SPECIALIST SECURE PSYCHIATRIC CARE

Introduction
This paper results from a seminar held by the Forensic Faculty at the Royal College of Psychiatrists in October 2003. The purpose of the meeting was to explore whether the Faculty could agree on a model of high secure care that could inform future policy. As will be clear from the paper, the discussion, in fact, ranged much wider than that and concluded that high secure care could not be understood except against an overall vision of forensic care at every level of security.

As a profession, forensic psychiatry has been successful in using needs assessment to drive forward pioneering services to meet the needs of mentally disordered offenders. As the profession of forensic psychiatry matures, there is a risk of identification with the place of work and its level of security rather than addressing the needs of our patients. At the time of the seminar, the Forensic Faculty did not have a policy statement on security and secure psychiatric care. This results in frustration on the part of policy makers, in that they cannot get from our Faculty a coherent professional view. It makes the profession prey to policy makers, picking off individual clinicians who will support a particular stance on the provision of high or medium secure unit care, leading to a lack of balance in discussion of future policy affecting forensic practice.

Limitations of this paper
Though it is hoped that this paper will be of value outside England and Wales, nevertheless it largely addresses service provision only in England and Wales. The paper confines itself to adult patients. No attempt had been made to address the specific needs of those with learning disability, pervasive developmental disorders such as Aspergers syndrome, patients with acquired brain injury or others with special or specific needs. However, we expect that the main issues presented in this paper will be of relevance to all groups of patients treated in secure units.
PART ONE

HEALTH AND CJS POLICY AFFECTING SECURE CARE

Recent trends in provision of secure care

- Historically, high secure hospitals have steadily grown in size, but that upward trend reached a plateau between 1993 and 2002. High secure hospitals are expected to reduce in size over the next decade. As the high secure hospitals have begun to reduce in size, there has been a significant increase in the number of medium secure unit beds, including significant contribution from the private sector. The following trends are taken from the Jamieson, Butwell, Taylor and Leese paper on “Trends in High Secure Hospitals” (British Journal of Psychiatry (2000), 176: 253-259).

- No health region manages without referral to high security institutions though there is considerable variation between the regions in terms of the demand in admissions. The reasons for such variation are not immediately apparent.

- Routes into special hospitals have become more complex over time, with more admissions resulting from failed placements elsewhere. Before the 1990s, the largest single group used to come directly from court. By the mid-1990s, the vast majority of patients had been placed in prison or another hospital first and it seemed failure in those placements led to hospital referral.

- The acceptance rate for those with a Mental Health Act classification of mental illness has consistently been above 60%; the acceptance rate for admissions under the Mental Health Act classification of psychopathic disorder has never risen above 30%.

- In the period studied, the number of medium secure beds rose dramatically, with the present total of around 2,000. During the same period, the numbers of referrals to high security have also risen from a figure of around 300 per year in the 1980s to over 400 in the 1990s.

- In the high secure hospitals, while the number of beds has reduced, expenditure has increased, leading to expenditure per bed increasing substantially between 1993 and 2002. This has been helped by the re-investment of monies released from the retraction of the high secure estate. The cost per high secure bed now nearly matches that of regional secure units. As the accelerated discharge programme is implemented, the patients in high secure care will be those with complex and challenging needs. The cost per case will therefore be likely to increase, as the cost per case will not be diluted by patients who need less complex or intense care.

- The accelerated discharge policy from high security is designed to gradually decrease further the number of high secure beds. At the same time, most regions (particularly London) plan to extend medium secure unit provision as well as known expansion in the private sector. These shifts in the balance between high and medium secure service provision makes it difficult to model how services will develop over the next decade.
• Over the period 1993 to 2003 there has been a significant trend for admissions to high and medium secure services to result from prison transfers. The proportion of patients on “civil sections” is decreasing.

• Training numbers in forensic psychiatry have not kept pace with the expansion of secure unit provision. Dr Robert Dolan has estimated the likely shortfall between actual and required number of forensic psychiatrists in England and Wales based on known expansion to medium secure provision. Reporting in 2002, Dr Dolan calculated from this survey that there were 215 consultants with higher training in forensic psychiatry within existing services (including the independent sector). By 2006, national policy initiatives and regional strategic developments will result in an expected consultant workforce requirement of 444 consultants, an increase of 228 posts on current numbers. With present numbers of training places (including planned expansion of specialist registrar numbers) there should be 292 more consultants available by 2006, leaving a shortfall of 152 over estimates of demand for consultants.

• As the provision of secure care shifts in unpredictable ways, this can result in experienced staff being displaced and lost to future forensic care. Workforce development and training are important when there is a change in service provision, as otherwise experienced and valuable staff will be lost to forensic services.

Planning assumptions
Concern was expressed at the seminar that the assumptions made in planning future high secure provision did not take account of changeable dynamic factors, but assumed that the service was currently meeting need and that that level of need would remain reasonably constant over the immediate future. There are, however, a number of factors which could have a variable effect on utilisation of high secure beds.

1. The accelerated discharge programme may affect medium secure units by altering length of stay. Certain units have developed long stay medium secure units but these fill rapidly, leading to other discharges in the future from high security going to mainstream RSU beds. As the length of stay of high secure patients averages over seven years, and that for medium secure unit patients (at least in the past) was held to be around two years, there is much room for the length of stay of patients in medium secure units to rise significantly as the patient mix changes. A rise in the length of stay within medium secure units may lead to reduced capacity in that sector. There is evidence from many medium secure units in England and Wales that length of stay in medium secure units was increasing alarmingly before the accelerated discharge policy came into force. The net effect may be a reduction of RSU capacity, placing significant pressure on high secure beds because of reduced capacity to admit difficult to manage patients, and reduced capacity to transfer patients from high to medium security.

