

REPORT

Centre for  
Mental Health



# Pathways to unlocking secure mental health care



**National Mental Health**  
Development Unit



# Pathways to unlocking secure mental health care

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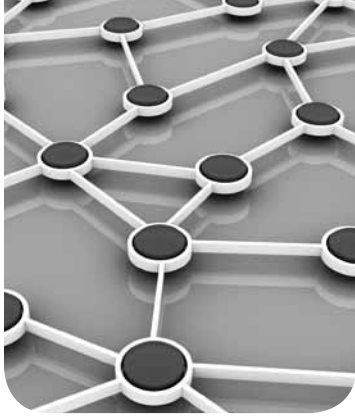
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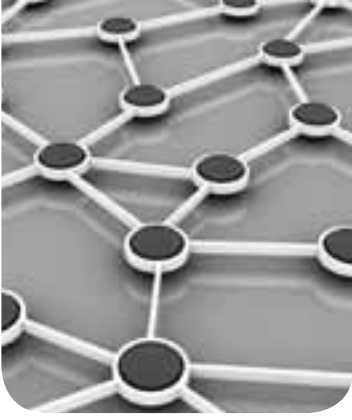
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# Executive summary

Secure mental health services provide accommodation, treatment and support for people with severe mental health problems who pose a risk to the public. Sometimes known as ‘forensic’ mental health services, secure services work predominantly with people who have been imprisoned or admitted directly to hospital through the 1983 Mental Health Act following a criminal offence.

Transfers from prison to secure services should ensure offenders with severe mental health problems have access to the right treatment and care. Such transfers, however, have been especially problematic, subject to excessively long delays even for very acutely unwell prisoners.

The Bradley Report called for a mandatory 14-day maximum transfer time for prisoners to be admitted to hospital and for a review of security at low and medium secure units.

This report examines the extent to which pathways into and through secure mental health services can be improved through the different security levels and ensure a better flow between prison and secure services. It is based on a review of current secure service provision carried out by the Centre, commissioned by the National Mental Health Development Unit.

## Caseloads and costs

It is estimated that secure services work with between 7,000 and 8,000 people at a time, most of these in medium and low secure. Medium secure services have about 3,500 beds and low secure services probably have around the same number again.

Secure care services cost the NHS a total of £1.2 billion in England in 2009/10, corresponding to 18.9% of all public expenditure on adult mental health care.

## Commissioning

Most secure services in England are currently commissioned by ten specialist commissioning groups (SCGs), each acting on behalf of several primary care trusts (PCTs). Current commissioning arrangements can be seen as a barrier to an effective through-care provision and pathway. Block purchasing of largely medium secure beds makes it difficult to move patients on to other forms of secure care.

A large and growing proportion of secure care is provided by independent sector organisations. In 2007, 35% of secure beds were independently provided.

## Admissions

Establishing who is eligible for medium secure services is complex. There are no clearly defined eligibility criteria beyond the provisions of the 1983 Mental Health Act. Admission criteria vary widely between different medium secure units and are dependent on a range of influencing factors from severity of offence to the absence of alternative arrangements. The risk a person is thought to pose,

the diagnosis they are given and their offending history appear to be the most important criteria for admission.

The major reasons for delays to admissions and discharges include:

- duplicated assessments – many people are assessed on several occasions by different professionals before an admission can be made, especially between different localities;
- risk aversion – requirements that all prisoners are transferred to high or medium secure units;
- high occupancy rates in medium secure units;
- lack of step-down and community services – many patients stay in medium secure for long periods, partly because of a lack of suitable provision at lower levels of security.

## Pathways and outcomes

Patients move through services in all sorts of different directions: up tiers of security, down tiers of security, from side to side (e.g. from one medium secure unit to another), between NHS and independent sector services, between secure services and general psychiatric services, and between secure services and prison. People with a mental illness diagnosis tend to have very different pathways through services to those diagnosed with a personality disorder.

Information about the outcomes achieved by secure services is patchy. Short term reconviction rates for all types of offences are low, with two-year rates for those discharged from medium secure ranging between 10% and 15%. But longer-term outcomes are much poorer, with up to half of former patients being reconvicted and more than a third readmitted to secure care within 20 years.

Little is also known about service users' and their carers' experiences of secure services and the wider outcomes they achieve, for example in helping people into employment.

## Recommendations

1. A needs assessment should be conducted in each region to assess requirements across all tiers of security.
2. A framework of guidance and quality standards for secure services should be developed to support equity of outcome and equitable access to all tiers across the country. This would be the business of the Commissioning Board, in conjunction with the National Institute for Health and Care Excellence (NICE), to develop pending the passage of the Health and Social Care Bill.
3. The role of low secure and step-down care should be reviewed to inform commissioning decisions and systems.
4. A better balance of investment is needed to enable step-down and community provision. This will necessarily involve the decommissioning of some existing secure beds.
5. Commissioners should purchase specific care packages with specified outcomes for care at any level of security.
6. Duplication of assessments should cease. Where appropriate a single assessment should take place that has the expertise and capacity to decide on timely entry to any tier of security. Such an assessment must have currency in all parts of secure care.
7. Clear service specifications should be developed for all groups of secure service users, including women, people from Black and Minority Ethnic communities and those with a learning disability or difficulty.
8. Guidance and quality standards should be used to define, develop and standardise treatment and care packages across different settings.

9. A specific focus should be given to developing more support for mainstream community mental health services.
10. A national secure service patient data-set should be developed to allow both individual progress monitoring and aggregated data to monitor performance and outcomes.
11. People discharged from secure services, including those with personality disorders, should not be excluded from mainstream mental health services.
12. Shared learning networks should be established to support the development and implementation of guidance and quality standards.
13. Improved relationships should be developed between prison and secure mental health services to help to facilitate faster transfers.
14. Commissioners should routinely use feedback from service users to measure the performance and outcomes of secure care services.
15. Consideration should be given to promoting the Recovery approach across the secure care pathway. Training in the Recovery approach should be available to all secure care staff.



# Introduction

Secure mental health services provide accommodation, treatment and support for people with severe mental health problems who pose a risk to the public. Sometimes known as ‘forensic’ mental health services, secure services work predominantly with people who have been imprisoned or admitted directly to hospital through the 1983 Mental Health Act following a criminal offence.

Transfers from prison to secure services should ensure offenders with severe mental health problems have access to the right treatment and care. Such transfers, however, have been especially problematic, subject to excessively long delays even for very acutely unwell prisoners. Secure services are typified by slow patient turnover with increased year on year admissions to inpatient units in medium secure, long stays compared to other inpatient mental health services and fewer discharges than admissions. This situation has led to growing concerns about the capacity of secure services to meet the needs of offenders with severe and enduring mental illness.

The Bradley Report (2009) reignited the debate on diversion of prisoners with mental health problems into more appropriate settings for treatment. Bradley acknowledged the importance of forensic services as a diversion option for offenders with severe mental illness, calling for a mandatory 14-day maximum transfer time for prisoners to be admitted to hospital and for a review of security at low and medium secure units.

The prison population, at the time of writing, is just over 84,000, some 90% of whom have a mental illness, personality disorder or addiction, while 70% have two or more such problems (see Table 1). Most significantly for secure services, one prisoner in ten has a severe mental illness (Singleton *et al.*, 1998) and one unpublished review of mental health inreach services in prisons estimated the need for secondary care mental services at 23% of the prison population (Inreach Review Team, 2007). Obviously most of these prisoners will be the business of prison based mental health teams, but some will be referred and transferred into secure care.

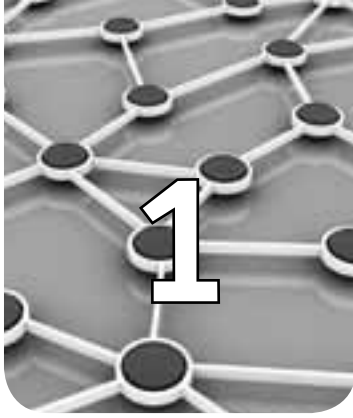
**Table 1 – Mental health problems in prison and the general population**

Mental health issue	Prevalence among prisoners (16+ years)	Prevalence among general population (16-64 years)
Psychosis (schizophrenia / bipolar disorder)	8%	0.4%
Personality disorder	66%	0.4%
Depression and anxiety	45%	17.6%
Drug dependency	45%	3.4%
Alcohol dependency	30%	5.9%

Source: Singleton *et al.*, 1998

Finding solutions to these problem areas requires an understanding of who secure mental health services are for, what they should provide, and what ‘pathways’ people should take into, through and out of them.

In this report, produced in collaboration with the National Mental Health Development Unit, we explore these critical issues to examine the extent to which pathways into and through forensic mental health services can be improved through the different security levels and ensure a better flow between prison and secure services.



# The review

This review had four key objectives.

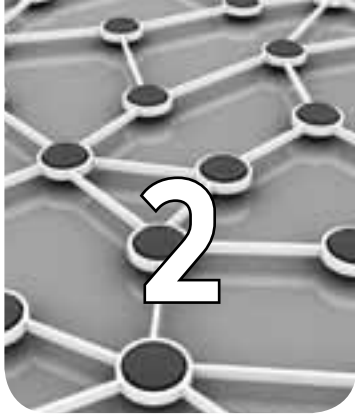
1. To examine the role of medium secure and related services for offenders with severe mental health problems.
2. To examine the costs and benefits of these services and whether these resources could be better used.
3. To examine how the flow between prison and medium secure services could be improved.
4. To examine possibilities in improving the flow between high, medium and low secure services and the ways in which discharge planning and aftercare could be improved.

Under the remit of these relatively broad, overall objectives, we addressed seven specific questions.

1. What are the barriers and facilitators for transfers to secure units from prison and courts, and what are the ways to implement a maximum 14-day transfer procedure?
2. What are the availability of beds, bed occupancy and lengths of stay in medium secure services?
3. What is the cost-effectiveness of services and are services making effective use of existing resources?
4. Can the flow between prison and medium secure services be improved, and what examples are there of good practice?
5. Is the balance between medium secure and prison inreach services right?
6. What are other alternative models of service provision and what are the potential resource implications and benefits/outcomes?
7. What are the possible benefits to a possible expansion of forensic aftercare services?

What in part motivated this review was a concern about the considerable delays in achieving successful transfer from prison into the NHS. The 'default' for transfer has by and large been into medium secure units and so this review has given much of its attention to medium secure care in order to understand the issue of transfer. However, the report is also informed from data collected by visits to a range of other tiers of security within the UK but also in other jurisdictions.

The review used a variety of data sources and methods. Methodology and key data findings are described in Appendix 2.



## Secure mental health services

It is estimated that secure services work with between 7,000 and 8,000 people at a time, most of these in medium and low secure. Because data collection in this area is not standardised across the regions, and 'low secure' in particular is poorly defined, it is hard to achieve a firm patient figure for all secure services. Medium secure services may have in the region of 3,500 beds and low secure services probably have around the same number again. Secure care services cost the NHS a total of £1.2 billion in England in 2009/10 (Mental Health Strategies 2010).

Secure services operate on three levels of security: high, medium and low (see below), and some secure care services also have a specialist community team, providing community based care for former secure care service users or liaison for mainstream community mental health teams working with them.

### High secure services

All high secure beds in England are provided by the NHS. There are three NHS high secure hospitals, and these are Ashworth, Broadmoor and Rampton hospitals. High secure beds are designed for patients detained under the Mental Health Act 1983 who 'pose a grave and immediate danger to the public'. The high secure population has shrunk in recent times; a report in 2000 noted that some patients detained in high secure hospitals did not require this level of security, and should be moved to a less secure environment. Subsequently 400 people were 'stepped-down' by 2004 (see Tilt *et al.*, 2000).

### Medium secure services

Medium secure beds are provided by both the NHS and the independent sector; the latter providing around 35% of medium secure capacity. They are designed for patients detained under the Mental Health Act 1983 who 'pose a serious danger to the public'. Medium secure services have been a particular focus of this review.

### Low secure services

“ There are no definitive rules on what does or does not constitute low secure treatment...[and] some services are indistinguishable from services for 'recovering mentally ill' people in care homes.” (Laing and Buisson 2006, p. 20).

It is important to state from the outset that 'low secure' is more of a concept than a title for a discrete type of provision. As 'low secure' is poorly defined, it is difficult to establish what it consists of and how many patients it supports beyond the crude estimates made earlier.

Low secure beds are provided by the NHS and the independent sector for patients detained under the Mental Health Act 1983 who 'pose a significant danger to themselves or others'. Low secure provides step-down from higher tiers of secure care and often people will move down through to low secure after a period of time spent in medium secure. Some patients will have voluntary patient status (often former detained patients who have been in higher tiered units in the past) and some patients will be directly admitted under the Mental Health Act from the community.

It became apparent throughout our interviews that there was also considerable uncertainty about how low secure services should be used. It should also be noted that the definition of what constitutes 'low secure' is somewhat unclear and a small number of such units visited by the Centre appeared superficially at least to be very similar to medium secure. The average cost of low secure (presented later) is lower than medium secure, but the differential is not huge and certainly not as significant as that between medium and high.

Currently some medium secure services provide a pre-discharge service and some of our participants felt that pre-discharge services could be in low secure conditions.

