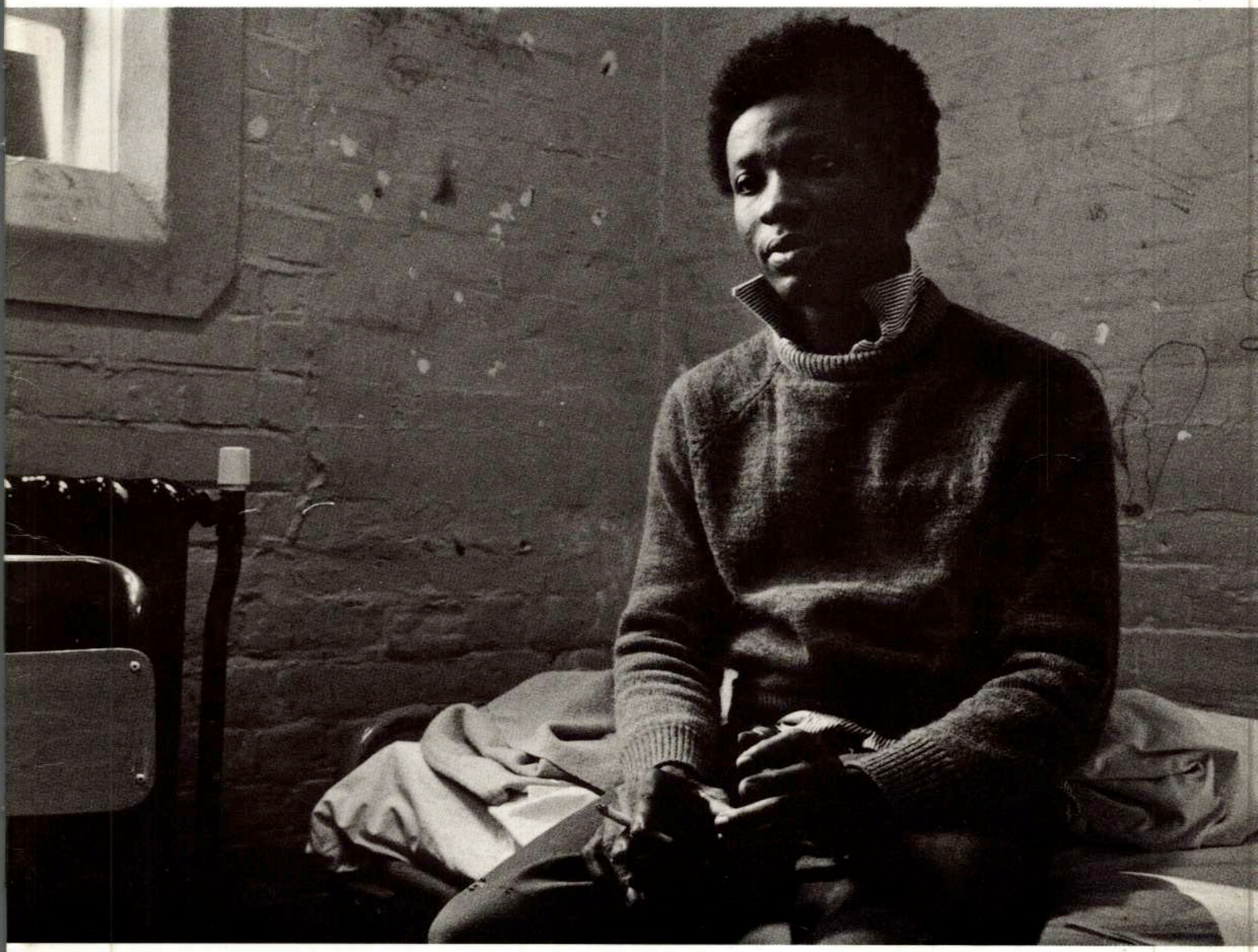
TREATMENT, CARE AND SECURITY

Waiting for Change



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Note on language

This report is about people whose lives are affected by decisions taken under the Mental Health Act and other legislation. Law and its application involves the regular use of generalised descriptive labels such as ''patient'', ''mental disorder'' and ''mental illness'' which define the features of a status and regulations which govern it. Some readers may find these crude, unhelpful and perhaps offensive. Where this report adopts such legal terminology it does so since this is unavoidable both for the sake of clarity and accuracy. This does not reflect any belief that these terms have a more general application, nor that they are appropriate in other circumstances.

Contents

1
Introduction

The taxi pulls up outside the main entrance to Ashworth Hospital. It is a cold, wet, February day at this place twelve miles north of Liverpool. A married couple of middle age, are making a regular visit to their son, detained in the hospital five years previously on his being convicted for wounding. Those years have been especially testing for them since the family has always lived in Cornwall and visiting demands a round trip of 620 miles with many changes of bus and train. Ashworth — then called Park Lane — had been the nearest hospital which would accomodate their son. Making the monthly journey in the past year had become all the more stressful. Psychiatrists, the Home Office and the Mental Health Review Tribunal were all agreed that their son should leave for a local unit but no place had yet become available nor was this likely for another year.

An imagined scene but one reflecting reality. Recent figures in a letter to South Western Regional Health Authority reveal that about 50 patients detained in the three high security 'special' hospitals in Merseyside, Berkshire and Nottinghamshire come from the counties of Cornwall and Devon[1]. A recent patient census in these hospitals estimated that 400 out of the 1700 held there may not require their excessively restrictive security — often compared to a Category 'A' prison — and should be transferred to regional or district services or be released altogether[2]. What is it which prevents this happening? Is ignorance or indifference the reason our society tolerates such a situation?

On 8th October last year a Southwark Inquest jury had to decide how a prisoner, convicted of attempted burglary and awaiting sentence, could have hung himself in Brixton's medical wing. It heard the following from the man's brother, James O'Grady:

'When I saw him in Brixton prison for the last time I could not believe how anyone could let someone deteriorate like that. You would not treat a dog that way. He was locked up 24 hours a day in a strip cell. He had no clothing on him — just a sort of canvas straitjacket which was not done up and some old shoes with no socks.

He had burn marks all over his legs: there were round scabs. A prison officer said Paddy had been burning himself with cigarettes. He had cuts on his wrists and both the cuts and burns were not clean. They were just left open. Paddy's face was swollen and he had dried blood around his face and chin. He looked terrible.'[3]

The jury decided Mr O'Grady killed himself in circumstances brought about by lack of care — the fourteenth Brixton suicide in two years: a series of deaths which appear at last to have brought nearer the closing of this wing.

Mr O'Grady was in a system which could not meet his needs. Many like him remain in prison custody often for very minor offences. The situation is candidly acknowledged by the Home Office. In February 1992 it wrote to each of its prison medical officers

encouraging them to arrange transfers from prison to psychiatric hospitals. The letter included the following statement:

'...recent research has shown that if all prisoners requiring hospital treatment were transferred at least 1,000 prisoners would be admitted to hospital'.[4]

Where would they go? Would they receive more care than Mr O'Grady received? Would they recover their liberty as soon as justice required this? What of the community services they might need on being released? The research mentioned concerns only sentenced prisoners. How many remand prisoners — just like Mr O'Grady — are held in grimly inappropriate surroundings and where will they go?

Carol Barratt was admitted to Doncaster Royal Infirmary in March 1991 from the local police station. She had threatened someone with a knife and was detained in hospital under s.2 of the Mental Health Act 1983. Despite her unsuccessful appeal to the Mental Health Review Tribunal, and other incidents of her violent behaviour her psychiatrist agreed to her discharge on 14th April. In doing so he believed her to be still dangerous but 'expressed the hope that the police would then get involved which could allow for more long-term detention of Carol to be arranged'[5]. A hope soon to be rapidly and fatally fulfilled.

