Psychiatric Bulletin (1991), **15**, 257–262

A survey of patients from five health districts receiving special care in the private sector

Jeremy W. Coid, Senior Lecturer in Forensic Psychiatry, Department of Psychological Medicine, St Bartholomew's Hospital, London EC1

There has been a rapid growth in the number of patients receiving secure and special care in private hospitals, although their overall numbers are still comparatively small. The behavioural modification unit at St Andrews Hospital, Northampton, has the largest concentration of detained patients outside the National Health Service (NHS), but there are plans to increase the number of beds at Kneesworth House, Royston, Herts, and Stockton Hall, Yorkshire. St Andrews Hospital has been run as a charitable trust but Kneesworth House and Stockton Hall are currently owned by a private French company, Generale de Santé division of Generale d'Eau, together with Langton House, Dorset, which provides places for disturbed adolescents. Marks & Thornicroft (1990) noted that recent entrants into the private sector have been from private for profit rather than voluntary non-profit providers, catering for what are seen as "market niches" such as eating disorders, impotence, alcohol or substance abuse, and stress reactions. They criticise these developments, claiming that few people benefit and that the "bull market" in private hospital development challenges the catchment area concept and seems to be producing a two-tier system of psychiatric care in Britain.

It is not clear whether these arguments extend to patients receiving private secure and special care. Marks & Thornicroft referred to individuals with private insurance and those who could pay fees directly, but the former group of patients are funded by regional and district health authorities who do not have adequate local provision and use their annual allocation of monies raised by public taxation. Brandon (1987) has voiced his concern over these developments and asked why a private company can provide this form of care at a profit but the NHS cannot. More specific cricitisms have cóme from the Mental Health Act Commission (1989) over the distance of these units from patients' homes and the extent to which the sponsoring health authorities can continue to monitor the care being given to their patients. More importantly, they recognised a "strategic problem" in the development of private units offering secure and special care as a direct result of health authorities' lack of provision of suitable facilities.

These developments pose the inescapable question of why these facilities are not provided locally. There may well be multiple reasons, including factors of health care philosophy, managerial strategy, professionals' attitudes towards difficult and offender patients, and inadequate funding of the appropriate resources. However, a first step in understanding the problem is to identify who the patients are receiving this form of care, what is wrong with them, what problems they present with that cannot be coped within local NHS facilities, and what facilities should be provided by the NHS that would ensure that they are.

The study

A previous administration of the North East Thames Regional Health Authority (NETRHA) introduced the policy of funding patients who required admission to a regional secure unit (RSU) in private hospital care pending the development of local services. A separate budget was set aside and included monies provided by the DHSS for the development of forensic psychiatry as recommended by the Butler Report (1975). Patients were admitted to two private hospitals, St Andrews, Northampton, and Kneesworth House, Herts. An arrangement was also negotiated with the Dennis Hill RSU in the South East Thames Region to provide a small number of beds for a limited period, to cease upon opening the 12-bedded interim secure Unit (ISU) at Hackney Hospital.

With the progressive development of forensic psychiatry services in North East Thames by a new administration, it became important to reassess the numbers of patients in these facilities and their needs. The consultant and nurse manager of the newly opened Hackney ISU visited and assessed all patients in private care from a 5-district catchment area between December 1987 and March 1988. The same patients were followed up two years after the initial assessment.

Findings

Description of sample

In December 1987 there was a total of 176 patients requiring special care in two private hospitals at

https://doi.org/10.1192/pb.15.5.257 Published online by Cambridge University Press

the expense of different district and regional health authorities in England and Wales. Fifty-eight (33%) originated from North East Thames. Of these, 26 (45%) originated from the 5-district catchment area covered by the Hackney ISU, with another four patients in the Dennis Hill Unit. The sample totalled 30 patients, with the remaining 28 originating from the districts covered by the other two ISUs at Runwell and Friern Hospitals which were not included in the study. A disproportionate number (19; 63%) originated from the City & Hackney District, compared to 5 (17%) from Tower Hamlets, 4 (13%) Barking, Havering and Brentwood, 1 (3%) from Newham, and 0 from Redbridge. Their mean age was 31 years (range 16–53 years) and 8 (27%) were female. Fifteen (50%) were Afro-Caribbean and 10 (33%) were non-British born. Four (13%) were informal patients, 9 (30%) detained on civil orders, and 17 (57%) under Part III of the Mental Health Act, 1983. Ten (33%) had been placed in private care due to disruptive and aggressive behaviour in catchment area wards, two (6%) because appropriate district facilities apparently did not exist, and 18 (60%) following criminal charges (see Table I). Table II shows the primary diagnosis of each patient. This facilitated division of the patients according to their needs but oversimplified their problems. For example, the two women with borderline personality disorder also suffered from episodes of bipolar affective illness, one schizophrenic was blind, another was epileptic, etc.

