CHAPTER 1

The evolution of secure and forensic mental healthcare

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Introduction and aims

It is in all likelihood a by-product of human evolution, and of the complexity of the human brain and of society, that there have always been dysfunctional individuals who present overtly with a mental or behavioural disorder. They may cause significant harm and disruption to others, as well as to themselves. The most seriously affected depend on the concerted efforts of those around them to provide a safe and supportive environment, or risk neglect, rejection, homelessness and even persecution. Perhaps there always will be such problems in our communities, and thus a continuing need for secure mental health services, at least until science and society have advanced greatly from their present position.

Mentally disordered offenders and others presenting serious challenging behaviour are more often successfully categorised and labelled by local juridical and medical practice, and subject to other processes of social stigmatisation, than they are helped towards recovery. In many instances temporary or indefinite containment is achieved, which may serve to protect the public, but alone this acts as a poor substitute for well-being and social recovery. Those with knowledge of social exclusion and those who work closely with this group will grasp both the immense long-term cost of this failure to society, in terms of morbidity and mortality, crime, social dependency and family breakdown, and the strategic value of early and late intervention. Governments, however, need to be persuaded that the investment involved will reap longer-term benefits (Sugarman, 2012).

It is important to appreciate how the very human need for secure containment of disturbed individuals transcends boundaries of time and place, of gender, age and developmental stage, and of diagnostic and criminal justice status. Very similar challenges of care, control and rehabilitation are seen in different cultures and in different groups. While the international psychiatric community is moving on with active information-sharing on areas such as service models (Maj, 2008), a fundamental debate is just beginning about how societies around the world can best catalyse effective

mental health service development (Sugarman & Kakabadse, 2011). We believe that local diversification in provision accelerates improvement in secure and forensic care, focused on service user need rather than organisational goals, with hospitals centred on the care and recovery of the most challenging and needy individuals, and on the promotion of excellence through teaching and research.

This chapter identifies the need, globally, for secure mental health provision and presents an overview of the history and development of secure care. It charts its social evolution, from origins in the earliest psychiatric hospitals, to growth into the complex pattern of forensic and secure mental health service specialisation that exists in the most advanced societies today. A narrative shape is given to historical patterns of innovation, differentiation and decline in secure services, within an appreciative critique of the achievements so far in this important area. We offer a sociological as much as a mental health professional view, although the chapter is intended as a balance to the abundance of critical sociology of psychiatric hospitals, for example as 'total institutions' (Goffman, 1961). A Whiggish view of inevitable progression is not offered, rather one of cycles of progression interspersed by periods of inertia or decline. We argue that we must be able to learn from the past, to identify and link coherent historical patterns with current trends and emerging developments.

Secure care is an expensive and intensive use of taxpayers' resources to deal with problems of a relatively small group. In the current financial climate it is more important than ever to develop the most efficient models of care possible. This requires an element of innovation as well as evaluation; we need to develop insight into how these services have changed so far, in order to be adept in engineering change for the future.

Background

The construction of a global overview of the development of secure care is challenging. Numerous reports on psychiatric services across the world are available, often identifying stretched, under-resourced or run-down (and traditionally locked) hospital facilities in low- and middle-income countries, as well as newer community services (e.g. Onokoko *et al*, 2010). New information is emerging about forensic and secure clinical practice in hitherto neglected areas, including the former Soviet Union (van Voren, 2006), China (Topiwala *et al*, 2011), Africa (Ogunlesi *et al*, 2012), Latin America (Taborda, 2006) and in Islamic countries (Pridmore & Pasha, 2004). Global reviews barely touch on the configuration of forensic psychiatry services, but they do identify how the growth of these services has been fuelled by deinstitutionalisation of the general mental health infrastructure and the related failure of services to keep those with a mental illness out of prison (e.g. Arboleda-Florez, 2006).