Two days later, hearing voices which told her to kill a girl called 'Stephanie' because she was evil, Ms Barratt ran towards an 11 year old girl in a shopping centre stabbing her with a knife and killing her. She had never met the girl before.

Carol Barratt is now indefinitely detained in Rampton high security hospital. Her fate in the local psychiatric service could be regarded as merely the aberrant decision of a psychiatrist criticised for his 'clinical error'. On the other hand it might reveal attitudes and actions which are more commonplace. Evidence appears to suggest this doctor was not alone in believing a district service would have nothing to offer her. At the time, one psychiatrist wrote the following, against the tide of public dismay which greeted the case:

'Use of the Mental Health Act to admit such people to an ordinary psychiatric ward is wrong, because it means using a ward for imprisonment, because secure confinement is impossible in such a setting and most importantly because there is the false presumption that treatment can reduce the dangerousness.'[6]

Was this a fair comment, acknowledging a genuine respect for civil liberties, or simply justification for refusing help to those whom local services ignore and have excluded from their provision? The answer to this question will have importance in many more situations than Carol Barratt's singular discharge.

One common theme in these three stories was an apparent need for treatment with 'security' — the right to detain deriving from use of some legislation. Courts or doctors applying their ideas of 'public interest' had demanded it. A second theme was the mismatch of our current system of health and social services with the needs and rights of those obliged to use them. Our protagonists found themselves in some grim game of musical chairs. Except that in their case when the music stopped, there was no place for them to sit.

No longer are these issues confined to theoretical argument nor are they simply the stuff of transient, usually sensational, press reporting. For there is an air of change across many of the services providing treatment in this area prompted by a wide ranging review of their adequacy and effectiveness and a hope that more resources may soon be available. Within the space of the next few months, Ministers will be marshalling their response to numerous reports[7] on the state and future of services ranging from neighbourhood community resources for diversion from custody, to special hospital treatment in the 1990's. Already, an increased commitment of £18m capital to the building of regional secure units offers the prospect of 400 additional places at 'medium' security by the end of 1994. Who will be contenders for these places amongst men and women whose stories are like those we have portrayed? What will be their experience of secure provision and its effect on their lives and rights and on their families and friends?

The Finance Advisory Group of the Reed Committee conducting this review estimates the cost of just one of the Committee's recommendations — raising Regional Secure Unit places from 650 to 1,500 — to be £71m for capital and £63m per annum for recurring revenue at £70,000 per place. If very substantial additional sums are to be secured for new services will these extend the current system on a 'more of the same' principle? Or will the rarely seen interest in the subject at a national and political level lead to a longer term, strategic vision and a determined attempt to break with the past where this clearly inhibits a modern and humane approach? The criminal justice system treats groups of people unequally and unfairly, discrimination often arising on grounds of gender[8] or race[9]. Secure health provision mirrors this with differential treatment, often leading to injustice. Will new services retain these features or will real attempts be made to ensure equal opportunity and treatment within the system?

In 1985 MIND adopted a policy paper on secure provision — 'Fluid Security' — with many recommendations, some now reflected in official reports or recent administrative changes[10]. Developments during 1992, and the discussions which these have prompted, provide an opportunity, indeed create a necessity, for that policy to be reviewed and updated. This report is a contribution to that process and its ideas are intended to stimulate discussion. We aim to play some part in building a better future for those who will have to use secure provision. We anticipate the report will be of value to those who plan, or operate such

services, or have to purchase them on behalf of health or social services authorities.

The report covers England and Wales and specifically addresses the position of a person treated or regarded as 'mentally disordered' under the provisions of the Mental Health Act 1983. This person's detention or supervision has been arranged or ordered because of concerns for public safety or the prevention of crime or they are a person whose 'management' within the health system calls for the imposition of compulsory methods of treatment. This will cover both those persons detained under the administrative procedures of the Act and those ordered by a court to be treated usually following conviction. It is not limited to an examination of the 'bricks and mortar' of secure provision. The law and procedures which govern the ways people do or do not enter the system are equally important and their value must be assessed; so also, are the regimes under which people are held, and how their rights might be protected.

Chapter 2 outlines four factors leading to the present crisis. These factors affect local health and social services, the prisons, regional secure units and the special hospitals. The reports and recommendations of the Reed Committee set up to help resolve the crisis, which is currently reviewing services, and of its Welsh equivalent, are examined.

Chapters 3 and 4 together suggest a possible basis for new policy. In the former, seven guiding principles are proposed. In the latter, these ideas are linked to policy priorities across the criminal justice and penal systems and health and social services. Practical measures to achieve these objectives are outlined.

MIND is concerned with the needs, interests and rights of people with problems relating to their mental health. It is not an organisation which promotes the rights of people with a learning disability. This report does not examine issues of special concern to them. However, much of what we suggest would apply with equal force to learning disabled men and women held in secure provision.

MIND welcomes written comments and observations on the contents of the document, and in particular on the suggested proposals mentioned in Chapters 3 and 4. These should be sent to MIND, 22 Harley Street, London W1N 2ED (ref IB).

2
The Way We Are Now

Any survey of developments in NHS and prison medical services during the past twenty years leads to a number of fairly firm conclusions.

- In general, the local district health service seems no longer oriented to meeting the needs of the 'mentally ill' offender who is regarded as 'dangerous or difficult' within its mainstream facilities[11]. When services are not locally available they are sometimes purchased from the private sector.

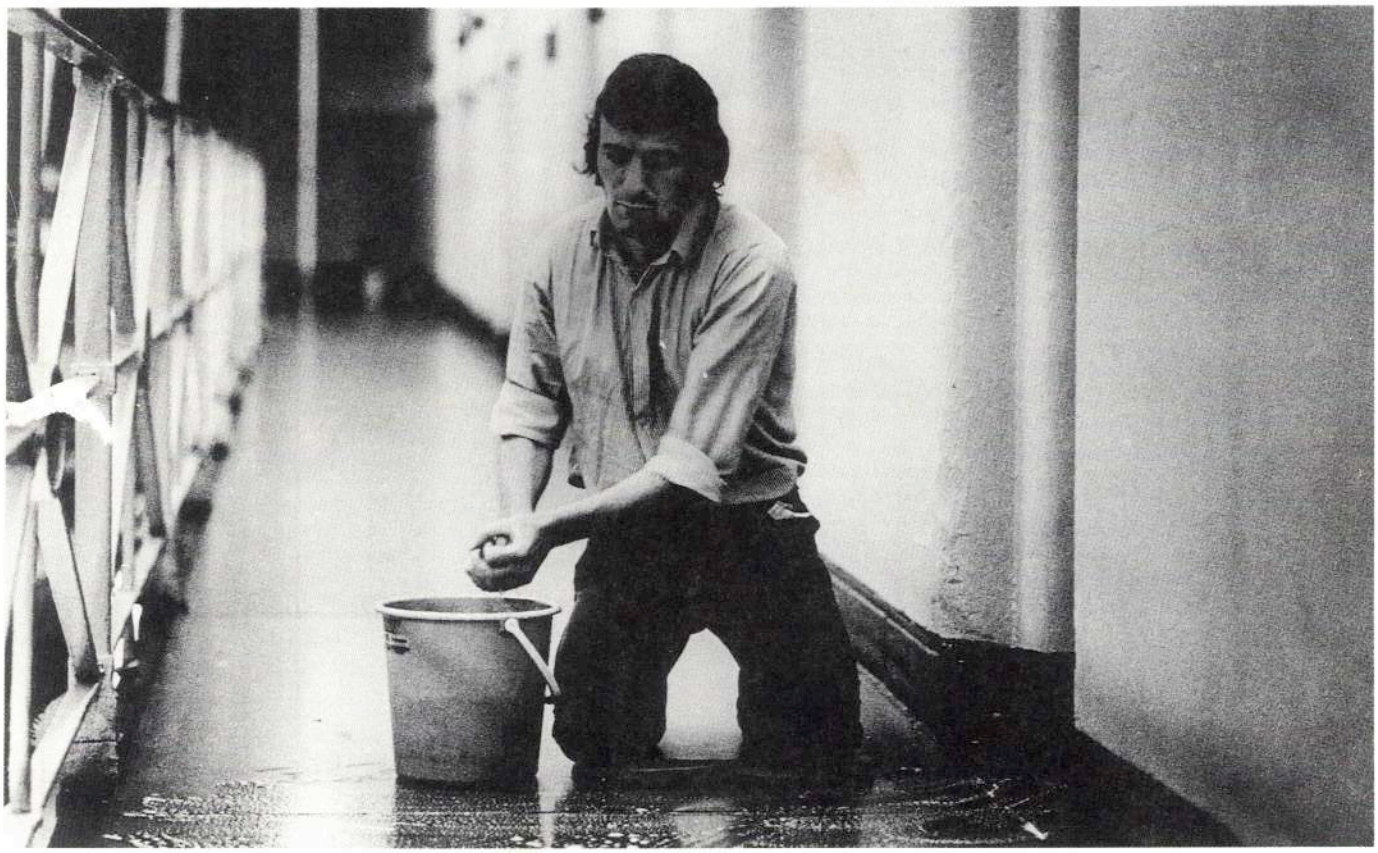
- The medical services available in prison are well below the standards found in even the worst NHS inpatient psychiatric facility and are wholly inappropriate for meeting the needs of the prisoner diagnosed as having psychosis[12].