TABLE I
Behaviour resulting in transfer to private care

	N	%
Criminal charges		
Manslaughter, infanticide	3	10
Attempted murder	2	7
Grievous bodily harm	3	10
Actual bodily harm	2	7
Buggery	1	3
Indecent assault	4	13
Arson	2	7
Criminal damage	1	3
Behaviour in catchment area ward*		
Violence	10	33
Sexual disinhibition/promiscuity	5	17
Firesetting	1	3
No available local provision	2	7

(*Not mutually exclusive categories)

TABLE II
Primary diagnoses of subjects

	N	%
Mental illness/psychopathy	20	66
Schizophrenia	13	43
Schizoaffective disorder	4	13
Puerperal mania	1	3
Borderline personality disorder	2	7
Mental impairment	7	23
Brain damage	3	10

Unmet needs

The subjects' histories, diagnoses, and current circumstances were assessed with a view to planning their return to local catchment area facilities, or if these were unsuitable the type of facilities that were required. Patients fell into three main groups: mentally ill/psychopathic disorder (20; 66%), mentally impaired (7; 23%), and brain damaged (3; 10%).

Mental illness/psychopathic disorder

Secure unit (n = 4)

Only four patients still required the level of security offered by the newly opened ISU. Of these, three were in the Dennis Hill Unit and were transferred as soon as the ISU opened. One personality-disordered woman remains an in-patient in medium security five years after she killed her baby and two schizophrenic patients have been discharged to out-patient status. After 18 months the fourth schizophrenic man was transferred to his catchment area ward, still on a hospital order, after a violent sexual assault. His mental state soon showed a spontaneous deterioration, with inappropriate sexual overtures to female staff and patients. He is currently in a locked ward and has been referred back to the ISU.

Catchment area psychiatric ward (n = 8)

This group was ready to return to the care of their catchment area consultant and no longer required conditions of security. All were detained under Part III of the Act except for one whose hospital order had been allowed to lapse to informal status. There had been considerable delays over their return and some had essentially been forgotten. It was thought that half would have originally required the security of the ISU or a locked ward. One continues to remain an in-patient on a restriction order and one was discharged. He was later admitted to the ISU following further convictions, from where he was transferred to a special hospital. The remaining six were discharged to out-patient status almost immediately after their return. One promptly left the country, two attend out-patient clinics, and three are lost to follow-up.

https://doi.org/10.1192/pb.15.5.257 Published online by Cambridge University Press

"Difficult to place" requiring long-term structured care (n = 8)

Of these, seven suffer from chronic, treatment-resistant schizophrenia and one a severe personality disorder. The latter patient was eventually discharged to her own flat, by way of her local psychiatric hospital, after a prolonged period in private care. All except one schizophrenic patient on a hospital order were detained under Section 3 of the Mental Health Act. They had shown assaultiveness, sexual disinhibition, and had damaged property in their catchment area facilities. One remains in the private hospital as his catchment area team were not prepared to have him back under any circumstances. Three were successfully returned but continue to block acute and rehabilitation beds with no current prospects for transfer to a hostel. One man insists on wearing a skirt in the hospital grounds and threatens staff if his routines are disrupted, another blocks toilets and sinks, and a third shows classic symptoms of the "buffoonery" syndrome. The other three have been returned to the private hospital. One began to make progress on return to an acute admission ward and application was made for a place in a hostel. He then burst into a state of catatonic excitement and was admitted to the ISU for emergency ECT. Another remained settled and compliant during his return by way of the ISU. However, within 48 hours of his transfer to an open ward he kicked a nurse in the groin who required emergency surgery. The third was turned down for admission to a special hospital despite regular assaults on female nurses in the ISU on the grounds that her behaviour was more stable in the previous behavioural regime of the private hospital. Her behaviour continues to be more stable in this setting since her return.

