**Working effectively with People with Learning Disabilities and Offending Behaviours**

**Keywords:** Learning disability, offending, training, capacity, criminal justice system, risk, patient stories

**Duration of project:** February 2010 – January 2012
Report received for publication: December 2011

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**Project summary**
The project team provides support for people with learning disabilities who have been convicted of a criminal offence or are deemed to be at risk of conviction. The overriding ethos of the Forensic Support Service is to provide support to the service users in the least restrictive environment possible whilst ensuring public protection.

Recent additions to the service level agreement for the FSS, requires that they provide learning and development opportunities for the Community Learning Disability Teams. With this in mind, the project team (both members of the Forensic Support Service) developed a project proposal to enable the Community Learning Disability Teams to provide support in the community to service users with less complex learning disabilities and offending behaviours.

A number of approaches were used to understand the context of care, to engage the Community Learning Disability Teams in a process to create opportunities for change; and to capture the service user experiences of care to inform the development of an education package. Whilst the educational package has been developed, due to contextual factors, it has not yet been delivered; this is planned for the coming months. A strategy has been developed to evaluate if the knowledge and

skills gained will reduce the number of people with a learning disability in secure environments and enhance the experience of service users requiring supervision and support in the community. Also it is envisaged that as a result of the project there will be an increase in the capacity of the Community Learning Disability Teams to manage future referrals of service users with forensic needs thus enhancing the quality experience of the service user.

**Acknowledgements:**

Sincere thanks are expressed to all of our friends and colleagues working for Cheshire and Wirral Partnership NHS Foundation Trust and indeed the Trust itself for supporting this project. Particular thanks go to:

- Pat Thomas, Community Nurse, Specialist CLDT, West Cheshire
- Charles Ingram, Forensic Liaison Nurse, Forensic Support Service
- The Specialist CLDT, West Cheshire for acting as our pilot team

And including a special mention to:

- Debra Moore of Debra Moore Associates
- The Foundation of Nursing Studies in partnership with The Burdett Trust for Nursing and in particular Diana Calcraft for her on-going support
- Anne Kingdon, Nurse Consultant, Forensic Support Service, for on-going clinical supervision

**Background to the project**

While public protection remains a priority, there is a growing consensus that prison/secure environments may not always be an appropriate environment for people with learning disabilities who have committed an offence and that custody/detention can exacerbate behaviour and heighten vulnerability (Bradley, 2009).

The Secretary of State for Justice asked Lord Bradley in December 2007 to undertake a six-month independent review to determine the extent to which offenders with mental health problems or learning disabilities could be diverted from

prison to other services and the barriers to such diversion. Lord Bradley made a total of eighty-two recommendations however he concluded his review by stating:

“The first step to the effective management of offenders is the existence of good early identification and assessment of problems, which can inform how and where they are most appropriately treated,” (Bradley, 2009, p 149).

He went on to add:

“By ensuring early identification and assessment, along with improved information sharing, there will be better informed charging, prosecution and sentencing decisions. In the longer term, the impact may be that more offenders can be treated in the community, ensuring that those individuals who must be in prison can receive targeted, effective care while they are there,” (Bradley, 2009, p 149).

Following deinstitutionalisation (the process of replacing long stay institutions with community based services for people with learning disabilities) the needs of people with learning disabilities and offending behaviour, some of whom also have additional mental health problems and other mental disorders, have been largely overlooked (Lindsey, 2002). Local provision of services for this group has failed to keep pace with demand and has resulted in many people with learning disabilities and forensic needs being placed in residential facilities a long way from their local communities, and at times in unnecessarily restrictive environments (Mansell, 2007).

The lack of training of how to address people’s needs has contributed to the creation of a vacuum of know-how for this population. Care for people with learning disabilities and forensic needs require strong interfaces and partnership between learning disabilities, mental health and forensic services (Talbot, 2007). Such links are still weak and hampered by differing agendas, priorities and ideologies, insufficient policies, blurred perceptions about responsibility and shortage of resources (Bradley, 2009).

A key function for the Cheshire and Merseyside Forensic Support Service (North West Secure Commissioners, 2006) is to develop capacity within the local specialist

Community Learning Disability Teams (CLDTs) through both collaborative working and the provision of learning and development activities. There are many barriers which need to be overcome in order to provide a cohesive response to the needs and risks of people with learning disability who engage in offending behaviour and local area expertise is essential if this is be achieved. Nationally, it is recognised that with the closure of large institutions and a move towards community care, there are increasing numbers of people with a learning disability who are coming into contact with the criminal justice agencies (Lindsay, 2002). The needs of this group have been the focus of a number of studies and government reports as ways are sought to meet the needs of this client group in mainstream criminal justice services (Talbot, 2007). The failure to meet these needs (Bradley, 2009) continues to drive initiatives at both national and local level which has resulted in the creation of the Learning Disability Forensic Support Services both locally and nationally.

