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Tilting the balance: the first long-term medium secure unit in the NHS in England and Wales

Rollo May Ward, a long-term medium secure facility integrated within the West London Mental Health National Health Service (NHS) Trust, is the first dedicated long-term NHS medium secure unit to have opened in England. It caters for a group of men with complex clinical needs and risk assessment issues who had previously been inappropriately detained within high secure services owing to a lack of suitable, less secure placement facilities. We describe the background to the development of the long-term medium secure service, the referral and assessment processes, the structure of the ward and the therapeutic programmes available to patients. We also outline the characteristics of the first 21 patients to be admitted to the ward and offer advice for similar future developments.

High secure services (special hospitals) provide access to a wide range of educational, occupational and social facilities in addition to medical care, although the level of security is associated with a greater degree of restriction than is necessary for many patients. Further disadvantages for patients arise with geographical isolation from families, friends and local community psychiatric services, as well as limitations in opportunities for leave. The review of health and social services for mentally disordered offenders and others requiring similar services – the Reed report (Department of Health & Home Office, 1992) – established the principle that patients should be cared for under conditions of no greater security than is justified. Subsequent surveys (Maden *et al*, 1995; Reed, 1997) suggested that considerable numbers of patients cared for in special hospitals were inappropriately placed, in that they required care in conditions of medium security.

Traditional medium secure units have, however, focused on patients expected to require in-patient treatment for up to 2 years, so the group requiring longer-term care in medium security has been, by default, resident in special hospitals, prison and medium secure facilities that do not optimally cater for their needs. Maden *et al* (1995) suggested that those requiring longer-term medium secure care can be seen as partially treated patients whose clinical state is not expected to improve significantly over the subsequent 5 years and for whom risk assessment is complex. The majority are men with serious mental illness and diverse clinical needs, involving complex psychopathology, a long psychiatric history with difficulties establishing treatment, ongoing disturbed behaviour, institutionalisation, frustration at slow progress and social disadvantage.

The NHS Plan (Department of Health, 2000*a*) identified the need for the development of 200 long-term medium secure beds at a national level, while the *Report of the Review of Security at the High Secure Hospitals* – the 'Tilt' report (Department of Health, 2000*b*) – recognised that the local reprovision of services for those no longer needing high secure psychiatric care would require additional financial support. Funding of £25 million, to be used in the first instance to facilitate the movement of patients no longer needing high secure care, was identified.

The long-term medium secure service in west London

In 2000 a multidisciplinary team was set up within the Ealing, Hammersmith and Fulham Mental Health NHS Trust (now the West London Mental Health NHS Trust) to consider the establishment of a long-term medium secure service for the North West Thames Region. A needs assessment of all patients from this region detained in the special hospitals was compiled and their responsible medical officers were invited to nominate patients who they felt no longer required maximum security. These patients were assessed by the multidisciplinary team and 24 were felt to be suitable for long-term medium secure care.

Rollo May Ward, the long-term medium secure service, opened in November 2002 in a refurbished building on the St Bernard's Hospital site. It provides 24 beds, of which 16 are in a main ward designed to accommodate both new admissions and those requiring ongoing assessment, and 8 are in an annexe designed for continuing rehabilitation. The ward has dedicated therapy, education, interview and meeting rooms and a seclusion suite, as well as direct access to a secure balcony and secure garden. There is a dedicated secure work rehabilitation space located off the ward.

Therapeutic and leisure activities take place both on and off the ward and comprise a mixture of group

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activities and one-to-one sessions. Patients receive individualised therapy programmes, updated at regular intervals. The rehabilitation of patients is a primary aim and the ward philosophy incorporates aspects of the therapeutic community model, such as regular community meetings. In addition to their timetabled therapeutic programme, all patients are expected to attend a 'plan the day' meeting at 09.30 h. There is a monthly Clinical Improvement Group, a forum where staff and patients discuss issues relating to the quality of clinical care with a view to improving it. An elected patient representative, who holds the role for 3 months, brings the patients' views to the forum. The weekly timetable is shown in Table 1. A work rehabilitation project runs parallel to this timetable for nine sessions per week and accommodates up to five patients per session. Patients are paid for their work. Work rehabilitation options include painting and decorating, desktop publishing, picture framing, woodwork, bookkeeping and horticulture. All escorted and unescorted leave from the ward is taken at times outside scheduled activities for that individual patient so as not to interfere with the therapy programme. The ward social worker initiates and maintains contact with the patients' families and with the appropriate local authority. The range of therapeutic activities includes communication and concentration, and project groups (occupational therapy); sex offender treatment, cognitive–behavioural therapy and enhanced thinking skills (psychology); and GCSEs, bookkeeping and computer literacy (education).

The multidisciplinary team currently consists of the following members: 1 consultant forensic psychiatrist, 2 junior psychiatrists, 1 ward manager, 1 clinical nurse specialist, 30 staff nurses, 15 healthcare assistants, 1 part-time consultant clinical psychologist, 3 part-time clinical psychologists, 1 assistant psychologist, 1 approved social worker, 2 occupational therapists, 1 activities coordinator, part-time art, music and drama therapists, 1 educational facilitator, 1 technical instructor and 1 full-time team administrator. All staff members have the opportunity to attend a weekly team staff support group facilitated by an external psychotherapist. Nursing staff, healthcare assistants and therapies staff are encouraged to undertake an accredited training programme (Diploma or MSc) in psychosocial interventions.

