at the start of the interview was therefore given to

creating an atmosphere within which participants were happy to discuss their experiences. In the majority of cases, the researcher was given quiet rooms in which to carry out the interviews in privacy. In only a couple of instances were there interruptions that disrupted the flow of the interview.

Most participants appeared to talk freely with only three (two in Group 1, one in Group 3) finding it more difficult. One of these three participants explained that they were feeling unwell but still wished to continue. For people in Groups 2 and 3 who had left FST some years before the interview, remembering their time with the project was more difficult than for other participants.

Not dissimilarly, one clinician nominated by participants in Group 2 had not known the individual concerned during their time at FST and so had greater difficulty gauging the project's impact. Overall, however, the interviews with clinicians went well. In the main, clinical staff talked freely about their experiences of the FST project and any impact they had observed on the participant concerned.

Where permission to access clinical notes was granted, the researcher spent time within the medical records department at Broadmoor reviewing notes taken during the period the participant was attending FST. These records provided information from Case Reviews but in some cases did not hold the most up to date reviews, as these were held on the ward. Furthermore, where clinical notes reported changes in participants, in most cases there was no reference to attendance at FST, so we have been cautious in drawing too much data from these sources. Where direct reference was made to FST, we have included this within the data analysis. However, the review of clinical notes was useful in enabling us to consider the relationship between FST and the care planning and assessment process following on from the views expressed about this by the project participants and clinicians we interviewed.

4. Results

Introduction

In this section the main findings from the study are presented under headings relating to:

1. The reported benefits of attending in terms of:

- Personal development e.g. confidence and social skills
- Work skills development e.g. learning new skills, improving and renewing existing skills
- Clinical benefits e.g. anger management, health benefits, attitude to treatment
- Potential future benefits e.g. goal setting, thinking about the future

2. The tensions inherent within the FST project:

- The project's function
- Broadmoor regulations and FST culture
- The relationship between the project and assessment/care planning

3. Participants' experiences within medium secure units

As noted earlier, in order to preserve anonymity, when data are presented in the following section the person concerned is referred to by a code relating to the three study groups (1a, 2a, 2b, 3a, etc.) so the reader can assess the range of data presented.

Where quotes are taken from the interview transcripts, they are indented in the text. Where project participant and clinician perceptions are cited from the researcher's notes, these are indented and italicised.

4.1 Reported benefits

4.1.1 Personal development

The personal development described by participants related to increased confidence and social skills.

Confidence

Participants identified a number of ways in which they had increased in confidence through their participation in the FST project, in terms of increasing self-esteem, self-efficacy or feeling empowered through their involvement in the organisation and running of the project.

Group 1

All eight participants in Group 1 talked about the impact of work on their confidence and the clinicians we spoke to also picked up on this:

Well, at the end of the day, you look at the things you've done and say 'well, I did that', you know. (1c)

Once you can do the job, there's a sense of satisfaction as well. (1d)

He'll get a lot of, sort of like, motivated by seeing whatever he is producing at FST... he would be happy to show it to everyone, [look what I've got].
(Clinician on 1e)

In the office, I used the computer for the first time. I felt nervous, but better later. (1f)

Some also expressed confidence in relation to seeing themselves develop new skills:

Well, well I'm quite, I'm quite confident. I'm not, I'm not saying I would *get* a job in an office, you know, or you know. I can't say I've got skills that would get me an office job. But, I can say that if I had a computer, 'cause nowadays a lot of people have got computers, I could mess about and do a little bit on it. You know what I mean? (1h)

In one case, a participant talked about how they had been able to carry this increase in confidence into other roles they had taken on within the hospital:

Yeah, I'm more confident, that type of thing. Mixing with people and doing different things. [Prior to FST] I was very quiet, not saying much. I probably wouldn't have seen you. (1a)

One clinician mentioned that despite seeing an increase in confidence they still felt the person was quite fragile:

It's made him more confident, but he's still quite fragile. That's my main concern. (Clinician on 1b)

Other clinicians described the development of self-esteem particularly in relation to project participants feeling valued:

Developed some sort of self-esteem that he's doing something worthwhile, you know? And at FST, he also expresses that he's appreciated, he contributes when he's over there, which is a very good thing for a patient like him. (Clinician on 1c)

I think FST has helped to give that... to bring up [patient's] self-esteem and some responsibility. (Clinician on 1g)

Some participants described confidence in terms of having a voice, feeling more independent or organising particular tasks:

Feel voice is important, first time and in every way, yes. (1b)

More independent now, I can undertake certain tasks now without constant supervision. (1d)

Group 2

In Group 2, increases in confidence were described, but not to the same extent as in Group 1. As with Group 1, FST participants and clinicians discussed confidence in terms of seeing the results of the work and feeling valued:

[Designs were used for the Christmas cards] 'that gave [patient] a big boost (Clinician on 2b)

You think, like again, you say 'Right, you've done something worthwhile'. [Referring to making the garden look nice] (2f)

Increased self-worth. (Clinician on 2a)

One of the same participants described their increased confidence in terms of realising that the work they had done had commercial value:

Somebody's actually going to pay for something that you made. (2f)

Another participant in Group 2 expressed confidence in relation to seeing themselves develop new skills. They went on to consider this in relation to being given more difficult tasks and seeing that they could succeed:

Q Well, I mean, I haven't used any of the skills that I've learnt, but the one thing I would say is that it give me confidence. Even though I left here, I went on there and I could do certain things... I've proved to myself I could be useful at some things... I was given the more difficult tasks to do... I didn't like, I didn't find like barriers in my way, or I was always getting things wrong, or I didn't know how to do it. You know. I was sort of, I was sort of like ninety-nine percent successful, and if I didn't know what to do, I would only need to ask once or twice, and then I would remember how to do it, and carry on doing it. You know.

Q So that... Yeah, very reassuring. Like you say...

A Yeah, reassuring. Very reassuring, yeah. (2e)

A third participant commented on the way in which FST could encourage quieter people to find their voice:

Q And if you were to sort of say anything else about FST, what else would you say about it?

- A I'd say if anyone's thinking about starting it, then give it a go. 'Cause it does help you in some ways, yes.
- Q And what do you think are the key ways it helps people?
- A It brings the quiet people out.
- Q Oh, right. Is that... Go on.
- A It brings them out. Instead of being quiet, they use their voice to express themselves.
- Q Right. So, people who might be quiet on the ward, they're sort of, they're brought out of themselves a bit more.
- A Yeah, they get confidence.
- Q Yeah. Why do you...why do you think that is? How do you think they've managed to do that? Because it's a particular...
- A Well...when you, when you get there. You're taken around and shown everything and... explained everything. And you're told straight away, if there's anything you're worried about, come and see us. (2d)

One clinician described in detail how they had realised that the project participant concerned had become more assertive:

If you'd met him eighteen months [prior to attending FST] ago he would have been very passive not assertive in himself. You would see that he...if I meet with him now he sort of says 'I would like to this and I'd like to do that'. When I met with him eighteen months ago he...I would say 'Why don't you try this or why don't you try that', he would be very passive and very reluctant to try, to try new things. He would be quite low in mood. But now he...his mood does fluctuate *now*, but he...he has a greater understanding about how activity can lift his mood and have a positive effect on his mood. You would have met somebody that was quite down and quite...very, very quiet and, and it was very difficult to engage him in discussion... Eighteen months ago, I would never have seen him standing up with a whiteboard and a pen writing stuff out in a meeting. Yeah? Going past a window one day in FST I saw that and was really amazed. Up with a pen, you know, saying 'You talk now', you know. I just caught that, and I was really, really surprised and really, really impressed. I wouldn't have seen him doing that eighteen months ago. (Clinician on 1g)

However, in several cases participants in Group 2 described situations where they felt a lack of involvement or choice. For example, one person who had left FST felt that their confidence had grown but explained that expectations had been raised which then were not fulfilled:

Confidence grew – yet raised expectations, let down, frustrated. (2a)

Another person in Group 2 talked about an increase in confidence but did not relate this to attending FST, although their clinician did:

Feels more confident now, but doesn't link this to FST, changes happened more recently, new medication has really helped. (2b)

I think it made [patient] more confident. Meeting people from outside i.e. FST staff – seeing that ... 'I'm a proper person, not just locked away in here'.
(Clinician on 2b)

Group 3

Not all participants in Group 3 made comments specifically relating to increases in confidence, although as with Group 1 and 2 one participant in Group 3 did discuss the feeling of satisfaction from completing work at FST:

I made shelves for the unit, although I needed help to do this, it was satisfying when it was done. (3e)

Another participant indicated that FST had increased their confidence, albeit obliquely:

I don't know that FST actually got people who were hopeless and had never worked into a working mood. But it certainly helped those who had some glimmer. (3a)

A third participant did not feel they had benefited, but spoke of the benefits to others:

FST was about filling time, I feel I wasn't attending enough to get much out of it, but recognise that for others they were attending more and getting more out of it. (3e)

Social skills

In addition to increased self-esteem and confidence, FST participants and clinicians discussed personal development in terms of improved social skills, particularly:

- Increased communication skills, understanding and use of politeness strategies and the ability to mix with others, particularly those from different groups from oneself
- The ability to take responsibility through working in a team, through taking on specific projects, through taking on the role of a section manager or being managed by other FST participants.

Several people discussed teamwork in the context of how FST differs from other work services they had been part of, where they had worked by themselves on individual projects. They discussed the effects this had in terms of the need to adapt to working in groups and the need to build an understanding of others.

In order to present the data, we have grouped social skills into two categories: communication and taking responsibility.

Communication

Group 1

One participant discussed improved communication in terms of mixing in a group:

Mixing with people and doing different things... Taught me to keep up my confidence enough to... chat, and things like that. (1a)

Two others discussed communication skills in terms of some of the basic rules around talking to others:

Clear rules on the way we relate e.g. not shouting across the unit, I have learnt this and learnt coping mechanisms e.g. wouldn't listen to criticism, now I will... Have developed patience and the ability to listen. (1b)

Prior to FST was an aggressive bloke; answer question with a question - getting on better with people now as well. (1c)

Group 2

As with Group 1, participants in Group 2 talked about improved communication from mixing with others, but spoke more specifically about mixing with the opposite sex, or with people who are outside their usual social circles:

Very helpful to be mixing with women – helped with relationships with women. (2a)

I think the, some of the other skills I learnt whilst in there was mixing with other people. People that I wouldn't mix with out of the work area, on the wards and socially otherwise. I was mixing with females a lot more, because I worked with them, and working with people that were a lot slower at doing things and, how do you say, not the brightest in the world, but willing to give it a try. (2g)

A clinician discussing a participant from Group 2, also highlighted a gain in communication skills:

Benefited from contact with females... Increased communication skills (Clinician on 2a)

Like some of the participants in Group 1, one participant in Group 2 discussed communication skills in terms of some of the basic rules around talking to others:

Q I mean, when I was over there, one person would say, would you like a drink? In the old days, I would say, I'll get me own. But I learnt, when I was over there, just to say the polite words like 'yes thanks', or 'no, thank you'.