The need for forensic mental health provision around the world is underlined by numerous studies of the millions of mentally disordered people detained in prisons (Fazel & Danesh, 2002). In Europe there is a trend to increase forensic hospital provision (Priebe *et al*, 2008), with growing numbers of compulsory admissions visible in several countries, including larger jurisdictions such as Germany and France (Salize & Dressing, 2004) and the UK (Health and Social Care Information Centre, 2011). Different European nations have very varied patterns of forensic service provision, but there is an inverse relationship between the national rate of imprisonment and the number of forensic hospital beds (Priebe *et al*, 2005), the latter supplemented by specialist housing provision in several countries. A few European countries favour mental health treatment for prisoners in facilities outside prison – such as Cyprus, England and Wales, France, Iceland and Norway (Salize & Dressing, 2007). Forensic mental health provision in the Netherlands has been well described (e.g. Derks *et al*, 1993), and is notable for its early therapeutic focus, ahead of most other jurisdictions.

Secure and forensic mental health services in the USA are less advanced than other areas of healthcare (Bloom *et al*, 2000), although there are wide local variations. In some states there are equal numbers of mentally disordered offenders in hospital and prison, while in others there are as many as ten times more similar offenders in prison than in health services (Torrey *et al*, 2010). Elsewhere, a number of other English-speaking countries have been in the vanguard of forensic hospital and community service innovation, including Australia (Mullen *et al*, 2000), New Zealand (Brinded, 2000) and Canada (e.g. Livingston *et al*, 2012). The service in Victoria, Australia, is one of the leading examples of rapid development of a modern prestige service, drawing on the UK service model but with a strong emphasis on teaching, new clinical research and newly identified syndromes such as stalking, as well as multi-professional work, assessment and rehabilitation in both hospital and community (Ogloff, 2010). This 'teaching hospital' model is also well established in some of the larger providers of secure care in the UK, which run major specialist centres, such as the Bethlem (London), Rampton (Nottinghamshire), St Andrew's (Northampton) and St Bernard's (London, Ealing) hospital sites. The history of institutions such as these is worthy of study and can be instructive for the future.

Ideals and institutions

Psychiatric institutions typically begin as places of care and support, inspired by high spiritual and charitable ideals. The reception of the sick and the insane can be traced back to monastic healthcare facilities in the 5th c. BC in the Far East (Retief, 2005) and to temples in ancient Greece, where dream interpretation as a treatment foreshadowed its reappearance

in European psychiatry 100 years ago. The separation of medical and psychiatric hospitals dates to the Golden Age of Islam, from the 9th to the 13th century AD (Retief, 2005), with the Persian language differentiating between psychiatric hospital (*maristan*) and medical hospital (*bimaristan*). *Maristans* are often said to have had tinkling fountains to calm the patients.

In Christian Europe of the Middle Ages, a few charitable hospitals were notably founded specifically for mental health use (e.g. López-Ibor, 2008), whereas in others such as the (Priory of St Mary of) Bethlem in London, this use evolved over time (Andrews *et al*, 1998). In the UK these origins have not been entirely lost. The largest secure care facility in the country, St Andrew's in Northampton, is a long-standing charity, as is the historic Retreat in York, also a secure care provider (Digby, 1984; Foss & Trick, 1989), and, interestingly they have Church of England and Quaker origins, respectively. Indeed, much of the secure care provision in the UK is still located on a surviving corner of large county asylum sites (such as St Bernard's and the Bethlem in London), most developed by local public authorities, and some founded as charities, but virtually all boasting a fine chapel, giving a sense of their original high-minded ethos.

The espoused values of mental health provision have, however, to be contrasted with the documented history of psychiatric hospitals and secure institutions, which catalogues numerous treatment interventions, of which some appear insightful and kindly to modern eyes, but many much less so. Initial high ideals at the laying of foundation stones later give way to more controlling and intrusive interventions in the face of practical necessity or custodial certitude. In spite of the values that inspired their creation, medieval infirmaries as well as later private madhouses became notorious bywords for stigmatisation and mistreatment (e.g. Scull, 2006).