The Learning Disability Forensic Support Service (FSS) in Cheshire is a relatively new initiative which was developed following a successful bid for funding from the North West Specialised Secure Commissioning Team in 2008. The service is linked to a low secure unit for adults with learning disabilities and provides assessment, intervention and support to patients entering, leaving and receiving care in the secure hospital setting, other secure environments and the community. The FSS is a nurse led service and is comprised of mainly nurses with some psychiatry input and a full time social worker. The team is based on the secure service site near Macclesfield and primarily provides for service users across the areas served by Cheshire and Wirral Partnership NHS Foundation Trust. In addition, professionals in the team provide an assessment, consultation and advice service into Liverpool Prison and a clinical review service to people with learning disabilities who originate from Cheshire and Merseyside and who are placed in secure (NHS and third sector) services outside the region.

As well as meeting the recommendations of the Bradley (2009) review, it is also part of the service level agreement for the FSS, that they provide learning and development opportunities for the CLDTs. With this in mind, the project team developed a project proposal that would enable the CLDTs to provide support in the

community to service users with less complex learning disabilities and offending behaviours.

The project would be facilitated by Mick Swinswood and Michael Beasley, Forensic Practitioners of equal grade under a shared leadership model described as: "… a model that supports senior nurses in extending their influence about decisions that affect their practice, work environment, professional development and it results in higher levels of fulfilment," (Rosengren and Bondas, 2010, p 289).

**Aims of the project**

- To improve the care experienced by service users with learning disability through identifying educational needs of CLDTs and enhancing their understanding of what works well for service users with learning disabilities and offending behaviour
- To enable local CLDTs to support service users with less complex offending behaviours

**Objectives**

- Explore current knowledge, skill and working practices of local teams in relation to supporting service users with learning disability and offending behaviour
- Explore what works well for service users' with learning disability and offending behaviour through the gathering and analysis of patient stories
- Develop and deliver an education package to local CLDTs
- Evaluate outcomes in relation to leadership skills, experience of staff and service users
- Development of leadership capacities of project team to bring about change in local services and a strengthening of local service capacity to establish a supportive, team response to the needs and risks of people with learning disabilities and offending behaviour

**Methods and approaches**

A number of approaches were used to achieve the project aims. These are identified below and will be discussed in detail:

- Activities to develop an understanding of the context of care
- A practice development away day for local CDLTs
- The collection of service user stories
- The development of an education package

**Understanding the context of care**

In a district-wide initiative it is better to pilot in one area to maximise learning which can be drawn on later (Abbott and Hotchkiss, 2001). For this reason, and due to the demands on the time of the project team which made it difficult to work across all six CLDTs, the project team decided to involve the largest team in activities to understand the context of care with a view to generating as much information as they could in order to inform the project.

Lewin's (1951) model of 'force field analysis' states that for change to occur the driving forces must be increased whilst the resisting forces restrained. Participative strategies of change (Thurley and Wirdenius, 1973) stress the full inclusion of those involved and affected by the change and although driven by senior staff, the change is seen as less management dominated and more driven by groups or individuals within the team. Ideally to implement change the change agent needs to enlist followers in the vision and in understanding the rationale (Cork, 2005). It was the view of the project team that this strategy would empower individuals and the team and therefore driving forces would be increased.

Two activities were therefore undertaken with the pilot team at the end of their usual team meeting. This enabled the project team to capture the views and perspectives of as many of the team as possible and not to disrupt the workplace.

<u>The Context Assessment Index</u>

The successful implementation of change can be influenced by the strengths and weaknesses of the context of care (McCormack, 2009). It is therefore important to

understand the context of the care setting prior to commencing change (McCormack, McCarthy, Wright and Coffey, 2009). The Context Assessment Index (CAI) (McCormack, 2009) is a self-administered questionnaire that enables practitioners to assess the context (leadership, culture and evaluation) within which care is being provided in clinical areas to determine its readiness for implementing evidence into practice (McCormack et al., 2009).

Claims, concerns and issues

Claims, concerns and issues (CCIs) is an approach that comes from Fourth Generation Evaluation (Guba and Lincoln, 1989) and facilitates the involvement of and understanding between different stakeholder groups about a particular subject. This approach was used to gain the views and perspectives of staff working in the pilot team about working with people who have a learning disability and offending behaviours. Claims are favourable assertions and concerns are any unfavourable assertions about the subject; issues are questions that reflect what any 'reasonable person' might ask about the subject and usually emerge from the concerns.