Q And is that something you learned at FST?

A Yeah. It does say over there there's no swearing. And I find that hard sometimes, 'cause I was brought up with it. (2d)

Group 3

Participants in Group 3 also discussed improved communication in terms of mixing in a group and, like Group 2 participants, related this specifically to mixing with participants from the other sex or with people outside their usual social circles:

To start with, I like male company. You know, they're, they're poles apart. People are poles apart in type, and everything, everything else. They, I think they impart a point of view that one, you know, can appreciate on aspect. So there was, there was that, and also it was such a nice atmosphere. (3a)

People I don't normally mix with, and don't even acknowledge and talk to... Suddenly I was finding I had to be civil to... Which was okay, I could deal with that. (3d)

One participant (3a) also highlighted the written communication skills they had to build as a result of the implementation of a segregation policy:

Yes, like job sharing. But it was, without ever meeting the other half. And having to do it through meeting intermediaries, and writing notes. We've sort of got to this having a book and having to record everything so...the next lot can see what has happened. It was, it was an education I suppose in communication. Although I didn't see it like that at the time. It was just one big irritation... it did prompt communication skills. (3a)

The same participant went on to talk about communication skills in terms of building friendships and learning to manage people:

I built up, one or two friendships. And I got to manage people much better. And I thought it was quite fun on occasions. There, sort of, coffee mornings, and we'd, sort of, get ready for this and we'd do all the ordering up. Decide what we were going to eat. (3a)

Taking responsibility

As noted above, participants talked about taking responsibility in various ways: through taking on specific projects, working as a team, becoming a Section Manager or being managed by another participant.

Group 1

In Group 1 the emphasis of much discussion was on the benefits of teamwork, an issue raised by both FST participants and clinicians in Group 1. For example, one clinician described the ways in which a participant had learnt to work as part of a

team, while a participant highlighted the sense of inclusion gained from working in a team:

He's had to adapt, he's had to become more of a group, if you like, as a team... The major thing is dealing with people. The way he deals with people. The way he associates with people. Communicates with people. (Clinician on 1b)

You have more of a feel that you're part of something... like a team and you feel you're part of something. (1g)

People also spoke about reciprocity: learning to work with others, supporting others and helping each other with job tasks. For example, one participant (1e) talked about carried out small repairs such as mending clothes for fellow participants, and about passing on the skills he had learnt to pass to others. Others commented:

We're a team, we're all a team together and you all work on one thing. You know, if someone needed help somewhere else, and they say 'you're not busy', you'd go and help them. (1c)

I got a lot of support from the, not only the people that run the project but also the people, the other participants who work there. (1g)

Two participants compared the teamwork at FST with other work services they had been part of:

It's not like other work areas within here. You have more of a feel that you're part of something, you know. I mean when you're in another work area and I worked in all the other areas in here and you almost go in and punch your ticket, and punch your ticket on the way out, but over there it's like a team and you feel you're part of something... you're not treated as a normal patient in FST. You're treated as a worker. Or you're treated as a colleague. (1g)

[At FST] a sheep, might go on the card. Then someone might paint the legs. And then, someone might, you know, fold it and then someone might be putting it in plastic, you know... [Whereas in other work areas] they'll make for themselves, say a cupboard or whatever, right you know, they'll get help from the staff over there who are qualified craftsmen or whatever they are, and they'll build it, and you know, help get built. And then they'll buy it, and send it out to their, you know, their family or, you know, when they get their flats or whatever. You see what I'm saying. So, it's not a team thing, it's an individual pass for them. You know what I mean? (1h)

The following quote highlights how one participant took responsibility through recognising the consequences of his actions:

But like I say I've changed. I've grown up... I've admitted to what I've done. I've come to terms with what I've done. I also realise the victim needs me to do this, so I won't create no more victims. You know, because I got a sexual, for a sexual offender I've got a whole vari...- I can never say that word - a variety of crimes, you know what I mean? There's not just one, there's quite a few so, you

know, I've got to be, make sure I don't ... do something again, which I feel really strongly about. (1c)

Participants also discussed how they had built an increased understanding of others through their participation in FST, for example:

Built understanding of others – not thinking this before, I was full prison culture... Can see other people's input as valuable. (1b)

When asked about the experience of acting as Section Manager, one of the three participants in Group 1 who had taken on this role (1a) thought this made little difference, although they sometimes got involved in looking at the budget, the finances and the orders. The second participant, however, described how taking on the role had helped them develop new skills:

Learning how to delegate tasks. (1b)

Referring to their decision to stand down from the role, the third participant nevertheless expressed a sense of responsibility:

I did have the feeling that, that I'd let them down. (1g)

Group 2

As in Group 1, the importance of teamwork, the learning that takes place from working as part of team and the reciprocity associated with this, was raised by both FST project participants and clinicians. As two participants put it:

It was, it was, yeah. But at the same time I didn't lose sight of the fact that I could actually benefit in terms of inter-personal skills because dealing with guys who weren't fully up and running... you're bound to be challenged at some point, by their, either inability or their inconsistencies, whatever. And bringing them into a team situation and maintaining them in that, and also maintaining yourself in that. Because there are various levels and the one with the inter-personal skills is the one that is expected to find those levels and readjust all the time. And I was finding this fun. I was finding it a challenge, but I was also finding it useful, because it was improving me as a person as well. (2c)

It was just nice to be working as a team as well, you know. We'd have the meeting in the morning, we'd all discuss what we were going to do for the day, or, or the morning. Everybody had something to do, could either work in, in, a few people were cleaning, you'd have discussion. You'd have a, a... you know. If you didn't like something you were doing, you didn't have to do it, if you felt uncomfortable. I mean, out of... I felt, you know, there will be... something there that I will be able to carry on when I get back outside. Like the garden, 'cause that's what I'm very interested in. And I really like doing that, you know. And it's just really nice to work, you know, in a, in a environment were everybody's... I've never worked like that before, because I come here when I was seventeen you see. I've never worked in, in a like an office or anything like that. So, when I did get the chance, I really enjoyed what I was doing... I'm not

really, I used to be sort of like, working alone most of the time. But when you do get to work in a team, you get to know how other people act and how they do things and you can learn off them. You know. Maybe you can help them with things, they help you with things. Everyone has different ideas and you try them all out. You know, it's, it's just, like I said to you it's good, it's a good environment, it's a good atmosphere, and if you mess up, you mess up, and you can try again. But if you're doing good, then you just carry on. (2f)

Both FST participants and clinicians again also discussed how an increased understanding of others could be developed through participation in FST:

More able to consider other people's opinion whilst still giving his views including when people challenge him... Speaks up for more vulnerable patients... Takes the needs of others on board. (Clinician on 2a)

He did have a problem of taking on board other people's feelings and he's had to do that at FST.... he had to learn that other people are important too. (Clinician on 2g)

And it was also, learning about myself. Being able to teach people and train people. Bit more compassion for them. And understanding that, their, of their needs as well. (2g)

In addition to discussing the benefits of teamwork, in this group participants also focused on taking responsibility for particular FST projects. For example:

So we had to organise that [the coffee morning]. Who was doing what, what was going where. You know. Our opinion, our opinion was...they fully asked us. It was down to us how, how this thing went. You know. How, how it worked. Who was gonna sell T-shirts. Who was gonna sell Christmas cards. Did you know what to do, you know. I had to log it in to, how to log it down on paper, you know, so that the FST got paid, you know. Yeah, so it was, it was. There was always lots to do. You know. But... Yeah, that was one of the main things I remember. (2e)

Another participant discussed taking responsibility in the context of producing a quality product:

Everything's got to be on top form and completed. Exactly as you would in a workplace... I learnt, you know, that we have to perfect everything, you know. If you're going to make something to sell, you've got to do it to high standard. And you can't just, you know...that's a thing making money is like the cards, you can't just stick a rose on it and write blah, blah, blah in normal handwriting. You're not going to make it all nice and fancy and...and it was nice just to, you know, look at what you've done. After, I thought I made that, you know, it's going to sell. People like my work I can carry on making it. (2f)

Only two participants in Group 2 had taken on the role of Section Manager. One participant (2e), although they hadn't been a Section Manager themselves, shared the view of the participant in Group 1 who thought the role made little difference. On

the other hand, one of the participants in Group 2 who had taken on this responsibility described learning new skills:

Whereas they'd take all day. I'd have to keep showing them, and keep showing them, and keep showing them. But I learnt that I had to do that. I had to keep showing them. You know, yes they might learn slower, but they're learning, which is what they're there for as well... Being a Section Manager and having to manage a section and make sure things were done on a daily basis as well as a weekly basis, and the various tasks that needed to be doing and allocating them and knowing who, you know, sort of thinking to myself, well who was going to be in this week. Who wasn't. What sessions they were in, and what needed to be left for the females to do when it was segregated. What they could cope with. What they could do, and what I could do. You know so, it was working it all out. (2g)

The other participant (2a) who had taken on the role of section manager had found it difficult, as they put it, 'to order other people around'. However, other participants' experiences of being managed by a fellow-participant were quite positive:

It was good, it was good. (2d)

I didn't mind being told what to do or how to do it. I think that's you know, quite good that, that a patient had the skill to show me, another patient, she was capable of doing that, and how I could do it, you know. I didn't feel like I was, you know, I didn't feel like I was being talked down to by another patient, or being bossed around by another patient. I thought that was fine, you know. Thought everybody's got a right to learn all this, you know. (2f)

Group 3

Like participants in Group 2, three of the four participants in Group 3 gave examples of taking on responsibility for FST projects, for example:

Well, the ordering. There's quite a lot of ordering from stationery to coffee, to the materials. I mean the carpentry people ordered their stuff, but you had to keep a record of it. And then one kept like a duplicate set of accounts, very roughly to know where the budget, how the budget was going. So I had a very definite hand on the money. And did see the invoices. You really had to know how, how much you'd got...say you'd spent three thousand pounds that month. Well you had to see at the end of the month how many orders were still outstanding. So how much you'd actually got, you know, booked out and hadn't actually gone out. This type of thing. I did sometimes, not always, but patients got paid. Someone had to keep a record. Well, a member of staff worked out the hours, but a patient would actually put it on the computer. With the payslips to tell people how much they had got. (3a)

Here too, teamwork was valued and a sense of reciprocity was evident:

Felt I built skills to work in a team. (3e)

Yeah, I was a bit. I felt like...I don't think they can get a bottle of paint again. I don't think they can get another bottle of paint. There's no more in store.
[Referring to spilling a bottle of paint] (3b)

Only one person from Group 3 had taken on the role of Section Manager. Like two participants from the other groups, they thought this made little difference, explaining that they had not been particularly interested in titles or roles. Another participant in this group who took on the role of organising a particular work area, although not designated a Section Manager, described how they found managing others difficult:

People wouldn't listen to what I was saying... They wouldn't do what you tell them, it just got out of hand...I didn't want to do it no more... because people wouldn't listen to what I was saying. (3b)

4.1.2 Work skills development

The theme of work skills development encompasses increasing motivation, particularly having something to get up for, and the development or renewal of technical skills.