It was also suggested to us that low secure units were actually taking on the role of psychiatric intensive care units (PICUs), taking on patients from general psychiatric services who were too challenging to be managed on ordinary inpatient wards. In some parts of the country, prisoners requiring treatment for mental illness but who posed low risk, and who elsewhere would have gone to medium secure, had been admitted to PICU during the acute phase of their illness. On the whole these had been transferred back on the conclusion of this phase of treatment.

The Department of Health is currently developing guidelines on both low secure services and psychiatric intensive care and how the latter might be deployed at any tier of security.

One clinician stated that a number of people coming into medium secure services from prison had committed minor offences, and could have been managed within low secure.

“Now, the big difficulty that we have come across in the last year, is that for people committing fairly minor offences, who were in prison and needed urgent transfer, where PICU had said, yes, fine, that's perfectly appropriate for us, and then the Ministry of Justice say absolutely not, they must go to medium security.”

Consultation with managers and clinicians in other parts of the country reveals a mixed picture about the use of low secure services for prison transfers. As stated above in some areas, there had been greater success in using mainstream PICUs for those prisoners with lower assessed risk and presumably therefore in reassuring the Ministry of Justice of such placements. In one area a barrier to such transfers came from staff and managers of the PICU. This was overcome by the prison mental health team offering outreach support to staff in PICUs in managing a group with whom they did not feel confident in working.

It seems therefore that the role of low secure services is also somewhat ambiguous currently. There is a need to clarify their role. Are they designed to be used as a step-down for medium secure or are they more likely to be used as a place of security for people who cannot be managed on an acute psychiatric ward; or are they needed for both?

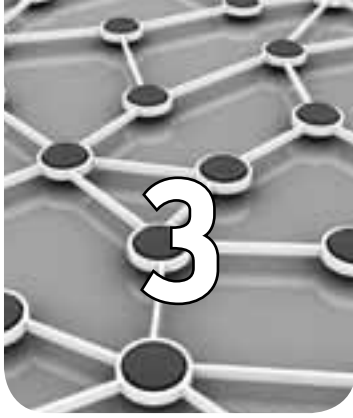
## Definition of a ‘mentally disordered offender’

The Crown Prosecution Service uses the term ‘mentally disordered offender’ to describe a person who has a ‘disability or disorder of the mind’ and has committed or is suspected of committing a criminal offence. This term covers a range of offences, disabilities and disorders. A mental disorder may be relevant to:

- the decision to prosecute or divert;
- fitness to plead; and
- sentencing/disposal.

Prisoners with severe mental illness can be transferred from prison or the courts to secure mental health care services. By and large this has been to medium secure units with a small group going into high secure.

A significant finding of this review is the general lack of written and standardised entry criteria for secure care (beyond the policy statements relating to ‘grave, serious and significant danger’), which means that professionals have to propose a clinical rationale as to why an individual requires secure care.



## The cost of secure mental health services

Spending on secure services amounted to £1.2 billion in 2009/10, corresponding to 18.9% of all public expenditure on adult mental health care (Mental Health Strategies, 2010). Growth in spending on these services has been particularly rapid in recent years, having increased by 141% in real terms (i.e. after taking account of general inflation) between 2002/03 and 2009/10. This is equivalent to a growth rate of no less 13.4% a year in real terms. In contrast, expenditure on all adult mental health services increased at the slower rate of 5.9% a year, with the consequence that the share of secure services in the total rose sharply, from 12.3% in 2002/03 to 18.9% in 2009/10. Of all the additional money made available for adult mental health care over this period, more than 30% went on secure services.

Looking ahead, it is clear that this very rapid expansion of spending is not sustainable, given the much more constrained financial environment within which the NHS will be operating for the foreseeable future. Indeed, there are likely to be strong pressures not just to slow down the growth of expenditure on secure services but even to stabilise or reduce spending from its current level. Such a change in the financial position is a crucial backdrop to this report and coping with more limited resources will undoubtedly be a major challenge for secure care services.

Also relevant to this report is that secure care is a high cost, low volume form of service provision. Average lengths of stay are very long, when compared to acute mental health admissions, implying limited turnover and relatively small numbers of people using these services over the course of a year. For example, only a third of people in high and medium secure units stay for less than two years and nearly half stay for more than five years. In sharp contrast, among all people in ordinary (non-secure) psychiatric hospitals, over 50% stay for less than one month and only 4% stay for more than one year. Of all those in high and medium secure hospitals at any one time, over 70% will still be there a year later.

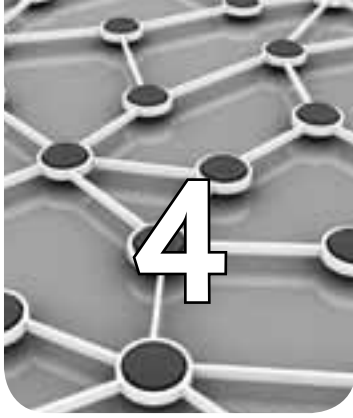
Cost data published by the Department of Health show the following unit costs for secure services in 2008/09.

	Patient cost per day	Patient cost per year
Low secure	£416	£152,000
Medium secure	£482	£176,000
High secure	£749	£273,000

For low and medium secure services, these figures are averages for NHS and non-NHS units combined, although in practice there is relatively little difference in costs by type of provider. For example, costs per patient day for medium secure care are £481 in NHS units and £497 in non-NHS units. For comparison with the above figures, average cost per patient day in an acute non-secure psychiatric hospital is £288, which is equivalent to about 60% of the cost of a patient day in a medium secure unit.

In addition to the generally high cost of secure care, it is important to note that there are also significant differences in cost by level of security. For example, one year spent in a high secure hospital costs nearly £100,000 more than the same period of time spent in a medium secure unit. Such differences highlight the importance of appropriate placement, as detaining a patient at a higher level of security than necessary carries a substantial cost penalty. The difference is less marked between medium and low secure, at around £24,000 a year.

This cost differential applies not just within the secure hospital sector but also between secure hospitals and other settings, such as prison, which may form part of the pathway that offenders with severe mental health problems follow from initial arrest through detention to eventual release back into the community. At every point on this pathway there are cost differences between settings. Optimal efficiency in the overall use of resources is likely to require a high degree of flexibility in moving people between settings in line with changes in their needs and other circumstances. The blockages in the system described by this report significantly constrain the scope for such flexibility, with major cost implications. Measures to relax this constraint will be particularly important at a time of much tighter budgets in the NHS and elsewhere in the public sector.



## Commissioning secure mental health services

Commissioning is crucial to the role and functioning of secure services. Most secure services in England are currently commissioned by ten specialist commissioning groups (SCGs), each acting on behalf of several primary care trusts (PCTs). PCTs are set to be replaced in the next two years by consortia of GPs supported nationally by an NHS Commissioning Board. At the time of writing the precise secure care commissioning arrangements are unclear but it is likely that the NHS Commissioning Board will have a significant role with high and medium secure care as well as prison mental health services, and some if not all low secure provision.

### The role of case managers

PCTs/SCGs can appoint case managers to organise pathways for individual service users. This role involves a lot of contact with service providers, for example by attending assessment and care planning meetings. Case managers will decide where the most appropriate placement for the person is based on their needs.

Cost can have a big impact on where people can be placed. The case managers we interviewed noted that services were most expensive when service users were placed on a high level of observations (for example if a service user requires nursing staff with them at all times).

Case managers noted that there is an increased level of competitiveness in the market for independent specialist provision, and there has been a growing number of independent sector placements in both medium and low secure. One case manager suggested that they will always attempt to get people into an NHS setting, rather than the independent sector, as the latter tend to cost more as they come outside strategic purchase plan the PCT has made.

### What do commissioners do?

The role of the 'commissioner' (largely delivered by SCGs) generally takes place on a strategic level, and while very occasionally there may be a need to deal with individual cases, this is more the responsibility of case managers. As stated, SCGs conduct much of this strategic level commissioning. The East of England SCG, for example, commissions high, medium and low secure services for patients with mental health problems and those with learning disabilities for 13 PCTs. In addition to purchasing beds on behalf of these PCTs, the Group has, in the past, planned strategies for the development of services and standardised protocols across the region.

## Provider opinions about commissioning

Interviews with staff from secure services gave us a picture of how they view the role of commissioners and their priorities. They believed that commissioners were driven by concerns about the cost of secure services and put providers under pressure to make speedy decisions about admissions.

- “Local commissioners buy... 20 of our beds. And they get them cheaper if they buy in bulk. So if they wanted to place someone elsewhere, they would have to buy a bed there as a one off for which they will get charged more. [This] puts a cost-pressure on them. So obviously they want to keep people local when they can.”
- “We’re given targets for assessments by our commissioners. We have to respond to referrals in a certain timescale....six weeks after the date we accept the patient for admission.”
- “I know that commissioners are worried, because lots of new beds are springing up and their concern is that psychiatrists going into prisons will identify people who need to be in hospital, and these people will move into all the new beds...”

## Relationships between providers and commissioners

Our visits indicated that relationships between providers and commissioners varied widely and that positive and pro-active relationships were crucial to effective patient movement.

- “Commissioners want outcomes. We can work together on this. There doesn’t have to be animosity. Outcomes can come in various forms...so we can be held accountable for [achieving them]. This is about managing the service we provide...you need clinical space and independence from commissioners to facilitate the process, with a slight degree of pressure, to make sure that we don’t just keep the patient here and review him whenever we get the time to do it.”
- “Commissioners are checking up much more on what we do...every two weeks...care plans, policy and procedures, attending referral meetings. So they’re quite involved, which is great.”

## Future commissioning of secure care

Commissioning in secure care appears to have become more sophisticated in recent times and involved a greater scrutiny of outcomes for individual patients. This is important given the high level of spending in this area. Nevertheless, many participants felt that commissioning had to develop more. It was suggested that a move from block purchasing beds to purchasing discrete care packages of care, perhaps across more than one tier, even purchasing pathways, with specific outcomes attached would be more appropriate. This, of course, is the direction towards which commissioning policy is moving.

Commissioning for outcomes will become a part of mental health commissioning from 2012 as a system of ‘payment by results’ is developed. At the time of writing, it was not clear what outcomes secure services will be required to achieve under this new system.

## The role of the independent sector

A large and growing proportion of secure care is provided by independent sector organisations. In 2007, 35% of secure beds were independently provided.

There was a certain degree of prejudice against the independent sector from some of the public sector providers we interviewed. There was criticism of what was described as speculative development, i.e. building to capitalise from future opportunities. However, the review team found evidence of public sector providers also engaged in or considering speculative development.

Some of the people we interviewed raised concerns about the admissions practices of the independent sector, claiming that private providers were too ready to admit people and conducted assessments too quickly. However, one of the main criticisms of secure services as a whole was the slow assessment process, so perhaps this is a somewhat perverse complaint.

One of the reported strengths of the independent sector was the relative degree of flexibility they had in developing new services, for example they were not limited to where (geographically) they placed units. Independent sector services had in recent times developed more specialist secure provision, such as units for those with learning disability and those with profound hearing deficits. This meant that some small need groups could potentially have their needs better met than they would if placed on an NHS unit serving a broader patient need group.

Other participants argued that independent providers offered a similar level of service to the NHS.

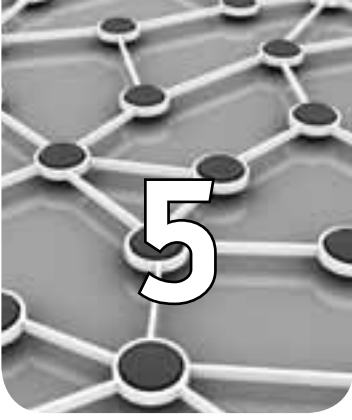
“I think there is a general misconception in the NHS that all independent sector places just want patients coming in generating an income stream and then they forget about rehab because they’ve settled in and they’re still getting the money. And I think that is true of some independent sector places, but certainly the good ones are every bit as interested in rehab as anywhere in the NHS.”

While the expansion of private sector beds was causing concern for commissioners it was also acknowledged that this expansion was in part a response to capacity issues in NHS, and uncertainty about the role of secure services.

“Around here, there has been a massive expansion recently. It’s not just the NHS...we’re expanding... but there are lots of private providers who are expanding in this part of the world... They’ve just built a big new low secure hospital, which is just opening.”

“There are enough beds in total, including private sector beds, but we’re now getting to a stage where there is not enough money to pay for these beds in the commissioning system.”

The independent sector providers, spoken to by the review team, had recognised the need for developing a range of lower secure services and some had already embarked on this. The difficulty for this sector in developing more was that as much of the resource was ‘locked’ in medium secure it was hard for commissioners to find resources to move people into lower secure provision.



## Community services

Services in the community that are skilled and have the confidence are an essential element of the pathway for those leaving secure care. The degree of support that former secure care patients receive is something of a postcode lottery. There are very few specialist community forensic teams. One participant told us:

“You need something robust in place [in the community] to help people....Medium secure units’ cost per bed per patient per year...[is] around £150–200k. And high secure is £250k. You could fund three community teams for that sort of money...”

The vast majority of those who receive ongoing care in the community will do so from a mainstream community mental health service. In some parts of the country, secure services will provide some degree of outreach support to these teams and in others there is a forensic community mental health team that provides such support (a parallel service).