Similarly, the Enlightenment values embodied in the 'moral treatment' movement and reflected in 'non-restraint' policies, were introduced at the Retreat and spread to the emerging county asylums (Yorston & Haw, 2004). However, Victorian doctors soon ran a national infrastructure, which by 1900 became a closed, sometimes abusive institutional world for 100 000 people (Porter, 2006) and the power base for medical superintendents whose association later became the Royal College of Psychiatrists (Bewley, 2008). The rise and decline of the British asylum system is well documented (e.g. Jones, 1991), and its direct influence can be seen in a wide international context of social, psychiatric and colonial control which is still playing out (Melling & Forsythe, 1999). In 1948 the nationalisation of hospitals in England inherited a system which peaked in the later 1950s at over 150 000 locked beds. Subsequent radical and progressive change introduced unlocked wards, voluntary, out-patient and community treatment. By 1990 the national combined capacity of government and independent hospitals had dipped below 35 000, a figure from which it is now again falling (Laing, 2012).

Provision for mentally disordered offenders

A parallel system to general mental health services has appeared in many jurisdictions. In England and Wales, after the Criminal Lunatics Act of 1800 empowered the courts to send those found insane to hospital, special wings at the Bethlem hospital were established. In 1863 a secure institution was opened at Broadmoor in Berkshire to house this burgeoning population, to become the first of the sites later known as 'special hospitals' in England. Twentieth-century expansion saw the addition of Rampton and Ashworth hospitals, together with Carstairs in Scotland forming the 'high secure' estate in modern parlance. These facilities suffered increasing isolation from broader progressive changes in psychiatric hospitals, their overly custodial culture exemplified by the power of the Prison Officers' Association as the main representative body for nursing staff. It was against this background that in the later 20th century these hospitals were troubled by repeated scandals about both public safety and abuse of patients, creating an impetus for new developments.

In 1971 Graham Young, a lethal poisoner, was released from Broadmoor into the community, deemed 'fully recovered'. Young was assisted in finding paid employment as quartermaster in a military equipment manufacturing company, with access to highly toxic chemicals. He poisoned many work colleagues, and was convicted on two counts each of murder and attempted murder just nine months after his release (Bowden, 1996). It was consequently recommended in the influential 'Butler report' that regional secure units (RSUs, later defined as 'medium secure' hospitals) were created as an innovative intermediate step-down between the special hospitals and the community (Home Office & Department of Health, 1975). At the same time, the 'Glancy report' (Department of Health and Social Security, 1974) recommended provision of secure services for those too disturbed to be cared for in a general mental health hospital. Concurrently, television programmes such as *The Secret Hospital* alleged institutionalised bullying and abuse of vulnerable patients in the special hospitals. The result was implementation of the Butler recommendations in the development of new, smaller, regional secure facilities from the 1980s, with patient transfers in from both sides, i.e. step-downs from higher security and admissions from courts and lower security. Thus the impetus for change was adverse publicity, an important pattern in secure services where service inertia and failure has developed.

The relatively open culture of the new regional medium secure services triggered the development of forensic psychiatry into a professionally and academically credible specialism, supporting multidisciplinary care, including forensic mental health in-patient nursing (Dale *et al*, 2001). Further innovation saw medium secure nursing, and medical and social work staff lead 'diversion' schemes for mentally disordered offenders,

based in local courts, prisons and police stations. Later, the emerging ideas of closest-to-home care and the 'least restrictive alternative' as outlined in the 'Reed report' (Department of Health & Home Office, 1992), and escalating compulsory admissions both from prisons and the community (Rutherford & Duggan, 2007) fuelled demand for more local secure provision, which has since been codified as 'low security' (Department of Health, 2002). Allegations at the high secure hospital at Ashworth in the late 1980s of abusive regimes (Blom-Cooper, 1992), and later of security failures (Fallon *et al*, 1999), brought a renewed focus on security (Tilt *et al*, 2000) and acknowledgement that many patients, particularly women, were being held in inappropriately restrictive conditions. This initiated the development of regional 'enhanced medium secure' services for women.