Motivation

These comments from Groups 1 and 2 highlight the important role FST could play in providing meaningful occupation during the day and developing participants' motivation to get up and go to work:

Gives me motivation, keeps me off the ward, active and occupied, not scratching my head doing nothing on the ward. (1e)

Has to be on his last leg before he can say he can't attend FST. (Clinician on 1c)

They [the clinical team] said that I was a lot more motivated. (2d)

I'm a lot more active. There was something worth getting up for in the morning. (2f)

Technical skills

Group 1

Almost all the participants in Group 1 and some of their clinicians were able to identify new skills gained through the FST project. These extracts from the data provide an overview of the range of skills described:

Learning a new management style. (1b)

They think that I've come pretty good in here, in transfer printing. (1c)

I've been progressing with computer work... now I'm clued up on basic text processing which is good. (1d)

It's not about what I like most it's about the skills learnt... and being able to pass these skills to others' 'once you've learnt them no one can take them away. (1e)

In the office, I used a computer for the first time, I felt nervous, but better later (1f)

I knew more or less how to work a computer, but I hadn't been using those particular programmes on that computer, like Word and such... Excel, Publisher some of the other programmes that are not Microsoft... they're programmes we use in line with the T-shirts that we're doing, or the garments that we're using along with the transfers. (1g)

I don't think his cognitive capacity has changed. I think it's just his skills have developed. (Clinician on 1g)

I'm not great at paperwork, but I found I could do quite a bit, you know, on the computer and that. I was learning, you all, all the time... when I knew how to do it, you know, I got all excited and I couldn't stop doing mail merges and, and... I'd never worked in an office before. (1h)

This clinician highlighted that a new skill is something that is sustainable and can be used in the future:

He's got a skill that he can use after he's left maybe the mental health services. (Clinician 1e)

Participants also described how existing skills were recognised and in some cases renewed:

Just because they're patients doesn't mean that they haven't got more skills than those who are running the centre sometimes... the project here tends to recognise them. (1g)

I have adapted my training methods to the environment and to people's abilities. (1b)

One participant particularly valued the opportunity to try out different skills across a range of work areas in order to find the most appropriate for their particular needs:

The office is where I started. And then I got a bit disillusioned with that, so I went from there to the textiles, spent about three months there, being taught by [staff member] and then I started getting a bit 'no, this is not for me' so I moved from there to cards and craft did a bit there and I thought 'no, this is not for me neither', so I went back to the office for a while – about two months – and I thought, 'no, this is still not for me,' then I went to transfer printing and I've been there ever since... I've been there about a year, maybe two, two year now... I settled to transfer printing – you can actually see the product straight away. Once you've put the thing on and printed it you can think 'I did that!' you

know, so that's what I liked about it; it's quick, it's done quick same as the textiles, you do things in there and it's quickly done. (1c)

Group 2

Although gaining new skills was mentioned somewhat less frequently in this group, several participants did highlight this as a benefit:

There was a lot of stuff you could learn there. Stuff like typing and ... word processing. Woodwork. Printing T-shirts. (2d)

I learnt quite a bit from the computer. It was a whole different range of things I learnt. [Staff member] just told me how to do it [VAT returns]... I didn't understand, I didn't understand at first. But you know, [staff member] explained it to me, and I just got on with it. A few times I got it wrong, but that's to be expected, you know. After that, it was, it was just easy. (2d)

Learnt computer skills and desk top publishing... Learning about others, how to teach and how to train and how to show compassion, the effective management of others. (2g)

In contrast to Group 1, participants in Group 2 did not mention the renewal of existing skills, but one participant did speak of the benefits of being able to try out different work areas after becoming upset about not succeeding in one area:

Well, I was, I was actually painting something at the time, and one of the staff come over, and we had a chat and I explained what was going on. But [staff member] was very helpful, and said, you know, we can try different things. Everybody's good at something. You know, just do something you want to... We can test you on different things. Do something you enjoy. You know, it doesn't necessarily have to be this, this, this and this – you have to do it. Try it, see what you like, what you're good at, and then, you know, we'll go from there. (2f)

Group 3

The new skills gained through attending FST were similar in this group to those described by the other groups:

Management was a new skill. (3b)

I could type letters... But I'd not worked with the computer. (3b)

I didn't know how to use a computer, so I started to learn, to learn bits and that. The fact that there were deadlines and stuff, that you actually had to do, *had* to do. I was feeling quite...it was all part, it was all, it was all down to you. Whatever you was involved in, whether it was printing T-shirts, or office work. I learnt a bit about computers and stuff. I learned the basics. (3d)

At FST they told me about protective clothing, toxicity of products, so all about Health and Safety Awareness, useful skills and knowledge. (3e)

As in Group 1, participants in Group 3 also discussed renewing or improving existing skills:

I certainly increased my computer skills, yes... And I got to manage people much better. (3a)

Increased my computer skills. (3d)

However, one participant, now in a medium secure unit, could not identify any work skills development, suggesting that any skills they may have gained had been lost:

If I did learn I've forgot it now. (3b)

4.1.3 Clinical benefits

This third category of benefits associated with participation in the FST project encompasses managing anger and dealing with frustrations more appropriately, health benefits and changing attitudes towards treatment.

Within Group 1 both FST participants and clinicians made many comments about participation in FST assisting rehabilitation. While the range of responses in Group 2 were similar to those in Group 1, no one in Group 3 commented on clinical benefits. Where clinical notes discussed benefits in relation to FST we have taken extracts from them and included them alongside the interview data below.

Managing Anger

These comments from FST participants and clinicians in the Groups 1 and 2 illustrate the benefits described in relation to anger management:

I don't let things build up. I think through problems, how I dealt with things – during the night. (1b)

Yeah, he was frustrated. I mean, yeah, he was... I say angry. But he vented it in a positive way, rather than take it out on a wall or somebody else or... Previously he would have exploded. (Clinician on 1b)

I'll tell one of the managers, yeah, or an assistant manager. Yeah, I always go, if someone's giving me hassle ... when I used just hit them or say something... It's made me grow up, and look at myself, and not be so angry. Lately, people have said things and I've just laughed it off, I've thought 'what's the point of getting angry? It's a wasted emotion'. (1c)

They'd be things happening on the ward and he's sometimes getting involved in the allegations... You know when twenty people live together it's not easy, you know, it's their house, there are rules and regulations. But he was able to keep his cool and going to FST would maybe make him more relaxed, have

something to look forward to do and come back on the ward more relaxed and different, completely changed from what he was before he went for the session. (Clinician on 1e)

Has seen him cope well with huge disappointments, has built up coping mechanisms. (Clinician on 2a)

It's going in there and raising issues in a positive way, rather than just going in there ranting and raving and arguing about it. You know, you, you just can't do that. So, it's understanding that you have to, you have to be diplomatic about it. And fortunately, I can be... I think it's just something I've learnt over the years, and certainly in the last few years with myself. Being, being able to calm down and look at things from both sides. Not just from my view, from their view as well. So...it's useful. (2g)

FST made him more assertive and more appropriate - his demands were not always appropriate when he first came to the ward. (Clinician on 2g)

Health benefits

Participants in Groups 1 and 2 associated the following benefits with attending the FST project:

Totally off medication – all down to FST. (1b)

This has pulled him around. He's cut his medication. He's positive. He's put on weight. (Clinician 1b)

Improved personal hygiene, lost weight. (1c)

So, you know, the ethos of trying to get people back into that frame of mind of working for a living sort of, the understanding that they need to work. That it also helps your mental health state. Because while you're working as I was, whilst I was working in FST, I was so busy thinking about FST during the morning, the day and the evenings on the ward as I said, you're not worried about your mental health state. You're not sat there thinking, feeling sorry for yourself, the situation you're in, and how am I going to move on, you know, and how long are they going to keep me here, and these drugs and all this...this sort of rubbish. You're not thinking about that. (2g)

Other people in Group 2, however, suggested that the changes they experienced were a precursor to joining FST, for one participant, (2e) they stopped medication and started attending FST for another (2d) the clinical team felt they had made excellent progress over the last year and then they joined the FST project.

Attitude to treatment

Changes in respect of attitudes to treatment were described by one project participant and one clinician in Group 1. The project participant described how they changed their attitude towards cognitive behavioural therapy (CBT), while the clinician

explained how the clinical team had realised that the person no longer needed to attend anger management therapy as a result of attending FST:

Q And is that something, that sort of intense day, is that something you could've done a few years ago? [the CBT]

A No, not at all. I would've told them to '.... off', basically.

Q Right.

A I would have walked out more than likely. But like I say I've changed. (1c)

When he got to FST he started finding purpose in his life, he started getting focuses, better insight into his illness, and started being more flexible, more communicative, more, getting involved in a lot of things that were happening in that department as well... He was becoming more receptive to treatment, more receptive, because he would.... There was talk of referring him to the Newbury Therapy Group where he was going to do anger management programme, but somehow, because of shortage of beds and everything this didn't happen for a very, very long time, because there was no vacancies in the group, so he got to FST and it was something for him to do, even in a time when we were still trying to get him into the anger management group. But after a long while we realised there was not really no, there was no pressing need for him to attend as such because we were not having any problems with him in terms of anger. (Clinician on 1e)

None of the clinicians or FST project participants interviewed from Group 2 mentioned attitudes to treatment, but the clinical notes for one person did state that they were 'distinctly more co-operative with the clinical team than they had been a year ago'. Although not attributed to FST, this change had taken place during their time with the project.

4.1.4 Potential future benefits

Several participants discussed their goals and plans for the future during the interviews. Some, particularly those in Group 2, reported having clear goals on starting FST that had prompted their decision to join the project. Other participants described how their goals changed through their involvement in the project.

Group 1

Two participants in this group described changing goals: in one case from simply passing time to a vision of working in the future; in the other in relation to identifying a particular trade:

Over the time I've been at FST, its function has changed from being somewhere to pass time away, changed to being somewhere which could give the support I needed/wanted outside - workwise... Now looking at the future. (1b)

Now aspiring to be a Section Manager, also would like to get a job outside in transfer printing. (1c)

Although a third participant now felt they had the potential to work, they identified age as a barrier to realising their potential

I could do a job as a machinist, but problem is when I leave I'll probably be a pensioner! (1e)

Group 2

In this group, two participants reported being clear about their goals from the outset:

I was thinking about if I was going back to my local area and I know FST has a project there, so I felt that they might be able to help me get back into work in the future. (2f)

I could see it was a good opportunity to develop myself and some skills and learn some new skills which would be useful for me upon release. (2g)

Although a third participant had left the FST project, they had done so in order to pursue alternative work experience available at the hospital as a result of clarifying their goals while with FST:

I didn't leave for the reason it was boring... I left because I wanted to, to... pursue a career in bricklaying. (2d)

A fourth participant (2e) felt they had picked up a number of different skills at FST and aimed to build on these to sustain them in work rather than remaining on benefits once they were discharged.