There is little research on which model is more effective and that which does exist suggests little difference bar cost (Coid *et al.*, 2007). Parallel services were found to be more expensive because where forensic community teams provide the care directly and readmission is required this tends to be to a secure bed (to which the service has direct access) whereas generic teams tend to admit to a generic psychiatry service. However, as stated, the evidence is limited in this area.

The majority of people in secure services will have been in custody for quite some time and will have been supported to a high level. The leap between secure settings and the community represents a huge step in the pathway, and one which patients and staff alike will find anxiety provoking and challenging.

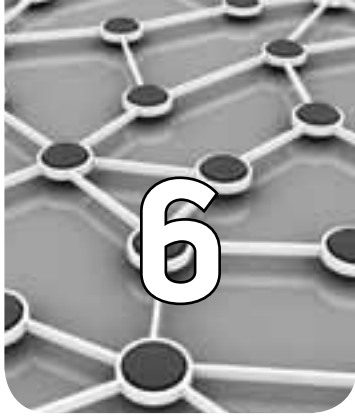
In one of the services we visited, people discharged from medium secure services were followed up for a period of time by the service until they were picked up by a generic community mental health team.

“Unfortunately we don’t have any forensic community service to routinely follow up people. Even though we’re not commissioned to do so, we invariably follow up for six months following discharge.”

There is a clear need for some form of enhanced community support for those leaving secure care, but there is not a particularly strong evidence base for the development of a new specialist community service providing parallel care, nor is there the resource. Therefore developing the capacity of secure care services to provide outreach so that mainstream community mental health services can provide the care is the route that should be explored.

Further to this our participants felt that the accommodation needs of discharged secure care patients should also be considered. Many move from very restricted living conditions in both medium and low secure to independent living (albeit with some support). There is a clear need for exploring how other forms of accommodation might support this transition.

The Centre visited TBS ('ter beschikking stelling') services in the Netherlands. At the time of the visit the TBS services estimated that about 15% of their clients could leave secure care but remained very dependent and requiring support. For these, an appropriate form of supported accommodation had been developed. It is likely that for some of England's former secure care population such accommodation might be the optimum, while for others it would be transitional and part of a pathway to totally independent living. These accommodation needs are not well understood and require further research.



## Prison mental health services

To understand the role of secure services, it is vital to examine who prison mental health services exist to support and how they decide to admit prisoners or refer them on to secure services.

Prisons are among the very few settings where the NHS operates outside its domain and indeed in the domain of another organisation and system with a radically different purpose and objectives, i.e. punishment and public protection. Durcan and Knowles (2006) describe the different ethos that underpins custodial practice and mental health practice and the challenges and potential conflicts this presents for health professionals and in particular prison mental health inreach workers. Even where there is potential common ground there can be a very different focus. Both services have a role in the rehabilitation of offenders, for example, but the focus of the prison service is on reducing offending and that of the NHS is on improving health and, ideally, in pursuing continuity of care post incarceration.

The relationships between secure services, the prison service and prison mental health services are crucial. Anecdotal reports suggest that the growth of prison inreach services has led to greater numbers of prisoners being transferred into secure mental health services. Indeed part of the argument for the development of prison mental health care was to facilitate such transfers. At one of the sites we visited, the prison inreach service for at least one prison was part of the local secure service. Those we interviewed stated this made a great difference to the transfer process in that there was seldom delay and that the assessment process for admission was simplified and indeed conducted by the inreach service. Crucially this assessment by inreach has currency in the secure service. This is in great contrast to the experience of transfer in many other parts of the country.

As already noted two-thirds of prisoners have some form of personality disorder. This has major ramifications for prison mental health services.

“*[Prison mental health teams have to be] comfortable with a hell of a lot of people with personality disorders. And these are not the sort [of people] that by-and-large general psychiatry and community mental health teams have operated [with].*”

It has also been noted that by definition people in secure services are predominantly those deemed high risk, whereas most people in the prison system are not.

Participants reported that people in prison tended to have a range of low level problems including dependency on drugs and alcohol, personality disorder, depression and anxiety and learning disability. Many such people have a complex array of problems but do not meet the specific criteria necessary to gain access to more specialised services.

“*To come into forensic services, you have to be above a threshold for risk. To come into general psychiatry services, you have to be above a certain threshold for severe and or enduring mental illness. If you want to go into substance misuse services, you need to be above a certain threshold for that.... And I think part of the problem...is that people [in prison] have sub-threshold pathologies in multiple domains. ... Nobody's looking at it collectively.*”

*When you add up all the pathologies, they will be double or triple the [needs] than for one particular domain. 99*

Conversations with many inreach services reveal that although the original intention for most of these had been to replicate the community mental health team model in the prison setting, with its prioritisation of those with severe and enduring mental illness, the reality of providing the service in a prison meant they had to broaden their service to those who fell below the severe and enduring threshold. In some prisons dedicated primary mental health teams have developed to respond to the needs of those with more moderate mental health problems. However, there has been a creeping realisation in prison mental health care that the needs of prisoners are very different to those of the populations served by mental health services in the community – multiple need is the norm and often at the sub threshold level. Therefore, models designed for the wider community may not be appropriate for prison settings. It has also become clear to the prison mental health practitioners we spoke to that the environment of the prison can limit what can be treated and that often it is not possible to treat acute mental illness and certainly not so where compulsory treatment is required.

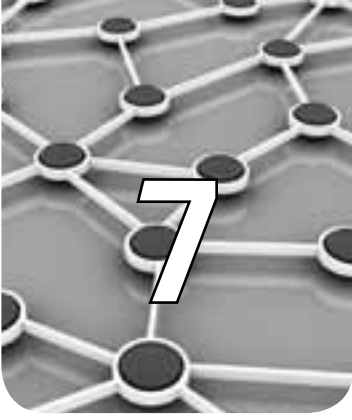
Transfers from prison have reportedly changed the profile of the secure services patient. Some patients in secure services have a severe mental illness which cannot be treated in prison even though their offending may not have been serious or linked to their mental illness. The Ministry of Justice plays a part in determining where in the NHS they are placed and typically this is medium secure; though also as reported previously some areas had greater success in achieving transfers to lower secure services and PICU.

Meeting the needs of offenders in prison with severe and enduring mental health problems has attracted much attention in recent years; a focus that was marked by the introduction of prison mental health inreach services from 2002.

However, the limited size and scope of prison mental health services and the overwhelming demand has meant only a fraction of mental health needs are being met in prison (Durcan, 2008). Prisons are not ‘places of safety’ under the Mental Health Act and prisoners deemed to require compulsory treatment need to be transferred to the NHS to receive this. There will also be other cases in which clinicians will judge that appropriate care cannot be given in prison.

The option to transfer to an inpatient unit for those in prison experiencing a mental health crisis is available under sections 47 or 48 of the 1983 Mental Health Act. Waiting times for such transfers have been notoriously long, sometimes involving months of delay. Recent guidance has set a period of 14 days in which a transfer should occur (DH, 2007) though this is not a requirement of the NHS.

While conducting the review, some participants supported the notion of developing specialist mental health treatment units within prisons or the development of hybrid prisons. Such developments in the UK of course would be complicated by the need for a change in mental health legislation, which recent history tells us would be far from simple. The Centre’s visits to a small number of such units overseas (see Appendix 1) suggest that step-down from these is just as much an issue as it is here in the UK. The number of secure beds has grown rapidly in England and Wales in recent times and yet transfers from prisons remain problematic. There appears to have been a marked growth in medium secure beds and the cost of providing these appears to have reduced the capacity for investing in step down provision.



## Eligibility for medium secure services

Establishing who is eligible for medium secure services is complex. There are no clearly defined eligibility criteria beyond the provisions of the 1983 Mental Health Act. Admission criteria vary widely between different medium secure units and are dependent on a range of influencing factors from severity of offence to the absence of alternative arrangements (Coid and Kahtan, 2000).

A national survey in 1999 looked at admissions to 34 medium secure units in England and Wales (Melzer *et al.*, 2004). It concluded that key admission criteria included:

- having features of acute schizophrenia;
- non-compliance with treatment;
- a history of sexually inappropriate behaviour;
- a referral because of self-harm;
- a 'grave' current offence;
- a recent prison sentence or many previous sentences.

The same survey also found that just under a fifth of the 418 patients assessed as requiring admission to medium security were not admitted, particularly if they were seen to need long-term care.

Grounds *et al.*, (2004) found that admissions to medium secure units were subject to discretionary professional judgements, clinicians' own professional values, experiences and beliefs and contextual pressures. Our review suggests that this is largely still the case. There is no national model of secure care. Instead services have evolved locally, often influenced by individual clinicians' interests.

“I'm fairly sure we don't have written criteria for admission... The criteria I work on are that 1) someone has to have mental health needs, 2) they have to have mental illness for access to my service, not just personality disorder or they should be going to the Personality Disorder service. Many with mental illness will have personality disorder as well... they have to present with risks that are commensurate with conditions of medium security. So really [they should have] a risk of violence, inappropriate sexual behaviour or self-harm, which can't be managed in a less secure setting... not self-harm, but a risk to others.”

Traditionally, a person who had a 'primary diagnosis' of personality disorder would be unlikely to be admitted to medium secure because they were deemed untreatable and likely to 'bed block' (Grounds *et al.*, 2004). However, in more recent times there has been a growth of specialist personality disorder units and programmes within secure services.

One clinician noted that the occasions for admission were different for people with a primary mental illness and those with a primary personality disorder:

“Most of my patients with mental illness present with some crisis or another. You know they are psychotic and paranoid and selfharming, aggressive and violent. It's the personality disorder patients whose problems have generally been with them since adolescence, so if they're now in their 40's, they're still abusive, violent, selfharming, but they've been that way for 30 years.... Generally, a patient for me [in the mental illness service] is someone who's been in prison, and

*who has either been on medication which they have stopped, and have become unwell and dangerous, or they have not been on medication and have become unwell for the first time... 99*

As a result of this distinction, the therapeutic programmes on personality disorder wards were different to those on mental illness wards: with a greater focus on psychological therapies in the former. This at times can lead to some patients with personality disorders being returned to prison if they are not ready or willing to engage with treatment.

## Risk

The key determinant of admission to secure services is the perceived risk of causing psychological or physical harm. The higher the risk that someone is considered to pose to themselves or others, the higher the level of security that it is likely that person will be detained in. At many of the medium secure units we visited, while a few individuals on the wards did not have a criminal history, the risk posed by these patients to themselves or others was still deemed to be high:

*99 [Secure services are for a] specific group of patients who present high risk. They may have been through the criminal justice system, or may not, but when they haven't, they may be considered to have been too high a risk to be managed on a general inpatient service. 99*

However, there is a debate as to the level of security a person is held in when they are only deemed a risk to themselves. Some medium secure services have developed considerable competence in managing people with extreme self-harming behaviour, but placing patients in such a service may mean they are 'contained' in more restrictive and secure conditions than is indicated by the risk they pose.

In many units there is a small group of patients transferred from other NHS psychiatric units who are described as challenging, high dependent and treatment resistant ('new long stay' is also a label applied by some) who may or may not have offended in the past. This group appear to have 'migrated' into medium or low secure settings as they have proven difficult to support in mainstream mental health care.

One clinician noted that there were quite a few people on their unit without criminal convictions. The clinician also noted some of the issues that having people on civil sections threw up:

*99 We have quite a number of people on civil sections, who haven't acquired convictions, but who have engaged in concerning behaviours: fire setting, etc.... They are particularly difficult to manage, because a benignly minded tribunal may discharge them relatively quickly. 99*

## Offending

Some of our participants suggested that secure services, and particularly the high and medium tiers, were for people whose offending behaviour is linked to their mental health problems.

*99 In determining what makes a 'forensic' patient... it is the link between the mental disorder and dangerous behaviour, not just any behaviour.... 99*

It was evident in the units we visited and from the clinicians we spoke to that some patients who had transferred from prison had not committed serious crimes or their offences were not necessarily linked

with their mental health. These had been admitted as it was not possible to administer appropriate treatment in prison (compulsory treatment under the Mental Health Act is not possible in prison).

In terms of offending histories, there appear to be three main groups of people in secure services.

1. People who have committed serious offences and whose offending is linked to mental health issues.
2. People who have committed any type of offence which is not linked to their mental health, but who become unwell in prison and need transfer to secure services.
3. Those who may or may not have an offending history, but whose risk to themselves or others cannot be managed on general inpatient units due to treatment resistance and challenging behaviour.

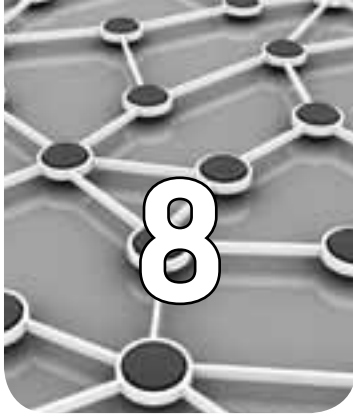
### Other reasons for admission

Additionally there will be patients in secure services who may fall into one of the previously listed groups but who also have additional characterising disabilities, such as learning disability and speech and communication difficulties (including those without hearing).