The mix of individuals transferred from medium secure services, individuals diverted from custody and acutely disturbed non-offenders in local mental health services is a clinical challenge, now addressed by intensive care units, longer-term low secure units and newer 'enhanced' low secure units for acutely unwell prisoners. This is the current crux of the care pathway in England, between general and forensic services, with intense pressure to move patients through stepwise rehabilitation. Out-patient forensic psychiatry also grew with some RSUs, and after a slow start specialist community forensic teams now either work in parallel to, or are integrated with, general community mental health teams. These models represent the ongoing conflict between general and forensic mental health professional teams, which may resolve over time as professional identities regroup more functionally around secure and community care.

The growth of medium and low secure care has seen an increasing diversity of provision both from the state National Health Service (NHS) and from 'independent sector' companies and charities. In this century, Rampton Hospital in Nottinghamshire has emerged as the largest high secure hospital in the UK, with around 350 beds, including a unique collection of national specialist centres for women, people with intellectual disability, personality disorder and pre-lingually deaf patients. The high secure estate now sits at the tip of a pyramid of secure care encompassing around 20 000 beds (designated secure or locked). State-provided care is increasingly delivered by semi-autonomous, not-for-profit public bodies known as NHS foundation trusts, which are partially detached from state control and are increasingly taking on the characteristics of trading charities (Sugarman, 2010). These are not-for-profit, largely mental health-specific organisations, with the potential to be autonomous, effective and dedicated to service user need. Ideals and values, so often key in founding new care provision, must be embedded in their organisational mission and governance, to enable the innovation essential to service improvement in any jurisdiction (Sugarman, 2007; Sugarman & Kakabadse, 2011).

Effectiveness and outcomes

With the development of services and growth of admissions in this sector, at least in Europe (Priebe *et al*, 2005; Gordon & Lindqvist, 2007), and the current economic downturn, there is a debate to be had about resource allocation. For example, secure in-patient services in the UK have been castigated by some radical forensic psychiatrists as counter-therapeutic and self-perpetuating institutions which inhibit the development of wider systems of support for mentally disordered offenders (Wilson *et al*, 2011). In particular, the 'medium secure' level of care, which is the main powerbase of forensic mental health professionals, was caricatured as a financially unsustainable juggernaut, moving forward irrespective of the needs of patients or the realities of healthcare funding. This critique acknowledges that, at least in the UK, forensic in-patient services are well funded relative to local in-patient care, such that designated secure care takes a disproportionate part of the budget for psychiatric hospitals.

It can be argued, however, that the distinction between forensic secure and other hospitals is increasingly misleading in England, where the great majority of psychiatric wards are now physically locked even in the daytime, and the proportion of patients detained compulsorily has been climbing rapidly in recent years (Health and Social Care Information Centre, 2011). However, secure psychiatric care in England and Wales, broadly defined to encompass all psychiatric hospitals, still accounts for only around 15% of direct spending on mental health. Including community and social care, government spending on mental health has grown to well over £20 billion per annum (Centre for Mental Health, 2010).

Meanwhile there is limited evidence on the overall clinical, public safety and economic impact of secure care. In the absence of reliable service-wide data, a few focused studies have examined those with severe personality disorder, perhaps the most difficult to treat group (e.g. Dolan *et al*, 1996; Chiesa & Fonagy, 2002; Barrett & Byford, 2012), producing mixed conclusions on whether patients show significant improvement. Reconviction rates after discharge from secure care are much lower than for released prisoners (Coid *et al*, 2007), but are still significant for younger patients with substance misuse or personality disorder who have a criminal record. It is important there is a broad future social research effort in this area to inform national policy and service planning (Kane & Jordan, 2012).

In the absence of good evidence, a more emotional stance is likely, given that people have always had strong feelings about severe mental disturbance and locked psychiatric institutions. Taxpayers are entitled to know that these apparently advancing services are effectively protecting the community, and offering good value by helping patients to recovery

ever more quickly through shorter, less costly stays. Mental health providers use their varied public, corporate and charitable governance systems to make sense of a complex legal, regulatory and commissioning (purchasing) environment, and must run coherent clinical governance infrastructures. The right cultural balance of audit processes, transparent information and innovative teamwork is crucial (Sugarman, 2007), supporting truly integrated governance that targets recovery outcomes (Sugarman & Kakabadse, 2008).