2. The assumption that the service is currently meeting need is debatable. The Gunn Study showed significant unmet need for prison transfers. Prison services and clinicians have consistently fed back that there are a
significant number of patients, particularly within prisons, who should transfer to hospital care if facilities were available. The lack of referral should not be held as lack of need, as referrals are only made if there is a likelihood of admission. The Gunn Study represents the most conservative estimate of unmet need. The Office of National Statistics’ survey revealed even higher figures for mental disorder in prisons, but was not designed specifically to address unmet need.

3. The impact of the provision of care in prisons being provided by the NHS rather than through prison health is as yet unknown. It seems likely that this change will lead to increased numbers of referrals from prisons to the NHS, though not necessarily to high security units.

4. If the new Mental Health Act goes through Parliament in its present form, the wide definition of mental disorder is predicted to increase the number of people detained under the Mental Health Act, including detention under provisions relating to mentally disordered offenders.

5. Changes in the Criminal Justice System, including lengthening sentences and increased use of indeterminate sentences, will have an impact upon length of stay in secure care.

6. The impact of the dangerous and severe personality disorder service on medium secure units is unknown. It may be that few, if any, patients move from DSPD services, bearing in mind the nature of the admission criteria and the lack of evidence in this particular group of treatment efficacy. However, if this is the case, then those units will quickly become full and planning will need to take into account future DSPD cases that will merit admission to high security. It is not clear whether the planning of DSPD services has taken into account the expected length of stay, and taken into account the need to gradually expand the services over years to meet future expected pressures on admission.

The DSPD services are expected to address the needs of a group of patients who do not currently receive a service. The Department of Health Guidance on Personality Disorder envisages mainstream services providing treatment to those with a diagnosis of personality disorder. The combination of the wide definition of mental disorder, current DOH guidance on developing personality disorder services, greater input from the NHS to prisons, and the impact of Multi Agency Public Protection arrangements should result in greater numbers of patients with a primary diagnosis of personality disorder being referred for secure psychiatric care. The impact on high security may be reduced by the development within mainstream forensic psychiatry services of specialist services for those with personality disorder which at the time of this report include

i. Four MSU pilot sites to provide treatment for PD patients (Newcastle, Leicester, East London and SLAM) who between them will total 56 beds by spring 2006.
ii. Community Forensic PD teams (Newcastle, Leicester and SLAM)

iii. Specialist forensic hostel provision and supported housing for PD patients (South and East London)

There is currently no clarity on how district services will develop and sustain services to PD patients. If it is left to local enthusiasm to be involved in developing PD serves this is likely to lead to patchy and uneven developments, which may lead to patients from certain postcodes receiving treatment while others reside in areas not developing PD services. If the recommendation below on developing a catchment based admission system for access to all levels of security is accepted, then a consistent approach to the development of services to patients with personality disorder is required. It would be very difficult to manage a catchment area admission system if there were wide variation within the service area in the provision of PD services. Policy developments in services for personality disorder, together with CJS developments such as MAPPA, are likely to increase demand for treatment for patients with personality disorder. Until specialist serves are widespread, that demand will be have to be absorbed by prison and existing secure unit provision. There is currently no Forensic Executive guidance on the development of personality disorder services. Consultants leading the pilot personality disorder services report that it is exceptionally difficult to provide treatment or management of forensic personality disordered patients within mainstream services, whether hospital or community based. As specialist teams develop, they may be able to more effectively manage personality disordered patients in the community, thus achieving greater throughput within services.

Recommendation One. The Forensic Faculty should develop policy guidance on the development of forensic personality disorder services.

7. The needs of low volume, high complexity cases make planning difficult. Certain regions may not have a critical mass to provide services for particular patient groups (eg serious violent offending associated with acquired brain injury).

8. The assumptions behind beds do not seem to take account of the impact on length of stay in high secure beds of leaving behind in the high secure hospitals those patients with high morbidity and high cost after the less demanding or complex patients have moved through the accelerated discharge programme.

Though it is technically difficult (if, perhaps, impossible) to factor in these dynamic factors when arriving at an estimate of bed numbers, to avoid doing so will inevitably lead to planning inadequate number of beds or the wrong type of beds to meet expected demand.

Recommendation Two. Planning for bed numbers in secure care should be based not only on historical bed usage but on predictions which take into account dynamic factors impacting on secure psychiatric care arising from changing health and criminal justice public policy.
The seminar heard presentations on various aspects of secure care, including the relationship between high and medium secure services. The following observations were made on the changing relationship between high and medium secure units:

- The past decade has seen an improvement in recruitment to high secure consultant posts, with improved quality and better training. Academic departments have been established in the high secure hospitals.

- TILT has had a negative impact upon care in the high secure hospitals. Clinicians believe that security determines admission rather than clinical needs. Clinicians reported that the change in definition of security within the high secure hospitals impaired the ability of high secure hospitals to provide effective care of patients.

- There is diversity of opinion as to whether admission criteria to high security have changed in the past decade. This remains unresolved but the perception remained that, whether admission criteria have changed or not, thresholds may have changed. Evidence concerning acceptance rates creates the impression that thresholds have altered.