Mental impairment

Special facilities with security (n = 4)

These patients required admission to a specialised unit for the mentally impaired where staff had expertise in dealing with patients posing criminal and deviant behaviour, as described by Day (1988). They were mildly mentally handicapped and had psychopathic traits, sexual perversions, and exhibited criminal behaviour in the community. One predatory paedophile on a restriction order continues to remain in a private hospital. Another on trial leave from a special hospital was placed in private facilities as there were no in-patient beds in his catchment area district. He had previously been convicted of manslaughter, indicating the need for a careful assessment. His case conference was attended only by two untrained staff from his catchment area who worked in a "Respite" centre. He was later returned to the special hospital after unsatisfactory behaviour while in the private hospital on trial leave. Two women from the same district have an additional diagnosis of personality disorder and both mutilated and prostituted themselves. Attempts to restrict their activities had resulted in assaults on hostel staff. They were returned to local hostels by way of the acute psychiatric admission wards of their district but continue to abscond and receive intermittent criminal charges. Without mental handicap in-patient beds, the burden of such patients appears to have been shifted to acute general psychiatry.

"Difficult to place" requiring long term structured care (n = 2)

These patients have full scale IQs of 51 and 61 respectively, the latter with a diagnosis of autism. They had grown up in local institutional care but in adulthood their intermittent explosive outbursts rendered them unsuitable for a hostel in the community. Catchment area staff considered them unmanageable on an open ward for the mentally handicapped. They remain in private care with no prospects for return.

Other (n = 1)

A 16-year-old female had never shown any serious problem behaviour but was described as overweight, preoccupied with food, making noises in her sleep, interfering with others, and failing to learn at school. Her mother was unwilling to cope with her at home and there were apparently no appropriate local facilities for a girl of her age. Upon reaching the age of 16, the local child and adolescent services considered her the responsibility of the mental handicap team but no referral had been made. She has now returned home.

Brain damaged (n = 3)

These three patients were very different but illustrated many of the problems surrounding the admission of patients to private hospitals. One had post-traumatic brain damage following a road traffic accident, but no psychiatric or behavioural problems. There appeared to be disagreements over catchment area responsibility and his parents who had never come to terms with his disabilities, had complained about his care. He has returned to live at home and receives day patient care.

A second patient suffered from post-traumatic frontal lobe damage and had frequent admissions to his catchment area psychiatric hospital. He was repeatedly discharged to his flat where he was quite unable to care for himself independently. Eventually he set fire to his mattress and was charged with arson. No bed was made available on the grounds that all that could be done for the patient had already been

https://doi.org/10.1192/pb.15.5.257 Published online by Cambridge University Press

done. The Judge sentenced him to life imprisonment with leave to appeal. On appeal, this was quashed and a hospital order with restrictions substituted instead. He remains in a private specialist unit for the brain damaged.

The third man was deaf, dumb, post-meningitis brain-damaged, schizophrenic, intermittently assaultive, and sexually disinhibited. He never progressed from the most secure ward of a private hospital except when he escaped. After years of care within these confines and a short-lasting, disastrous placement in a special unit for the deaf, he has been transferred to a special hospital.

Comment

This survey included very small numbers from a limited geographical area but demonstrated some of the implications of failure to provide local services. To some extent this sample gives a misleading overall impression of patients receiving private secure and special care, as many would not have been transferred to the private sector had the full complement of RSU beds been available. Plans are under way to develop these facilities and NETRHA has encouraged districts to develop locked intensive care wards. These have resulted in further reduction in demand for private beds from two districts studied and an additional fall in the number of in-patients referred to the ISU, similar to the effect observed by O'Grady (1990). However, the identification of a "difficult to place" subgroup demonstrated a need for structured, long-term in-patient provision that may well not be available in many other health districts nationally. It was this subgroup that appeared to characterise many of the patients in private care from other RHAs at the time of study and who have been targeted by the private sector as a "market niche".

The "difficult to place" subgroup were identified as suffering from particularly severe variants of schizophrenia, mild or moderate mental handicap, and brain damage. They presented with what is currently euphemistically termed "challenging behaviours". Most were detained under Section 3 of the Mental Health Act and, in this survey, had come from deprived, inner city districts, without recourse to long-stay beds. It was clear that this lack of district facilities had contributed towards their displacement towards the private sector, but may also have been influenced by the possibility that certain locations have more than their fair share of these difficult patients (Inter-Register Technical Committee, 1982). This may also be supported by the observation that overall referrals to the local forensic psychiatry service for the years 1987–90 originated in disproportionate numbers from the City & Hackney District. The level of these referrals did not appear to correspond with relative provision of resources or attitudes towards mentally abnormal offenders (Coid, in preparation).