Group 3

In contrast to Groups 1 and 2, although two participants in Group 3 did discuss work plans, they did not associate these with their time at FST:

To get a part-time job through STATUS employment – a goal I've always had. (3e)

Yeah, well my brother's got his own business doing patios and conservatories and such... He's going to take me on. (3d)

Of the other two participants in this group, one had no plans (3b) while the other despaired of ever leaving the medium secure unit:

Well I would like to think I was, but I really can't see it. I really can't, can't see it at all. Because they, they move so slowly. No one will take responsibility for anything. (3a)

4.1.5 Summary

In this first section of results we have presented the benefits of participation in the FST project as reported by project participants and clinicians. These included personal and work skills development as well as clinical benefits and potential future benefits.

Alongside the many benefits identified, FST participants and some clinicians reported tensions that left them dissatisfied in some respects. This second main theme to emerge from the data analysis is considered next.

4.2 Tensions inherent in the FST Broadmoor project

The tensions reported by FST participants and clinicians are categorised under three headings:

- The project's function
- Broadmoor regulations and FST culture
- The relationship between the project and assessment/care planning.

4.2.1 The project's function

One of the major tensions to emerge from the research interviews concerned whether the FST project was seen as providing real work, 'make work', work experience or therapy. For example, should participants have specific breaks for smoking (real work) or be able to smoke whenever they chose (therapy)? Should they receive market wages and if not, is this exploitation or useful work experience?

Real work or make work?

Two participants clearly saw FST as providing a real working environment, as did one clinician:

When you work at FST, you know it's like actually working... it's working at a job... work on the computers is proper work. (1h)

The fact that there were deadlines and stuff, that you actually had to do, *had to do*... It wasn't ...a bunch of dribblers sitting round in a ring. (3d)

To go to work, go home, and maybe talk about work. Share it with...whatever, or not as the case maybe. More often it would be to share... And he does. (Clinician on 1b)

In other cases, while participants thought FST should function as a real workplace, in some respects it fell short of their expectations:

I'm not the sort of person who likes praise... but if you achieve something, you usually like to, that to be recognised... I mean if you've done a good job, they tend to, say the fact... And, you know, I did all of my printouts for the finance side of thing, I didn't miss anything, and I was pretty crestfallen, I must admit [not to have it acknowledged]. (1g)

Allocating seniority when people aren't technically qualified to do it – this wouldn't happen in the real world. (2a)

With men there – teamwork and ideas, not a natural environment to be segregated... Looking for basic pay. (2b)

Like this last participant, another participant raised the issue of pay, but in this case the low level of pay did not appear to detract from a sense that FST provided real work:

It had been labelled as too much pressure. Not enough pay. But I didn't go for pay – I mean 37p an hour, I mean is nothing, you know. I wanted to work because it was something I wanted to do myself. But I think the pay, the staff on the ward, when I was working around on other wards when I was going over there, people were slacking saying they were too tired to go. Less people started going. Don't know why. Not really sure their true feelings, but some people saying First Step Trust were ripping them off certain things. I, I stepped back and I thought well, that's not really true. It's competitive, not, not ripping us off. (2f)

And this participant drew an explicit distinction between FST and the 'make work' available elsewhere:

Because, you know, they're there just to give you work. Whereas FST are there for you to learn to understand that you need to work. And that work in the real world, at the end of the day, you have to produce a product. If you're in a manufacturing company, at the end of the day, you've got to produce something. So, you can't just sit there, and sit there and have a smoke. Oh, I'm not well, I'm mentally ill today. You can't do that. (2g)

Real work or work experience?

Across all three groups, much of the discussion about levels of pay revolved around whether these should reflect the going rate for the real work carried out, or whether the experience and skills gained justified lower levels of pay. One participant took the former view, as did one clinician:

Want higher wages – get 47p per hour as section manager. (1b)

We need more information about FST, so we can identify if it's good for the patient and to know where the profits go, so we can see if [patient] is being exploited. We have a moral obligation to protect [patient]. (Clinician on 1c)

On the other hand, these participants valued the experience they were gaining and were less concerned about pay:

I wasn't in it for the money. Just for the... skill chance... The pay was a bit little. (3b)

Well... I think it was, you know, seeing beyond what some of the other people were seeing. You know, people were thinking that a lot of people were complaining, that it was exploiting patients. Working for next to nothing... All this sort of thing. But, I could see it was a good opportunity to develop myself and some skills and learn some new skills which would be useful for me upon release. (2g)

Setting aside the issue of pay, other participants' comments reflect a view of FST as work experience rather than real work, in that the project's persistence with people went beyond what could be expected in a real workplace:

A business is only as good as it's workforce. And it recognises that and it looks after us well... But it's, it's more than that and whereas some of the other work areas are – if something's not working out with a patient we...we've got loads more patients to choose from. Whereas FST will try to embrace its workforce and, you know, rather than saying well, okay you go back to the ward and we'll pick someone else...They'll stick with that person and try to...you know sometimes it's beyond, you know their, their capabilities of helping someone, and they may not see him again. But they don't give up on, and they're always welcome back. Depending on why they left in the first place. (1g)

But I learnt that I had to do that. I had to keep showing them. You know, yes they might be a slow learner, but they're learning, which is what they're there for as well. (2g)

And they seemed to have a terrific lot of meetings about ...it took me a while to realise that these were rather necessary in planning and getting people to understand what was happening. Because the average participant doesn't even seem to comprehend ordering and selling and buying and keeping a record of it. (3a)

Work or therapy?

In some cases, particularly in Groups 2 and 3, the participant accounts that reflected a view of FST as providing therapy rather than work revolved around the introduction of rules, particularly a restriction on smoking, that brought the project closer to real workplaces. In these cases, the participants concerned would have preferred the more laissez-faire approach they associated with therapy:

A lot of people left because of the smoking policy. I wasn't gaining anything from going, stayed for about a year, then segregation and no smoking policy etc. (2b)

A In FST, it was more, more of an ordinary...it was, it was, it was like a...actual work area... It, it felt like you were being pushed to work.

Q Right. And was that good?

A No. It felt like you, you had to work, before you can get a smoke break or paid. You have to be pushed to do your work. And you have, you have to

constantly just, just sit and work. Weren't allowed... we wasn't allowed to smoke, so... we had to have special smoking breaks. (3b)

Part of the reason I left was because of loss of smoking room. (3e)

For other participants, however, this was less of an issue. What was more important was the need for a balance, on the part of both staff and project participants, between work and therapy:

But I'm not, you know, on the whole, you're there to work. You know, to get on, and to a certain extent that is the same with FST. You know you're not there to sit and drink tea all day you know, you are there for a reason. But it's more – it's more than that. If people have any problems, and people do have problems that's why they're here. And they will...they'll take that off the ward and sometimes take that into the work area. Where with the other work areas, if that happens...there, there's no interest in that. It's like: well you come along and you be as normal as possible and you do the work or you don't come. Or you know, you go back to the, to the ward and...Where that's...that's not the ethos of FST, you know if there's a problem you know – there's, there's people there who are more than willing to put aside what they're doing to...to discuss it. And yeah, okay some people may have to go back. But there's, there's the feeling of a lot of support. (1g)

Patients need to want to attend, need to manage the balance between 'real business' and 'rehabilitation' very effectively. (2a)

4.2.2 Broadmoor regulations and FST culture

As outlined in the introduction, the work of FST is based on a model designed to maximise the role of participants in the development, running and management of their projects, including acting as key holders, drivers and managers, taking responsibly for stock orders, production of quality goods and services, handling cash and so on.

In this context, the challenge of developing an FST project within a high security hospital created a second key tension, namely how to maximise involvement within the constraints of hospital rules and regulations aimed at maximising security.

Participants in Group 2 in particular described the frustration of developing the project, only to find their ambitions restricted. For these participants, reduced levels of involvement in running the project were a second key issue. In contrast, discussion in Group 1 focused more on the overall relationship between the project and the hospital than on specific rules and regulations. Across all three groups, the segregation of men and women from May 2002 caused frustration, in that the number of days on which people could attend was reduced, as was their pay.

Key themes relating to this tension revolved around whether the FST project was separate from or a part of Broadmoor, levels of participant involvement and the impact of the segregation policy.

Separate from or a part of Broadmoor?

These comments reflect the contrasting views expressed on this issue in Group 1:

It's all Broadmoor-based so... it's Broadmoor orientated. (1d)

Well he's not from Broadmoor, he's from FST... So it's totally different... They always think that FST is part of Broadmoor, but it's not... It's nothing to do with Broadmoor. Though we work and do business with Broadmoor, but we're not with Broadmoor. It's good to feel that. (1c)

Participants in Group 2 focused more specifically on the implications for the development of the project:

I thought Broadmoor wanted FST to be there, yet they kept saying 'no'. It was monotonous, frustrating. Then found out there was this rule about the fact that patients couldn't be any more than three foot off the ground! How were we going to set up this business? ... It has made inroads and it has changed things for the better, FST has moved the hospital. (2a)

I tried to see it differently. Anything that's run on site here tends to be influenced by, firstly, security. That's a, ... I mean they're a bloody nuisance to put it They are just everywhere you know? It's like something that gets into the water supply, yeah? It gets everywhere. It inhibits the development of an outside agency to the point, I think where there's a certain amount of, you know, couldn't care less comes into it. You know, we'll go so far and we get a bit resistant we won't try and negotiate, we won't try and compromise, we'll just back off. And that's what was happening. (2c)

And I just think that some of the things they did here I would like to try to challenge and change. The rules of the hospital. Every time you're sort of, swinging along, they, you know, they bring in all these sort of rules from time to time. It just kept causing us problems, you know. Problems with the computer and all that sort of thing. You know, I think they should look at their ethos why they're here and what they're doing. And they're here to provide a real work opportunity and all that, and they should try to get the management to understand that some of the rules that might apply throughout the rest of the hospital needn't necessarily apply at FST. So, try and challenge some of the rules that restrict patients so much. (2g)

Levels of involvement

Many comments from Group 2 revolved around levels of involvement in the running of FST and in decision making:

It's run on business lines even though it's a charity – Chief Executives make decisions. Did have business meetings, tokenism – excluded from a lot of decision making that affected the workforce e.g. agreed which businesses to develop and how, then [staff member] would come back and say we are going to

x,y,z and these weren't what we had agreed'. 180 degree u-turn on business proposals – workforce not involved in decision making, not in reality. (2a)

In the end, all the power I suppose, had gone from me to [staff member]. And I just felt that, you know, [staff member] was taking this away from patients, this was something that was happening. (2g)

I was disappointed, found that the designs had already been done, it was just colouring and sticking... I found I was told all the time what to do, I felt that I could get on, on my own. E.g. A member of staff standing over me and watching me – I know how to use a sewing machine... I thought I could be more individual, more creative – yet this didn't happen. (2b)

You know, I put down to work in the textile area, the sewing machine area. And I was always chosen to go in the office...ninety-nine percent of the time, I was in the office... By the time I left, I never got to go out [on the terrace]. (2e)