<table>
<thead>
<tr>
<th>Year</th>
<th>Acceptance Rate</th>
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<tbody>
<tr>
<td>1970</td>
<td>50% of referrals accepted</td>
</tr>
<tr>
<td>1980</td>
<td>42% of referrals accepted</td>
</tr>
<tr>
<td>1994/95</td>
<td>42% of referrals accepted</td>
</tr>
<tr>
<td>2000/01</td>
<td>32% of referrals accepted</td>
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- Admission panels at the secure hospitals were perceived by regional secure unit consultants as acting to adjust admission thresholds according to pressures on the system, either through policy or through changes such as the TILT redefinition of security.

- There was considerable concern about the welfare of patients not considered suitable for medium secure unit care, but also not thought to meet the criteria for high secure unit. They tended to remain in prison. Case studies were presented that suggested that such patients fare badly within the prison system.

- There was concern that, where disputes arose between high and medium secure units about admissions, the Home Office or judges in court determine the issue. There is disquiet at not being able to settle disputes professionally but allowing bodies, such as the Home Office or judges, to act as arbitrators. It is perhaps inevitable that when disputes about level of security are resolved by the Home Office or the courts, the conservative position is taken, namely that the patient should move to high security. Furthermore, they cannot make the decision on clinical grounds. There should be clinical disquiet about this, as it may mean that some patients are admitted to a higher level of security than is perhaps warranted by the level of risk they present.

- Certain regional secure units could be seen as model services in that they “consume their own smoke” by having a reduced need to refer to high security compared to other services. An assumption could follow that all regional secure units could, in time, match the flagship services, reducing need to refer to high security. However, this can be challenged on the basis that not all regional secure units are the same or will ever
conceivably be matched in the future because of variations in historical development, funding, skilled staff availability or availability of backup services outside the RSU that could reduce pressure. There are intriguing differences between the regions and the pattern of use of high secure beds, which do not seem to be determined by availability of medium secure unit beds but by certain demographic factors within the population and perhaps by aspects of service provision outside medium secure units which remain obscure. Professor Jeremy Coid’s work, showing that secure beds are linked to indices of social deprivation, and the work from the National Oversight Group by Fender, showing that there are wide variations in the use of services by ethnic minority groups in different parts of England and Wales, are two examples of factors which have an impact upon medium secure units to create quite significant variation in their service provision.

Clinical directors of RSUs report that there is generally an increase in the level of disturbance and risk exhibited by admissions to RSUs. A perceived cause of this increase in disturbance is the impression that the “safety valve” function of the high secure hospitals is no longer easily accessed. This increase in the level of disturbance experienced in RSUs could have a number of unforeseen consequences, such as:

1. Increased length of stay.
2. Confining disturbed patients for long periods of time in small spaces within ICUs in medium security.
3. Reducing availability of therapeutic activities and treatments to patients with complex needs because of unavailability of services targeted at the most disturbed end of the patient spectrum within RSUs.
4. Increased assaults on staff.
5. Staff “burnout”.

It is recognised that such perceptions are unlikely to be used in predicting high secure bed numbers or in developing services but, nevertheless, may be very important early warning signs of pressure in the system.

Consultants in RSUs report that there is concern about the use of ICU beds in medium security. These were originally designed in most RSUs to manage people for relatively short periods of time. Clinicians report that patients remain in intensive care areas in RSUs for increasingly lengthy periods of time. Concern was expressed about the availability of therapeutic treatment for patients and their quality of life in such small contained areas, which were originally designed for relatively short lengths of stay. This issue will be returned to later in this paper. It is, of course, not necessarily an argument for admission to high security but, if the trend in RSU admissions continues, then consideration must be given to the quality of life and treatment facilities for patients who need intensive care for long periods of time within medium security.
Socio-political and service development pressures
The provision of care for mentally disordered offenders is intimately connected with public policy on crime and public risk. Of many issues affecting the provision of high secure care, the following were highlighted at the seminar:

- We were informed that there is a policy debate at central government about whether high secure services should be seen as part of the Criminal Justice System. In parallel with this paper, the Forensic Faculty is debating the role of psychiatry in the Criminal Justice System and, particularly, the ethical issues that arise if there is an obligation to address the rights of third parties to be protected from violence. The Royal College has always taken the view that ill people should be treated within the National Health Service.

- As the changes unfold in the provision of health care to prisoners, a response will be required to the inevitable increased pressure for transfer from prison to hospital for treatment. Clinicians working for a significant portion of their time in prisons are frustrated with the lack of joined up thinking between having an ethical stance that patients requiring care should be transferred to the NHS, and the reality, which is that prisons contain significant numbers of severely disturbed patients who are refused access to NHS beds by both general and forensic psychiatrists. The conjunction of policy on expanding and improving services to patients with personality disorder with patchy development of NHS services further exacerbates the problem. The debate around the provision of compulsory treatment in prisons is linked to this concern. This merits further debate but it lies outside the scope of this particular document. The debate centres on whether we provide treatment facilities within prisons to manage people with severe mental disorder (including, of course, personality disorder) or whether we advocate that treatment facilities should be concentrated in NHS forensic facilities. The latter would require a very major shift in public policy away from imprisonment to health care and considerable investment in secure hospital beds. As a profession, we need to have a view on this.

We are aware that other countries manage their prison populations differently. Those jurisdictions without mental health law allowing a hospital order (Section 37, Mental Health Act 1983) at point of sentencing provide services that involve greater and more flexible transfer between prisons and hospitals (USA, Australia and Ireland, for example).