Another admission issue that arose in our interviews was the need for compulsory treatment among prisoners who would otherwise not take medication for mental illness. One psychiatrist suggested that some patients with a mental illness may never fully recover, and would only be able to control their illness through medication, which some would be reluctant to take. Consequently, their time in medium secure care was lengthened due to concerns they may stop taking their medication on return to prison and relapse very quickly.

“Some of our mental illness patients come here for treatment and never get better. I’ve got a guy here who’s been here for three years and has just stayed very unwell. And sadly they’re too unwell to go back to prison. They are only maintained here by constant badgering from staff about taking their tablets or injection. And some of them are being treated against their will under the Mental Health Act.”

“There are three subsets of people [in medium secure care]. One group need to go and stay in medium secure. Another group never needed to go to medium secure: they could have been managed in low secure or in prison... And the third group, they need to come into medium secure, but they don’t need to be there for forever, they just need three months and can then be moved to low secure, back to prison or whatever. ... Outside in the community, people who are admitted to hospital for inpatient care... by and large, once you have treated them, they go back home. Why can’t we do that in prisons? The barriers are historical, attitudes, culture. However, economic pressures that are coming on will force us to re-consider.”



## Blocks to access and egress

This chapter examines how people access medium secure services; what the blockages are in services and the interfaces with other services; and some of the ways in which services have attempted to deal with them.

### Assessment procedures

Assessment delays and bureaucracy were blamed by almost all interviewees for delays and blockages in secure services. The review team heard of cases where three prison assessments had taken place (four including the inreach team's original assessment). This is seen as a significant barrier to timely transfer, especially by those participants working in prison inreach. Attempts have been made to speed up prison transfers to psychiatric hospital and secure forensic mental health services in recognition of the huge delays.

As all secure units complete their own multidisciplinary team assessments, the process can be time-consuming and expensive. Some assessments are conducted out of area and involve the assessment team travelling a considerable distance. The assessment may require 2-3 members of a team (usually a registered mental nurse and psychiatrist, but occasionally also a psychologist or social worker as well). In one case we were told that assessment teams from high, medium and low secure had all visited and conducted an assessment and all had agreed the prisoner required medium secure care. In this case the prisoner did not meet this particular medium secure unit's admission criteria. Once the assessment is made, a decision about whether to admit is made by an admission panel and this decision is communicated to the referrer. If the assessing unit is not able to admit, patients get held in services before the next assessment, which again may not lead to an admission.

### Paper-based assessments

Some participants suggested that a consultant could conduct an assessment of whether a patient is suitable for a secure service based on a referral letter and any other documentation. This would be carried out by a psychiatrist and would avoid the need for an assessing team to travel to a unit in order to carry out a face-to-face assessment.

“I'm also encouraging my consultants to do paper-based assessments. I don't think everyone has to be seen face-to-face. I think in the DH specifications, you have to do a [multi-disciplinary team] MDT assessment. If you've got a great assessment dossier sent to you by a consultant forensic psychiatrist you know and trust, what else is there to ask? Clarification can be done by telephone... We over-assess for everything.”

However, a rider to this suggestion was that the source of referral needed to be a known and trusted one, and someone who understood and supported the receiving unit's entry criteria.

The value of meeting a potential new patient was cited by other interviewees.

“We may have to go out and assess them. It would come to referral meeting and [be] allocated to a particular member of the team, and they would do a joint assessment for suitability and we have to look at the people who we have on the ward already because we don’t want to form a unit with a prison population, because of the toxic effect that prisoners could have. Sometimes you get a group of characters that when they come together it makes the effect worse.”

## A single assessment

Admitting people on the basis of a single assessment was also suggested. A number of services already operate in this way to some extent, having implemented contractual arrangements between local prisons and secure units. It seems important to note that these arrangements take place at a local level, so may help facilitate movement between one particular prison and secure unit, but this does not have an impact on the movement nationwide.

## Regional admission panels

A number of interviewees proposed shared regional (rather than local) admission panels with members of all levels of security present. This way, one assessment could be done by a single member of the team, and then fed back to the panel to decide on the most suitable placement. A similar strategy could be utilised for hospital orders. Currently, the courts cannot make a hospital order unless a willing consultant is prepared to accept the service user. There could be a process whereby if a court wants to make a hospital order, patients could be directed by the Ministry of Justice or a panel to a unit which would then have to accept them.

“The experience for the patient is so poor... There are very detailed assessment processes at the end of which people say, sorry, but we can’t take you because... A better assessment process [would be] where everyone knows what assessment processes are being used elsewhere, a generic assessment, for instance. So I could assess someone in the community, and I could say, well I think that this guy should go to Rampton. These are the reasons. This is the evidence. The people in the service would accept my judgement....”

## Funding pressures

One interviewee suggested that one reason as to why prison transfers may not always be timely was the level of funding in prison health services. As health care funding within the justice system is locally determined, this can have a detrimental impact upon the standard of prison inreach teams and a knock-on effect on prison transfers.

“I think there is a lot more to be done with being proactive within the prisons to prevent hospital transfers. It’s about having adequate resources a lot of the time... I think teams are very stretched... Some of our prisons are so poorly funded that we literally can’t manage the population, so what we find is that people are deteriorating and relapsing without us being able to input into that, because we’re already over capacity anyway.”

Another referred to disagreements over transfers towards the end of prison sentences:

“It’s a particular difference between these two systems when people are towards the end of their sentences, and have been given a release date... These people might have been in prison for ten years, they’re being released three weeks on Tuesday, and all of a sudden there is an urgent referral that this man needs to be in hospital.”

### Out of area assessments

A barrier in some cases was the difficulty in working out of area. Providing an assessment can be resource intensive on medium secure services as often a team conducts these and prisoners can be placed all over England and Wales due to pressure on prison places. This means teams often have to travel considerable distances to conduct assessments. Additionally, secure services may receive referrals from people who are not from their locality.

“We have difficulties out of area, I suppose, and we’re working on getting a much more clear pathway with the different commissioners, because I think sometimes it’s very hard to know exactly where to go – if people aren’t known to services.”

### Definitions of a psychiatric emergency

A barrier identified by our participants is an ambiguity about what constitutes a psychiatric emergency. Clinicians seemed to agree that a rapid transfer procedure is necessary, but only in a very few situations, predominantly when an individual has stopped eating or drinking, or is behaving in such a way to put themselves or others at serious risk of harm.

### Perceptions of level of security needed

A difficulty some participants raised was the insistence of the Ministry of Justice that people transferred from prison go to medium and not lower secure units.

As stated previously some areas have had greater success in transferring to lower secure and PICU units and in these areas the prison inreach teams have had to work particularly hard with the Ministry of Justice, but also with the units to which they are transferring. One participant reported that generic mental health services ‘worry’ about taking on people from prison, ‘they get seen as forensic’ and that the inreach team had provided outreach to PICU staff ‘mainly as reassurance’.

### 14 day transfer procedure

We received mixed responses about the possibility of implementing a 14 day transfer procedure. Participants in one prison, for example, said they were not having any difficulty moving people out of prison within a 14 day period because of the high standard of practice they were maintaining within the prison. Consequently, if a person does need a transfer to a secure unit in an emergency, the system

is less jammed, and the medium secure unit will be more willing to accept a transfer, knowing that the referral is of a patient in serious need of transfer.

At this site, the secure mental health unit and the inreach team were part of the same service. The key difference here was that the inreach assessment was trusted and had currency with the secure service. Being part of the same service also made it easier to exchange information and have case discussions in advance of a crisis or at least very early on in it.

Another inreach team reported that it had less difficulty in achieving transfers to low secure and PICU. It had achieved transfers within 14 days when this was piloted.

In some areas, psychiatrists from medium secure provided some clinics in local prisons and, though not formally part of the inreach service, they liaised frequently. This arrangement seemed all the stronger when these clinicians attended meetings such as prison 'single point of referral' meetings.

Other interviewees, however, felt the target was unrealistic and problematic:

“Is [14 days] the complete time, from the time when someone in prison says that this person needs to be in hospital? Is it the time from then, through assessment, onto actual admission.... we call that the referral. If someone sees someone in the local prison today, and faxes the referral to me today, saying that 'I think that this guy should be in hospital' I should be admitting him 14 days later. I think it's difficult to see how that would work in practice, and I know that's the view of my colleagues here as well.”

One participant said that a flurry of prison assessments and admissions over a short space of time could very much disrupt secure wards, and have an impact upon the efficiency of the 14 day procedure.

Another said the 14 day transfer is sometimes impossible and particularly in the case of request for transfer to high secure. This was due to the perceived lengthy periods of assessment for these services.

One participant argued that the 14 day transfer procedure is not helpful because some need transfers quicker and others are not considered to be as much of an emergency case:

“There are people who need to be in hospital in a week or less. They need to be admitted much quicker. But there are plenty of other cases where the prison refers them and suggests that it is an urgent referral that needs dealing with quickly, and you go and see them, and it's clear that the situation has been grumbling on for months to years. And six months for transfer to hospital would be a reasonable time scale, but for others, they don't need to be in hospital at all. So the fixed one target for everyone is not particularly helpful.”

Some participants felt that it was appropriate for some transfers to take longer than the 14 day recommendation and even in some cases for it to take considerably longer. However, not all participants saw things this way and some recognised that the particular 'toxic' effects a prison environment can have sometimes necessitated a speedy transfer. Some participants pointed to the differences in transfer for acute physical illness and that often these occurred within a day or even hours.

One participant, meanwhile, noted that more effective diversion at the point of sentencing would help to ensure that people initially went into the right environment, rather than going into prison and then having to be diverted out to secure services.

## Lack of low secure and step-down facilities

Another very commonly cited cause of blockages was a lack of provision of low secure and step-down services. This can lead patients to stay in medium secure units for longer than necessary until an appropriate step-down service is found that can accommodate them.

- “There are blockages in the community where you are trying to find somewhere for people to go back to. It’s maybe about funding issues, maybe a restriction on area because of victim issues, so people may have to be re-housed in an area which they are not familiar with. It may be about the pathway from medium to low secure. We’ve only got [a handful of] low secure beds, but more male medium secure beds. So the pathway to low secure may be blocked because of a lack of beds.”
- “There is a real commitment to throughput, but it’s just a huge juggling act of who, where, next. It’s like a big game of chess that can get very complicated.”

It was reported that specific offences, such as arson, have an impact on the options for moving people on to low secure and step-down facilities in the community. A patient in medium secure whom clinicians believe is appropriate for community placements, but has in the past committed a particular type of offence, may have to remain in medium secure until an appropriate community placement which will accommodate their specific offending history becomes available. This sort of situation will have the effect of blocking the pathway further up.

The use of low secure services as psychiatric intensive care units (PICUs) for people stepping up from ordinary psychiatric wards can also create blockages in the service for people who need to take a step down.

- “On my admission ward /rehabilitation ward, there are probably five patients who don’t need to be there, as there is nowhere else for them to be contained appropriately. Some of them could be contained within a forensic low secure setting.”

We were told that there is a particular shortage of low secure provision for some specific groups of people:

- “[There are] other groups who are currently not provided for within the trust at low secure level. So those are the borderline learning disability group, the personality disorder group...head injury, older people or younger people, 16-18.”

Our participants felt that there was the need for further exploration of what step-down should constitute and saw a need for forms of supported accommodation (see previous discussion).

## Lack of support in the community

Some secure services provide a degree of outreach for discharged patients, while others have developed dedicated community teams. These teams either provide parallel community services or support to generic community mental health teams working with former inpatients, or perhaps a combination of both. Forensic community teams are relatively rare.

Secure services that do not have an associated community forensic team may experience delayed discharges or have to stay in touch with patients after they have left the unit.

“ I think the area where we could provide more is for people with personality disorders. There’s no specific provision for community forensic personality disorder patients, it’s a bespoke service. We do provide for quite a number in this service, but it’s ad hoc. We don’t have enough psychologists, so we don’t have a bespoke programme. ”

The lack of community provision was described by some interviewees as a missed opportunity to improve outcomes for service users.

However, it was recognised that perhaps the best approach would be to support generic community services in developing the capacity and ‘confidence’ to deal with discharged patients from secure mental health services.

## Risk aversion

Secure services accommodate and treat a population of individuals who present a risk to others. Clinicians and managers in secure services have to assess risk on a very regular basis, the Ministry of Justice is also involved in risk and managing the risks that individuals pose, and determining whether someone gets leave or is discharged or not.

The issue of risk has strong political dimensions linked to public perceptions of dangerousness and how much risk services should be prepared to take, for example in permitting unescorted leave and in staffing levels in the community.

Our interviews suggested that there is a high level of risk-aversion among clinicians and Ministry of Justice (MoJ) staff. One interviewee argued that services were very unwilling to allow decisions to be made locally or on a case-by-case basis, with too much reliance on fixed policies and procedures.

This may also have an impact on service costs by reducing flexibility and lengthening delays in decision-making.

“ [The MoJ represents] a lay person’s view, from the public point of view, because they are dealing with the protection of the public. We are dealing with them clinically. ”

“ It is extremely time consuming as there are negotiations with various parties, including the MoJ... it blocks beds. ”

One clinician suggested that occasionally the MoJ can revoke leave and passes against clinical judgement that the patient presents a minimal risk.