The admission criteria for Rollo May Ward are outlined in Box 1. Following Home Office approval, patients are transferred from special hospitals on 'trial leave' for a period of 6 months; many have experienced a previous 'failed' trial leave to a traditional medium secure unit or have been assessed as unsuitable for transfer to other secure services. Active participation by patients and their families in the transfer process is sought and facilitated. Patients still considered a grave and immediate danger to others are not admitted, neither are patients who continue to engage in aggressive behaviour giving cause for concern (e.g. requiring seclusion within the preceding 12 months) nor those considered a severe absconding risk.

Referrals to the service

Between January 2000 and December 2003, Rollo May Ward received 73 referrals, of which the majority (74%) came from special hospitals. Other sources of referral included traditional medium secure units within the NHS and secure facilities within the private sector. Of the 73 patients referred, 33 (45%) were deemed suitable for admission and 40 (55%) were rejected as unsuitable. Reasons for unsuitability for admission included an ongoing requirement for care within high secure conditions owing to levels of assaultive behaviour or instability of mental state (15 patients), inappropriate primary diagnosis such as psychopathic disorder (7 patients), lack of

Table 1. Therapeutic programme

Monday	Tuesday	Wednesday	Thursday	Friday
10.00–12.00 Psychology 11.00–12.00 Games room	10.00–12.00 CTM 10.00–12.00 Psychology 11.00–12.00 Games room	10.00–12.15 CTM 10.30–12.00 Community access 11.00–11.30 1:1 Music therapy	10.00–11.30 1:1 Cooking 10.00–12.00 Psychology 10.00–10.45 1:1 Music therapy 11.30–12.00 1:1 Music therapy 11.00–12.00 Games room	09.00–12.00 Psychology 11.00–12.00 Gym
1.15–2.15 Drama therapy group 1.15–2.00 1:1 OT session 2.00–3.00 Gym 2.30–4.30 Psychology 2.30–4.00 CPA	1.00–1.45 1:1 Art therapy 1.00–1.46 1:1 Drama therapy 1.00–2.30 OT printing group 2.00–4.00 Psychology 3.00–4.30 1:1 Cooking 3.15–4.15 Art therapy group 4.00–5.00 Gym	12.30–2.00 African–Caribbean cooking 2.00–2.45 1:1 Drama therapy 2.30–3.30 Music therapy group 2.30–4.00 CPA 3.45–4.45 OT individual projects	2.30–3.30 Communication and concentration group 3.30–5.00 OT cooking group	1.15–2.00 1:1 OT session 3.00–4.00 Community meeting 4.00–5.00 Social drop-in

CPA, care programme approach; CTM, clinical team meeting; OT, occupational therapy.

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Box 1. Admission criteria

- Male gender, aged 18 years or over
- Primary diagnosis of serious mental illness, detainable under the Mental Health Act 1983 (primary diagnosis of personality disorder or significant learning disability excluded)
- Previous admission to a special hospital of at least 3 years' duration and patient thought by his current clinical team to require further care in conditions of medium security for at least 2–5 years
- Potential to benefit from the treatment provided
- Willingness to participate in the transfer process (e.g. familiarisation visits, overnight stays)

engagement with treatment (4 patients) and other reasons (8 patients). Four patients were deemed unsuitable at the time of assessment but were considered likely to be suitable for reassessment within 1 year.

By June 2004, of the 33 patients identified as suitable for admission, 21 had been admitted, with a further 3 awaiting Home Office permission for their transfer. The remaining 9 patients were either admitted elsewhere, discharged from hospital or had died in the interim. The demographic and clinical characteristics of admitted patients are shown in Table 2.

An audit of physical health conducted on 18 patients between November 2003 and January 2004 revealed only one patient with no physical health problem. The main physical health problems involved the cardiovascular system, with half the patients having abnormal electrocardiograms (not solely attributable to antipsychotic medication); the gastrointestinal system, with 6 of 18 patients (33%) complaining of symptoms, including 2 patients with hepatitis C; and dermatological complaints (8 of 18 patients). In addition, 3 patients had diabetes mellitus and a further 5 were clinically obese. Over 60% of the patients had significant dental problems.

Between November 2002 and June 2004 there was no incident of assault on staff or fellow patients and no patient required seclusion. One patient was deemed unsuitable for the ward and was recalled to a special hospital. Within 1 year of their admission, two patients had been granted conditional discharge by mental health review tribunals (one of them against medical advice). There has been no episode of absconding from the ward, and several patients are now in receipt of unescorted leave (both within the hospital and in the community).