Recommendation Three. The Forensic Faculty should hold a seminar to articulate a policy position on the provision within or outside prisons of psychiatric treatment to those mentally disordered prisoners not currently transferred to NHS treatment facilities. This is particularly needed in the light of the transfer of responsibility for prison based health care from the Home Office to PCTs as from April 2006.

- Dangerous and severe personality disorder services are developing and operating separately from mainstream forensic services. The relative balance between DSPD services, services within mainstream forensic psychiatry for personality disorder, and community facilities, has been debated above. There is an apparent discontinuity in policy for offenders with personality disorder in that the Department of Health Guidance is entitled “Not a Diagnosis of Exclusion” but for certain offenders, the “diagnosis” is changed to dangerous and severe, making their management within forensic psychiatry services rather different from those in the rest of the service.
• As will be evident in the section on women’s services, the national strategy for women’s service, “Into the Mainstream”, will have a marked effect upon provision of secure services, not least because a women only service inevitably means that there will also be a men only secure service.

• Criminal Justice and Penal Policy will impact upon forensic practice, not least as changes in sentencing policy may effect capacity assumptions about secure unit provision.

Needs assessment
During the preparation of this document, the National Oversight Group published a plan for high secure beds over the next five years. The Forensic Faculty accepted that in terms of bed utilisation the figures were well considered. Data collection was done thoroughly and likely to be accurate. However, this was not a true needs assessment but was essentially a bed utilisation exercise. As such, this data on bed utilisation provides reasonably short to medium term estimates of continuing use. This exercise did not take into account any of the pressures on the service described in the sections above.

We do not consider that bed utilisation figures are a sound basis for planning secure bed numbers. Bed utilisation figures are weak for a number of reasons. Such figures do not utilise any systematic process to identify people in need of treatment. Small capacity systems, such as secure services, are particularly unsuitable for planning based on bed utilisation data, because when resources are scarce “gate keeping” will be particularly robust and tough. Waiting list arguments are particularly weak, since when potential referrers know that the chances of getting a bed are low, they will not “waste” time making a referral with little prospect of success.

In the absence of data on real need for secure health services, we are not convinced that either Department of Health or clinicians’ estimates are good enough for the kind of information based policies on the development of secure health services that should be developed.

Recommendation Four: We recommend that the Department of Health and the Forensic Faculty of the Royal College of Psychiatrists should jointly develop a methodology to move planning of secure health serves from a bed utilisation basis to a needs based system.
PART TWO

PRINCIPLES OF SECURE CARE

What is security?
The word “security” is widely misunderstood. Safety would be a better word. People can more clearly understand that it is about

1. The safety of the public.
2. The safety of staff.
3. The safety of the patient.

When decisions are made in psychiatry about disposition into high, medium, or low security facilities, all three of these dimensions of safety are being evaluated, and the disposition may well turn on the needs in only one of these areas. It is not the case that security is solely about the safety of public.

Inevitably, an assessment of security needs will include some degree of prediction that this should be set in the context of flexible arrangements, which can be changed as needs change. Security can be extended into the community and a very long (sometimes lifelong commitment) made to patients may be about their security needs.

Security is the means by which safety is achieved, and it involves:

1. **Relational security**: the most important type of security in mental health work, which achieves safety through establishing good rapport and an effective therapeutic alliance between patient and staff. Though poorly researched, it seems to rely on high and dependable staff ratios organised into a multi-disciplinary team. Safety is enhanced through prompt action by staff following detection of changes in mental state or behaviour, which are detected because of the thorough knowledge staff have of their patient's individual case.

2. **Procedural security** concerns the policies and practice guidelines in place to provide an environment tailored to the patient population and which enhances safety. Typical policies will include policies on searching, testing for drug misuse, access to weapons, visiting arrangements, patient correspondence, access to money, de-escalating of violent episodes, and leave.

3. **Physical security** (sometimes called environmental security) refers to the structural features of the unit. These include perimeter fencing, design of windows, double airlock doors and the physical layout of units to enhance observation. Use may be made of CCTV and alarm systems.

The relative mix of the three types of security will differ between different types of secure institution and have a profound effect on the ethos and atmosphere of the institution. Under the heading of relational security, professional staff will need a detailed knowledge of the patient's background, mental state and habits. Drugs, depression, psychotic ideas and suicidal ideas all give security problems. There needs to be confidence and trust between patients and staff. The
multi-disciplinary team needs to know the patient’s visitors and relatives, including their trustworthiness and their types of concern about the patient. The provision of a good quality of life for the patient is a vital security measure. Maintaining good physical health as well as good mental health is of importance to maintaining security. Staff and patient morale needs to be high for security to work effectively. It follows that oppressive systems, whether oppressive from procedures, staff attitudes or grotesque perimeter security, are counterproductive. Increasing physical security may impair relational security and thereby paradoxically reduce security.

Revisiting the Reed Principles
The Department/Home Office Review of Health and Social Services for Mentally Disordered Offenders (and others requiring similar services) reported in 1991. This committee was chaired by Dr John Reed from the Department of Health and has become known as the Reed Committee. The principles that were designed by the Review Committee have come to be known as the Reed Principles and will be referred to as such in this paper. The Reed Principles remain the accepted principles for the provision of services to mentally disordered offenders. They have stood the test of time.