By facilitating these two approaches during the team meeting, the views of 23 professionals from a variety of disciplines (nurses, occupational therapists, physiotherapists, speech and language therapists, psychologists and student nurses) and grades (3 – 8b) were captured. This ensured that the project team were able to evaluate the responses of all participants as the forms were completed and returned during the activity. From the data received the project team:

- Analysed the responses to the CAI to identify the strong and weak indicators in the three elements (leadership, culture and evaluation)
- Undertook a thematic analysis, described as: "a process for encoding qualitative information … this may be a list of themes … A theme is a pattern that is found in the information that at the minimum describes and organises possible observations" (Boyatzis, 1998, p 5-6) of the staff's CCIs to generate a catalogue of the strong and weak indicators in the three elements of the CAI and themes within the CCIs exercise

The analysed data were then considered collectively and thematic analysis of the CAI and CCIs exercise revealed that it was the perceived belief of the team that they had no power or authority regarding change, there was a low regard for individual clinicians, there was an absence of any form of feedback or information from senior management and they did not have the time, knowledge or experience to undertake work with people with learning disabilities and offending behaviour.

**Practice development away day**

One of the key elements of the project was the practice development away day to enable the project team to explore the organisation's mission and vision for meeting the needs of people with learning disabilities and offending behaviour with all of the trust's CLDTs.

Community learning disability nursing has seen a reorientation towards a more health-oriented focus (Barr, 2006), however consideration needs to be given to how well this will meet the changing needs of people with learning disabilities (Kearns, 2001; Bradley, 2009) and the Department of Health's (2010) radical reform in how service provision will be funded. Nemeth (2003) argues that nurses have an inherent resistance to change and questions whether they are actually in a position to influence change especially when change is habitually imposed from the top down rather than engendered from the bottom up (Cork, 2005).

In essence the aim of the project would necessitate the local CLDTs taking on further responsibility previously met by the FSS; that is meeting the needs of people with learning disabilities and offending behaviour albeit less complex cases.

Bearing in mind the findings of the CAI and CCIs and the aims of the project the project team needed an approach that would enable the CLDT to become a major contributing factor to the process of change as opposed to having it enforced upon them. When planning changes many initiatives focus on the problems to be solved but instead of offering solutions these problem-focused approaches lead to a negative pattern of coping (Barrett, 1995). Appreciative inquiry (AI) is a transformational process that can create opportunities for change (Cooperrider and Whitney, 2005) by building on positive ideas emerging from the collaboration of

individuals or groups working towards developmental changes (Richer, Ritchie and Marchionni, 2010). Typically whilst using AI when organisational change is the primary focus expert external facilitators are brought in to facilitate the process (Carter, 2006). The project team therefore chose a consultant who was experienced in AI, had worked in learning disability services (community and secure), been an advisor to the Department of Health and displayed transformational leadership qualities.

Cork (2005) suggests the greatest influence is achieved when group members discuss issues that are perceived as important and make decisions based on those discussions. In order to realise this discussion the project team planned a practice development event that would involve the entire workforce from each of the six CLDTs, a total of over sixty employees. Often projects fail due to staff being unable to get time away from the workplace (Abbott and Hotchkiss, 2001) however the funding from the FoNS covered the cost of the event whilst the NHS Trust offered their support by freeing staff to attend.

AI is based on the 4-D cycle which consists of four phases, Discovery (the strengths of the current service provision), Dreaming (what might be), Designing (what should be) and Destiny (what will be). The external facilitator provided an overview of the current situation in health care provision for people with learning disabilities and offending behaviour. She continued by discussing the potential impact of the devolution of power and responsibility for commissioning services to healthcare professionals closest to patients and an expectation to increase productivity and efficiency in the National Health Service (Department of Health, 2010).

Appreciative interviews are at the heart of the ‘Discovery Stage’. The aim of the appreciative interview is to unearth stories of times when things went exceptionally well – times which are often overlooked in the rush to identify and solve problems. By reminding ourselves of what is important about these peak experiences, we have a clearer idea about what we want to do more of in the future. We also start to feel better about our work, our organisation, our team, and ourselves (Cooperrider, and Whitney, 2005).

Each attendee was asked to pair up with someone they would not usually work with to undertake ‘paired interviews’ with a prepared set of questions:

1. What has been your best experience of working with the forensic support service?
2. What’s really important about this experience? What do you value most about it?
3. What do you value most about your work when working with the forensic support service?
4. Without being humble, what do you value most about yourself and the way that you do your work with the forensic support service?

Upon completion of the paired interviews, attendees were then asked to join up into tables consisting of about ten people to pick out the ‘emergent themes’ and create a poster of this.