The success of the unit thus far is reflected in comments from patients, professionals, mental health review tribunal panel members and external inspection panels such as the Commission for Healthcare Audit and Inspection (further information available from the authors upon request) and in the low number of untoward incidents to date. We believe this success to result primarily from the comprehensive multidisciplinary team assessment of patients' suitability for admission, patient involvement in the transfer process, and the enthusiasm and dedication of the team. Nevertheless, difficulties and unforeseen issues have arisen. First, as a result of the ward's location (a refurbished building on a busy general hospital site), there have been problems with outdated heating and plumbing systems, a lack of large rooms

Table 2. Demographic and clinical characteristics of patients

Age, years: mean (range)	47 (33–65)
Ethnicity, *n* (%)	
Black	10 (47.5)
White	10 (47.5)
Asian	1 (5.0)
Length of stay in special hospital, years: mean (range)	15 (4–33)
Primary diagnosis, *n* (%)	
Paranoid schizophrenia	18 (86)[1]
Schizoaffective disorder	3 (14)[2]
History of substance misuse, *n* (%)	
Polysubstance misuse	5 (24)
Cannabis	10 (47)
None	6 (29)
Legal status (MHA 1983), *n* (%)	
Section 37	17 (80)[3]
Section 47/49	2 (10)
Section 3	2 (10)
Index offence, *n* (%)	
Homicide	6 (29)[4]
GBH/ABH	8 (38)
Sexual offences	4 (19)
Property/acquisitive offences	1 (5)
None	2 (10)

GBH/ABH, grievous/actual bodily harm; MHA, Mental Health Act.

1. Two cases of paranoid schizophrenia with additional diagnosis of personality disorder or borderline learning disability.
2. One case of schizoaffective disorder with additional diagnosis of personality disorder.
3. Sixteen under Section 37/41; one 'notional' Section 37.
4. Two multiple, four single.

suitable for group activities and difficulties in identifying suitable secure outdoor space, necessitating an unsightly perimeter fence. Second, the patient group is considerably older than that found in traditional medium secure units and has higher levels of physical morbidity than anticipated. Mental health NHS trusts planning a similar service should ensure adequate medical and nursing resources to deal with the physical health needs of the patients and should establish and foster close working relationships with relevant medical and surgical colleagues. Lastly, although the long-term medium secure service envisaged patient admissions of 2–5 years, some patients have been discharged within 1 year of admission. Hence, early identification of and regular liaison with the future community responsible medical officer and mental health team should be initiated from admission in order to effectively plan discharge.

Declaration of interest

None.

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Using the scarce resource of child and adolescent psychiatrists equitably

The authors, all consultant child and adolescent psychiatrists working in the north-west of England (an area that has experienced recruitment difficulties throughout the past decade), seek to stimulate discussion about the serious issues of recruitment and retention faced by child and adolescent psychiatry. Current thinking about staffing and models of provision is challenged.

Child and adolescent psychiatrists are a scarce resource. Some services have used the recent investment in child and adolescent mental health services (CAMHS) to create new consultant posts. However, the workforce to fill these posts has not been created. Furthermore, the National Service Framework for Children (Department of Health, 2003) states that CAMHS must expand by 10% year on year for the next 3 years. Whether the 10% is defined as resource, budget or personnel, it is to be expected that there will be some increase in number of child and adolescent psychiatrist posts therein.

The crisis in recruitment

Certainly, the National Service Framework expectation that all CAMHS will extend their age range to 18 years by 2005 will bring an increase in demand for child and adolescent psychiatrists. The College has recently redefined the norms for consultant child and adolescent psychiatrist staffing levels, reducing the total population served per consultant from 100 000 to 67 000 (Royal College of Psychiatrists, 2002). Yet there are services that have no consultant in post, and that have been unable to recruit for several years. There are unfilled National Training Numbers in our specialty and, consequently, little expansion in trainee numbers.

There are particular reasons why child and adolescent psychiatry trainees are filling less of the recruitment gaps than was expected. An increasing number of trainees wish to train and then to work flexibly, and individuals from double-income families may have domestic reasons for being able to consider consultant posts in only a limited geographical area.

It seems to remain the case that well-resourced services are going to find it easiest to gain College approval for new consultant posts. These tend to be in centres of education and population. Services in more remote areas are, with exceptions, disadvantaged.

What are the recruitment 'black holes' to do? Services that have been unable to retain and/or recruit may be able to create more posts (finding a stash of new money, or reviewing priorities within the current budget) that gain easy approval from the College. However, if there is an overall shortage of specialist registrars graduating from training schemes, creating new consultant posts will not solve the overall problem, although the vacancy may shift to another locality. There are services that have created new posts from modernisation monies, yet have struggled to recruit. Services that have had no psychiatrist for a long period, have only one post for a large population or are distant from major cities will continue to face problems.

Thoughts about using the glut of young paediatricians by fast-tracking training conversions are coming to fruition, but it is still a long wait to the harvest. Courses in psychopharmacology for paediatricians, teaching something about medication for attention-deficit hyperactivity disorder (ADHD) and Tourette syndrome, are all very well if paediatricians have adequate training in the assessment and other aspects of management of these disorders. This is questionable on current evidence.

Moreover, the problem remains of ensuring that one's postcode does not dictate whether one can get access to the advice of a child and adolescent psychiatrist. Child and adolescent mental health teams without

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