Central to the Reed Principles for secure care is that patients should receive treatment at a level of security no greater than is required of the dangerousness or risk they represent. The “security” of a medium secure unit was devised to allow patients to be treated in that unit. However, security within the high secure estate has shifted to defining security, not on the basis of patient need, but on perceived risk and the need to meet the general public’s concern about risk of absconding and containment of “dangerous” individuals. This has led to problems in applying the Reed Principles, as this principle assumed that the level of security would be defined around patients’ needs, not around a definition of institutional security.

Category B security is a security designation applied to the prison estate and is not necessarily applicable to hospitals, which are radically different institutions. Category B security, as understood in a high secure estate, is a security designation of the hospital, not of the patient. Security is a way of defining a dimension of care, not an attribute of the patient treated in the institution. There is a danger that risk and security considerations will determine admission to hospital rather than clinical need. Clinical care in high secure hospitals should be seen as personalised care for unique patients within a campus that is designated Category B for security purposes, and that can provide programmed activities for very unwell patients.

With the shift to the security of units being determined by concern about absconding and containment of dangerous individuals, should the Reed Principles now include a principle around the clinical need of patients? Pragmatically, it seems unlikely that the “tilt” in security of high secure hospitals will change. If it is argued that Category B perimeter security is a designation of a hospital, not of the patient, it may be possible to argue that a patient could benefit from treatment within a high secure hospital, though they may not require Category B perimeter security. Accepting this argument might result in a lack of consistency in our approach to secure care. On the one hand, we express concern about the effects of increasing security upon treatment within high secure hospitals and the ethical dilemma involved in admitting a patient to a level of security that is not strictly required by the level of risk of dangerousness. If we then go on to argue that patients should be admitted to high security if they are likely to benefit significantly from the treatment services available there, we are explicitly allowing for such patients to be detained under a higher level of security than is justified by the level of danger they present to themselves or to others. If, as will be suggested below, one adopts a “whole system
approach” to forensic care, that approach could bring benefits to patients and the service if, for example, respite care could be part of the function of high secure hospitals.

Those working in high security have argued that, to weaken the Reed Principles in this way could lead to a disincentive for services to develop appropriate treatments and treatment settings for those patients within medium security who are most challenging. Once again, this is tempered by the need to develop services on a “whole system” or catchment area basis, and make best use pragmatically of the treatment services available, knowing that the security definition of a hospital should not necessarily determine whether a patient could benefit or not from admission to that hospital.

Acceptance of potential to benefit, and availability of appropriate services, may lead to different kinds of tension between high and medium security. For example, would the lack of availability or particular treatment services within an RSU then justify admission to high security? If that were the case, will this remove pressure on regional services to develop better facilities for patient treatment? How would a system based not only on the traditional Reed Principles, but adding treatment need and availability of services, deal with those RSUs that struggle to provide an adequate service?

The problem lies not with the Reed Principles per se but with a narrow definition of security understood solely as physical security. TILT did not understand the clinical context within which we work, and its legacy is to lose sight of the fact that physical security is but a small part of keeping patients and the public safe. Relational and procedural security are far more important, and the balance of different types varies from individual patient to individual patient. Thus there should be no contradiction in patients “needing” high secure care because of their need for the mix of procedural and relational security available at that level, while not needing the Category B secure designation of the institution.

Recommendation Five. The Reed Principles should be modified in the light of changing service provision to include a principle that the clinical needs of a patient are relevant factors to be considered in determining the level of security for that patient. The level of security required for a patient’s treatment should not be equated solely with the physical security of a hospital (especially its security designation) but with the relative mix of relational, procedural and physical security needed to safely treat that patient. Lack of services in a particular area should not be a reason for transfer to a high security.

If the above recommendation is accepted, it does not negate the Reed Principle that patients should not be admitted to a higher level of security than they require for their treatment to be provided. Rather it clarifies the Reed Principles to emphasise that “security” is not just physical security but also involves relational and procedural security. The problem arises from the high security estate now being equated with its perimeter security designation.

The other Reed Principle that causes concern is that patients should be cared for as near as possible to their own home and families, if they have them. In practice, this seems to have been interpreted as a return to their home communities and, hence, to the PCT area responsible for commissioning their care. The seminar recognised that many people could benefit from moving away from their home communities, and often wish to do so because they have highly abusive families, sometimes because their offence has caused such community or local survivor concern or because of unavailability of effective community provision. Current NHS interpretation of this
Reed Principle is inextricably linked with funding arrangements, and acts to frustrate clinical efforts to find the most appropriate discharge setting for patients.

**Recommendation Six.** Though the Reed Principle of treatment as near as possible to the patient’s own home remains sound, it should not act as a barrier to transfer to another area where the patient could benefit from change of area of residence.

**Admission decisions to levels of security**
The above debate led to a consensus that the best means of ensuring proper clinical decision making regarding admission to high and medium security was through decisions being made by the clinical teams responsible for the patient’s care. There is no reason why multi-disciplinary input cannot be guaranteed through such processes. High security hospitals are to become catchment area high secure hospitals. This should allow for proper integration between the catchment area teams in high security and catchment area teams in medium security.

Decisions about high secure care could then be made in the light of the total patient population and knowledge of the resources available in the catchment area. Such a catchment area based admission system would also involve equal and reciprocal joint catchment area decisions on transfer down from high secure to medium secure care. Such care pathways will require joint treatment plans between high and medium secure clinical teams on admission to high security, with joint decision making as the patient progresses. Such a clinical system could lead to significant gains in reducing length of stay. A catchment area system with integrated care pathways should lead to more liberal use of trial discharge from high security, but also trial admissions to high security, and perhaps respite admissions to high security.