I tried to get my head around the actual tasks that were being performed in the woodwork section where... what's the word I'd use? Basic to say the very least... My attempts to raise their game, as it were, were shoved to the side by [staff member]... It should be leadership and teamwork. Those of us who could should have been allowed to. But we weren't. We've been inhibited right across the board... I thought the core reason for FST was to allow people to be involved and engage in something that was going to improve their abilities and their self-sustainability. And that ethic had seemed to have gone into decline. (2c)

The impact of segregation

As noted above, the impact of segregating men and women was an issue for participants in all three groups. These extracts illustrate their views:

It was better mixed with different people. 'Cause there's only about five...five that go there now. Yesterday, I was staying on my own, yesterday afternoon. (1a)

Felt it went downhill after segregation. (2b)

I think at the time, it affected people quite a bit. It's not realistic to work in a single sex, outside. Just not realistic at all. And certainly not pleasant. Some of the jobs, you know, like for me working in an office, I'm not going to work in an all-male office. That's very unusual, you know. Don't think I've ever seen an all-male office, you know sort of, to that degree, you know. It's just no realistic. Yes, I can understand why it came about and the problems it caused because of the, having mixed genders. But, not sure whether total segregation was the answer. (2g)

And the standard of workmanship went up. And then they got in this T-shirt stamping machine, which was all quite exciting... And suddenly we had this segregation. So, yeah, so, there had been a very rapport between patients and

staff. And, and male and female. There hadn't been any problems there. But it all sort of came to an end, and it became sick. It became rather sick after that, because everything had to be duplicated. If you had a meeting for the men, you had to have a meeting for the women. So, you know, the staff must have been bored to tears with it...Of course, it affected everything, I mean it really was... typical Broadmoor. Completely OTT. But it became a mess because there were too few women to form, you know, to do much...And the men, some of them had worked five days a week, to suddenly work three, they couldn't go on paying them for a week's work. So it was long faces all round, and you know, it did mean a very strong change of, sort of feel. (3a)

4.2.3 Relationship with assessment & care planning

A third tension to emerge from the data analysis concerned the project's role in relation to the hospital wards and to the care planning and assessment process. The current practice within the FST project is to write reports, following consultation with the individual concerned, and to submit these to the clinical team for inclusion in the case reviews held at six monthly intervals.

Discussion in the interviews reflected three perspectives:

- That there was, or should be, no relationship between FST and assessment and care planning
- That there was a limited relationship, which should be strengthened
- That the relationship was already strong.

These perspectives are examined in turn below. We also rated the centrality of FST to care planning as depicted in clinical notes (see table in appendix 3). Eleven of the 15 sets of notes available were rated as '*FST mentioned but not central to assessment/care planning*'.

No relationship between FST and assessment and care planning

Amongst several project participants and clinicians there was a view that no relationship had been established between FST and the clinical teams. From the project participants' perspective, it was thought unlikely that the clinical teams would notice any changes that took place as a result of attending at FST:

- Q Have people here [the ward] noticed any of this... have any of the staff here noticed a change in confidence?
- A God no. (1a)

Didn't have a clue – no motivation for them to involve FST. (2a)

From this clinician's perspective, however, the problem lay in a lack of initiative in establishing a relationship on the part of FST, a view shared by one participant:

No one has really come to us and said, 'look we are FST and this is what we're doing with the patients'... we have a contract with Broadmoor... and what money we get, you know, we spend it on this and that. Once our patient goes to

them we get no control on this side, we don't know what they do with our patients... FST should attend ward meetings and CPA reviews, talk to us directly, will the new manager come round and introduce themselves? (Clinician 1c)

FST ought to be involved in the clinical side - sit in CPAs, Rehabilitative Therapy Services go, FST don't, work affects you and needs to be part of clinical decisions. For example, they're losing part of the workforce when someone self-harms, 'cos they're not allowed on the project for 6 months (that's the rule) yet work might help someone to stop self-harming. (2a)

As a further illustration of the perceived lack of any relationship, one participant (1h) deliberately asked their primary nurse to sit in on their interview with the researcher because they wanted the clinician to have a better understanding of what they did at FST. On the other hand, this other participant saw the FST reporting system as unduly intrusive:

I think they were quite aware, but it wasn't necessary...because it's... I wasn't really doing anything about it. I wanted that, it was more an effect on myself, and I didn't really like that report sent back to the team. It's just I don't like everything I'm doing being analysed and watched all the time. That's all. ... I did it for me, and I didn't want it to be seen, you know, doing this because...because you get reports done about it. 'Cause then, it makes the whole situation a bit false. And I was trying to get away from that, that, that whole feeling of, of, that everything you do, every impediment and peak is all part of your stay there. (3d)

A limited relationship that should be strengthened

In contrast to the comments above, a number of project participants and clinicians did observe a relationship between FST and the clinical teams and care planning process. Some participants considered the relationship in terms of whether or not the ward saved their evening meal, as FST closes later than other projects at the hospital:

Cause it's from nine o'clock until five. Cause we miss our dinner, and sometimes they save, they save it, and sometimes they don't. (1a)

Very supportive, very yeah, they understand... that we won't be back until five, so they save our tea for us, when we come back. (1c)

The second participant quoted above was aware of the FST reports and felt that his clinical team would be fairly aware of the work he did at FST:

I should imagine they are quite aware [of the work I do] because every two or three months they issue, FST issues an appraisal. (1c)

One clinician mentioned that their ward encouraged participation in work areas, while a participant in Group 3 saw the relationship between work services and the clinical team as one of mutual reinforcement rather than partnership working:

We encourage attendance of work areas – good for people e.g. dealing with the public. (Clinician 2g)

I wouldn't say that any of the occupational therapists or their subsidiaries, auxiliary services... dominate or direct, you know. They merely reinforce. (3a)

In one case there was a clear conflict between the FST report included with the clinical notes and the case review notes regarding the reason for the participant (2b) leaving the project, illustrating miscommunication rather than any real relationship. And for this participant from Group 2, the inclusion of the FST report in case review documentation was a rather limited contribution, in comparison with the preferred option of a member of staff from FST attending the review meeting:

Yeah, I mean I had a case conference when I was there. And... I think I told [staff member], and I remember distinct-, distinctly I told [staff member] as well, that I had a case conference. And I...think like they forgot. But there was a report there. Yeah, [staff member] done a report that, that they sent off to the wards.... It wasn't, wasn't read out, but they had it in their files, so... They'd probably spoke about it before hand, because they... Before you go in, they're in there for about a couple of hours. You know what I mean. So they must of – well, I presume they would've done. They would've definitely read it, you know and passed it round to other members on the, on the CPA that day. (2e)

In one case (2g), an FST manager had attended a review meeting some years previously but this was the only mention of attendance in the clinical notes.

A strong relationship

Only one participant and one clinician, both from Group 1, thought there already was a strong relationship between FST and the assessment/care planning process:

This ward is 100% behind FST, they make comments like: 'what are you doing over there, must be wonderful' – they rearrange appointments if they know I am at work, the Regional Medical Officer knows all about FST. FST write and influence case conferences, CPAs, tribunals. (1b)

Yes, yes I get copies [of the reports from FST]... Actually they're quite good in terms of...from my perspective as an occupational therapist, I mean it gives you an understanding of what their communication skills are like, their social skills are like. Their ability to take on responsibilities. What their functional skills are like in terms of you know...what...what department they're working on, what responsibilities they take on, and also in terms of 'tool use', I get an understanding of risk assessment...you know...what tools they're currently using. ...It would be more beneficial if FST could be more involved in the clinical teams. 'Cause they were able to come to CPAs, 'cause they could report back something very different from what the rest of the teams can see... I can see their perspectives as very different so, to have FST in the CPA on a regular basis would be beneficial ... They might just think 'Section Manager' is just a label, they probably don't realise that it is really just like being a Section Manager. (Clinician 1g)

Our rating of the notes relating to participant (1b) support the participant's view of a strong relationship: 'FST seen as integral to participant's treatment'.

Summary – tensions inherent in the FST Project

Tensions between the FST project and Broadmoor Hospital revolved around three themes:

- The project's function, in terms of whether it provides real work, make work, work experience or therapy
- Broadmoor security regulations and the FST culture of empowerment and involvement
- The level of communication and extent of the relationship between the FST project, as a work project, and the clinical team and the care planning/assessment process.

Next we examine participants' experiences of medium secure units.

4.3 Experiences of medium secure units (MSUs)

The interviews with people discharged from Broadmoor did not specifically ask about their experiences in the medium secure units, as our focus was on their experience of the FST project, but participants did discuss their current situations. Some participants from the other two groups also discussed their expectations of medium secure units or the availability of provision like the FST project on discharge.

Three of the four participants in Group 3 spoke of a lack of activity at their MSU, especially compared with their experience at Broadmoor:

So, I go to the magazine group, and I go and peddle on the bicycle [for 3 or 4 minutes] at the gym. And, and that is it. For the week. And the magazine group takes an hour, so that's a really big deal, and half the time it's cancelled. It was cancelled last week. Cancelled the week before. Cancelled the week before. So, this is how it goes on... I was just shaken when I came here. That everything was so sleepy, and so...completely...lethargic... And it was different [Broadmoor] and we also got, you know, perks, perks out of it. You know, little bits of money if, if you know what I mean. It's miniscule in real terms, but it helps in those sorts of places. And here, one misses it, and notices it... The attitude is you can do it voluntarily, but if we're going to pay you, it won't be very much and therefore it's exploitation. And the attitude here appals me really. It's all terrible individual. If you sit at a computer you have somebody sitting by you. I mean, at Broadmoor, even in the school, you know, the patients helped each other. Very often if you got stuck there was a teacher. She would come and see you if, you know, you got stuck. But, the patients say 'Oh, you press this and that.' You know. You know what I mean. Nothing like that in this place. You've got this person sitting, sitting by you, telling you exactly what to do. And, and people just don't learn anything. You know, there really, there isn't a learning ability for people learning by experimenting you know, being told by friends one across, you know! And the attitude to doing

anything... 'cause I, I help another person with bits of gardening. Not very much, because our spirits are very low at the moment. (3a)

There isn't a lot to do here, I'm in groups – drug misuse, staying healthy, dealing with schizophrenia... I had lots of trips at Broadmoor – Reading, Slough, Windsor. Here there's nothing, not doing anything at all. I do feel you can take a step backwards when you come here. (3e)

This last participant, who had been in the MSU for just over a year presented at the interview very differently from the positive way they were described on discharge from Broadmoor:

Excellent progress achieved in past 2 years, settled behaviour, no evidence of symptoms (Clinician on 3b)

Two participants in Group 3 discussed the feasibility of an FST project at the MSUs, where at present work that could be done by patients is contracted out:

FST at MSU would be good, but not as good 'cos not as many paid work opportunities here, gardens done by contractors etc. Here not allocating parts of contracts to patients. (3e)

There's plenty of work to do. There's plenty of work to do. There's one man employed to do the entire ground. I mean, there's a, there's a lot to do and he can't possibly do it all. There were quite a lot of patients who would've helped, but there just wasn't any ability whatsoever to get [it off the ground]. There's certainly the work. Certainly the work. (3a)