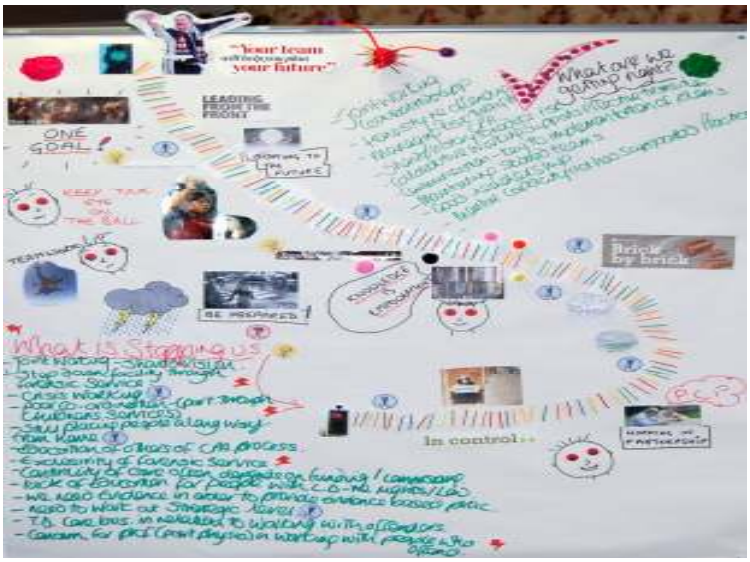
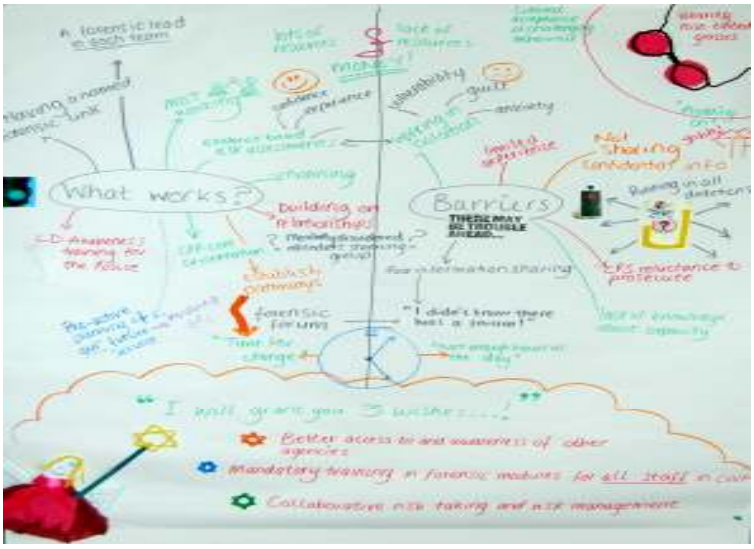



Figure 1

Figure 2




The groups identified common themes behind their examples of good practice constructed of, core practices, structures, values, customer services, partnership working, good communication, collaboration and sharing of experience. They were also able to identify barriers to effective working (Figure 1 and 2).

The next two stages of the AI process 'Dreaming, What Could Be' and 'Design, What Should Be' were developed on the common themes that surfaced through the examination of the past excellence. The groups were asked to develop a picture of the ideal future, grounded in the organisation's reality along with short and long term goals to achieve the dream.

The final stage of the AI process, 'Delivery, Action Plan and Execute' asked the attendees to identify a strategy/plan that they could do as they returned to the workplace that would help achieve the vision. Each attendee was provided with a card and asked to assign themselves a strategy within a self agreed time frame. Below are a number of the strategies the attendees identified:

- "Health facilitators going into GP practices and selling the services of the LD team and offer LD awareness training within individual practices so that you can target all staff" (Health Facilitator)

- “Get into the GP services to sell our services, let them know ‘we are out there’, give them info about the teams and what we can offer” (Health Facilitator)
- “Contact local police services re: how they deal with LD clients and what support they might like-need” (Consultant Clinical Psychologist)
- “Discussion within psychology meeting about our role in forensic work as a part of community team working” (Consultant Clinical Psychologist)
- “Pass on my experience of working with forensic support service to fellow students” (Student Nurse)
- “To offer training in communication difficulties in mild LD (as is more relevant to offenders)” (Speech and Language Therapist)
- “Offer to help to sell our services and become as involved as possible” (Physiotherapist)
- “Learn more about the occupational therapist role in forensic services, speak to other OTs and undertake a literature search to enable to offer more support to clients and team” (Occupational Therapist)
- “To visit the occupational therapist at the local regional secure unit to find out more about the role of the OT with individuals who have offending behaviour” (Occupational Therapist)
- “Review the Bradley Report and feedback to nurse’s group” (Senior Nurse)
- “Take the next forensic case in the team” (Community Nurse)
- “Find out more about the legal process and people who make lack capacity” (Community Nurse)
- “Values based training for example, how our values impede outcomes” (Clinical Support Worker)
- “I will contact the local custody suite to identify a link police officer re: liaison on a local level with the community team” (Community LD Team Leader)
- “To offer peer support (knowledge of forensic issues) to community teams” (Regional Secure Unit Manager)
- “I can commit to giving community staff more knowledge and training around forensic issues” (Regional Secure Unit Nurse)
- I will support facilitators to present this work to the trust quality committee. We will use the energy and outputs from today to tell senior executives in the trust

about what we are doing to drive up quality in relation to people with the most complex need" (Clinical Director)

We are aware, from feedback from attendees that a number of these self assigned strategies that required a single action have been achieved, and that others continue to be the focus of ongoing work in their attempts to raise awareness of issues relating to working with learning disabled service users who engage in offending behaviours.