Though this paper is narrowly concerned with secure care, it is clear that any catchment area management system will need to involve a wide range of services not obviously “secure”. Shared decision making involving general psychiatry and prison based NHS services might best be organised at a relatively local level, involving lead clinicians in forensic psychiatry, general psychiatry clinical directors, PICU teams and prison health teams. We understand that such systems work well in New Zealand and avoid the boundary disputes between services. A pilot system on these lines was developed in the Mersey area, involving clinicians at all levels of security and general psychiatry. It ceased at the time of the Ashworth Inquiry. The compact geographical area, individual clinician commitment and flexible work patterns across levels of security all aided the development of this approach.

The catchment area system has been developed through the National Oversight Group and could potentially allow for the management of discrepancies between services in their capacity to contain difficult to manage/complex patients, and to provide adequate treatment facilities. This could be achieved through audit, benchmarking and dispute resolution.

This paper is not concerned with wider management issues, but mention is made of the potential benefits of a catchment area system to make better use of resources. The total resource could be looked at to determine the best way of delivering, for example, longer stay services, intensive care or respite care, rather than thinking of the institutions that have, up to now, provided such services. A robust dispute resolution process will be required, not just to deal with disputes about transfer to high security but also disputes regarding transfer from general adult psychiatry, prison transfers and transfers from high to medium security.
Recommendation Seven. Secure psychiatric services should be managed as catchment area services where high, medium and low secure services (perhaps, in time, with prison based services) are understood as a total combined resource available to patients and managed as an integrated service.

Recommendation Eight. A rigorous system of audit, benchmarking and dispute resolution should form part of any catchment area management system, to ensure that the level of security employed to treat a patient is determined by patient need and not by unavailability of services at a lower level of security (recognising that there will never be perfect fits between need and level of security).

The above considerations lead to review of the merits of admission panels for entry to high secure care. The arguments for an admission panel include:

- Admissions to be determined through full multi-disciplinary input.
- Admission panels allowing for consistency in admission decisions, thus eliminating the problem of the impact of poorly functioning RSUs, or RSUs with poorly developed treatment facilities on admission decisions.
- The process to be open and transparent.
- Preservation of a high threshold for admission to high security, thus meeting the Reed Principle of avoiding admission to an unnecessarily high level of security.
- That where an appeal’s procedure is available, as well as the admission panel, the system becomes fair and equitable.

Notwithstanding these strong arguments, there was consensus at the seminar that the admission panels were unhelpful. Decisions about patient care always involved tension between the individual needs of the patient, security, the service provision available to the patient and the pressures on various systems, both high and medium secure. Admission panels take away public debate around these tensions, allowing a gap to exist between high and medium security, particularly where there is perception that security designation of the institution (TILT Category B security) is the greater determining factor than the clinical need of the patient.

The most significant criticism of the admission panels made at the seminar was that they do not follow normal clinical practice for decisions about admission, which is through discussion between the requesting service team, the assessment team from high security and the team that will treat the patient. A catchment area system determining all admissions and transfers to all available levels of security would overcome that criticism.

Recommendation Nine. Admission panels for the high secure hospitals should cease and should be replaced by catchment area admission decision making, utilising the total resource available to that catchment area through high, medium and low security.
If greater integration between high and medium security unit clinical services is desirable, a number of issues may need to be tackled. The Faculty Executive may need to engage the Home Office in discussion of security needs of patients, transfer between different levels of security, and decisions on leave into a system where treatment goals and expectations of length of stay are built in to the patient’s admission to high security from the very beginning.

Recommendation Ten. The Forensic Faculty should meet the mental health unit of the Home Office to agree systems to integrate the responsibilities of the Home Office for restricted patients into catchment area admission and discharge procedures.

Longer stay patients
Medium secure units were designed on the premise that length of stay would be no more than 18 months. Design did not take into account the needs of longer stay patients. Presumably, if planned for at all, the assumption was made that the high secure hospitals would continue to provide the longer stay facilities. It was made clear at the seminar that lengths of stay in MSUs are now well over 18 months, including stays measured in years. A worrying trend is the accumulation of patients in intensive care areas with long lengths of stay. The accelerated discharge programme for special hospitals is at the same time divesting those hospitals of longer stay patients. The impact upon MSUs is considerable. Though not articulated as a policy shift, the result is that existing RSUs are providing longer stay care which was not built into the original design of such units. Some (and that includes services in the private sector) have developed specific longer stay units. Collaborative work by the Forensic and Rehabilitation Faculties concluded that there was no clear policy guidance on the design, culture, staffing or skill mix of these longer stay units. The impression was of longer stay services being an adjunct to existing units, rather than being designed with the specific purpose of providing an environment designed for rehabilitation purposes.

This is not to argue that the special hospitals are the right hospitals for longer stay. At their best, they provided the skills, culture, rehabilitation ethos and relaxed campus necessary for a good quality of life for longer stay forensic patients. The point is that longer stay treatment facilities should not be simply an add-on to existing services, but should be designed and planned specifically for the welfare of longer stay patients.

Concern was raised about the quality of life afforded to patients cared for over long periods of time in intensive care areas of MSUs. Within any long term policy for the care of longer stay patients, the needs of those who require intensive care over extended periods must be addressed.

Recommendation Eleven. Specific policy and design guidance should be produced to inform the development of facilities for longer stay patients in secure units.

Recommendation Twelve. Policy and design guidance on longer stay facilities should address the needs of patients requiring prolonged intensive care.