The fourth participant in Group 3 had initiated their own work programme, maintaining the gardens. They kept very busy and had achieved this within just a few months of being at the MSU:

Grounds maintenance. It's alright. I'm out, I go out all day if I want. On me own. Mowing, strimming all over the place... I, well basically, I do [set the work]. I keep up the maintenance you see. And I do it when I want. I might have to ask for the strimmer. I'm not asked why am I'm doing it like that. It's just me. Cause although I'm on medication and things like that, I'm on the level. They are here. They are more flexible. (3d)

In contrast with the general lack of activity reported by participants at the other MSUs, participants still in Broadmoor were clearly motivated by their experience to remain active after discharge:

Planning future, looking to be part of a FST project in the community on discharge, will look to continue Section Manager role there. (1b)

He's got a letter from one of the bosses of FST, saying he's got a job in [name of town] if he wants it. (Clinician on 1b)

The clinical team feel that an MSU where he can continue his work at FST is very important. (Clinician 1b)

Like, depending on where I go outside, I know that there's a FST in the area. (1h)

So more and more people can, you know, carry on when they get outside the hospital. 'Cause there's lots in Lambeth, Bexley. Got 'em in other places, I can't remember exactly where but. (2f)

It's not going to be easy for people like us that have been in an institution for ten years or more... but there are, you know, spaces, you know, in places like FST and things like that. Where you can start again, and keep sort of just keep yourself busy, rather than be unemployed, on the dole, sitting at home, dwelling on your problems. (2g)

However, this participant was less than optimistic about the work opportunities available on discharge:

Unfortunately, my MSU that, that comes up and sees me every six months, doesn't feel that they have that same sort of – nowhere near the same set up – in their unit as what FST right here, because it's not one of those MSUs that has an FST project. I've been there and there are things to do...but it's more on an occupational therapy basis. Really nothing like FST. Worried that...when...it'll be like you going from your job to do stacking shelves in Tesco I guess. (1g)

The results and their implications are discussed in the following section.

5. Discussion of Results

5.1 Overview

In this section we discuss the methodological limitations of our study and consider their implications. We then summarise the main results presented in Section 4 before discussing each cluster of results in turn, considering the implications for policy, practice and further research.

5.2 Methodological issues

Although there were some differences between the study sample and all participants at the FST project, and between the sample and patients at Broadmoor more generally (see appendix 3), overall we interviewed a good cross-section of participants from different age, gender and ethnic groups, with varying lengths of time at Broadmoor and attendance at the FST project.

However, the ease with which we were able to gain access to project participants decreased with distance from the FST project. Whereas FST staff approached current project participants (Group 1) on our behalf, we were dependent for contact with Group 2 on peoples' clinical nurse manager or primary nurse. Contact with Group 3 was more complex still, involving a letter and follow-up phone call to each potential participant's RMO, who in some cases passed on our request to the ward manager, who in turn passed it on to the primary nurse, usually only after much 'chasing' by the researcher. Even when a participant agreed to be contacted by the researcher, research governance approval had to be obtained and the delay meant several project participants had changed their mind by the time an interview could be arranged. Of thirteen potential participants contacted for Group 3, only six agreed to be contacted and only four went ahead with the interview. The refusal rate from this group was therefore considerably higher than for the other groups.

The small sample sizes across all three groups, and particularly in Group 3, mean the results cannot be generalised to contexts other than those in which the interviews took place. In addition the retrospective nature of the study means we cannot attribute the benefits reported to the FST project with complete certainty. For Groups 2 and 3, it is likely that time and distance from the project skewed participants' memory of and views about their experience of the project.

Despite these limitations, we were able to gain insight into participants' experiences as they saw them and to develop an indicative picture of the FST project's potential in assisting rehabilitation and discharge at Broadmoor Hospital.

5.2 Summary of results

5.2.1 Benefits of participation

Participants from all three groups reported increases in confidence, social and work skills. Groups 2 and 3 placed greater emphasis on communication skills and taking

responsibility than on increasing confidence and building self-esteem. Groups 1 and 3 placed a strong emphasis on gaining new skills and renewing skills, whereas Group 2 did so to a lesser extent. The value of teamwork was highlighted frequently, especially by Group 1, for whom a sense of teamwork appeared particularly important.

In terms of clinical benefits, both Groups 1 and 2 reported a number of benefits around managing anger and learning coping mechanisms to deal with frustrations. Participants from Group 3 did not discuss clinical benefits.

Several participants discussed their goals and plans for the future during the interviews. Some, particularly those in Group 2, reported having clear goals on starting FST that had prompted their decision to join the project. Other participants described how their goals changed through their involvement in the project.

5.2.2 Tensions inherent within FST

Participants from all three groups saw FST as providing real work or work experience. However, some participants in Groups 2 and 3 discussed FST as 'make work' or 'therapy'. Three participants, one from each group, raised the issue of needing to balance 'work' and 'therapy'.

Participants in Group 2 described frustrations around trying to develop the project and feeling restricted by the hospital regulations. In contrast, discussion in Group 1 focused more on the overall relationship between the project and the hospital than on specific rules and regulations.

Many participants in Group 2 also talked about a lack of empowerment, or a shift from feeling empowered to losing power, which didn't come up when talking to the other two groups.

Participants from all three groups discussed the impact of the hospital's segregation policy on the operation of the project and the implications this had for the amount of time participants could attend, and hence the pay they received.

Both project participants and clinicians discussed the relationship between FST and the clinical teams and care planning/assessment process. One or two participants from Groups 1 and 2 felt there was very little relationship, while several participants from all three groups felt there was a relationship, albeit a limited one that should be strengthened. Only one participant and one clinician, both from Group 1, felt there was already a strong relationship and only one participant, from Group 3, thought a stronger relationship between the clinical teams and FST undesirable.

5.2.3 Experience of medium secure units

Of the four people we interviewed in medium secure units, three highlighted a lack of meaningful activity. The fourth had initiated their own schedule of work. A couple of participants discussed their ideas about how an FST type project could operate. One pointed out that although plenty of work was available, the unit needed someone to

organise it so patients could be involved. The other highlighted a lack of work opportunities due to much of the work being contracted out.

5.3 Discussion of main results

This section examines each set of results in turn, looking at their implications for policy and practice.

5.3.1 Benefits of participation

The increased confidence and social skills reported by FST project participants and clinicians are in line with the earlier evaluation carried out in 2001 (Grove and Lockett, 2001). The particular contribution of this study is that people who were no longer participating in the FST project also reported these benefits. For many increased confidence was associated with seeing the results of the work they had done, from their involvement in the running of the project and from the sense of value they felt: all key features of the FST work project.

It should be noted, though, that fewer references to increased confidence were made by those who had left the project, although many of these participants did come across as confident. It could be that they had internalised an increased confidence and no longer attributed it to participation in the FST project. Alternatively they may have been confident individuals when they joined the project.

As outlined in the introduction, research from the UK and USA on the client characteristics that are more likely to result in positive employment outcomes has highlighted the importance of self-belief, confidence and motivation. Arguably, work rehabilitation programmes that support participants to develop these attributes will support more effective preparation for discharge.

Again, the skills development described by participants in this study support the findings of the 2001 evaluation. A recent study of the effects of sheltered workshop environments on the well being of mental health service users also highlights the importance of opportunities to make use of existing skills and abilities (Crockard, (2004). However, amongst those participants who had left FST and were still in Broadmoor only a couple reported gaining skills and none spoke of renewing existing skills. This could be related to their reasons for leaving the project. Certainly, some participants in Group 2 expressed frustration that their existing skills were not being used. For example, two participants had wanted to use their creative talents but had been unable to do so, while a third had wanted to use his skills to help others but had also been unable to do so. Alternatively, since participants in Group 2 were not at FST as long as participants in the other groups, they may not have had as much time to gain new or utilise existing skills.

That participants in Group 3 did not identify the clinical benefits identified by Groups 1 and 2 may be the result of fading memories, because any benefits had not been maintained, or because participation in the project had no clinical benefits for this group. It may be that in the very early stages of the project's development, when these participants were involved with it, the benefits were not as great as for subsequent groups of participants.

5.3.2 Tensions inherent in the FST project

Differences in perceptions of the project's function highlight the need for a balance between real work/work experience and therapy, and for the nature of the balance to be carefully explained to potential participants and referrers. For example, some of the participants who had left the FST project related this to their perception of the 'work/therapy' tension being out of balance, either in terms of an overemphasis on work, or an overemphasis on therapy. On the other hand, when participants understood and were happy with the balance between work and therapy, their participation seemed to be enhanced.

That most participants in Group 1 did not discuss this tension is perhaps an indication that as the project has matured the required balance is being achieved and is better understood. However, recognising the work/therapy tension in the project's function has ongoing implications for the management of the project and how it portrays itself to stakeholders. From an operational perspective there is a constant need to manage this tension.

Tensions between the FST and Broadmoor cultures were particularly apparent in the interviews with participants in Group 2 and this seems likely to stem from the fact that these participants were deliberately drawn from amongst people still in Broadmoor who had joined but later left the FST project. Although their reasons for leaving were not known at the sampling stage, for most the decision to leave was clearly related to dissatisfaction with the extent to which they were able to be involved in decision making.

It may also be that expectations of the extent to which participants could be involved in decision making were higher in the early days of the project's development, and that by the time participants in Group 1 joined the project the extent to which it had to adapt and work within the constraints of Broadmoor policy and procedures was better defined and better understood.

However, being involved in decision making is a second important feature identified by the recent study of mental well-being in sheltered workshop environments (Crockard, 2004) and it is therefore important that some latitude in this respect is maintained if the potential benefits of participation in the FST project are to be realised. This has implications for the management of the project in terms of the need for ongoing negotiation with the hospital, particularly where new policies and procedures have significant effects on the project's ability to function effectively in relation to its core aims and objectives.

For the most part, both the interviews and the analysis of case notes, indicated that the relationship between the FST project and the care planning process was not strong. Many study participants clearly saw benefits in strengthening the relationship, particularly through the involvement of FST staff in case reviews.

That one project participant and one clinician from Group 1 did describe the relationship as strong suggests that some progress may already be being made in this respect that could be built on. As outlined in the introduction, research in community

settings has highlighted the importance of work rehabilitation services working closely with clinical teams. Vocational workers need to be included as part of the clinical team so that employment is always considered as integral to a person's recovery process and to ensure that the different perspectives of vocational workers and clinicians are available at review meetings. It is therefore likely that the clinical benefits of participation in the FST project would be enhanced through closer working relationships between project staff and clinicians. As noted earlier, the integration of vocational expertise within clinical teams and the processes of clinical management is one of the key characteristics of successful vocational rehabilitation programmes. From an operational perspective, this could have resource implications since FST staff would need to take more time from the project itself to visit the wards and regularly attend CPA meetings.

5.3.4 Experiences of medium secure units

Although we were able to interview only four people who had been discharged from Broadmoor to a medium secure unit, it was clear that for these four people participation in the FST project was not part of an integrated pathway to eventual discharge into the community with open employment a real possibility. Two participants' assessment of the work opportunities potentially available at the medium secure units highlighted that, with the will and resources to do so, such a pathway could become a reality. That one of the four people interviewed had been able to develop their own busy work schedule suggests that progress is possible where people are motivated to continue their development after discharge from Broadmoor and the future aspirations of many of the people we spoke to who were still in the hospital clearly demonstrated that motivation.