**Service user stories**

Patient stories are an attempt to redress the balance of power between healthcare clinicians and the people they serve, and partly an attempt to give decision-makers a different kind of opportunity to understand the needs of patients – other than the dry results of surveys and statistics (Department of Health, 2001). If patients are really to be 'at the heart of healthcare', as the Department of Health (2001) suggests they should be, then their views and their stories are of paramount importance in any attempt to reform health care services. Existing studies within the criminal justice domain (Talbot, 2007) draw on the experiences of prisoners in order to shape the service development. This project aimed to expand this further to include the views and experiences of learning disabled adults involved in the criminal justice system within the Cheshire and Wirral footprint to develop a locally sensitive initiative.

The project team consulted the secure inpatient service users and community client group to ascertain what skills they thought that a professional requires to meet their needs. The project team were aware of the complexity of getting this right and required support/guidance for this aspect of the project. They were also aware that if they undertook this work themselves, their existing relationship with the service users may influence their responses; colleagues in the Speech and Language Therapy Department within the trust were therefore approached in order that they might develop an overview of the service user experience of, the service and the stakeholders within the criminal justice system (Police, Probation, Prison, Courts etc). These will then be taken into consideration with the development of the training package.

The service user stories were transcribed and reviewed and collated into themes for reflection of how to incorporate their meanings in to the education package.

Feedback was collated into key themes:

- Support from the Forensic service
- Police
- Solicitors
- Court
- Probation Service
- Court of Protection

Specifically the findings were:

- The role of the health facilitator was noted as extremely positive for service users in explaining and supporting them with any physical health needs
- Service users found it more beneficial when staff supported them practically with intervention plans
- Service users found it difficult when staff changed and felt they had to start again with building new relationships
- Service users felt that staff should be on time for their appointments and should contact them if they were going to be late
- Having time to talk to staff was noted as essential and really beneficial by several service users
- Service users responded well when staff thought individually about how to support them with intervention plans e.g. one member of staff developed a board game to help a service user understand information
- When service users did not understand the terminology being used e.g. forensic, police mark, this can cause worry and concern
- When staff had an understanding of learning disability this was recognised by service users and they felt better supported
- Service users want to be involved in the planning of meetings about their care/support

The findings influenced the development of the education pack as they highlight that in addition to a good knowledge of forensic issues and procedures used in a criminal justice setting, there is a fundamental need for practitioners/clinicians to have a good understanding of the needs of people with learning disabilities.

**Education package**

There is a danger that the project could be disabled due to the historical perception of the CLDTs that this is a specialist area of clinical practice requiring knowledge and skills outside of their remit. This is further complicated by the number of CLDTs and the expansive geographical area of Cheshire and Wirral Partnership NHS Foundation Trust. This raises a challenge for the project facilitators in terms of ensuring each team receives equal opportunity to have access to the training package, input to the project and ongoing support once the training package is delivered therefore sustaining motivation to work with this challenging client group.

The project team have developed an education pack to incorporate the four key areas of 'Working with People with Learning Disabilities and Offending Behaviour' based upon the work of Chaplin, Henry and Hardy (2009). The development of the pack was largely influenced by the findings of the context of care exercise and the themes identified in the service users' stories. The pack will be delivered in a modular format in one day. The four key modules include:

1. Background and Overview – Exploring the history and epidemiology of offending; policy and service provision in forensic learning disabilities; partnership working
2. Legal and Ethical – The criminal justice system; The Mental Health Act 2007; other legal and ethical considerations
3. Working with Offenders with Learning Disabilities – Working with sexual offenders; working with fire setters; working with violent offenders
4. Risk assessment and risk management

Modules 1 and 4 will be delivered to all attendees by the project leads. On completion of module 1 the attendees will be spilt into two groups and each project lead will deliver modules 2 and 3 to both sub-groups alternately. This allows for opportunities to discuss key issues in a less intimidating environment therefore

encouraging greater level of participation. On completion of modules 2 and 3 all attendees will reconvene in the original group and the project leads will jointly deliver module 4.

**Discussion**

Senge (1992) suggests that organisational decisions made at a local level unleash commitment and encourage staff to be responsible for producing results. Whilst the project team considered the views of one of the CLDTs, they did not determine if these views were comparable within the remaining teams. The project team made the assumption that the contextual factors that would enhance or hinder practice development would be similar if not the same in each area. On reflection this was a dangerous assumption to make since the focus of the development day had been constructed around the original data collected. Lewin (1951) believes that only by gaining the commitment of all those who would be affected by change would change be effective; whilst Abbott and Hotchkiss (2001) suggest that the progress of a project can be impeded by trying to make decisions in isolation. Cummings and McLennan (2005, p 65) claim that it is necessary in planned change, "…to understand the perspectives of each stakeholder and align the changes to be meaningful to them". As each local CLDT has a representative at a clinical network, a senior nurse/psychologist, who meets with the service on a regular basis (bi-monthly) and disseminates information back to their individual area, The project team could have utilised the 'forensic leads' to undertake the CAI and CCIs exercises with their individual teams thus providing the contextual factors of 'all' the CLDTs.