In England, health policy is now focused on patient choice, provider diversity, outcomes and payment by results, to identify variations in performance and improve effectiveness. In response to cost pressures the National Health Service (NHS) is encouraging earlier discharge, with falling lengths of stay in some secure providers (Partnerships in Care, 2011). This requires improving rates of recovery, to the level where care in the expanding range of less restrictive settings is practical. Adverse incidents are routinely reported to health purchasers, and payments linked to measures of quality are in place, including minimum volumes of weekly therapy, and standard risk, recovery and outcome tools. Advances in information technology may support future service comparison on a standardised 'dashboard' of clinical and service data, built up from protected clinical information. Current UK Department of Health work on 'payment by results' in mental health appears to be largely about price tariffs, built on a scheme of patient categorisation (Fairbairn, 2007). An appropriate model of 'forensic clusters' linked to this may be a basis for developing meaningful comparison between services on clinical performance for defined patient subgroups.

Important outcome domains for mentally disordered offenders (Cohen & Eastman, 2000) include symptom reduction, social rehabilitation, quality of life and public safety, as well as reconviction for offending. Health of the Nation Outcome Scales (HoNOS) data, measuring symptoms and functioning, are reported to the Department of Health and HoNOS-secure (Sugarman & Walker, 2007) has been adopted by forensic services in continental Europe, Australasia and North America, but ideally it should be superseded by similarly brief but more sensitive measures. Meanwhile it remains unproven whether measurement of clinical and risk outcomes improves 'real' outcomes such as patient-reported quality of life and recovery experience.

Reconviction and readmission have high face validity as real outcomes for policy makers and the public. High readmission rates indicate the need to support patients in the community, and high physical morbidity and mortality in this population must also be addressed. The ultimate outcome measures of the future might be shorter time in hospital by level of security and longer, healthy, crime-free survival time in the community. Using these as a basis for true 'payment by results' seems logical, but remains for the moment impractical.

Priorities and challenges

The identification of high psychiatric morbidity in prisons in the UK (Singleton *et al*, 1998), replicated in most countries studied (Fazel & Danesh, 2002), reinforces the need not only for transfer to hospital where appropriate, but also for prison in-reach services driven by the ideal of equivalence to community care. Importantly, there is a resurgent impetus for diversion into mental healthcare (Bradley, 2009), but regrettably a target to expedite prison transfers to hospital within 14 days has been dropped – apparently driven directly by the post-credit crunch NHS cost savings programme. There are many reports of reduced numbers of prison transfers as well as excessive delays (e.g. Wilson *et al*, 2010), falling foul of the equality principle between physical and mental health set out in recent government policy (HM Government 2011). It is reasonable to raise this with policy makers as both a human rights issue, on the grounds that people with cancer in prison would not be denied specialist hospital treatment in the same way, and an economic issue, highlighting the long-term cost of not meeting these needs (Sugarman, 2012).

In overview, rising demand for secure care, related to closure of old hospitals and worsening inner city deprivation, has stimulated the development of a hierarchy of new facilities, with risk management skills now central at every level of security. Some would see the forensic system as the 'new asylum', and certainly an intensive focus on length of stay and moving patients on is essential. Length of stay has fallen, as forensic care is increasingly a multi-directional pathway, from national specialist facilities to services with a presence in local communities and the criminal justice system. As specialist provision expands, it puts pressure on public expenditure but provides a diversity of care pathways, including some non-secure forensic care homes and hostels, with major potential to enable discharge from hospital.