6. Conclusions and Recommendations

6.1 Introduction

Our conclusions and recommendations are set out first in relation to the development of the FST project in Broadmoor, then in relation to developing discharge pathways from high security settings to the community, and finally in relation to the further research required.

6.2 Developing the FST project in Broadmoor

Overall, the results of this research study indicate that the provision of 'realistic' vocational preparation as delivered by the FST project can have a positive impact on individual rehabilitation and preparation for discharge, as perceived by FST project participants themselves and their clinicians. Enabling the renewal of existing skills may be as important as facilitating new skills, both for maintaining engagement in the FST project, and for increasing people's potential to find work once discharged. A comparison of the perspectives of people who were attending the project at the time of the study with those who had left forms the basis for our first recommendations for the further development of the project:

1. The induction of new participants into the FST project is a critical time for identifying people's existing skills and facilitating the use of these skills within the project, or managing expectations if the skills cannot be utilised. We recommend that this become a routine, integral aspect of the induction process
2. The induction process is also a time to build an understanding of an individual's reasons for attendance and managing expectations in relation to the project's function and the tensions between 'real work', 'therapy' etc. We recommend that this too becomes a routine, integral aspect of induction
3. It is important that the project builds more integrated working with the clinical teams. We recognise the complexities surrounding this, particularly the importance of maintaining the FST ethos and identity. We therefore recommend that FST identifies a way to achieve this and works to secure the resources required as necessary

In addition, Broadmoor Hospital and the FST project need to ensure that the project has sufficient latitude to work in line with FST principles in order to ensure that the benefits to participants are maximised:

4. We recommend that ongoing negotiations between the hospital and FST are initiated to ensure that existing and new hospital policies and practices do not undermine the project.

6.3 Developing discharge pathways

Both this study and the earlier evaluation (Grove and Lockett, 2001) indicate that vocational rehabilitation leading to discharge pathways should be a core part of an individual's programme throughout their time in both secure and medium secure settings. To enhance the effectiveness of FST, the project needs to be part of a continuum of vocational opportunities such that individual discharge pathways can be developed through medium secure settings and into the community. The benefits for participants in the FST project identified by this study are very promising and support the development of services within other high security and medium secure settings using the FST model. In developing new services, attention needs to be paid to the factors perceived by FST project participants and clinicians as central to their rehabilitation and personal development:

5. We recommend the development of new services in high and medium secure settings with the following key features:
 - Production of a real product or service to sell, where quality is important
 - A teamwork approach
 - Involve patients in decision making and empower them to take responsibility for running the business
 - Use and build on patients' skills and abilities as well as facilitating the development of new skills

6.4 Further research

Further research is needed to contribute to our understanding of the effects of work rehabilitation in secure settings. In particular, a larger scale prospective study is required to track individual changes over time, both quantitatively and qualitatively, through the discharge pathway from high security settings to the community.

6. We recommend that such a study be prioritised for NHS research and development funding and be taken up as a topic of special interest by the NIMHE Mental Health Research Network.

If new services are developed in medium secure settings, as recommended above, research will also be required to evaluate their effects and support their development.

7. We recommend that adequate funding for evaluation be made available alongside the development of new vocational services in medium secure settings.

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Appendices

Appendix 1 - Correspondence Relating to the Research

1. FST project participant information sheet and consent form
2. Letter to nominated clinician and consent form
3. Information sheet for First Step Trust Manager

Appendix 2 – Research Instruments

1. FST project participant interview schedule
2. Clinician interview schedule

Appendix 3 – Profile Tables

Table 1: Profile of project participants who were part of the research study

Table 2: Profile of people who have attended the FST project since it started until 1st March 2004

Table 3: Profile of patient population in Broadmoor as of 31st March 2004

Information Sheet for FST Project Participants

First Step Trust Research Project

Studying the effects of having work opportunities at the First Step Trust (FST) project at Broadmoor Hospital

Invitation to take part in the research

We would like to invite you to take part in this research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If you need more information, please ask. A contact name and address are provided at the end of this information sheet

Why is the research being done?

We are trying to find out whether the FST project helps people's recovery and whether there is a need for continuing work opportunities in the discharge pathway after Broadmoor Hospital.

Why have I been chosen?

We would like to interview people from a wide range of backgrounds. As well as interviewing people who used or are still using the project, we would also like to talk to people who gave up using the project. You have been invited to take part to help us make sure this broad range of people is represented.

Do I have to take part?

No. Participation in this research study is voluntary. It is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet to keep and asked to sign a consent form. If you do decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the care and treatment you receive.

What will happen if I decide to take part?

You will be asked to participate in a one-hour interview carried out by the researcher, Helen Lockett. The time and place of the interview will be agreed with you. You will be asked a number of questions about your experience of using the FST project and any difference it has made to

you. We would like to tape record the interview but if you are unhappy with this we can take notes instead. We will also ask your permission to look at your medical notes and to interview a person in your clinical team who you feel knows you well. As a courtesy we would like to let your GP know you are taking part in the research and we will ask your permission for this.

What are the benefits of taking part?

There are no direct benefits to individuals who take part in the study but we hope our findings will help FST to develop their work at Broadmoor Hospital and elsewhere. If you would like a copy of the research report you can say so on the consent form.

Will what I tell you be kept confidential?

All information that is collected during the research will be kept strictly confidential and you will not be named or identified in any verbal or written reports. The interview tapes will be transcribed and wiped clean at the end of the study. We will only disclose your involvement in the study if you reveal information that suggests you may harm yourself or someone else. If this happens we will ask your permission to contact your clinician. If necessary, we may have to contact your clinician without your permission.

Who is organising and funding the research?

The FST at Broadmoor have asked the Employment Programme at The Sainsbury Centre for Mental Health to carry out the research. This work is being funded through a grant from the First Step Trust and West London Mental Health NHS Trust.

Who has reviewed the study?

The Broadmoor Hospital Research Ethics Committee and the Thames Valley Multi-centre Research Ethics Committee have reviewed the study.

Contact for further information

If you would like further information on the study please contact:

Cathryn Logan	or	Helen Lockett
Project Manager, First Step Trust (Berkshire)		Researcher
Main Workshops, Broadmoor Hospital		SCMH
Berkshire RG45 7EG Tel: 01344 754 370		(as at above address)

Thank you for taking the time to read this information.

PATIENT CONSENT FORM	Participant no.
First Step Trust Research Project	
Studying the effects of having work opportunities at the First Step Trust (FST) project at Broadmoor Hospital	

Lead Researcher: **Helen Lockett**

I confirm that I have read and understood the information sheet dated for the above study and I have had the opportunity to ask questions.	<input type="checkbox"/>
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.	<input type="checkbox"/>
I understand that sections of any of my medical notes may be looked at by responsible individuals from the research team. I give permission for these individuals to have access to my records.	<input type="checkbox"/>
I give my permission for the interview to be recorded on tape.	<input type="checkbox"/>
I understand that the research team would like to interview a person in my clinical team who I feel knows me well in order to discuss the team's perceptions on the outcomes for me. I nominate and give my permission to the research team to invite them to take part in an interview.	<input type="checkbox"/>
I give permission for my GP to be told I am being interviewed for the study	<input type="checkbox"/>
I would like a copy of the research report	<input type="checkbox"/>
I agree to take part in the above study.	<input type="checkbox"/>

Name of Patient

Date

Signature

Name of Researcher

Date

Signature

March 2004

Member of Clinical Team - Invitation Letter

Dear

**First Step Trust Research Project
Studying the effects of having work opportunities at the First Step Trust (FST)
project at Broadmoor Hospital**

..... has given permission for me to contact you regarding this study. As you will be aware, was/is involved with the First Step Trust employment project at Broadmoor Hospital. The aim of this research is to identify the effects of this involvement on:

- i) The development or renewal of technical skills e.g. carpentry, gardening, printing, office skills
- ii) Personal development and increased social skills e.g. the ability to communicate, increased confidence and self-esteem
- iii) Assisting rehabilitation e.g. changes in attitudes towards the future, reduction in symptoms
- iv) Ability to handle the transition from Broadmoor Hospital, in terms of the ability to deal with the pressures and responsibilities of everyday life, to cope socially and to formulate personal goals

Your views on these questions would be valuable and I am therefore inviting you to take part in a one-hour interview, to be arranged at your convenience. Your participation is of course voluntary and any information you provide will be treated in complete confidence. I would like to tape record the interview, but if you are unhappy with this I can take notes instead. If you agree to take part you are free to change your mind at any time. If you do agree to an interview I will ask you to sign a consent form. The research report will be available towards the end of 2004 and you can request a copy on the consent form.

The research has been approved by the Broadmoor Hospital Research Ethics Committee, the WLMHT Research and Development Peer Group and the Thames Valley Multi-centre Research Ethics Committee.

I would be grateful if you would complete the enclosed slip indicating whether you are willing to be interviewed and if so the best way to contact you. Please return the slip to me via the FST project in the envelope provided. If you need any further information before deciding, please contact me at the address or phone number above.

Yours sincerely

Helen Lockett
Associate Consultant/Researcher

First Step Trust Manager - Information Sheet

First Step Trust Research Project

Studying the effects of having work opportunities at the First Step Trust (FST) project at Broadmoor

Introduction

The research team has produced this information sheet, in addition to the information sheets provided to patients, so that staff are fully aware of the study and can answer any questions that patients have, should they arise.

If you need more information, please ask. A contact name and address are provided at the end of this information sheet

Why is the research being done?

We are trying to find out:

- If there are any changes in terms of people's skills, recovery, preparation for discharge and how this relates to their participation in the FST project
- Why some patients leave the project while others remain involved, or drop out and return.
- Whether there is a need for continuing work opportunities in the discharge pathway after Broadmoor.

Duration

The research will run for one year from October 2003 to October 2004

How have patients been chosen?

The FST project drew up a list of everyone who had used the project, grouped in terms of whether the person was:

1. Attending the project
2. No longer attending the project and still a patient in Broadmoor
3. Discharged from Broadmoor

We would like to interview 8 people in each of these groups. We would also like to include both men and women of different ages, from different ethnic groups and with different mental health histories.

Do patients have to take part?

No. Participation in this research study is voluntary. It is up to patients to decide whether or not to take part. If they decide to take part they will be given an information sheet to keep and asked to sign a consent form. If patients do decide to take part they are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the care and treatment they receive. If they decide not to be involved the research team will make no further contact with them.

What is the research process?

Patients are asked to participate in one interview carried out by the researcher, Helen Lockett. The interview will take about an hour. The time and place of the interview will be agreed between the patient and Helen. The patient will be asked a number of questions about their experience of using the FST project and any changes they have observed in themselves.

If at anytime during the interview the patient wishes to stop the process, they may do so. The interview can be stopped permanently or a break can be taken and the interview resumed at a later date.