Kodjababian and Petty (2007) use the analogy that a development project is like a symphony whereby the project leader is the conductor who has the vision and ability to bring the project to a successful conclusion. So what happens when the symphony loses its conductor, does it lose its rhythm? One member of the project team who was jointly leading on the organisation of the development day unfortunately went on long term sick leaving the other member as the lone project lead. Barrett et al. (2005) found that projects came to a standstill when led by those with a lack of support networks and modest experience. Ibarra and Hunter (2007, p 46) state that, "Aspiring leaders must learn to build and use strategic networks that

cross organisational and functional boundaries". The remaining project member was able to utilise the supportive networks from the FoNS to provide guidance on facilitation and project management. They also called upon their manager who provided them with a number of contacts who could facilitate the practice development day. Registering the project with the Trust's Effective Practice Team as an effective practice project ensured executive support from the NHS Foundation Trust. These measures allowed the negotiation of protected time to undertake the necessary tasks to keep the project moving forward.

From the CCIs exercise within the pilot area, the project team were able to anticipate behaviours and reactions ranging from adoption of the practice development to complete resistance. Harvey, Loftus-Hills, Rycroft-Malone, Titchen, Kitson and McCormack (2002) suggest that the purpose of facilitation can vary from enabling teams to analyse, reflect and change their own attitudes to providing help and support to achieve a specific goal. Whilst supporting the pilot team to undertake the CAI and the CCIs was within the scope of the project leader's clinical competence, facilitating the development day was not; this realisation therefore enabled the involvement of an external facilitator. This had the advantage of access to higher levels of expertise and experience, and up to date ways of thinking. Additionally, they are, "…valued by clients for their outsider objectivity and their ability to give tough feedback or to ask the difficult question" (Scott and Hascall, 2001, p 25).

Change may be intimidating to individuals who want to maintain the status quo, there is a security in familiarity with tradition and tampering with the experience people have in doing something the way they know best will often cause individuals a degree of fear (Nemeth, 2003). Herold, Fedor, and Caldwell (2008) argue that when change has extensive implications for one's role, then willingness to support the change has been closely associated with their perceptions of the change agent's ability to smooth the transition. A change agent is someone who engages either deliberately or whose behaviour results in social, cultural or behavioural change (Fogg, 2002).

The project team have been unable to deliver the training programme as yet due to long-term staff sickness, impacts of increasing caseloads, existing commitments and

underlying strategic responsibilities on a small team covering a large geographical area; however, they did not want to lose the impetus achieved from the practice development day. 'Refreezing' looks to stabilise after changes to ensure that new behaviours are safe from regression (Burnes, 2004). Burnes (2004, p 986) states: "The main point about refreezing is that new behaviour must be, to some degree, congruent with the rest of the behaviour, personality and environment of the learner or it will simply lead to a new round of disconfirmation". Therefore, in an attempt to keep the aims of practice development project clearly focused amongst the teams, the project team are currently ensuring that all referrals are undertaken jointly between a member of the CLDT and a member of the FSS.

**Evaluation/Outcomes**

Swanson (1996) defines evaluation as, "a systematic collection of evidence to determine if desired changes are taking place" (p 26). When considering evaluation of learning from a training programme Goldstein (1992) suggests that the evaluation process centres around two procedures; establishing measures of success (criteria) and using experimental and non-experimental designs to establish if changes have occurred during the training programme and transfer process (on the job transfer). Similarly Buckley and Cape (1990) intimate that the intended learning outcomes are assessed in terms of improved performance by those who underwent the training. When considering 'designs' to establish 'improved performance' Ellery (2006) and DeSilets (2009) acknowledge the importance of utilising a multi-method approach to obtaining reliable and valid evaluation evidence such as qualitative and quantitative analysis of participants satisfaction, self reported changes, pre-test/post-test and understanding and observed learning outcomes.

Existing tools utilised for evaluation are predominantly founded upon Kirkpatrick's (1959a, 1959b, 1960a, 1960b) four levels of training effectiveness (Lee-Kelly and Blackman, 2012). Kirkpatrick (2006) describes the four levels as:

- Level 1 – Reaction: evaluation on this level measures how those who participate in a programme react to it
- Level 2 – Learning: can be evaluated as to the extent to which participants change attitudes, improve knowledge as a result of attending the programme

- Level 3 – Behaviour: can be evaluated as to the extent to which change in behaviour has occurred
- Level 4 – Results: evaluation at this level includes results such as, increased productivity, decreased costs, increased sales or improved quality.