“ One of our patients absconded from here recently, and he didn’t do anything; just got drunk. Fell asleep in the cinema....And the MoJ have taken away all of his leave, taken him right back. ”

A number of interviewees also suggested that at times clinicians in services can also be risk-averse. Clinicians are shouldering a lot of responsibility in regard to high risk patients, and a wrong decision could have very severe consequences. However, it is possible that this could, at times, lead to patients remaining in secure services for longer than is necessary.

## Reluctance of general services to work with ‘forensic’ patients

Many interviewees suggested that other mental health services were reluctant to work with people who had been in a secure service or in prison.

A consequence of this apparent reluctance could include the readmission of service users who become unwell to a secure unit even though they could safely be admitted to another psychiatric unit or managed outside hospital. This adds to the blockages in secure services as well as being more expensive.

Where there is movement between general services and secure services, however, this can be managed through good communication and joint working.

“Most of the traffic is between adult mental health and low secure ...If a forensic patient has been with us some time and we have treated them to a level where dangerousness has reduced to a level which means they can be safely managed by generic services, they don’t require specialist knowledge and do what they’re supposed to do in their plan, that patient can go out and will be assigned a community worker who can check on their medication, look for relapse signs, look for issues.....We’ve done a lot of work on blockage. We’ve got together with adult mental health and developed a joint procedure which has addressed and set up the agreements and processes of the movement of patients between the two systems at all levels.

“Another way we’ve tried to address this is a directors’ meeting once a month that looks at blockages and sorts out problems. And it’s incredibly successful. So one of the side benefits of the group, is the deeply considered understanding between the two teams, to establish trust, break down barriers and reduce stigma [of the forensic label]...that’s been a success, but needs constant work.”

## Bed capacity

Some of the data we examined seemed to suggest that more people are going into secure services than are leaving. This is related to the high occupancy rate and the relatively long lengths of stay in secure services.

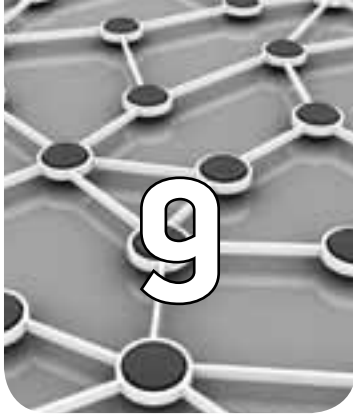
In order to be financially viable, secure services need to be relatively full, with some services aiming to have up to 96% of their beds occupied. This can make it difficult to get people into services as there are few free beds at any given time.

“There are blockages everywhere. Not just forensic, even in general services. Reality is, we’re contracted to be 90% plus occupied. Everywhere is full. ...The commissioners say they want throughput, but also say that we want you full. They want us to be responsive, but all our services are virtually full.”

Increased lengths of stay were cited as being one reason as to why capacity was stretched and blockages formed.

## **Patient anxiety about discharge**

Focus groups with service users emphasised the considerable concerns they have about leaving secure services after what will normally have been a long period. Both staff and service users stated that discharge from secure services was very anxiety provoking for service users, and stated the risk of relapse at this time because of this. Both groups of participants talked about the ultimate goal of any pathway being independent living, but that achieving this should be done in graduated steps. Some service users felt that their previous experience of discharge had been anything but graduated.



# Pathways and outcomes

This section of the report examines the routes people take in and out of secure mental health services; the various therapeutic programmes provided within secure services; and the evidence about what outcomes they achieve for their patients.

## Pathways

A pathway could generally be described as being the movement a patient makes from service to service on their way to eventual maximum mental health and social wellbeing.

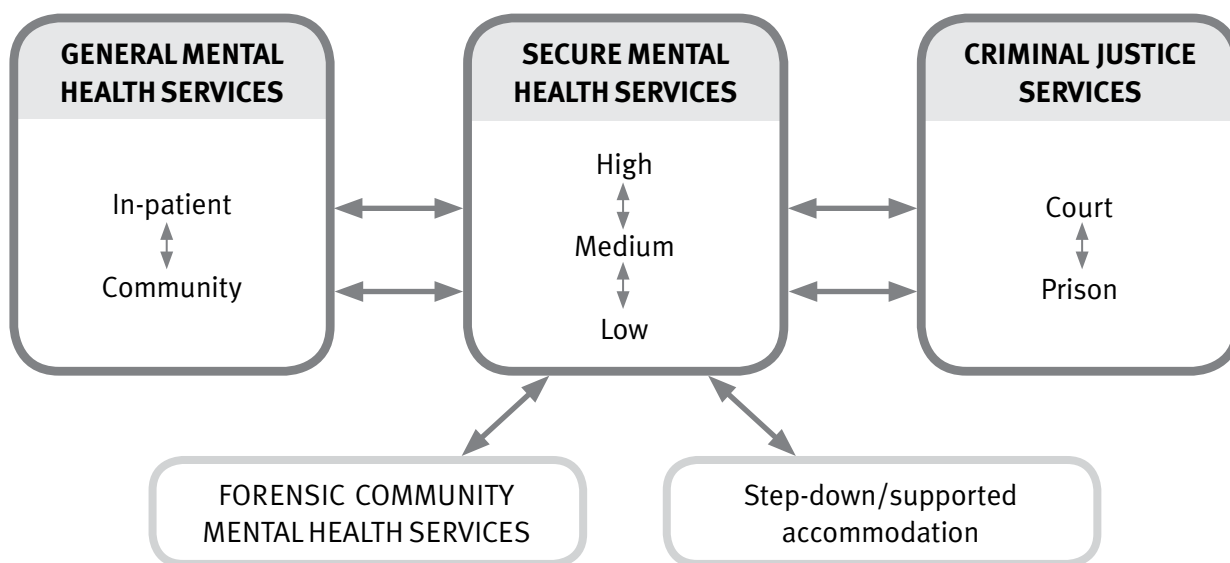
It is important to note that pathways are unique and specific to each individual patient. It is equally important to note that, with exceptions, as there is no national model of secure mental health care and services have evolved locally, pathways are more often than not notional rather than actual in that movement along the pathway is actually often quite difficult. In many cases beds are purchased long distances from home, family and community. One of the sites included in our review had a more complete range of services that ranged from high through to low secure and also included prison inreach. The perception of the providers of these services was that for patients from that locality transition between services was much smoother than that reported in other areas.

It is apparent that movement of patients through services occurs in all sorts of different directions, with patients moving up tiers of security, down tiers of security, from side to side (e.g. from one medium secure unit to another), between NHS and independent sector services, between secure services and general psychiatric services, and between secure services and prison.

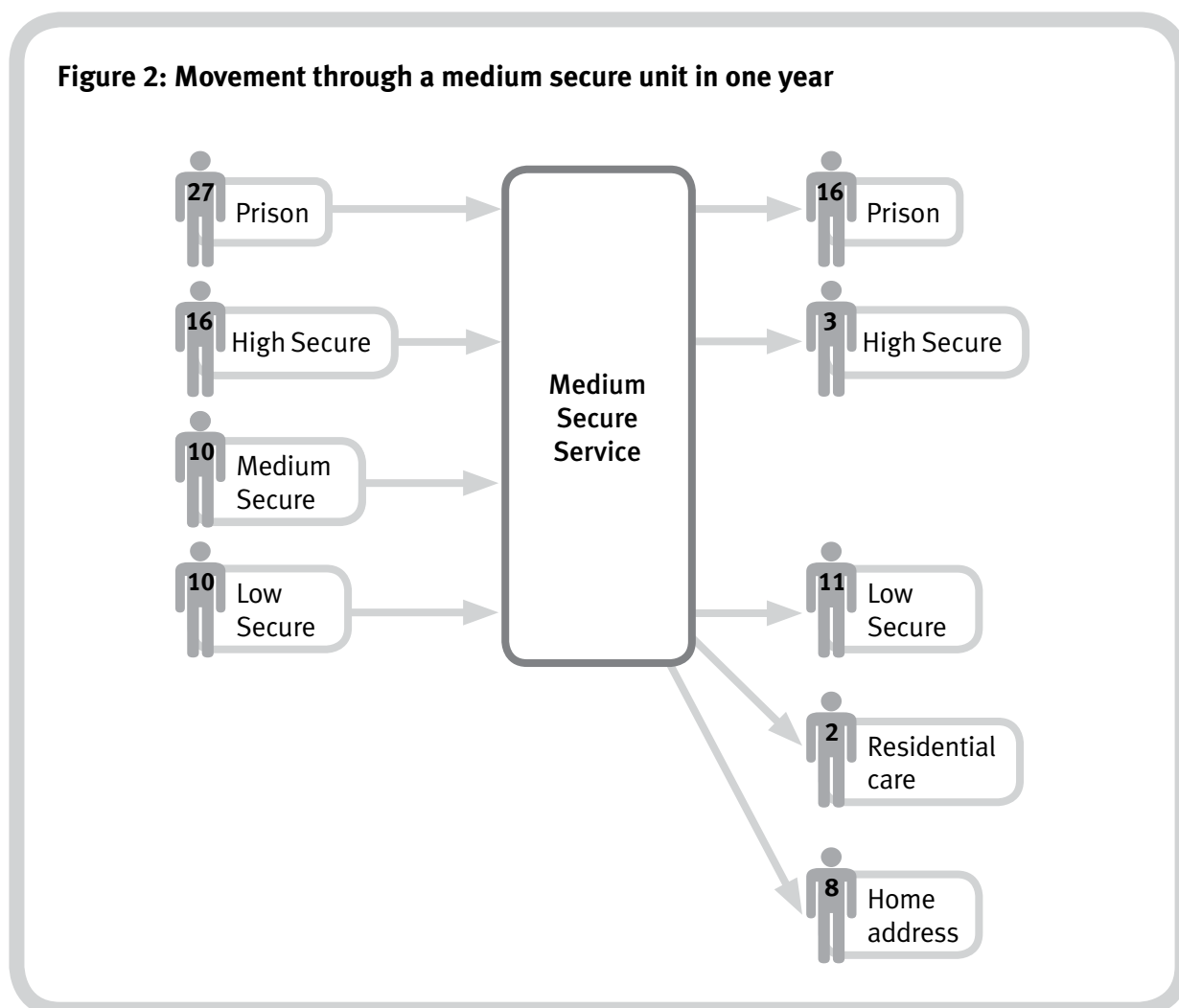
In order to gain an overall idea about some of the pathways through services, these are described diagrammatically in Figure 1 (overleaf).

Some of the data that we collected from one medium secure service demonstrate some of the movement that occurs through one service of this kind. Figure 2 (overleaf) summarises the movement through this service in the course of one recent year. The majority of people admitted to this unit during this year were from prison. And the majority of discharges are also back to prison. The findings of our review suggest that this is not a typical flow as this level of transfer back to prison is much higher than other units report. This is possibly because the inreach team and secure service are integrated.

**Figure 1: Pathways through criminal justice and mental health services**



**Figure 2: Movement through a medium secure unit in one year**



## Specific pathways

The pathways people take through services are often dependent on their individual characteristics. There are, however, patterns that occur based on people's diagnosis and gender.

### Mental illness pathways

One participant described the pathway for individuals with a mental illness diagnosis, most commonly of schizophrenia or bipolar disorder, and a history of serious offending, through their service:

- “The vast majority of men with mental illness come in from prison via the courts and they get hospital disposal. So this is someone who's been arrested and done something horrendously bad; murder, rape, arson, abduction... They go to prison and at some stage in the process, it becomes apparent that they're mentally unwell. Then they get here before trial if they're very unwell. And afterwards depends on how unwell they are. The norm is stepping down tiers of security.”
- “The other care pathway into male mental illness is someone who has a life sentence, but whom prison cannot manage... and they come into here for treatment of their schizophrenia or bipolar disorder. And then we have to make a decision; does this person finish their sentence in custody or do we take them along the hospital route?”

The pathway from medium secure to the community may be through low secure in some areas and through a 'pre-discharge' ward within the medium secure service in others.

Some other patients may take a pathway from medium secure to long-term low secure care if they are deemed unlikely ever to be released from custody because of the risk they pose.

### Personality disorder pathways

Some medium secure units provide specific pathways for people with personality disorder diagnoses. There may be different pathways again for those who pose the greatest risk and are labelled with 'dangerous and severe personality disorder' (DSPD).

One clinician described differences between these two pathways:

- “We have two services for personality disorder. One model of care is for young men who are in crisis in prison who have got severe personality disorder and for whatever reason cannot engage in prison services. The main reasons why they can't take treatments [in prison] is that they are so chaotic... They don't want to talk about their problems in front of groups of men in prison. It's very different when you come to a 12-bedded ward here and you're prepared for treatment. In a lot of prisons, the psychotherapy groups insist that the men are not on medication and a lot of these guys have got depression or Post Traumatic Stress Disorder, for which they generally need medications, so they try and get off the medication to get on the groups. So what's supposed to happen is that they are meant to come in [to medium secure] for two-year treatment programmes, and then go back and complete their sentence.
- “We have another personality disorder service here, which is the Dangerous and Severe Personality Disorder step-down. So we're taking the guys who have done a lot of treatment in high secure, or even in high secure prisons... but who actually need a lot more at less security...”

“The previous group are dangerous because they are chaotic, the latter group are dangerous because they’re dangerous.”

There appears to be a gap in community provision for personality disorder. One participant pointed to a lack of psychological support in the community for this group.