We would like to tape record the interview but if a patient is unhappy with this we can take notes instead. We will also ask patients' permission to look at their medical notes and to interview a mental health professional who they feel knows them well.

What are the benefits of taking part?

There are no direct benefits to individuals who take part in the study but we hope our findings will help FST to develop their work at Broadmoor. The findings may also eventually benefit other patients in other special hospitals. The research will be written up by the end of 2004, when it will be publicly available. Patients can ask to have a copy of the research report by indicating this on the consent form.

Will patient participation in this study be kept confidential?

All information that is collected during the course of the research will be kept strictly confidential and patients will not be named or identified in any verbal or written reports. The interview tapes will be transcribed and wiped clean at the end of the study. Names and any other identifying information will not be included in the transcript of the interview and all the information collected for the study will only be seen by the research team.

We will only disclose patient involvement in the study if a patient reveals information that suggests they may harm themselves or someone else. If this happens we will ask their permission to contact their clinician. If necessary, we may have to contact their clinician without their permission.

Who is organising and funding the research?

The FST at Broadmoor have commissioned the Employment Programme at The Sainsbury Centre for Mental Health to carry out the research.

Who has reviewed the study?

The Broadmoor Research Ethic Committee and the Thames Valley Multi-centre Research Ethics Committee have approved the study.

Contact for further information

If you would like further information on the study please contact:

Helen Lockett
Principal Researcher
Sainsbury Centre for Mental Health
134 – 138 Borough High Street
London SE1 1LB

E-mail: helen.lockett@ukonline.co.uk

Letter to Medium Secure Units

Dear

Re: Research Project: Studying the effects of having work opportunities at the First Step Trust (FST) project at Broadmoor Hospital

The following patient; has been selected for participation in an interview as part of the above research project. The project consists of interviews with a sample of patients who:

- i) Are participating in the FST project at Broadmoor
- ii) Are no longer participating in the FST project but are still patients within Broadmoor
- iii) Used to participate in the FST project and who are now in a medium secure unit or living in the community

We are approaching patients who have left Broadmoor via their current clinical team and are therefore writing to you to ask if you will speak to to see if they are interested in participating in the study.

This is a very exciting piece of work, a partnership between West London MH Trust, the First Step Trust, Sainsburys Centre for Mental Health and Anglia Polytechnic University to see the effects of the FST project on patient rehabilitation and preparation for discharge. No previous work has been undertaken into the impact of work opportunities in a high security setting.

Broadmoor Ethics Committee, the West London Mental Health Trust and the Thames Valley Multi-centre Research Ethics Committee have approved this research. Thames Valley MREC have also stated that this is a 'no local investigator study', and will therefore not require additional approval by further Local Research Ethics Committees.

I enclose an information sheet and consent form for

I will call you in the next few days to discuss this letter with you in more detail and so that you have the opportunity to ask me directly about the work.

Many thanks in anticipation for your help with this

Yours sincerely

Helen Lockett
Associate Consultant / Principal Researcher

Interview Schedule for FST Participants

Group 1: People participating in FST in Broadmoor (8)

Thank you for agreeing to be interviewed.

1. Can I begin by asking you what you like most about the FST project?
2. What do you like least about the project?
3. What sorts of work do you do when you are at the FST project?
4. What keeps you participating in the project? (I.e. what do you get from attending?)
5. When did you first start at the FST project?
6. Have you attended continuously since you started? (Explore timing and reasons for any breaks)
7. How did you find out about the FST project?
8. What caught your interest about joining the project?
9. What did you *hope* to get out of joining (probe for short term & longer term aspirations)
10. Could you tell me a bit about how decisions are made at the FST project - which decisions are you involved in and how?
11. What is your role and level of responsibility in the FST project? (probe re. whether this has changed?)
12. Has attending the project affected you in anyway? (Probe re. skills, personal development, attitudes, symptoms, examples and reasons behind your observations; have any of the staff at Broadmoor made any observations about your development?)
13. Are these 'observations about yourself' just related to the FST or have you observed this in some of the other things you do?
14. (*If applicable*) What do you want to do with the experiences and skills gained from the FST? (Probe re. plans for the future & how hope to achieve them?)
15. If you were helping to design a FST project how would you set it up?
16. Has your view of the hospital changed since attending the project?
17. Has the hospital made any adjustments in order for you to attend FST?

18. How aware are your clinical team about what you do in the FST and how it works?
19. Have you had a work progress review at the FST project? (probe for impact of review, anyone else attend?)
20. Are you undertaking any educational or training courses at the moment?
(Probe re. why taken up)
21. Is there anything else you would like to say?

Interview Schedule for FST Participants

Group 2: People no longer participating in FST who are still at Broadmoor (8)

Thank you for agreeing to be interviewed.

1. Can I begin by asking you what did you like most about the FST project?
2. What did you like least?
3. When you first started at the FST project?
4. Did you attend continuously and then leave or were there breaks?
5. How did you find out about the FST project?
6. What caught your interest about joining the project?
7. What did you *hope* to get out of joining (probe for short term & longer term aspirations)
8. What sorts of work did you do when you were at the FST project?
9. What did you feel you were getting from attending the project
10. Could you tell me a bit about how decisions were made at the FST project - which decisions were you involved in and how?
11. What was your role and level of responsibility in the FST project? (probe re. whether this changed)
12. Has attending the project affected you in anyway? (Probe re. skills, personal development, attitudes, symptoms, examples and reasons behind your observations; have any of the staff at Broadmoor made any observations about your development?)
13. Are these 'observations about yourself' just related to the FST or have you observed this in some of the other things you do?
14. (*If applicable*) What do you want to do with the experiences and skills gained from the FST? (Probe re. plans for the future & how hope to achieve them?)
15. If you were helping to design a FST project how would you set it up?
16. Has your view of the hospital changed since attending the project?
17. Did the hospital make any adjustments in order for you to attend FST?

18. How aware were your clinical team about what you did at the FST project and how it works?
19. Did you have a work progress review of the FST project? (probe for impact of review)
20. Are you undertaking any educational or training courses at the moment?
(Probe re. why taken up)
21. When did you leave the FST project?
22. Could you tell me about why you left?
23. Is there anything else you would like to say?

Interview schedules for patients

Group 3: People who participated in FST at Broadmoor and who have since been discharged from the hospital to the community or to a medium secure unit (8)

Thank you for agreeing to be interviewed.

1. Can I begin by asking you what you liked most about the FST project?
2. What did you like least?
3. When did you first start at the FST project?
4. Did you attend continuously and then leave or were there breaks? (Probe for timing and reasons for breaks)
5. How did you find out about the FST project?
6. What caught your interest about joining the project?
7. What did you *hope* to get out of joining (probe for short term & longer term aspirations)
8. What sorts of work did you do when you were at the FST project?
9. What did you feel you were getting from attending the project?
10. Could you tell me a bit about how decisions were made at the FST project - which decisions were you involved in and how?
11. What was your role and level of responsibility in the FST project? (probe re. whether this changed)
12. Has attending the project affected you in anyway? (Probe re. skills, personal development, attitudes, symptoms, examples and reasons behind your observations; have any of the staff at Broadmoor made any observations about your development?)
13. Are these 'observations about yourself' just related to the FST or have you observed this in some of the other things you do?
14. (*If applicable*) What do you want to do with the experiences and skills gained from the FST? (Probe re. plans for the future & how hope to achieve them?)
15. If you were helping to design a FST project how would you set it up?
16. Has your view of the hospital changed since attending the project?
17. Did the hospital make any adjustments in order for you to attend FST?

18. How aware were your clinical team about what you did at the FST project and how it works?
19. Did you have a work progress review at the FST project? (probe for impact of review)
20. Are you undertaking any educational or training courses at the moment?
(Probe re. why taken up)
21. When did you leave the FST project?
22. Could you tell me about where you went and the process of getting to where you are now?
23. Is there anything else you would like to say?

Table 1: Profile of patients who were interviewed

	Total	Gender		Age				Sect Mgrs	Ethnicity		Length of time at FST				Clinical Notes			Interview with Clinician		Diagnosis ³			
		F	M	20-30	31-40	41-50	51+		White British	Black British	< 1 year	1-2yrs	2-3yrs	>3 yrs	0 ⁴	1	2	n/a	Yes	No	1	2	2+1
Group 1	8	2	6	0	4	2	2	3	6	2	1	4	3	0	0	4	1	3	4	4 ⁵	2	5	1
Group 2	7	2	5	3	1	2	1	2	6	1	4	2	0	1	1	5	1	0	4 ⁶	3	3	4	0
Group 3	4	1	3	0	2	1	1	2	3	1	0	3	1	0	0	2	1	1	0	4	1	3	0
TOTAL	19	5 26%	14 74%	3 16%	7 37%	5 26%	4 21%		15 79%	4 21%	5	9	4	1							6 32%	12 63%	1 5%

	Admission date to Broadmoor Hospital		
	Pre 1990	1990 - 1999	2000 onwards
Group 1	0	8	0
Group 2	0	7	0
Group 3	2	2	0
TOTAL	2 (11%)	17 (89%)	0

³ 1 = Psychopathic Disorder, 2 = Mental Illness, 2+1 = Primary Diagnosis Mental Illness

⁴ 0 = FST not mentioned, 1 = mentioned but not central to assessment/care planning, 2 = central to assessment/care planning

⁵ In one case the clinician declined to be interviewed, another case the clinician sat in on the interview with the participant at the participant's request

⁶ In one case the clinician interviewed did not know participant whilst they were attending FST

Table 2: Profile of patients who have participated in FST as of 1st March 2004

	Total	Gender		Age (N/A)	Sect Mgrs	Ethnicity				Length of time at FST				Diagnosis ⁷				Admission date Broadmoor		
		F	M			White British	Black British	White Euro	Irish	< 1 year	1-2yrs	2-3yrs	>3 yrs	1	2	2+1	1+2	Pre 1990	1990-1999	2000 -
Group 1	31	9	22		6	21	9	1	0	12	13	4	2	10	15	5	1	2	22	7
Group 2	33	12	21		2	25	7	0	1	24	6	2	1	15	17	0	1	3	25	5
Group 3	39	17	22		4	32	6	1	0	21	14	4	0	12	18	4	5	9	25	5
TOTAL	103	38 37%	65 63%			78 76%	22 21%	2 2%	1 1%					37 36%	50 49%	9 9%	7 7%			

Table 3: Profile of patients in Broadmoor Hospital, 31st March 2004⁸

Total	Gender		Age				Ethnicity					Diagnosis			
	F	M	<29	30 - 39	40 - 49	50+	White British	Black British	White Euro	Irish	Other	1	2	2+1	1+2
309	48 16%	261 84%	60 19%	111 36%	84 27%	54 18%	207 67%	34 11%	7 2%	5 2%	56 18%	85 28%	176 57%	41 13%	7 2%

⁷ 1 = Psychopathic Disorder, 2 = Mental Illness, 2+1 = Primary Diagnosis Mental Illness

⁸ Does not include the 33 patients on leave from the hospital