An important question was posed over whether the "difficult to place" subgroup represented a particularly severe end of the spectrum of disability, or whether their selection for private care was merely fortuitous. If the latter were the case, then it could indicate that many patients are not currently receiving the services they need. It also poses the question of whether they are being rejected and diverted instead towards the prisons (Coid, 1988), hostels for the homeless (Marshall, 1989), and onto the streets of our major cities in increasing numbers. It is likely that both processes have been in operation but the striking feature of these particular patients was the sheer severity of their conditions and the impression that few could have survived in the community for long before they would have been returned to hospital in a grossly deteriorated state. In the case of two brain-damaged men who did commit criminal offences, the court (if not the local psychiatric service) had recognised their need for ongoing in-patient care and had ensured they would receive it by the imposition of restriction orders under Section 41.

The policy of funding these patients in private care was a humane and generous way of looking after them in the short term. However, it was expensive and the local development of three ISUs and district intensive care wards has demonstrated that it is not cost-effective for some patients over the long-term. Although the cost of private beds compared favourably with these facilities during the study period, it is my impression that patients stay longer in private beds. Without regular monitoring there had been little impetus to return this sample of patients to their catchment area. Some had been forgotten, some local teams had been extremely reluctant to accept them back, and catchment area responsibility had sometimes become blurred. For example, one consultant had retired, another died, and two adolescents turned 16 years of age without responsibility being passed on.

It also appeared that the RHA's generosity was sometimes abused. None of the five districts made plans to care for "difficult to place" patients while they were funded by the region. Fees for those who remain are now paid for by the parent districts. However the argument continues to be made that as the RHA has funded these patients in the past it should therefore continue to do so in the future. This impression was further reinforced by a telephone call to me from a district manager requesting that funds be made available for a patient to be transferred to private care from a non-psychiatric ward. This was to enable the ward to be closed for Christmas to save the district money.

The increasing investment in secure and special care beds by the private sector suggests that a

https://doi.org/10.1192/pb.15.5.257 Published online by Cambridge University Press

particularly lucrative gap in the market has been identified and that a challenge from the NHS is not expected in the near future. It is therefore important to place in context the purchase of private care using NHS funds. Inflow of monies to the private sector is dependent upon the admission of sufficient numbers of patients and this is maintained the longer they stay. In contrast, the fixed budgets of district health authorities are consumed in direct proportion to the numbers of patients admitted, to some extent their length of stay, but also in proportion to the level of clinical activity involved in their care. The "difficult to place" patients would appear to be ideal private patients. They do not require the level of staffing of a RSU or involve the level of expensive activity surrounding an acute admission that must later be passed on to the customer. By definition, they stay a long time. Furthermore, a continuing flow of clients now appears guaranteed as the NHS dismantles its long-stay institutional facilities.

The NHS could learn from the quality and organisation of these private sector facilities. "Difficult to place" patients receive a highly structured form of long-term "care" which contrasts with the acute "treatment" model of district facilities. Private hospitals are characterised by excellent facilities, well-trained and highly motivated staff, and regimes that emphasise humane containment at the same time as ensuring behavioural compliance using a range of behavioural and cognitive techniques. Progress of a patient from one level of security to another and the giving of specific privileges are determined by behaviour. It is noticeable that progress through different levels can occur with a degree of flexibility that would not be possible within the NHS. The equivalent might involve a move from one geographical location to another, one consultant to another, and require the agreement of more than one member of two multidisciplinary teams. This study has identified another important implication of purchasing this form of private care. It would appear that the behavioural gains made by patients in private hospitals do not necessarily generalise back to their catchment area wards. Some patients demonstrated a deterioration back to their former state, or worse, once they left these highly structured environments.

The private hospitals seem to be offering a well-managed, highly flexible and well-resourced form of institution-based care. This could surely be offered within the NHS, particularly with the proposals of the NHS and Community Care Bill to alter the mechanism of funding health care to a model similar to that of the private sector. However, this would require a major change in outlook and philosophy and an investment in appropriate resources. Without a clear and uniform DoH policy many health districts are currently set on a course of abandoning long-term special care to the private sector.

Conclusion

This small survey highlighted the type of secure and special care facilities that are required in the NHS but are currently missing from some health districts. These include:

Mentally ill/psychopathic disorder

(a) Locked, intensive care wards for short-stay patients during acute periods of acute disturbed behaviour consequent upon their underlying mental disorder.
(b) Long-stay, highly structured, in-patient settings for chronically disturbed, treatment-resistant patients whose conditions do not appear amenable to rehabilitation in the foreseeable future.
(c) Regional Secure Units for patients requiring conditions of security that cannot be offered in district facilities, but at a level below that offered by the special hospitals.