“There’s no specific provision for [ex secure care] personality disorder patients... We do try to provide for quite a number... but it’s ad hoc.... we don’t have enough psychologists... there’s a gap in the pathway between locked and community services. And we could stop people going into locked services.”

It is worth noting here that in some parts of the country services for those with personality disorder are negligible and that therefore in these areas no pathways exist.

## Pathways for women

A number of secure services we visited had female specific wards and pathways. One of the services we visited had a Women’s Enhanced Medium Secure Service (WEMSS). Our participants felt that women in secure care had quite different needs to their male counterparts and that there was a specific set of competences that secure service staff needed to have to manage them. In particular, skills in managing very marked self-harming behaviour were seen as crucial. There were also issues around being a ‘carer’ and loss of that role, and relationships with children that our participants felt were more to the fore with women than men.

Our participants felt that women needed specific step-down provision and at that moment this was very limited. There is a concern that some women are held in higher levels of security than their level of risk dictates – because staff in these services have the skill set required to work with these women. There is a clear need for these skills and competence be extended across all tiers for these people are managed in the least restrictive conditions possible.

## Interventions

The secure services we visited all seemed similar in the range of interventions they provided. All provided interventions centred on psychological and social wellbeing, as well as having an emphasis on offending behaviours.

However, there is a question about whether interventions are provided in the most effective way, when considering the paths people take between secure and other services.

All of the secure service sites offered a variety of forms of intervention. Assessment and in particular risk assessment are key interventions but they also offer psychological therapies, occupational therapy, vocational interventions and educational work. Many, but not all, are related to the offence for which the person was imprisoned or detained: the ‘index offence’.

“We do index offence and criminogenic work. There’s a whole army of people here skilling people up, doing basic skills, relationship management, lifestyle, communication skills, vocational training and courses. So we take them up to basic qualifications for free.”

“We run standard courses, in mental health awareness (understanding what schizophrenia is), substance misuse courses, the lifestyles group... All courses are personalised and prior to

- starting there is always a 1-1 with one of the course leaders on a number of occasions. Patients are also seen in-between sessions 1-1, and after sessions 1-1, usually by a psychologist or one of the nursing staff. ”*
- “ If someone comes in and doesn't have a clue about their offence, there are parts of the service which can offer an offending behaviour programme. Basically we start looking at behaviour and an understanding of the factors that lead to offending.*
- “ We've got CBT (cognitive behavioural therapy), a number of dialectic therapies, we've got occupational therapy interventions, a number of educational and vocational programmes, gardening programmes, picture framing, in terms of education, we've got numeracy and literacy... ”*
- “ There are leisure activities, social skills, social awareness, behaviour programmes...if they are challenging or confrontational to staff, we work with them to try and change these behaviours... There's also escorted community leave. And this can be from road-sense to social skills in a library or shop. Or integration back into crowds appropriately...Each programme is individually tailored. ”*

The psychological interventions that are provided span a range of therapeutic approaches:

- “ As psychologists, we do relapse prevention work, offence-related work because most of the patients here have a criminal history...we do sex-offender work, violence prevention. We do CBT groups, managing psychosis, etc. [We work with] the individual needs of the patients. CBT is a buzz word, [but] does not work for everyone. We offer CBT, and we also offer schema therapy and DBT [dialectical behavioural therapy] specifically for BPD [borderline personality disorder] to female patients. ”*

Although there was much similarity in what interventions and treatment programmes were offered in different units, and particularly across the medium secure estate, interventions and programmes did not appear to be entirely standardised even across these. Additionally, there were differences in the range of interventions on offer to patients with similar profiles across the different units we visited.

There was a concern among some participants, including clinicians, that many patients spent much of their time unoccupied and that interventions needed to be more intense. It was suggested that this could in some cases contribute to long stays in hospital.

## Outcomes

- “ ...there will be a relentless focus on clinical outcomes. Success will be measured, not through bureaucratic process targets, but against results that really matter to patients.... ” (DH, 2010)*

A handful of studies have been published on the outcomes achieved by secure services. This evidence provides some indication of the short, medium and long-term outcomes, including reconviction, imprisonment and readmission rates back into hospital. Short term reconviction rates for all types of offences are low, with two-year rates for those discharged from medium secure ranging between 10% and 14% (e.g. Edwards *et al.*, 2002). Reconviction rates for a violent offence have been reported to be even lower at 6% (Maden *et al.*, 2004; Edwards, 2002). The 6% reconviction rate for a violent offence has been questioned given that violent offences do not always result in a conviction.

These low reconviction rates in the short-term have been challenged by some commentators and may be attributable in part to the fact that many patients are discharged from secure services to other custodial settings. Examination of medium to long-term outcomes reveals gradual increases in reconviction rates.

A study of seven regional medium secure units in England and Wales with follow-up between a month and ten years studied reconviction and risk factors for those discharged into the community (Coid *et al.*, 2007). Of the 1,344 people identified, just over 30% of men were reconvicted, with almost 1 in 5 for a violent offence. For more grave offences 1 in 8 men and 1 in 16 women were reconvicted. Patients convicted before being admitted for a violent offence were at greater risk of committing a further violent offence following discharge.

Long-term outcomes from medium secure reveal more worrying figures. Over a 20-year period, 554 people discharged from medium secure were followed up in a study by Davies *et al.*, (2007). They found that almost half (49%) of patients were reconvicted, with 38% being readmitted to secure services. They also found that 57 patients had died during the follow-up period, one third of them from suicide.

Davies *et al.*, (2007) also found that 28% of patients at two-year follow up had committed a violent offence but were not convicted. At five years this proportion had increased substantially to 42%.

These reconviction rates, despite rising over time, are still less than those for people being released from prison. However, secure service and prison populations are not directly comparable unless matched for criminal histories, age and other important factors. So drawing any conclusions about the effectiveness of treatment and subsequent aftercare in reducing reoffending between these two populations should be avoided.

Coid *et al.*, (2007) note that long-term reconviction rates do not necessarily reflect the quality of treatment secure services provide:

“It is important when considering these findings that they are not perceived as a measure of the performance of medium secure services but the criminal careers of patients discharged from these services and their risks of reoffending. Furthermore, it is questionable whether treatment in these services had a bearing on offending several years after discharge.” (p. 226).

The long-term outcomes from medium secure services are particularly poor, however, and it is difficult *not* to judge these services by them. They suggest that there is a need for follow up care that is consistent and long-term, with a particular subgroup of discharged patients being better identified and their risk for reoffending managed appropriately. There is also a need to expand the evidence to include other outcomes, such as employment. Davies *et al.*, (2007) found that 51% of their sample had been employed prior to admission, mostly in unskilled jobs. After discharge, though, the employment rate had fallen to 14.5% and work was usually found through family members. Few other studies investigated employment outcomes despite the importance of being in paid work to reducing reoffending.

Another pertinent issue relating to outcomes involves location on discharge. Davies *et al.*, (2007) found that 27% of 554 discharges from medium secure were directly into the community (either home or a hostel). About the same proportion (26.5%) was transferred to the criminal justice system (either to prison or back to court for sentencing). Just over a third (34%) of patients were discharged to a low secure hospital.

## Outcome measures

It was clear from data we gathered that services routinely collect a wide variety of scale and rating based outcome measures. The HCR20 (Historical-Clinical-Risk Management-20) (Webster *et al.*, 1997) a risk assessment tool, particularly for risk of violence, designed to be used with ‘forensic’ patients, is widely used. HoNOS Secure 2b (a version of the Health of the Nation Outcome Scale with an additional seven areas focused on risk rating; see <http://www.rcpsych.ac.uk/quality/honos/secure.aspx>) is commonly used to provide a proxy for severity of problems and can quantify progress made across twelve broad domains and seven risk areas. Another tool quite commonly used is the CAN-FOR (Camberwell Assessment of Needs – Forensic Version) needs assessment tool (Thomas *et al.*, 2003). One of the strengths of this tool is that it collects both clinician and service user (and carer) ratings.

Participants thought other measures were important too:

“*Personally, the most important outcome is what the patient feels. Obviously when you are commissioning for this, you have to show that what you are doing is working. It can be contentious. A good outcome for one patient may mean something completely different to another. I think in general we use HoNOS Secure to say, this is what is happening and these are the outcomes, but I think that sometimes it feels a bit false, as if you are trying to fit things into boxes.*”

Standardisation would be useful across all the tiers of secure care in terms of routine outcome data collection. The three tools listed above might be a minimum expectation placed on services.

Some participants argued that commissioners had unrealistic expectations of what services could achieve through their outcomes data:

“*Sometimes my dilemma is that some of our patients have had serious histories of abuse. And there is sometimes an expectation that we should be able to sort this out overnight.*”

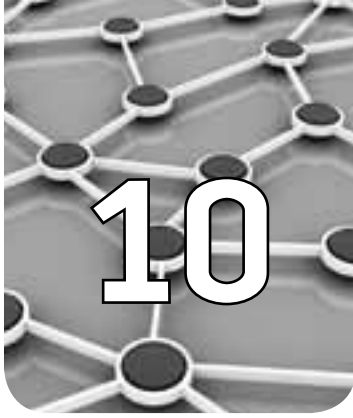
Participants varied in their views about what outcomes secure services should seek to achieve. Some focused on whether a person could be safely contained, engaged and discharged; others said measures should examine a range of clinical, social and offending outcomes.

“*To have an outcome, you have to know what you are measuring. And it should be in the care plan. So if, for example, we want to achieve mental stability, if we achieve it, that’s an outcome. If we want to maintain and develop skills, then that can also be an outcome.*”

A number of interviewees also mentioned recall rate as being a way of determining outcomes. One clinician we interviewed suggested that a problem with ascertaining long-term outcomes is that it is very difficult to find out about patients once they have left services and moved on. However, high secure service participants pointed out that for years they had collected a set of data, which followed patients over years and had been used for research purposes and would have been able to provide data on long-term outcomes.

There is merit in having a national data-set for all secure service patients that collects data to allow monitoring of their individual progress, but which can also be aggregated to monitor the performance and outcomes.

One senior clinician stated that services were not always motivated to collect data on outcomes; they have never been commissioned to produce particular outcomes. But it also reflected that demonstrating risk that had been reduced was no guarantor of placement in a lower secure setting or in the community. Commissioners, providers and the Ministry of Justice would be likely to be especially risk averse if the index offence was particularly notorious.



## Service user and carer experience

As part of the project, a number of service user focus groups were organised, as well as a few meetings with individual service users and carers. One of the key topics raised in these discussions was pathways through services.

A key issue was that service users tended to be mentally unwell or very medicated at the time of moving between services, making it difficult for them to have an idea about why they were in services and what they had to do to progress through services towards discharge. Some described simply waking up on a ward and not really realising where they were. There had been few people available to speak to them and meetings with clinicians were rare.

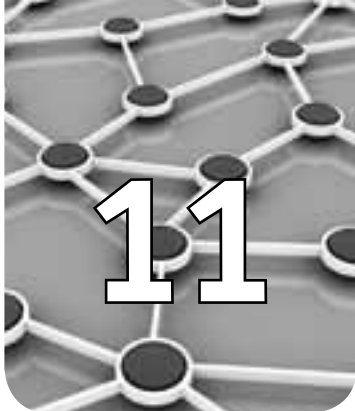
It became apparent that having a carer who was involved in the person's care was crucial for service users to understand how to move through services and why they were there.

As one carer asked:

“How do [staff] work with patients if you don't speak to the people who know them best...the carers?”

More carer involvement would seemingly be more beneficial in services acclimatising themselves with patients more rapidly and may have a beneficial impact on the speed at which people progress through services. This could be achieved through more education for carers and service users about mental health issues and clarity on what is needed to be done in order for a person to progress through services towards discharge and more training for service staff around carer engagement.

Whilst this review did run focus groups with secure service patients it was unable to organise all the interviews with service users it had hoped. This obviously is a gap in our review as understanding service users' perspectives and learning from their experiences are crucial to developing secure services.



# Conclusions

The review had four key objectives.

1. To examine the role of medium secure and related services for offenders with severe mental health problems.
2. To examine the costs and benefits of these services and whether these resources could be better used.
3. To examine how the flow between prison and medium secure services could be improved.
4. To examine possibilities in improving the flow between high, medium and low secure services and the ways in which discharge planning and aftercare could be improved.

Objectives one and two have been particularly hard to answer as secure care services have evolved locally and do not currently follow one model. The populations they serve vary by unit and most units have different discrete patient populations within them. This in itself is an important finding. Objectives three and four are of course somewhat dependent on the previous two objectives, and the review was further hindered by the difficulties many of the units we visited had in supplying data on patient flows, but nevertheless we have gained quite an understanding of these and generated numerous ideas about how aftercare could be improved. There is a need for outreach to the mainstream community mental health services and for developing forms of supported accommodation, but there should also be further exploration of the need for both of these.

We have also identified a number of major gaps in the evidence about the pathways people take through secure services. There is little evidence about the specific experiences of women nor about those of Black and Minority Ethnic communities, some of which are dramatically over-represented in secure services. And we still know too little about service users' or their carers' personal experiences of secure services and their interactions with the criminal justice system.

This section clusters the conclusions we draw into useful sub-headings.

## Cost of services

Secure services at any level of security are high cost services. Delays and inappropriate decisions carry a heavy penalty.