- The number of places at a level of medium security made available by the development of regional secure units has been quite insufficient for the obvious demand for them. This has resulted in a restricted role for the units which has forced them to keep many patients waiting for an inordinately long time before being admitted, whilst denying altogether others who would benefit from their regime and lesser security[13].

- The special hospitals have yet to demonstrate their ability to confront and eradicate serious flaws in their organisation and performance. These arise from their culture, staff attitudes, physical facilities and isolation, and have been identified in a number of external inquiry reports. Recently and very publicly they have been acknowledged by the Health Authority now entrusted with their management[14].

The limitations of local services

Local district health and social services authorities do not see themselves as primarily responsible for providing a service tailored to the needs of this group although government guidance requires them to do this. Those needs are perceived as clashing, firstly, with the 'open door' philosophy of most psychiatric hospitals and, secondly, with the emphasis now seen in practice of concentrating on admitting those requiring only short admissions during an acute stage of distress. Also, the high costs associated with the provision of what may be small units at a local level has discouraged managers from designing them into the service. Those whose problems may be more complex and more resistant to traditional treatment approaches now therefore find it very hard to obtain any continuity of service which can



truly be said to relate to their genuine individual needs. The policy is reflected in the staffing ratios, skill mix and environmental designs now seen in district general hospital units. It is also seen in a dismal lack of associated housing and personal social work support. These could be directed to providing effective preventative care and rehabilitation for the person who has been receiving treatment as a detained patient or who could be diverted from custodial care if alternative resources existed in the community.

This development originates with the report of the Percy Commission on the law relating to Mental Illness and Mental Deficiency (1957)[15] and the Mental Health Act 1959 which was its result. These stand at a turning point in the provision of psychiatric care and treatment, when past approaches involving legalism and excessive physical custody began to be replaced by more enlightened and informal attitudes to providing care. Since that time one overriding principle in the provision of psychiatric treatment has been to regard a patient as though they were receiving treatment for a physical condition. Wards were opened up as a result and these adopted regimes compatible with the greater freedoms given to those admitted to hospital, some even terming themselves a 'therapeutic community'. It was in the mid 1950's that the numbers of inpatient psychiatric beds reached their highest total of 155,000 and since that date that this number has been steadily declining as the hospital is no longer expected to provide indefinite long term care to persons diagnosed or treated as seriously 'mentally ill'. With the belief that care should be firmly rooted in a person's home community not in an asylum somewhere out of sight, the local hospital's role has changed. It has ceased to operate as a place which considers itself able or willing to treat and care for the patient who is regarded as dangerous or difficult and who has been accused or convicted of a criminal offence, particularly one which is serious.

The impact of this philosophy is seen most profoundly in the response of the district service to the assessment needs of the prisoner remanded for a psychiatric report. There are many delays and difficulties in providing these for the courts and then arranging a prisoner's admission following the making of any recommended hospital order. These reveal attitudes and practices consistent with the low priority given to this patient group compared to others using the service[16].

Prison medical services in crisis

The result is that the prisons have continued to accomodate large numbers of people who are seriously mentally disturbed, both for assessment when on remand and as prisoners after sentencing. The Prison Medical Service, recently renamed the Prison Health Service, is unable to meet the needs of such persons — particularly those who are diagnosed as psychotic[17]. Concern had been voiced throughout the 70's and early 80's as to the ability of the medical services available to the Prison Department to provide anything more than a 'first aid' service for the prisoner regarded or treated as seriously mentally ill. With crime rates and the total prison population growing, this has put enormous pressure both on the service and on those held in it. In 1986 the House of Commons Social Services Select Committee reported on the service with 58 recommendations, many relating to the 'mentally ill' prisoner, particularly the person at risk of self harm or suicide[18]. A Working Party of Home Office and Health Department officials was convened to consider proposals and reported in 1987[19]. It supported the broad objective of diversion from custody. However it had a limited brief and a status quite insufficient for raising the primary causes of the difficulties, namely the under funding of the NHS side of the problem and its lack of sophistication as a comprehensive and flexible service.

The Butler Committee and the Regional Secure Unit Programme

All this occurred despite the fact that there had been a major report which offered strategic vision for the service. The Butler Committee's Interim and Final Reports in the mid 1970's[20] surveyed the level of unmet needs for services and examined the legislative and policy framework in which decisions and actions about using these should be taken.

The Committee concluded that the difficulties mainly resulted from the absence of accommodation for treatment at a level of security between that of the local hospital and the high security special hospitals. It considered the depth of need so great and so urgent that it made interim recommendations 18 years ago in July 1974 for the creation of new services to help to resolve these problems[21]. Its proposal for 2,000 places in accommodation providing medium security within centres of population and close to the communities served by them led in due course to the establishment of Secure Units in Regional Health Authority areas. However, this has never been to the level envisaged by Butler, with only approximately 650 places available in 1992.

> *'. . . remands in custody of the mentally disordered were not carried out because of the nature of their offences, but because of their need for social and psychiatric help, and the remand prisons were being used primarily for the purpose of psychiatric assessment in these cases . . . remands in custody are an inefficient, ineffective and inhumane way of securing psychiatric assessment and treatment.'*
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> *Dell and others: 'Mentally Disordered Remand Prisoners'. (July 1991)*

Development has been slow and the role of secure units in a comprehensive service constrained[22]. In the early years Department of Health funding for regional facilities was diverted to other purposes. Further, Butler's figure of 2,000 places was never accepted by the Department of Health, which preferred instead the figure half that number, estimated by an internal DHSS Working Party[23]. The intervening 18 years seem to demonstrate Butler's was the more accurate calculation as we shall see below. Given the small number of RSU places and the relatively high cost of their services, admission has been limited to those requiring treatment and care for not more than two years. The combination of these factors has meant that the Regional Secure Units have been unable to ease the pressure on the prisons and special hospitals to anything like the extent envisaged by Butler.