Throughput and length of stay
Bed utilisation is the function of a number of admissions multiplied by length of stay. It seems unlikely that the pressure to admit to secure services will diminish over time. On the contrary, changes within provision to prisons and changes within the Criminal Justice System point in the
opposite direction, namely increased utilisation of secure psychiatric care. To make better use of facilities, the length of stay should be the target. A number of themes emerge from this discussion:

- Greater emphasis should be placed on rehabilitation and improving the skills of rehabilitation within secure settings.

- Equal emphasis should be placed upon developing services for exit from secure care as upon developing further secure beds. When a sound foundation for community care of graduates from secure care is in place, it is then possible to work forwards to make better use of available high and medium secure places.

- The main need identified by clinicians in medium and high security is the provision of slow stream rehabilitation through low secure service provision. The perceived lack of a buffer between medium secure/high secure care and mainstream general psychiatry provision extends length of stay. The seminar agreed that emphasis should be put on further development of low secure services, both medium and longer stay. Such services will have to manage two pressures: (1) to take patients out of higher levels of security and (2) to accommodate patients from prison requiring security short of medium security.

- A major priority for future service development is the provision of specialist high support accommodation in the community. If security is understood as a system that can, when necessary, ensure lifelong safe care, then community facilities that provide long term safe and supportive care must be considered as an essential component of secure psychiatric care.

- One barrier to successful discharge is limited availability of adequate psychology and psychotherapy services in secure settings. Where geographical conditions allow, the greater use of joint appointments between psychotherapy departments in high and medium security could improve continuity of care and reduce length of stay.

Recommendation Thirteen. The future development of secure psychiatric care should set as a priority the development of slow stream low secure rehabilitation services and integrated specialist supportive accommodation in the community.
PART THREE

SECURE SERVICES: WOMEN’S SERVICES

Introduction
In discussing women’s services, it quickly became obvious that the male and female populations in high security often had different needs, and that the relative balance between relational, procedural and physical security differs for male and female patients. There is by no means agreement within the profession that the high levels of physical security proposed through the TILT Report are necessary for safe management of the male population in high security. There is a very real danger of creating a dichotomy between “needy” women requiring enhanced therapeutic services and “dangerous” men requiring enhanced physical security. Both men and women in high secure care require a service that provides them with high quality therapy tailored to their particular challenging complex needs. As the patient population in high security contracts, both male and female patients may require “enhanced” medium secure care. A recommendation has already been made in this document to consider specialist medium secure ICUs.

Though the discussion below acknowledges the commonality between the needs of men and women, this must be read in the context of the long debate and research about the particular needs of women in secure care. Their needs were neglected for a long time and women were in such a minority that services have traditionally been planned round the needs of male forensic patients.

All the issues raised in the earlier section generally dealing with high security in particular apply to the women’s service. Part of the impetus for change within the women’s service was that services were being increasingly defined by security, not by patient need. High security for women was not just “high” levels of physical security, but the therapeutic expertise and specific programmes designed for women with particularly challenging complex needs. The increasing emphasis on physical security brought about through the TILT Report brought into sharp focus the need to define women’s service more by clinical need than by security need. Consultants working in the women’s service consider women do not need the Category B physical security recommended through the TILT Report, but do require enhanced relational and procedural security. If such arguments are valid for female patients, they may also be valid for male patients.

National policy on women’s services
This present era has seen an unprecedented interest in the needs and welfare of women in secure care.

Particular needs of women in secure care
A number of particular needs and challenges in the treatment of women (which also apply to men to a different degree) in secure care were identified:

• Issues to do with children are prominent in treatment. Offences can involve violence against children. Particular problems of children in care and access are important. Men do not have the physical experience of pregnancy, birth and possible removal of a child at birth.
• If the male parent is removed from the family (through imprisonment or secure care), the child is frequently cared for by the mother in the community. However, if it is the mother who is removed from the family, the child is more likely to placed in care.

• Self mutilation can be a particularly prevalent and challenging behaviour within women’s services.

• Arson is a more common offence among female admissions to secure care. Services need to develop particular programmes around the link between future risk of arson, aggression and abuse.

• The emotional intensity of cases can be greater than within the male population (linked to diagnosis of borderline personality disorder, though borderline personality disorder is not exclusively an attribute of female patients).

• Particularly within the early phase of treatment, there may be a playing out of abusive relationships within the institution. Because of the particular impact of sexual abuse, this can present particular problems in mixed wards during the early phase of treatment. Early in treatment, one of the main tasks for women is to learn how to relate outside of abusive relationships.

• The women in secure care may need a higher proportion of women staff.

• Catchment area medium secure units generally have a preponderance of men over women (in mixed units, women represent around 25% of the population). This acts as a barrier to the development of female orientated therapies.

• Women need specific female orientated physical health care.

Whenever the needs of female patients are highlighted, there is a risk of creating a false dichotomy between the needs of men and women in secure care. We recognise that men have similar problems to females but often present in different ways, e.g.

• Child relationship issues can be important to male patients.

• Many men in secure care have distorted body image problems.

• Mutilation can take a different form in the male population, involving punching, breaking bones etc.

• High intense emotion may be expressed in different forms in the male population.