We can see therefore that secure mental health service provision in England is in a state of transformation and innovation. Yet as we have shown, periods of innovation have historically been followed by periods of decline. The cycle of innovation and decline presents an opportunity to learn from history. Recent exposes of abuse, such as that perpetrated by care staff at the Winterbourne View unit in England for people with autism or intellectual disability (Care Quality Commission, 2011), indicates that progressive developments have not immunised the secure care sector from scandal when governance systems fail and when individual needs of patients are sidelined. The challenge for those involved in secure mental health facilities today is how to keep up a continual momentum of change driven by our ideals and ensure that descent into disreputable care and abusive practice is not the inevitable destiny for every generation of secure facilities. In the final part of this chapter we describe how diversification, technology and good governance can arm us for this challenge.

Emerging trends: specialisation, technology and recovery

Secure services are increasingly differentiating by gender, age, diagnosis and length of stay into new 'super-specialisms' – in the UK this is very visible at some larger specialist secure facilities. Bespoke programmes of care can meet the needs of forensic patients, who are often very different from the adult men with mental illness that standard secure services were designed for. These programmes increasingly build on the contribution of forensic and clinical psychologists in leading evidence-based intervention programmes, and on awareness of the importance of a high level of such patient-centred activity, integrated at the heart of services (Gudjonsson & Young, 2007).

Women in secure care have a distinct clinical profile and therapeutic needs, for which specialist services are effective (Long *et al*, 2010). The mental health needs of older prisoners have been poorly understood (Yorston, 1999) but specialist services are established, as are age-specific secure services for adolescents (Wheatley *et al*, 2004). Brain injury is associated with aggression and offending, for which effective neurobehavioural programmes are well evidenced (Alderman, 2001). Services are developing for groups such as young adults, the pre-lingually deaf and those with autism, in addition to established units for intellectual disability. The emerging picture is that highly specialist services are effective, offering improved outcomes and thereby shorter stays. The only exception to this may be signalled by England's Dangerous and Severe Personality Disorder Programme, which has struggled to demonstrate clinical and cost effectiveness (Tyrer *et al*, 2010), and is no longer a policy priority in an age of austerity.

There is a long established pattern in which adverse incidents have driven new thinking on safe and effective care, and this looks set to continue. Standardised security specifications now incorporate an expanding technology of safe design and materials solutions, which reduce many clinical risks. Information and communications technology is emerging in meeting new challenges and producing solutions in secure care, for issues such as media access, alarm systems and even GPS tagging of service users (Shaw, 2010). In Europe patients are protected under the Human Rights Act 1998 (Sugarman & Dickens, 2007), with restrictions imposed in proportion to risk, using evidenced approaches to professional judgement and control interventions. Active therapeutic regimes are based more and more on research and deployed across the range of needs. It seems as if practice in our specialty is finally beginning to have a tangible science and technology base.

In the meantime, the concept of health recovery, which can be traced to Greek sources such as Hippocrates (Coar, 1822), has seen something of a renaissance in mental health (Anthony, 1993). Recovery has been

completely rehabilitated as a primary driver for the mission of mental health providers, defined in terms of hope, optimism and meaning, linked for some with spirituality (Leamy *et al*, 2011), and the role of chaplaincy in mental healthcare (Cook *et al*, 2009). Such changes seem therapeutic, against the rather austere tradition of science and therapeutic nihilism in psychiatry, but what matters is how such positive impulses are translated into the reality of service delivery. In all likelihood linking provider payments directly with outcomes will be key, enabling service users and commissioners to make the choice for 'front-loaded' packages, intended to have a transformational impact, boosting the prospects of swifter and fuller recovery.

Conclusions

High ideals such as recovery are driving continuing innovation in mental healthcare. The aim must be to successfully rehabilitate as many people as possible, with low reconviction and readmission rates. Health purchasers and public protection agencies need to be better engaged with services in enabling efficient movement through the system. Further integration of care pathways with mainstream psychiatry and the criminal justice system is essential. The future evolution of secure and forensic care is likely to be forged between specialist centres, which have the scale to support service diversification and innovation in rehabilitation, local secure services focused on shorter stays, and forensic community care and prison in-reach solutions which are still emerging. New technologies, clinical specialisation and closer-to-home services can improve the balance of control towards rights and liberty, whereas better governance and reporting can help support the choice of safer, more effective services.

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