The shining of a light into dark corners: the Special Hospitals exposed

One of the reasons advanced by Butler for the creation of a level of service between the special hospitals and district provision was the difficulties which special hospital patients experienced in returning to the community. It was envisaged that the RSUs would provide an intermediate facility from which patients could be discharged to the community or move on to the district hospital service. Butler, like other observers, had found the Special Hospitals excessively overcrowded[24]. This was but one of their problems. Another was isolation from the rest of the National Health Service which was revealed in a series of worrying reports and inquiries. These exposed faults so fundamental as to cast grave doubts on the ability of the special hospitals to provide a service fully integrated with the standards and expectations of the rest of the National Health Service.

Firstly there was the Report in October 1980 of Sir John Boynton's Committee on Rampton Special Hospital[25], an inquiry established by the Minister after nurses were prosecuted and convicted of assaulting patients. Boynton produced a fundamental critique of the hospital, condemning many of the features of its organisation and practice. Though not recommending closure, the Committee listed numerous essential changes which a new management team would have to introduce for the hospital to have any viable future.

When a fresh inquiry team visited the hospital in 1989[26] to examine the extent to which these reforms had been introduced, it concluded that, although there were still grounds for serious criticism the hospital had demonstrated an 'obvious and general improvement', largely helped by a halving in patient numbers and a doubling of staff. The team confirmed there were many patients awaiting transfer or discharge and inappropriately held in the hospital and that patients' lives were still unreasonably restricted by excessively custodial security measures. Though it also judged the hospital as not needing to close, it raised the question of the future of the special hospitals and their relationship with other parts of the service — an agenda which ministers had consistently ignored during the previous decade.

'Established ways of operating, worked out over decades, have resisted change except for minimal, organisational tinkering. Modifications have mounted no sustained challenge to regimes which are, security notwithstanding, outdated and excessively custodial and depersonalising.'

NHS Health Advisory Service Report on Broadmoor Hospital. (July 1988)

As far as Broadmoor Hospital was concerned the Health Advisory Service and Social Services Inspectorate visited the hospital in 1988 recording in their damning report of July of that year[27] that many of the problems noted in an earlier unpublished HAS report of 1974 had not been confronted and resolved. In its view, time was 'running out' for a hospital largely without direction, displaying all the faults of a total, custodial institution, and housed in grim, Victorian buildings. Concluding that the 'pervasive culture' of the hospital was 'nontherapeutic', the Inspectors were clearly sceptical as to the capacity for the place to change sufficiently to find an identity and a credibility in the future structure of NHS services.

During this time the Department of Health had directly managed the special hospitals, save for Rampton after 1980. The isolation resulting from this was considered to have widely contributed to, if not caused, their problems. In 1989, the Department of Health therefore devolved their management to a special health authority, the Special Hospitals Service Authority ('SHSA'), charged with raising standards of performance and aiding the closer integration of the hospitals with other health and social services authorities and with criminal justice agencies.

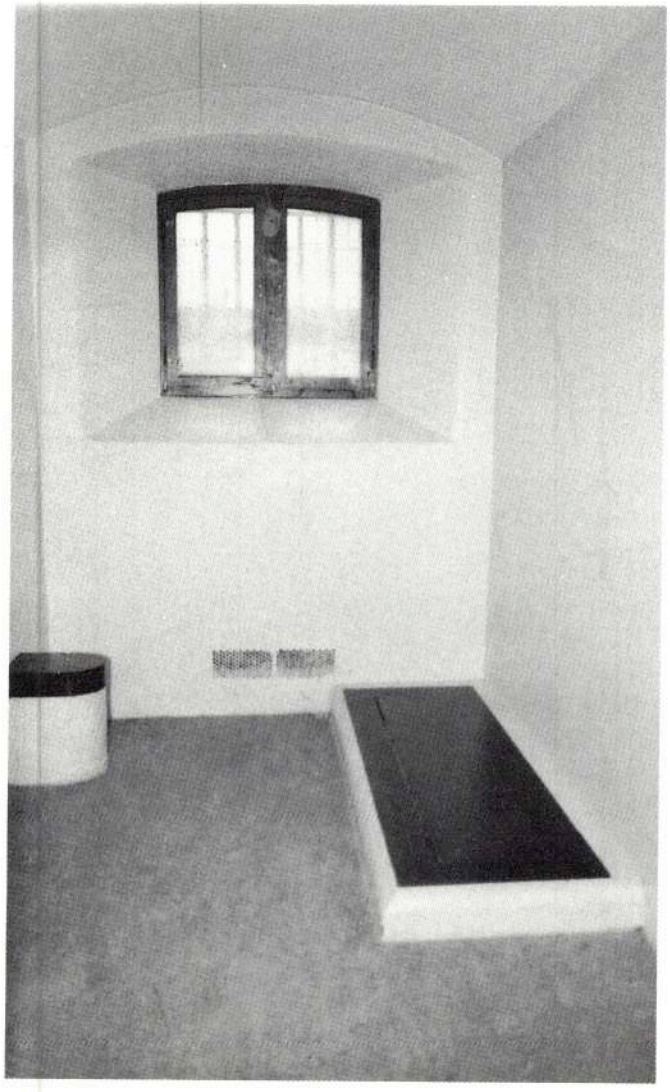
Ashworth Hospital in Merseyside, the third of the special hospitals, has provided an immediate test for the authority. Allegations of recent physical abuse and ill-treatment of patients made on a TV programme led to the appointment in April 1991 of an independent Committee chaired by Sir Louis Blom-Cooper, QC. This has held a public inquiry into the allegations, and into associated aspects of patients' lives and care in the hospital. The Committee's report is soon to be published. Whatever its conclusions and recommendations, the Inquiry heard of many examples of shockingly poor practice. This was in an environment where large numbers of patients found their legitimate and serious complaints unjustifiably ignored or rejected. The Inquiry also received evidence which strongly suggested many nursing staff associated themselves

more with the values and methods of their powerful union, the Prison Officers' Association ('POA') than with a genuine desire to improve conditions for patients in the hospital. This Association continues to exhibit values and assumptions rooted in an outdated philosophy of repressive and custodial care.

1990: a year of growing crisis

The developing crisis of unmet need came dramatically to a head during 1990. In that year fifty one prisoners died at their own hands in Britain's jails. Seventeen had been diagnosed in the past as having had a 'mental illness'. More evidence was accumulating which revealed further features of the lamentable system in which these prisoners had been trapped. Official research and reports completed during the year made striking connections between the increased suicide rate amongst prisoners and absent or inadequate psychiatric provision in the prison service, in the National Health Service and in community health and social services.

First, an internal Scrutiny of the Prison Medical Service[28] exposed its poor clinical standards and management. Then, two reports from the Chief Inspector of Prisons — into Brixton Prison and into Suicide Prevention[29] — graphically described the total unsuitability of penal custody for any person considered to be mentally ill. In addition, a Council of Europe Committee visiting UK prisons during the summer of 1990 privately condemned to the Home Office the conditions which prevailed for such prisoners as intolerable.[30]



Finally, the research for the Home Office by the Institute of Psychiatry referred to above[31] had told the government that 37% of sentenced prisoners had some psychiatric disorder and that 3%, or about 1,100 of the total, were so seriously affected as to require immediate hospital treatment for their condition.