• The psychological impact upon men who have experienced physical or sexual abusive relationships in childhood can manifest itself in power relationship problems in secure care. Such reliving of abuse for male patients can take the form of striving for domination and the acting out of rituals of humiliation and abuse from childhood.
Integration and separation
Female patients, in the early phase of treatment, need a single sex environment to begin to explore relationships and the effects of abusive relationships in the present. Female patients, in the early phase of treatment, need a specific programme on self harm, arson and child issues. Though there was consensus that such segregation was necessary in the early phase of treatment, it was also pointed out that abuse is not simply a male to female phenomenon but can involve female to female abuse and female to male abuse.

At the other end of the spectrum, there was also consensus that reintegration and rehabilitation required “real life” exposure to mixed sex environments in which new skills in relationship building can be tried out in a mixed sex therapeutic environment. Where there are integrated rehabilitation facilities, there needs to be a critical mass of women patients to avoid such services reflecting the needs of the dominant male patient group.

We have not identified robust evidence to guide service providers in determining at what point in treatment progress should be made from single sex treatment to integrated rehabilitation. The rapid move to single sex treatment in secure conditions may have the unfortunate effect of creating separate institutions with wholly separate buildings, management and staff groups. Because of the high cost of developing any form of secure care, once established this service will be very difficult to change.

One model that could be developed is of a campus style medium secure unit service with male and female admission and intensive care areas, but with programmes and residential settings which could lead to increased reintegration as rehabilitation progresses. A distinction should be made between living environments (living space) and therapeutic/rehabilitation environments (public space). Women might want to receive therapeutic services in a mixed environment (public space) while still wanting to live their private lives in an all female environment (living space). Such choice should be actively supported.

Choice is of paramount importance in shaping services, though because of economies of scale and cost, choice may be limited at a local level. Much of the impetus for change in women’s services has come from women service users who ask for a choice as to whether they live and mix with male patients.

Current service developments
The dismantling of the high secure women’s service has proceeded at a pace well in advance of the development of alternatives in local services. Enhanced medium secure unit care has been proposed as a means of developing local services to replace current high secure provision. However, nationally, there is no consensus as to what shape such services should take, their size, development or staffing. The number of beds required nationally is not known, and services are not necessarily being developed within an overall framework within which reintegration and rehabilitation form part of the care pathway. In the previous section on secure care, many changes within the prison service and Criminal Justice System were discussed which make prediction of bed numbers very difficult. Predicted bed numbers based on current usage are unlikely to be adequate in the future.

One lesson for the development of female services for the future is that service provision should be designed in its totality, taking account of the fact that people will need different levels of services at different times. Rather than starting with changes to the high secure service, should
the service developments have been driven by the prior development of adequate community rehabilitation and resettlement services? Changes could then occur up through the secure system leading, eventually, to planned reduction in high secure beds. The reorganisation of services in the opposite direction has meant that the needs of the most difficult to manage patients have been left to the end. The closure of large parts of the high secure system has meant, at least in one hospital, the dismantling of staff groups, with staff exodus. This reinforces the point made earlier that workforce development considerations need to be built into service change.
RECOMMENDATIONS

Recommendation One
The Forensic Faculty should develop policy guidance on the development of forensic personality disorder services.

Recommendation Two
Planning for bed numbers in secure care should be based not only on historical bed usage but on predictions which take into account dynamic factors impacting on secure psychiatric care arising from changing health and criminal justice public policy.

Recommendation Three
The Forensic Faculty should hold a seminar to articulate a policy position on the provision within or outside prisons of psychiatric treatment to those mentally disordered prisoners not currently transferred to NHS treatment facilities. This is particularly needed in the light of the transfer of responsibility for prison based health care from the Home Office to PCTs as from April 2006.

Recommendation Four
We recommend that the Department of Health and the Forensic Faculty of the Royal College of Psychiatrists should jointly develop a methodology to move planning of secure health serves from a bed utilisation basis to a needs based system.

Recommendation Five
The Reed Principles should be modified in the light of changing service provision to include a principle that the clinical needs of a patient are relevant factors to be considered in determining the level of security for that patient. The level of security required for a patient’s treatment should not be equated solely with the physical security of a hospital (especially its security designation) but with the relative mix of relational, procedural and physical security needed to safely treat that patient. Lack of services in a particular area should not be a reason for transfer to a higher level of security.

Recommendation Six
Though the Reed Principle of treatment as near as possible to the patient’s own home remains sound, it should not act as a barrier to transfer to another area where the patient could benefit from change of area of residence.

Recommendation Seven
Secure psychiatric services should be managed as catchment area services where high, medium and low secure services (perhaps, in time, with prison based services) are understood as a total combined resource available to patients and managed as an integrated service.

Recommendation Eight
A rigorous system of audit, benchmarking and dispute resolution should form part of any catchment area management system, to ensure that the level of security employed to treat a patient is determined by patient need and not by unavailability of services at a lower level of security (recognising that there will never be perfect fits between need and level of security).
Recommendation Nine
Admission panels for the high secure hospitals should cease and should be replaced by catchment area admission decision making utilising the total resource available to that catchment area through high, medium and low security.

Recommendation Ten
The Forensic Faculty should meet the mental health unit of the Home Office to agree systems to integrate the responsibilities of the Home Office for restricted patients into catchment area admission and discharge procedures.

Recommendation Eleven
Specific policy and design guidance should be produced to inform the development of facilities for longer stay patients in secure units.

Recommendation Twelve
Policy and design guidance on longer stay facilities should address the needs of patients requiring prolonged intensive care.

Recommendation Thirteen
The future development of secure psychiatric care should set as a priority the development of slow stream low secure rehabilitation services and integrated specialist supportive accommodation in the community.