The significant difference in cost between high and medium secure care highlights the importance of appropriate placement, as detaining a patient at a higher level of security than necessary carries a very substantial cost penalty. Equally, the similarity of cost between medium and low secure care suggests that more consideration should be given to whether a patient needs low secure care to 'move on' or supported community care, including forms of supported accommodation.

## Commissioning

Current commissioning arrangements can be seen as a barrier to an effective through-care provision and pathway. Block purchasing of largely medium secure beds makes it difficult to move patients on to other forms of care, nor does it incentivise providers. The clinicians we spoke to saw great challenges in moving to a more outcome driven form of commissioning, but still most wanted this. They also wanted commissioning of whole pathways of care and discrete packages of care (e.g. the latter could inform the former).

## Admission and assessment criteria

Beyond the general policy statements relating to grave, serious and significant danger, secure services do not have a clear and consistent understanding of the profile of who should be treated in medium secure care. This leads to inconsistent decision making, potential inequity and higher costs. There is no national model of care and the services provided can differ dramatically by locality.

## Blockages in the system

A number of blocks exist in the system such as how services are commissioned, limited provision, and difficulties in providing adequate community care. This means that medium secure provision can be difficult to access and results in 'blocked beds'.

## Referral and assessment

The process by which people are referred, assessed and admitted to medium secure care can impose considerable delays on the admission of a person to secure care and does not appear to make the most efficient use of resources.

## Local variations

A striking finding from this review is that the services on offer and the pathways available vary considerably across England. In some areas there appear to be well-developed pathways across all tiers of security and good links with prison in-reach, but in most areas accessing lower secure services can be difficult. It is clear to us that there ought to be informed by guidance and quality of standards and as much as possible equity of access to services across the country.

## Outcomes

Both commissioning and care need to be more concerned with outcomes. We need a framework of outcomes: social, health related, offending related, but also outcomes that speak to the needs and expectations of those who use the services, and their families and carers. This framework should be the tool with which secure service performance is monitored and should drive quality.

## Provision of care

There is a marked variation in provision for people with particular needs (including a primary diagnosis of personality disorder or a learning disability).

The result of this variability in provision is often delays in receiving treatment and placements some considerable distance from community of origin for some patients. With regard to the latter, this will always be the case for high secure and specialist medium secure provision, but placements far from home can create real difficulties in reintegrating people in the community.

There is also a need for standardising interventions so that when a patient moves between units and tiers, effective treatment programmes are not disrupted but continued.

## Communication

In addition to there being difficulties in moving along the pathways there is often little connection or communication between different tiers and again the greatest issue appears to be between medium secure and the tiers below.

## Continuity of care

While psychological programmes at various levels appear to be of a good quality, a lack of joined-up working between units of different tiers of security could reduce their effectiveness. For example, a service user may have completed a wide range of treatment programmes in a high secure unit. Once perceived risk has reduced, the patient may then get transferred to medium secure, where they may be presented with therapeutic programmes that are very similar, or very different, to the programmes they have already completed. If very similar treatments are provided, this may appear to repeat a programme they have already completed and cause disillusionment about their progression. If the programmes are very different, the patient may not be able to build upon the skills already achieved, for example due to different treatment philosophies and terminologies.

A similar discontinuity may occur between medium secure services and those in low security or the community once a patient is discharged.

### **'Step-down' provision**

There was a broad consensus among our participants that early intervention and diversion required more investment and that greater step-down provision needed to be in place. Investing in another form of institutional provision is not likely to help address gaps in early intervention or step-down.

However, forms of supported accommodation probably do need to be developed and there needs to be further research to understand the needs of former secure care patients in this respect.

### **Prison mental health care**

Though beyond the scope of this review, perhaps the greatest need in prison mental health care is developing an approach that addresses multiple need and often with prisoners whose mental health needs fall short of the traditional secondary care threshold. However, secure care services do have a role in supporting prison mental health care and where prison mental health services have a good working relationship with secure care practitioners, providing sessions within the prison and being part of the prison multidisciplinary team, the transfer process has fewer barriers.

### **Low secure services**

There is considerable uncertainty in the system about how low secure services should be used. The definition of 'low secure' is currently unclear and a small number of units visited by the Centre appeared superficially at least to be very similar to medium secure services.



# 12

## Recommendations

This section discusses in brief the aspects of secure services that the Centre believes require further exploration and development. There is considerable overlap between the various recommendations, which may therefore be most effectively addressed together rather than separately. These recommendations relate to the QIPP (Quality, Innovation, Productivity and Prevention) challenge and we are aware that the NHS is actively working to address several of the concerns raised by this review and on implementing some of our recommendations.

### Guidance and quality standards for secure care

Our review has revealed that there is a disconnection between the different tiers of secure care and that the availability of lower secure care or appropriate community support is often very limited. We believe that the recommendations described below offer a means to addressing these gaps and to developing comprehensive and needs based secure care pathways.

**The Centre recommends the development of a framework of guidance and quality standards for secure services to support equity of outcome and equitable access to all tiers across the country.** This would be the business of the NHS Commissioning Board, in conjunction with the National Institute for Health and Care Excellence (NICE), to develop pending the passage of the Health and Social Care Bill.

Achieving more consistent commissioning and provision of secure mental health care is dependent on a number of factors:

- changing how secure services are commissioned, i.e. a move from block purchasing (of mainly medium secure beds) to purchasing pathways and discrete packages of care that provide incentives to move patients to the lowest level of security they need and support community aftercare;
- developing effective community support and liaison to support reintegration and mainstream mental health services' capacity to promote the recovery of former secure service patients;
- reviewing the balance of investment to ensure adequate step-down provision is developed;
- standardising treatment programmes so that treatment can be carried across tiers;
- developing a national secure service patient data-set that allows both individual progress monitoring and aggregated data to monitor performance and outcomes;
- developing shared learning networks to improve communication across tiers and in standardising treatment and care packages.

This work has to go hand in hand with developing an agreed patient profile of whom each tier of secure care is for. With regards transfer from the prison service to the NHS this requires much clearer criteria for admission to the different tiers of security and 'sign-up' to these criteria by both the NHS and the Ministry of Justice. Developing a set of secure services profiles may require further research specifically aimed at assessing the need for service and the requirements of specific groups, such as women and Black and Minority Ethnic communities.

## Defining and developing ‘step-down’

The efficient use of the higher tiers of secure care, and in particular medium secure, depends on having well developed and understood provision in the lower tiers. Commissioning pathways of care for individual patients also depends on this. Our review suggested the difference between some medium secure and some low secure provision is marginal. Low secure needs to be better defined and there is a debate to be had as to the value of some current low secure provision. There is also a need to review the accommodation needs of the different populations that use secure care. Some may require long-term supported accommodation. Many more may require forms of supported accommodation that support a transition to independent living. At this point of time there is not a clear understanding of who or what low secure or step-down are for and what they should constitute. **The Centre recommends that the roles of low secure and step-down care are reviewed to inform commissioning decisions and systems.**

## Changing the balance of investment

The people we spoke to in this review consistently reported that many patients currently in medium secure care could be managed in less secure settings and that many prisoners requiring transfer to the NHS could also be managed in lower secure provision but that often the default for such transfers was to medium secure. Our participants reported that there is a tendency towards risk aversion by all parties involved, i.e. commissioners, the Ministry of Justice and clinicians.

Currently, commissioning of secure care largely involves the block purchasing of mainly medium secure beds and additionally there is a requirement that secure care units operate at close to full capacity. The result of this has been a growth in secure care, particularly at the medium tier, and yet there are continued difficulties in accessing secure care in most areas. This is difficult to resolve without a greater understanding of the actual need for provision and without changing commissioning arrangements that commit a considerable level of resource in medium secure care and thus make it difficult to resource step-down services.

**The Centre recommends a better balance of investment to enable step-down and community provision based on a region by region assessment of needs.** This will necessarily involve the decommissioning of some existing secure care beds in order to free resources for more needs based provision.

## Reforming secure care commissioning – developing an outcomes framework

As has been stated, secure care commissioning is largely characterised by the block purchasing of beds and largely at the medium secure tier. Commissioners also require that secure care units operate close to capacity, and while this is understandable it means that units have limited flexibility and pressure on beds. There were few units we visited that felt that they had no problem with ‘bed blocking’. We did not identify any significant issue in moving patients up from medium to high secure but found that, typically, there was an issue when it came to moving people from medium secure either to low secure or into the community.

There is currently a move to outcome based commissioning and mental health commissioning outcomes are due to be published in 2012. There is a need to develop an outcomes framework to inform commissioning and monitor performance. The framework would help clarify expectations of service for all involved, including the service user, and should include outcomes that are informed by the service user perspective.

To date, mental health services have by and large been commissioned by volume, i.e. to provide a specified amount of service (e.g. number of beds) over a specified time period, and thus a move to commissioning for outcomes represents a major change. Secure care is especially resource intensive and reforming commissioning would therefore have considerable benefits financially to the NHS. Those placed in secure care are often there for years and therefore greater precision in commissioning is important to ensure the best use of resources.

Our participants argued for a move towards purchasing care across pathways, so that outcomes are delivered across different tiers, rather than just purchasing 'X amount of beds' over a year. Our participants also saw the benefits in purchasing specific care packages such as time-limited assessments, the outcomes for which would be recommendations about further care, and specific outcomes for that care delivered across the tiers. **The Centre recommends that commissioners purchase specific care packages with specified outcomes for care.**

Commissioning should include a system of incentives as part of a charging/payment framework that is geared to improve quality and efficiency, and overcomes barriers to both.

## Rationalising the assessment process

Some prisoners experience multiple assessments, which delay their receipt of appropriate care and treatment and waste the resources of those providing the assessments. There is a clear case for standardising entry criteria to secure care and for rationalising the assessment process. **The Centre recommends that duplication of assessments should cease.** Where appropriate a single assessment should take place that has the expertise and capacity to decide on timely entry to any tier of security. Such an assessment must have currency in all parts of secure care. A single assessment could be performed by regionally based teams operating to the same standards.

Currently secure services cater for those with:

- severe mental illness who pose risk to others (and themselves) and where there is an intrinsic link between offending and their mental illness;
- those with primary personality disorder who pose risk to others;
- those with a 'dual diagnosis' who pose risk to others;
- those transferred from prison with severe mental illness who do not necessarily pose risk to others and/or where there is no intrinsic link between offending and their poor mental health;
- those with severe mental illness, who may or may not have offending histories, but who have proven too challenging to manage in mainstream inpatient settings.

We need a review of the process by which people are identified, assessed and admitted. This ought to include specific review questions on sub-populations (e.g. women, people from Black and Minority Ethnic communities and those with sensory impairment, learning disability/difficulty and speech and communication disabilities).

There is some geographical variability in the availability of services for some of the groups identified above. Women and people from Black and Minority Ethnic communities may also have additional needs, as will those with a learning disability and difficulty. **The Centre recommends that clear service specifications be developed for each group**, to inform assessments and guide decisions on appropriate tier of security.

### Assessing the need for provision

It is estimated that 30% of the new money that followed the past decade of mental health reform has gone into secure care, and yet the reform strategy of the time (the National Service Framework for Mental Health and the NHS Plan) was largely concerned with reforming community services. It can be argued that investment in secure care in recent times has not been strategic and not been based on an understanding of need. While the Centre is confident in the findings from this review, these have largely emerged from qualitative data. There is a gap in knowledge that needs to be filled in order for our recommendations to be realised.

**The Centre recommends that a needs assessment be conducted that provides an understanding of the regional requirements across all tiers of security** for all the groups described in the previous section. It is quite possible that much of the data that would inform the needs assessment already exists. The needs assessment should be a concurrent activity with the development of the framework of guidance and quality standards for secure care as each activity will inform the other.

### Transfers from prison

There were some very different views on the appropriateness and achievability of the 14 day transfer target, but there was agreement that the process of assessment for transfer could often be somewhat Byzantine and convoluted. Examples were given of multiple and near identical assessments being conducted that taxed the resources of the units providing them as well as poorly serving the patient and referring in-reach service.

There seems to be a compelling argument for having one competent assessment process that has currency across all tiers of secure care. There are areas currently that have gone part way to establishing such an assessment procedure for local referrals and these appear to work well. Where these arrangements are in place, and also where there is a working relationship between prison in-reach and secure care (either literally or virtually part of the same team), there was much less difficulty in achieving timely transfer, often well with 14 days. **The Centre recommends that improved relationships should be developed between prison and secure mental health services** to help to facilitate faster transfers.

## Developing care and treatment packages

Data on care and treatment provided within secure care suggest that very similar programmes are available across secure care settings, but that not everything is available everywhere and that commissioning care and treatment across a pathway, were we to move to this, (i.e. across different tiers) would be very difficult currently. Some degree of standardisation of treatment and care packages is also required to ensure that the quality of care delivered is high wherever it is provided.

In addition, pathways for some groups of patients might involve movement off a secure care pathway, such as transfer to community mental health or generic mental health inpatient services, and also transfer back to prison. In the former case it would involve some investment of resources in mainstream mental health, to continue programmes of care when it is no longer appropriate to deliver these in a secure setting. In the latter case, information needs to be shared with offender managers and parole boards on the treatment programmes received and this should have the appropriate equivalent weight on parole boards' decision making as prison service 'treatment' programmes.