It was not just the prisons which appeared to be detaining people who had no reason to be there. One of the first things done by the SHSA was to reveal during 1990 that many hundreds of their patients need not be held in them[32]. Discharge was mainly prevented by the absence of adequate health and social services in the patients' home communities, and, it has to be observed, by a legal and political system prepared to tolerate such abuse of their human rights.

New services for Wales and England: reports of current reviews

Ministers' reaction to these developments was to appoint a Whitehall review. This was announced in October 1990. A Home Office/Department of Health Committee was formed, to review the nature and scope of psychiatric and social 'services' available to those whose alleged offending or challenging behaviours dictated a need for secure or supervised treatment and care. With a review in Wales already completed and its report about to be published, the Committee would restrict its attention to services in England. Chaired by Dr John Reed, a psychiatrist and Department of Health medical officer, the Committee's membership was drawn from service planners and managers in Whitehall, health and local authorities and the criminal justice system. The review was to concentrate on health and social services and have particular regard to the recommendations for the prison service contained in the reports mentioned earlier. Its examination would extend to funding and research issues and, although it was not intended to be a review of the law, the Committee could propose appropriate amendments to existing legislation if it deemed these necessary.

Though the committee was to work until the middle of 1992, it was expected to publish interim proposals. The first of these were issued for consultation in November 1991 with observations invited by the end of January 1992[33]. Three separate advisory group reports covered issues in the prison service, the hospital system and the community with a total of eighty seven recommendations ranging from a review of the Bail Act 1976 to the creation of 900 additional places at the level of medium security — in regional secure units.

Developments in Wales occurred earlier simply because the required review, by an All-Wales Advisory Group, was not to be of current services. None existed at all, so it needed to propose those which were required. In its very recent report[34] the group confirmed the complete absence of a service in Wales. This results in many Welsh patients being held without justification in Special Hospitals, prisons and distant private facilities. It called for the establishment of a comprehensive service to provide inpatient and outpatient treatment and care within the principality, linking with general psychiatric services, social services and criminal justice agencies where appropriate. Ministers' reactions to the financial and other implications of these proposals have yet to be announced. However, initial indications suggest that the Advisory Group's financing proposals are in jeopardy.

The Reed review is less sophisticated in its judging unmet need for the reports conclude that the nature and extent of this is still unknown. At least, as a result of its work, health and social services authorities were instructed to calculate their estimated demands for services. Somewhat unrealistically, they were given only thirty three working days in which to do so by the end of May 1992.

Who is intended to gain from this review? The Committee has approached its task with some fairly conventional assumptions. It presumes that 'more of the same' is what is needed and therefore assumes that the groups needing to benefit from new services can readily be identified. The approach may be justified for many situations — such as diagnosed severe 'psychosis' — but there will be many others, for example, where the treatment of so-called 'personality disorder' is concerned, in which the development of services is hindered by the absence of consensus on its ethical or clinical justification. Where the ambiguous boundary between punishment and treatment is drawn affects such people more than any other and some sort of clear vision is needed if the message that more should be done is to permeate to the local hospital service or social services area office.

The Committee formulates some general principles. Services should be local, as individualised as possible and the least restrictive necessary. These are welcome. As a benchmark to test the existing system, they demonstrate only too vividly its inappropriateness, in so many respects, for those having to use it.

Recommendations for community services concentrate on measures to keep people out of prison. These include duty psychiatric assessment schemes in courts and proposals for local joint planning between the agencies involved so as to promote a single, consistent referral point to aid in diversion.

The Prison Advisory Group urges a review of the Bail Act to remove a court's power to use a remand to jail solely to obtain a psychiatric report; the greater use of the legal power to transfer remand prisoners to hospital; the purchasing of NHS services by the Prison Department at clearly defined standards and the proper planning of aftercare for released prisoners with continuing mental health problems.

The Hospital Group highlights the role for local health districts in the expansion of provision and the present financial disincentives to their undertaking this. District authorities do not have to pay for prisoners to be detained in the medical wings of our jails, nor for patients waiting for years to be discharged from special hospital. What possible encouragement can this be for their taking over responsibility for the necessary treatment and care and providing this within or near to the person's community? (The Finance Group has now addressed this issue. Without setting any timescale for reform it has proposed that the district health authority should be responsible for financing care at whatever level of secure provision this is required.)

The Committee calls for the guaranteed maintenance of current inpatient services and, without delay, the creation of an additional 900 regional places in medium secure units. Even so this is still 500 less than Butler's 1975 estimate. As mentioned above, ministers have already agreed to the capital expenditure needed for 400 of these. There is no guarantee that all revenue costs will, as well, be met.

The review continues and further reports were published in June for consultation. They consider the implications of implementing the broad recommendations outlined above. The Finance Group emphasises the need to involve district health authorities in the purchasing of a full range of services for those in their area, up to and including special hospital provision; the need to develop the funding mechanisms for local social services spending by meeting 100% of costs from central resources and increasing sums available for social work training and participation by voluntary organisations in community projects. It could not cost all the changes needed since the scale of these is still unknown.

The Staffing and Training Advisory Group considered the impact of the new services which the Committee called for, though they were inhibited by not having available to them precise data on unmet need drawn from local objective assessments of need. They had no doubt that the staffing and training implications of the earlier proposals were 'very considerable' with greatly increased personnel resources being required. The cost of financing them would be of the same order. The Group considering the position of 'People with Special Needs' has drawn attention to the additional disadvantages faced by minority patient groups in the system of secure provision, women, children and adolescents, those with learning disabilities or with hearing impairments, for example. Issues concerning race and culture are to be the subject of a later report.

So far, this review has told us little which we did not already know. Although its activity has raised the importance of these concerns to a level not seen since the Butler Committee reported, many of these proposals were well known to ministers and their officials. The strategies which it has outlined are mainly short term ones based on expanding what exists. There is an absence of any clear, long term vision of a comprehensive service and where to locate high security accommodation within this. Thus, we have no idea of the ultimate fate of the special hospitals save for the opinion that the present capacity of 1,700 should be retained but 'kept under regular review' and that 'further consideration should be given to the proximity of Special Hospital provision to the populations it serves'[35]. Although, it is recognised that major changes at this level of provision will have very substantial resource implications, one has to observe that this has not inhibited the ambitious planning reflected in other proposals from the Committee.

As well, there is no sign yet of the Committee's willingness to face and resolve the deep-seated and worrying issues of race and culture which it acknowledges are 'among the most contentious, challenging and sensitive being considered'. The report on this issue to follow will be the work of officials. It is time this matter was accorded the attention it deserves. Its full consideration by the Committee must surely be warranted.

Answers to two key questions will judge the ultimate value of the Reed Committee's work. Firstly, will it persuade central and local government to spend more where this is needed and better use what resources already exist? Ministers will be examining the financial implications of its numerous proposals at a time when it is firmly predicted both health and personal social services are to face expenditure cuts not growth. Their decisions may put a firm brake on the pace and rate of change. Secondly, will it lead to the creation of a service truly able to meet the individual needs of men and women, often amounting to little more than decent housing and appropriate support in the community? To date, services have been dominated by institutional facilities and courts and other agencies have had their assumptions shaped by believing in the need for 'custody' to the exclusion of anything else. If the impetus from the Committee's work does not manage to break this pattern of planning and spending then its beneficiaries will be few indeed.

We next consider some guiding principles and proposals which might help achieve both objectives.