A number of other models of evaluation have been developed such as the Warr, Bird and Rackman's (1970) Context, Input, Reaction and Outcome approach; Hamblin's (1974) Five Level Model and Bernthal's (1995) Seven Steps. Despite the development of these other models and criticism of Kirkpatrick particularly by Kearns (2005) due to its failure to distinguish between pre and post training effects and, that it does not, "…fully identify all constructs underlying the phenomena of interest, thus making validation impossible" (Holton, 1996, p 6), it still remains the model most generally accepted by academics (Phillips, 2003) and the most commonly used in organisations (Bates, 2004).

The first level of Kirkpatrick's (1996) four-level model of evaluation, 'reaction', is defined as "…measuring customer satisfaction" (Kirkpatrick and Kirkpatrick, 2006, p 27), "…gauges the interest, motivation and attention levels of participants" (Smidt, Balandin, Sigafoos and Reed, 2009, p 267) and "…measures the student's perspective of course content, materials, learning environment and instructor's performance" (Siniscalchi, Beale and Fortuna, 2008, p. 30). Inevitably this level is evaluated by the "…ubiquitous happy sheet or reaction sheet" (Thackwray, 1997, p 37) typically using fixed choice response formats that are designed to measure attitudes or opinions, these ordinal scales measure levels of agreement/disagreement (Mcleod, 2008). If we do not evaluate reaction we tell trainees that we know what they want and that we can judge the effectiveness of the programme without them providing feedback. Also, value is defined by the receivers of the learning contribution and not by the trainers who deliver or facilitate it. To ensure the best possible outcomes and to avoid these potential pitfalls the project team will utilise the trust evaluation sheet to measure attendees 'reaction' to the education programme, facilitation and the facilities.

The second level of Kirkpatrick's (1996) four-level model of evaluation, 'learning' "…involves measuring what participants have learned in both knowledge and/or skills" (Smidt et al, 2009, 267). The project team will ask each attendee to provide an example of new knowledge, one from each module of the education programme. They will be provided with four different coloured 'post it' labels each representing a module. On leaving the education programme they will be asked to stick their labels on a chart against the corresponding module. These will then be analysed by the project team.

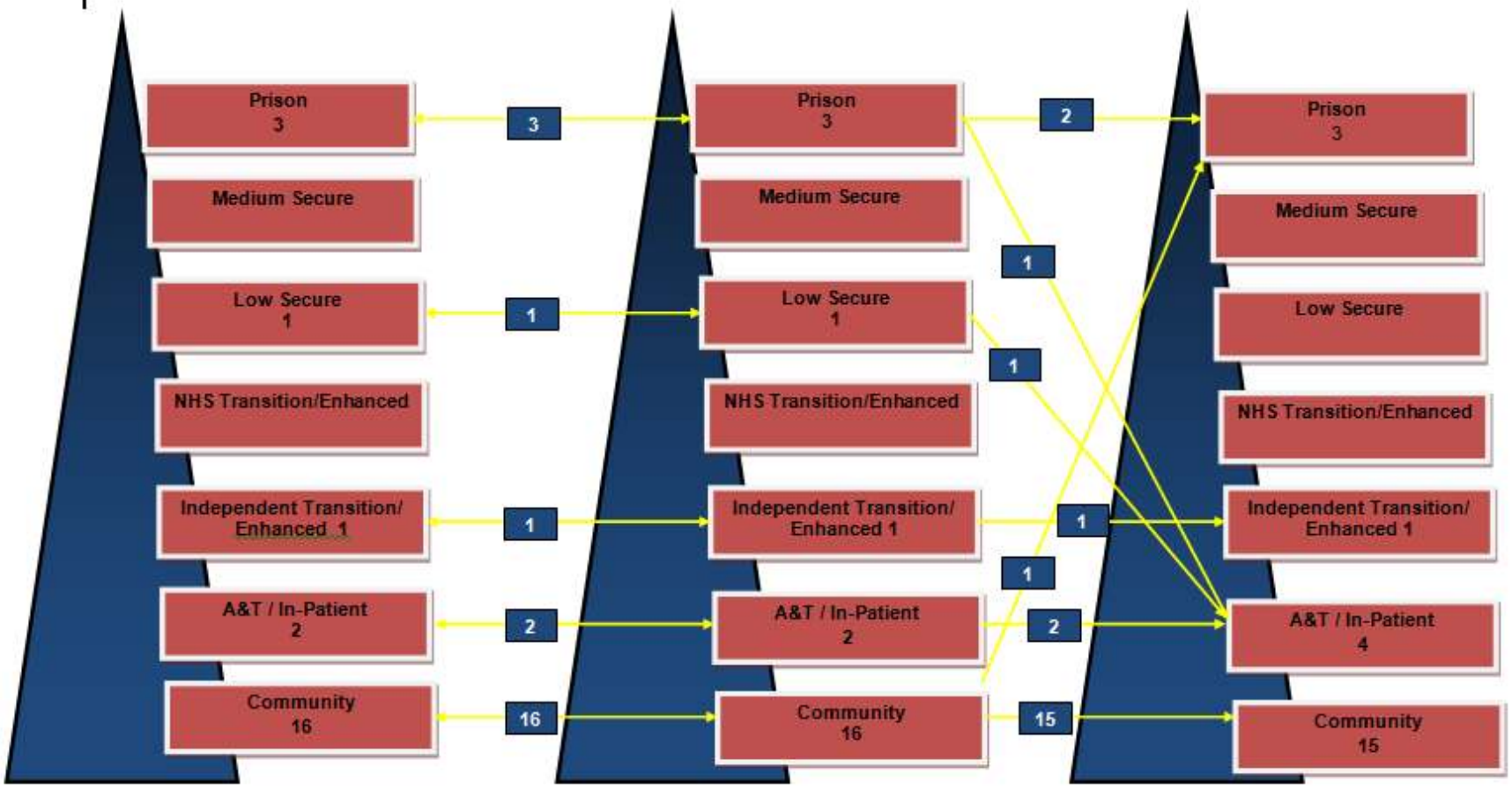
Behaviour change measures the degree of transference from what was learned to how the trainee behaves on the job, which in turn determines how much organisational impact the training can have (Hung, 2010). This third level of Kirkpatrick's (1996) four-level model of evaluation is the most valuable information about any educational activity. It is gathered after the activity is over and data should answer the question, 'were participants able to use or apply what they learned in practice? (DeSilets, 2009). Collection of data can be accomplished by using peers, co-workers, service users or supervisors and is measured by self report or observation. Evaluation at this level will be accomplished by the project leaders working alongside attendees and supporting them in taking a lead role when working with people with learning disabilities and offending behaviour.