**The Centre recommends that guidance and quality standards are used to define, develop and standardise treatment and care packages across different settings.** Part of this work would need to be done in partnership with the Ministry of Justice to explore the 'weighting' such programmes should have on decisions over parole, etc.

## Supporting mainstream mental health

There is an argument for developing each tier of secure care and the very first recommendation is just about this. It is also worth giving particular consideration to care in the community for those moving from secure care.

Some of our participants wanted to see the development of community forensic mental health teams that provide a parallel service to that of community mental health teams for those leaving secure care. Some teams already exist and still others provide more of what could be described as an outreach and liaison service to mainstream mental health. It is clear from our review that there is a need for developing community support but there is very little research in this area and that which exists does not make the case for any specific model.

There is little appetite or resource for developing yet another type of specialist community team and any resource that can be freed from redesigning secure care might be better used in developing outreach and liaison from secure care to support mainstream mental health teams and in developing capacity for treatment (e.g. training and skills) in existing community mental health and assertive outreach teams. **The Centre recommends that when developing guidance and quality standards specific focus is given to developing more support for mainstream community mental health services.**

Different groups within the secure care population will require specific consideration and particularly those with personality disorder who traditionally have not been seen as the business of community mental health care and yet have problems that are likely to go beyond the competency of traditional primary care. **The Centre recommends that people discharged from secure services, including those with personality disorders, should not be excluded from mainstream mental health services.**

## Developing shared learning networks

Ensuring coherent care across pathways means that more collaboration than currently is apparent needs to take place between providers of different tiers of care and with commissioners. One means of doing this is the development of existing and new shared learning networks that include clinicians and managers from all tiers and all sectors and which engage these in developing pathways and in further understanding what each do. The networks might be regionally based and also speciality based, but there should be some mechanism for ensuring all such networks are aware of the activity of others and this suggests both a national steering body and web-based communication. **The Centre recommends that shared learning networks be established.** The Royal College of Psychiatrists' Secure Services Quality Network is an example of such network, but there is much more that can and should be developed in this area.

## Data

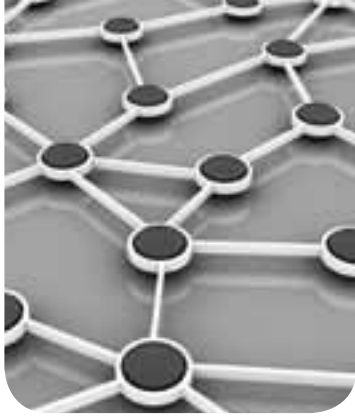
**The Centre recommends the development of a national secure service patient data-set.** This would allow both individuals' progress through services to be monitored and aggregated data to be collected to assess providers' performance and outcomes.

## Developing service user and carer voices

Those who use secure mental health services and their carers have a right to understand what those services can do for them as well as to have expectations of those services and to have an involvement both in service development and in their own care. **The Centre recommends that commissioners routinely use feedback from service users to measure the performance and outcomes of secure care services.**

Many of our participants were engaged in developing a Recovery approach in their services. **The Centre recommends that consideration be given to promoting the Recovery approach across the secure care pathway.** This would involve, among other things, developing routes into employment.

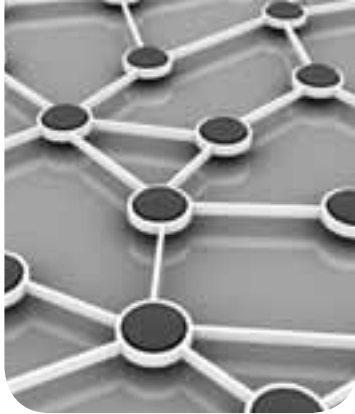
A possible function of the proposed secure care shared learning networks would be the promotion of the Recovery approach. In addition, **the Centre recommends that training in the Recovery approach should be available to all secure care staff.**



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# Appendices

## Appendix 1: Secure services in other countries

This section examines the structure of secure services in some other Western countries by way of comparison to the English system.

### United States

The USA has the largest prison population spread across a county, state and federal system of ‘lockups’ (usually for no more than 24 hours and often in police stations), jails and prisons. There is a much clearer distinction between prisons and jails and although the USA has one of the largest correctional populations, it is delivered at a lower cost per prisoner than many other European examples.

In terms of mental health, prisoners are not eligible to leave the prison environment except via the courts and a finding of not guilty by reason of insanity. Once within prisons, prisoners are classified according to security and other needs. The latter would include placement in more specialised psychiatric units. It is recognised that the American prison system holds more people with mental illness than hospital care outside of prisons and one prison in Los Angeles is now the largest psychiatric inpatient unit in the USA .

Involuntary treatment is available within American prisons and, like outside of prisons, is based upon issues around competency and whether that person is a danger to themselves or others.

### Canada and Australia

Canada and Australia have dedicated secure units, though the degree of provision varies by state in each country. In Victoria (Australia), there is the Thomas Embling Hospital, a high secure hospital, and a number of smaller low secure units. The latter may act as a ‘step-down’ from high secure, but are more frequently are a ‘step-up’ for more challenging patients from generic mental health care. The high secure hospital at the time of the Centre for Mental Health’s visit (in 2009) was also providing mental health screenings and assessments for remand prisoners at Melbourne’s Assessment Prison. The prison also had a number of dedicated secondary care psychiatric beds.

### Europe

There are many and varied models across Europe. In 2006 a major review of prison and secure mental health services across Europe was conducted and reported in the document, ‘Mentally Disordered Persons in European Prison Systems – Needs, Programmes and Outcomes.’ (Salize *et al.*, 2007)

In the majority of European prisons, health care remains the responsibility of either justice or the prison service. In only five jurisdictions, (Cyprus, England and Wales, France, Iceland and Norway) health is the responsibility of the Department of Health or its equivalent. The view that health care is

better delivered by health systems rather than judicial systems is therefore not shared. In the majority of prisons in Europe, delivery of mental health care is by a combination of external and internal services.

Prison health services in England and Wales cost around £200 million per year on prison health for around 84,000 spaces. This amounts to around £2,500 per prison place a year – equivalent to €2,779. Comparing this to other European countries, England and Wales is ranked 8th and behind Austria, Finland, Iceland, Italy, Luxembourg, Norway and Sweden. It is noted that most of the countries in Western Europe were unknown in their spending.

A number of other countries have dedicated mental health units (within their national health system) for mentally disordered offenders. For example the Republic of Ireland has had a high secure hospital for over a century, indeed the hospital at Dundrum is the oldest secure hospital in Europe. Ireland has developed medium secure facilities in more recent years and these are influenced by similar developments in the UK. Sweden has a range of secure units and a Centre for Mental Health visit to the maximum security forensic psychiatry unit in Sundsvall suggested very similar approaches to treatment to the UK.

Most countries provide mental health care as a part of generic health care within the prison system, but some have dedicated mental health facilities within the prison system. Spain, for example, has dedicated prisons or parts of prisons, as well as programmes with residential facilities within prisons for those with mental health problems. Centre for Mental Health had the opportunity to visit three of these, in Catalonia, Madrid and Seville, in 2009. These units appeared to provide for those whose offending was linked to mental illness as well as prisoners who had subsequently developed mental health problems. There was also a question as to whether some of those in these units might have been compulsorily treated in generic mental health wards had they been in the UK.

Several countries have treatment prisons. In the UK there are several therapeutic community prisons, HMP Grendon being the best known of these. Many of the prisoners in these units would be described as having a personality disorder. There are many examples of treatment prison for those with addictions across the world, but fewer that provide anything equivalent the UK's therapeutic community prisons. Denmark has a high secure psychiatric facility but also has a treatment prison (the Herstedvester Institution), with psychiatrists and psychologists on staff. The Herstedvester Institution provides assessment for prisoners with suspected psychotic illness before transfer to psychiatric hospital or, if they are deemed dangerous, to the high secure hospital. Involuntary treatment can be initiated at the prison. The main activity of the Institution is to provide treatment for offenders, both male and female, with severe personality disorder. The treatment offered is both individual and group treatment.

When Centre for Mental Health visited in 2008, staff at the Herstedvester Institution stated that continuity of care was an issue for prisoners released from the institution, often because community services were unwilling to engage with ex-prisoners (the same was reported in Spain). The prison had the facility to re-admit ex-offenders for up to two days (in a separate unit) in a crisis immediately post release. This would be a voluntary return to prison, instigated by the former prisoner and at the discretion of the prison management, and would be used to re-connect ex-prisoners with community services to resolve the crisis.

## The Netherlands

One of the most widely reported systems is that of the TBS in Holland. TBS ('ter beschikking stelling'), translates as 'at the disposal of the government' (see Avramenko *et al.*, 2009). TBS services came into being in the 1920s and have had over their history a particular focus on those who would be deemed to have personality disorder, but they also do provide for offenders suffering from psychosis. Some elements of TBS treatment programmes are provided separately for those with psychosis and those with personality disorder.

Dutch law has a concept of proportionality when considering responsibility for an offence and to some degree this influences the type of sentence. A person may be deemed to be responsible only partially (represented as a percentage) for their behaviour and if they meet the criteria for TBS then their sentence will be a combination of prison time followed by time in TBS.

Those in the TBS system are likely to remain in the system for a long time but with periodic review. When visiting the TBS units, Centre for Mental Health was told that while most TBS patients were expected to eventually return to the community about 15% proved to have very long terms needs and these were accommodated in units with less intense staffing and treatment programmes. A TBS transition to the community typically involved trial leave with staff, then unaccompanied leave, transfer to a rehabilitation unit in the community and outpatient treatment (e.g. see De Boer *et al.*, 2008). The decision to make such assessments is guided by risk assessments.

## Conclusion

There is a great deal to be learnt from studying other systems. TBS, for example, has operated treatment programmes for personality disorder for several decades and there may be much to be gained from the TBS experience, and De Boer *et al.*, (2008) suggest as much when comparing British DSPD units with TBS. However, such 'lessons' do not make a case for adopting such a system in the UK. TBS emerged as a result of circumstances unique to the Netherlands and operates within a radically different legal context. Our review, including the consideration of other systems, concludes that we do not require an additional system or alternate form of institution, but rather need to refine and improve the systems we have.

## Appendix 2: Methodology and data

### The review

The data informing this review include that collected from a specifically commissioned set of visits for the review (the ‘case studies’), but also a series of fact finding visits to high, medium, low secure services and prisons, conducted by Centre for Mental Health within the UK and internationally over the past four years.

### Existing data

We conducted an extensive literature search for publications (research and policy documents) related to the key themes of the project. We examined data provided by government documents relating to secure services and prison mental health care. An internet search also provided some information on costs of services, bed numbers and types of services.

### Case studies

We selected a number of case study sites to visit and collect data. In total, we selected seven sites in four different regions of England and visited four medium secure units, one high secure unit, one low secure and community forensic team and one low secure and step-down service.

Six of the services were run by the NHS and one was run by an independent sector provider. In one locality, we visited services at all three levels of security to understand better how they interacted.

At each site, we spent 2-3 days and collected both qualitative and quantitative data.

The type of data we were looking for included anonymised information from records (e.g. bed management records), audits, annual reports and cost reports. The sort of information we requested from each site is listed in Box 1 overleaf.

Not all of the sites were able to provide us with comprehensive quantitative data. Three of the seven were able to provide good quality data from their existing records.

At each of the case study sites we requested to speak to nurses, psychiatrists, psychologists, occupational therapists, social workers, managers, commissioners, service directors, or anyone who worked in the service who may have some understanding of the key project issues. For each of these individuals we conducted semi-structured interviews.

### Focus groups and interviews

As well as the case-study site interviews, we conducted a number of other interviews with commissioners and case managers from commissioning groups, policy makers, and voluntary sector project leads.

In addition, in order to gain an idea of service users’ perspectives, we conducted separate male and female focus groups (including some carers of people in secure services) and a number of individual interviews.

**Box 1: Information sought from sites visited**

- **Admissions** – numbers admitted, previous placement (e.g. prison, hospital, community)
- **Discharges** – numbers discharged, discharge location
- **Referrals** – numbers, location & type of referrers (to and from service), length of procedure
- **Transfer procedure** – length of time, locations, information on delays
- **Length of stay**
- **Bed occupancy and availability**
- **Outcomes** – psychiatric recidivism, re-offending, employment, re-settlement
- **Demographics of service users** – age, gender, ethnicity, offence history (general)
- **Demographics of general psychiatric services & local population**
- **Information about specific groups** – women, Black and Minority Ethnic groups, young people, personality disorder, dual diagnosis, drug and alcohol services, learning disability
- **Clinical characteristics & primary diagnosis of service users** – including legal category
- **Index offences of service users**
- **Staff information** – professions and numbers of staff
- **Therapeutic options** – types of interventions employed, effectiveness
- **Security & risk** – risk assessments used, levels and types of security
- **Costs** – overall costs of services, cost-per-patient, cost of staff.

**Other data collection**

Data was also used from other interviews and visits Centre for Mental Health has conducted for related reviews, including visits to Dangerous and Severe Personality Disorder (DSPD) units, medium and low secure, prison mental health inreach services and eight international visits to services for mentally disordered offenders conducted within the last three years.



## Pathways to unlocking secure mental health care

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