3
Making Change: Principles

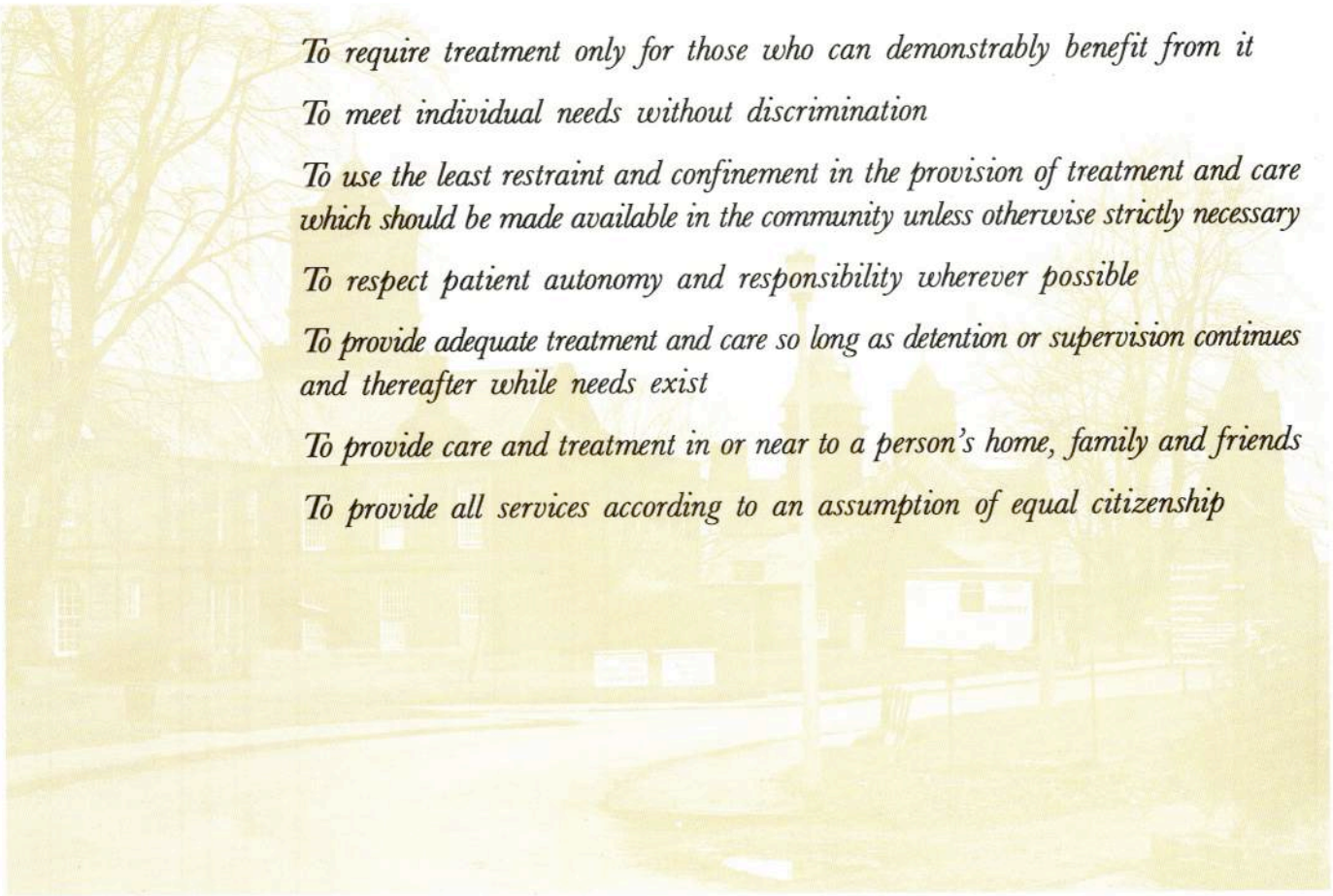
Why have any principles?

The social and ethical values which justify the use of secure provision form a complex mix of principles. Some values represent individual interests such as in personal health and safety. Others are definitely rooted only in the interests of others, such as the need for public safety. Further difficulty is added by the fact that a person in the system is, more often than not, compelled to receive care and treatment because an order has been made under the Mental Health Act.

It is so essential to distinguish between what may be beneficial to an individual and what society 'demands' as necessary since often these are in conflict. Most of the 'treatment', care and supervision which are provided are designed and offered not according to some choice exercised by a 'client' or 'consumer' but according to other people's views as to what is in theirs and the public's interests. It is therefore absolutely essential that there is clarity about the purpose for which 'treatment' or 'care' options are chosen over and above other possible outcomes and that these take account of principles of fairness and justice. The principles also need to be explicit for those spending public resources. Their accountability will need to be measured against accepted standards and expectations.

As well, present government policy is to enhance 'consumer' rights in the field of public services by the formulation of minimum charter standards these must meet. If such standards are to be applied to secure mental health services — and there is no logical reason why they should not be — guiding principles will be needed, before explicit 'rights' can be created.

Many examples can be employed to demonstrate what happens when principles are absent from service planning or are ignored when decisions are taken. The position of women in the special hospitals is one. When compared to men they are overrepresented at this level of security and their disproportionate detention is quite unjustified in relation to possible 'dangerousness' or absconding risks[36]. They arrive in the special hospitals sooner then men and for less serious offences, because men and women are not treated equally in the criminal



To require treatment only for those who can demonstrably benefit from it

To meet individual needs without discrimination

To use the least restraint and confinement in the provision of treatment and care which should be made available in the community unless otherwise strictly necessary

To respect patient autonomy and responsibility wherever possible

To provide adequate treatment and care so long as detention or supervision continues and thereafter while needs exist

To provide care and treatment in or near to a person's home, family and friends

To provide all services according to an assumption of equal citizenship

justice system. The special hospitals, as an adjunct to that system, simply incorporate its discriminatory assumptions and patterns of operating. Some would argue they have no option because of the worse decisions of those providing accommodation in lesser security who refuse a service altogether. Either way, the experience of special hospital is a different one for women than it is for men. This cannot be justified on any rational grounds. Similar points can be made in relation to the over-representation of black people as offender patients.

Principles are thus required to ensure that only those who clearly benefit enter the health system. Practical proposals can be made to reinforce this and we make some suggestions below. As well, standards are important in guiding managers and staff in how they decide to control their secure facilities — where the patient is generally powerless, often entirely dependent on the authority and influence of others. Some examples will illustrate this. In most secure facilities:

- ☐ a patient will find that labels, definitions and interpretations of them are crucial to their progress. These will not be formulated by the patient because the power to define who they are and where they are going has largely passed into the hands of others;
- ☐ a patient will find that institutional life determines who they will live with; what privacy, if any, they will enjoy; whether they will be at risk of assault from others around them; who may visit the patient and when; what clothes they will wear;
- ☐ a patient will discover that, within the institution, others will decide how, if at all, they will be able to express their sexuality, their creativity or sense of humour;
- ☐ a patient will quickly perceive that detailed information touching a vast range of their experience will be accumulating in the hands of staff, with the patient rarely, if ever, personally involved in its accurate recording;
- ☐ a patient will discover that some types of behaviour — non co-operation with treatment schedules, aggressive displays of anger or frustration sometimes leading to violence, a depressed and possibly suicidal mood — may result in isolation in a room (termed 'seclusion'), which will be felt to be punishment for letting feelings get out of control. However, at the same time, the patient may find that life in the hospital provides little opportunity to vent those very same feelings in any way which does not attract some some sort of sanction;
- ☐ although a patient will find that they are detained, sometimes for very lengthy periods of time, they will discover that very few of their rights or the responsibilities of those detaining them are enshrined in law or legal regulations, in marked contrast to the prison system of which the patient may have some experience;
- ☐ finally, and this will apply especially for a patient in the special hospital system, they may find that even when their doctor and clinical team believe that they can and should leave the hospital, for another psychiatric unit or for the community, that team may be completely powerless to arrange this until others co-operate. This occurs even after a Tribunal has ordered the discharge of a patient from hospital, their release only to await the practical arrangements necessary for aftercare in the community[37].