Level four 'results' is the highest level of evaluation but evaluation at this level is the most difficult and the most time consuming. It answers the question, 'what was the impact of the learning on organisational results?' The essence of the 'Patients First' programme is high quality and patient focussed care and so the project leaders will concentrate on the evaluation of service user outcomes. The overriding philosophy of the FSS is to maintain services users in the least restrictive environment. This involves the thorough assessment of needs and risks and the development of risk management plans that ensure that the service user can remain in the least restrictive environment. Whereas this has previously been something undertaken exclusively by the FSS, as a result of the education package it is intended that the CLDTs will begin to undertake this role also. To measure this, the project team will utilise the work of Wheeler et al. (2009) and their 'Pathways Model'. Each referral undertaken by a member of the CDLTs will be followed up by the project leaders at

the point of discharge and then 3, 6 and 12 monthly post discharge. The project team will analyse the data and feedback to the team via individual CLDT intake meetings. Below is a graphical representation (Figure 3) of what the project team envisage the evaluation will look like. The overriding principle of the FSS is to maintain service users in the least restrictive environment and the main aim of the project is to support community learning disability teams in achieving this. Figure 3 illustrates service user outcomes as it measures progress over a prescribed period of time. The figure demonstrates the number of service users open to the team (the active caseload), accommodated at a number of different levels of security ranging from community placements (least restrictive) to prison (most restrictive). This enables us to measure outcomes for the service user at various stages of their pathway and monitor the effectiveness of our interventions.

The graphical representation demonstrated in Figure 3 enables us to evaluate the impact of the education programme on the service users experience as it captures change over a period of time.

Figure 3


Prison 3
Medium Secure
Low Secure 1
NHS Transition/Enhanced
Independent Transition/ Enhanced 1
A&T / In-Patient 2
Community 16
3
1
1
2
16
Prison 3
Medium Secure
Low Secure 1
NHS Transition/Enhanced
Independent Transition/ Enhanced 1
A&T / In-Patient 2
Community 16
2
1
1
1
1
2
15
Prison 3
Medium Secure
Low Secure
NHS Transition/Enhanced
Independent Transition/ Enhanced 1
A&T / In-Patient 4
Community 15
30
At Point of Referral
At Point of Discharge
At Three Month Follow Up

## Conclusion

Whilst it is disappointing that the project team have not yet completed the delivery of the education programme, they can take some solace that the 'Away Day' whereby all the professionals of each CLDT attended (the first occasion this has ever occurred) has been received extremely positively. The CAI and the CCIs exercises provided invaluable insight into current thinking regarding this complex and often demanding service user group. The away day enabled the project team to begin to break down some barriers to working with this service user group and demystify the role of the FSS. The project team firmly believe that the education programme will build on these foundations and prove to further narrow the gap in service provision and continue to improve service user experience for people with learning disabilities and offending behaviour.

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