Mental impairment

(a) Special units with a level of security for patients posing problems of deviant and criminal behaviour (see model described by Day, 1988).
(b) Long-stay, highly structured, in-patient ward settings for a more severely handicapped group posing severe behavioural problems or "challenging behaviours" with little prospect of rehabilitation.

Brain-damaged

Special units for brain damaged patients with additional psychiatric and behavioural problems, requiring long-term, highly-structured, in-patient care. It remains unclear whether the overall numbers are sufficient for individual RHAs to develop economically viable specialist units.

Postscript

In the past, all patient subgroups would have received care within a single mental illness or mental handicap institution. In essence, this paper has proposed an expensive plethora of small units in line with the philosophy of mental health care over the last two decades. It is therefore somewhat ironic that the private sector has developed a model of care along similar lines to the earlier institutional model. Furthermore, patients within different diagnostic groups are currently housed in the same wards. However, these private institutions contrast dramatically with the corresponding public facilities. They are characterised by investment and professional enthusiasm instead of stagnation and neglect.

https://doi.org/10.1192/pb.15.5.257 Published online by Cambridge University Press

Acknowledgements

I would like to thank the staff of St Andrews Hospital and Kneesworth House for their kind help and cooperation.

The opinions expressed in this paper are those of the author and do not necessarily represent the North East Thames Regional Health Authority.

References

BRANDON, S. (1987) Conference Report: a subversive foray into private practice. *Bulletin of the Royal College of Psychiatrists*, **11**, 23–24.

BUTLER REPORT (1975) *Report on the Committee on Mentally Abnormal Offenders*. London: HMSO.

COID, J. W. (1988) Mentally abnormal offenders on remand I. Rejected or accepted by the NHS? II. Comparison of services provided by Oxford and Wessex Regions. *British Medical Journal*, **296**, 1779–1784.

DAY, K. (1988) A hospital-based treatment programme for male mentally handicapped offenders. *British Journal of Psychiatry*, **153**, 635–644.

INTER-REGIONAL TECHNICAL COMMITTEE (1982) *Psychiatric Care in Eight Regional Areas. Statistics from Eight Psychiatric Case Registers in Great Britain 1976–1981*. University of Southampton.

MARKS, I. & THORNICROFT, G. (1990) Editorial. Private inpatient psychiatric care. *British Medical Journal*, **300**, 892.

MARSHALL, M. (1989) Collected and neglected: are Oxford hostels for the homeless filling up with disabled psychiatric patients? *British Medical Journal*, **299**, 706–709.

MENTAL HEALTH ACT COMMISSION (1989) *Third Biennial Report 1987–1989*. London: HMSO.

O'GRADY, (1990) The complimentary roles of regional and local service provision for psychiatric patients. *Health Trends*, **22**, 14–16.

Psychiatric Bulletin (1991), **15**, 262–264

A retrospective study of charts according to size: implications for management and prevention?

BRIAN O'SHEA, Consultant Psychiatrist, Newcastle Hospital, Greystones, Co. Wicklow, Ireland; and JANE FALVEY, Senior Registrar, Eastgate Unit, Middlewood Hospital, Sheffield

In 1975 Sims published his celebrated paper on 'Factors Predictive of Outcome in Neurosis' (Sims, 1975). A big chart was associated with a poor prognosis.

We were interested in determining the significance of having a big file. A prospective study, while superior in terms of information gathering, would take many years to complete and would not necessarily reflect what happens in routine clinical practice. Therefore we decided to carry out a retrospective study. We predicted that large file patients would be characterised by extreme social disadvantage.

The study

We chose the In-patient Medical Records Department of a large public urban district psychiatric hospital. The study was cross-sectional and retrospective. All charts were constructed in a similar manner and using the same materials. Chart size was defined using one pair of steel calipers throughout. The width of the chart at mid-spine was chosen as the accepted size of the file.

Thick charts were more than 1.5" in size, the patient's first recorded address belonged to the catchment area of the hospital, and the chart was currently in the department. Thin charts were less than 0.5"in size, were adjacent to a thick chart, belonged to the hospital's catchment area, and were currently in the department.

Findings

The inclusion criteria were met by 56 thick charts (T group) and 64 thin charts (t). Of the T group, 19.6% were males, 80.4% being female (t = 37.5% and 62.5% respectively). Admissions averaged 25.7 (range 5–28) for females and 28.3 (7–53) for males in the T group (t = 4.3 and 7 respectively). The mean

https://doi.org/10.1192/pb.15.5.257 Published online by Cambridge University Press