Three reasons make clear values necessary in the design and operation of services. Firstly, because of the vagueness and generality of ideas about 'public safety', an elusive concept, and 'dangerousness', as hard to predict. Secondly, because of the degree to which power is exercised in institutional care — even when this is the most well intentioned — and how this will be experienced by the person on its receiving end. And, thirdly, because of the tension which will always be found at the heart of any secure provision system — between security and therapy.

> *'A conspiracy theorist might argue that some of those professionally associated with the tribunal system are content, on occasions, to allow considerations of dangerousness improperly to influence the application of the law. After all, who, apart from the patient directly involved, is liable to protest too loudly if a patient about whom predictions of dangerousness are confidently made by all concerned, is kept in 'treatment' longer than he might otherwise have been?'*
>
> *Peay: 'Tribunals on Trial'. (1989)*

Foundation principles for a just and accountable service

The following section suggests some basic principles which can be used as a foundation for decisionmaking, as the elements of a secure provision system are planned, purchased or operated[38]. As well as offering principles on which to base changes to law and procedure, they provide a benchmark against which current practice and provision can be measured. Some of the principles have an application or relevance well beyond the narrow field of secure provision.

1. **To require treatment only for those who can demonstrably benefit from it**

This ensures that a system purporting to be neither for punishment nor simply for preventive detention admits and detains only those who may genuinely and demonstrably benefit from its services. It should prevent the entry of those it cannot help whose detention would be harsh and unnecessary and should speed the departure of those no longer appropriately detained.

2. **To meet individual needs without discrimination**

Individuals being considered for possible admission to hospital should be entitled to have their personal needs carefully assessed and respected without unfair discrimination on the basis of social, cultural, religious, ethnic or gender differences. Such an expectation should touch matters of diagnosis and also judgements concerning 'dangerousness' as much as the management of a person's institutional care and approaches to their freedoms within it. For example, does the diagnosis of 'schizophrenia' frequently applied to young Afro-Caribbean men derive from culturally biassed and inappropriate assumptions? Or, is it right to detain women in special security for offences far less serious than men, with the diagnosis of 'personality disorder' far more often used to do this? It will call for a service which is comprehensive, flexible and, being relatively specialised, is able to adapt to individual requirements in pursuit of principles of equal opportunity and access. From this principle will be developed the need to monitor the impact of decisionmaking, particularly as this affects groups such as women patients and those from minority ethnic communities, and its compliance with such expectations.

3. **To use the least restraint and confinement necessary in the provision of treatment and care which should be made available in the community if at all possible and practicable; and to use treatments only for therapeutic advantage and at the minimum effective level**

In the provision of psychiatric treatment and care to a detained patient, interference with their liberty and restriction of their personal freedoms should only occur for reasons exclusively concerned with the demands of that treatment. This should only be required in hospital where community options are inappropriate and have been exhausted. This rationale provides a legitimacy for the detention it would otherwise not have. As soon as the patient's condition dictates a need for no security or for security of a specific degree, then the treatment regime must be altered or removed altogether with the freedoms formerly enjoyed by the patient being restored to them. As well, security should be as unobtrusive as possible. The same principle applies to the type of treatments given and the mode of their administration.

4. **To respect patient autonomy and responsibility wherever possible**

Individual patients are entitled to expect that they will be as fully involved as possible in decisions about their treatment and care and that this will be facilitated wherever necessary by the provision of information; acknowledged in a routine practice of seeking and recording a patient's views and opinions on their treatment and encouraged by assisting patients to present those views either individually or collectively to professional and managerial staffs.

5. **To provide adequate treatment and care so long as detention or supervision continues and thereafter whilst needs exist**

The justification for treatment with security, usually without the patient's consent, rests not only on the needs of that person. It also obtains its legitimacy from the standard and adequacy of the treatment provided. Where treatment is deficient, inadequate or plainly non existent, how can it be argued that the patient is properly detained? The purpose for which that detention was taken in the first place is frustrated by an indifference to the therapeutic duties owed to the person who is detained — duties which formed the very rationale for treatment.

6. **To provide care and treatment in or near to the patient's home, family and friends**

It should be the aim of such services to cause as little disruption as possible to the patient's home and family ties. These may be essential for their early and successful return to an independent life in the community. In any event, it should be their right as a citizen to be enabled to enjoy such contacts as much as possible and the unjustifiable removal or restriction of these must be seen as an infringement of their human rights.[39] Correspondingly, carers' and relatives' rights have to be formulated and respected.

7. **To provide and manage all services according to an assumption of equal citizenship**

Those detained in the secure provision system should be entitled to treatment on the assumption they are citizens with all the attendant rights, responsibilities and choices. Where requirements of the law, clinical, nursing or management decisions restrict or limit those rights, this must be justified according to specific considerations such as the health or safety of the patient or others, or the need to protect the acknowledged rights of third parties.

From values to rights

Even if widely accepted, how will this core of foundation principles be of any use? What has already been stressed is that the objectives of the service should be clear. The quality of planning and decisionmaking associated with

the entry of 'patients' into the system needs to be improved. For not all of the problems associated with the system can be laid at the door of inadequate or absent resources[40]. It is just as essential for those deciding about the allocation of resources to ensure that the very best decisions are made about how these are used. This will entail a clear adherence to objectives which are commonly accepted and which are given sufficient authority and prominence to guide decisionmaking by prosecuting authorities, by courts, by mental health and social work professionals and authorities and by supervisory tribunals and, where applicable, the Home Office.

The analysis presented in Chapter 2 reveals the gulf which exists between the current services and reasonable objectives which could serve individual and public interests. In terms, these are too often, and for too many, simply unable to meet the needs of the person within or about to enter them. What has been so clearly lacking has been anything approaching an adherence to the principles outlined above.

The reason that this state of affairs can be tolerated for so long without public outcry or mass litigation is, of course, a reflection on the civil and political status of the detained patient - particularly the person who is detained following a conviction for a criminal offence. Could anyone argue that the law and its application regards detained patients as full citizens entitled to be treated according to the same standards of equity and justice as prevail in many other institutions of society? The same question could be asked about the prisoner whose mental health problems are inadequately addressed in the prison system.

Just three examples of what is meant by this will demonstrate the point. Suspects who are detained in police custody on suspicion of breaking the law have ready access to independent, free legal advice from lawyers empanelled on a rota of 'duty solicitors' who will frequently reach them within an hour. Thereafter they may be represented in court under similar conditions. Patients who are detained, often in hospitals remote from lawyers' offices and when highly vulnerable to distress and the effects of medication, have no such service and must find, and if need be pay for, a lawyer themselves. It is hardly surprising to learn that in the busiest region of the Mental Health Review Tribunal, as many as 45% of patients go unrepresented before the tribunal[41], yet legal representation distinctly improves the chances of discharge being ordered[42]. Secondly, the policy governing visits to patients in Broadmoor Hospital was recently revised resulting in the removal of rights for visitors to give to patients food they had prepared and brought to the hospital — a practice which had existed at the hospital for many years and which was treasured by families and patients alike. In doing so, managers had no requirement to have regard to any stated body of patients' or visitors' rights. The storm of protest which their actions caused had to be articulated as a breach of 'human rights' granted under the European Convention of Fundamental Rights and Freedoms rather than as an infringement of clearly stated legal rights. That the representations may have been successful in helping to persuade the hospital to restore the practice does not detract from this institutional disregard of ''rights'' for persons held under the Mental Health Act. Lastly, in the 1989 case of Knight -v- Home Office, Mr Justice Pill ruled that a prisoner detained in a prison as a 'place of safety' awaiting transfer to hospital was not entitled to treatment and care at the same level as that available to an NHS inpatient — a blatantly discriminatory principle inviting the continuation of low standards of care in the penal system[43].

Raising the civil status of the detained patient would lessen the chances of their being treated inappropriately, with excessive restriction or inadequate care. What is needed is for the formulation of some fundamental standards, rights and expectations which recognise that those having to use the service, and detained in it against their will, are citizens as well as users of health and social services and their citizenship rights need to be clearly understood and acknowledged as much as their expectations as users of a health service. In short, people detained in hospital should be citizens first, patients second.

> *'I am unable to accept the submission that the law requires the standard of care in a prison hospital to be as high as the standard of care for all purposes in a psychiatric hospital outside prison.'*
>
> *Mr Justice Pill. (December 1989)*

In the long term this aim could best be achieved by amending the Mental Health Act 1983 to incorporate such a set of core principles to which any decision taken under the Act or concerning the use of powers given under the Act had to be clearly accountable. These would guide all aspects of decisionmaking under the Act and would be a benchmark for judging their appropriateness and fairness.

In the interim, amendments to the Mental Health Act Code of Practice should incorporate these principles in the guidance which it gives to medical and other professionals using the Act. We make suggestions below for the courts and tribunals to have greater powers, particularly to enable them to require health services to be provided. It will be essential for them to have clearer statutory guidelines when applying this extended jurisdiction and these principles in some statutory form or presented as guidance could serve this purpose.

Linking such standards to the decisions taken about secure provision is but one of the possible changes which will be needed in future. Other practical proposals we shall detail in the next chapter.

4
Making Change: Proposals

We have set out above the main principles which should underpin the formulation and implementation of policy in secure provision. What should be its specific objectives in the various areas of concern and what proposals do they call for in practical terms?

There are certain key issues which have to be faced and resolved before much will be achieved. These may be summarised as follows.

(a) Unmet need should be accurately and effectively assessed both for the present and the future. Local authority community care planning and public health surveys for the purpose of NHS purchasing already provide a framework for such assessments to be made. The perceptions and views of service users should be included in this process. Only when accurate and comprehensive data is available will planning be possible.

(b) The Reed Committee proposed the creation of a national forum to overview policy and developments in this field. This is essential and should be given priority. National minimum standards for implementation need to be set and such an advisory committee needs to play a full part in this. Secure provision is not narrowly the concern of clinicians and planners. The new body needs to include a broader range of opinion and experience, including people who have used such services, groups representing the interests of women in secure hospitals and people or groups with an interest in and knowledge of racial and cultural issues in this field.

(c) Many of the problems which have been outlined above result from the under-resourcing of current services. 'Slopping out' in the special hospitals; homelessness leading to inappropriate prison remands; inadequate or non-existent aftercare for discharged patients or released prisoners will not be touched by better 'practice'. More resources must match policy objectives for them to have any chance of viability and especially for community services, where current spending levels are so low.

(d) Research or practical investigation must be promoted and positively encouraged. Only then can untested assumptions give way to hard facts. This is all the more necessary if the service is to expand. Such research must incorporate methodology which records and evaluates user perceptions and experiences.

(e) Though law often frustrates the objects of policy, it can also help to further them. It is ten years since the Mental Health Act was updated. It is time for it to be reviewed again to determine where its provisions hinder the broad objectives mentioned above and how these can be changed if it does.

(f) The issues of institutional discrimination on grounds of race or gender referred to above must be given the highest priority and regarded as justification alone for fundamental reform of the system of secure treatment and the pathways by which patients arrive in it.

Our discussion of practical changes is divided into the following sections:

- ☐ the police: crime and crisis intervention
- ☐ the court: bail, custody and sentencing
- ☐ inpatient treatment: 'fluid security' and a comprehensive service
- ☐ inpatient treatment: rights and standards
- ☐ the prison: a health service for prisoners
- ☐ community services: prevention and aftercare

The police: crime and crisis intervention

Good police practice can make a significant impact in this area. Criminalisation of behaviour which entirely originates from distress will stigmatise the person affected, may lead them to unfortunate and unsuitable consequences, and may do little or nothing to serve any notion of 'public interest'. Indeed, it may provide a ticket to the wrong part of the system. Early diversion from custody and/or prosecution may often, therefore, depend initially on the observations and actions of police officers.

Is there any reason why police officers should be skilled in the identification or appropriate treatment of mental distress? They receive no special training in this subject and are expected to acquire any necessary understanding simply from their work.

In any event, the police station, both in its organisation and environment is wholly unsuited to meeting the needs of a person in distress. The police should not have to be therapists themselves, for the whole thrust of policy should be to ensure that they can obtain therapeutic advice and assistance whenever this is needed.

This is not to say that the police can ignore obvious training needs. Appropriate instruction has to equip police officers for the statutory responsibilities associated with use of s.136 Mental Health Act 1983, and custody officers and those interviewing suspects will need to be able to apply the protections provided by the Police and Criminal Evidence Act 1984 and its associated Codes of Practice. Given the likely limitations on police capacity to do more than seek the opinion of others, the object of policy in this field should be to limit as far as possible the occasions when they are obliged to deal alone with a person in distress, ensuring as well that their practice is not affected by discriminatory assumptions or perceptions of that person's behaviour or difficulties.

Already the introduction of national and local guidance should be encouraging greater collaboration at a local level between police divisions and their respective health and social services authorities, probation and housing departments[44]. The purpose of policy should be to develop this further to ensure that police actions are effective, appropriate, non-discriminatory and above all supported by their having effective liaison with local services which will consistently respond to the health and social needs — especially for suitable housing — of the person arrested where these are considered to be prominent.

Finally, conventional crime investigation and, where the results of that investigation justify this, prosecution should only occur where the public interest demonstrably requires this. Public interest considerations would include the seriousness of the alleged offence, which might be related to those amounting to a serious arrestable offence'[45], and the continuing risk, if any, of significant harm to the public. The attitude of the alleged offender to his or her behaviour and their willingness to co-operate with suggested treatment, care or supervision will be relevant to judgements concerning 'public interest', as will be also the availability, and appropriateness of medical and social care in the community or inpatient treatment on an informal or compulsory basis.

Practical proposals

To achieve these objectives we make the following proposals:

(a) initial police training should ensure that operational staff with responsibilities to employ or monitor the use of s. 136 Mental Health Act 1983, the Mental Health Act Code of Practice, and Home Office Circular 66/90 are familiar with their requirements, with culturally sensitive approaches to understanding and responding to mental distress and with the availability of local services to assist in the person's diversion from police custody if this is appropriate;

(b) a lead officer at least of the rank of Inspector, should have responsibility within the division for coordination of staff training, police liaison with other agencies especially to aid the policy of diversion, monitoring the use of s. 136 Mental Health Act 1983 and the local policy for implementing it;

(c) each force should have published policies on cautioning and on prosecution and these should provide detailed guidelines on the considerations which would have to be satisfied to justify the cautioning or prosecution of an alleged offender who is 'mentally disordered' within the meaning of the Mental Health Act 1983;

(d) health and social services authorities should co-operate in forming multidisciplinary crisis or emergency teams of designated staff, modelled on that which has successfully operated for some time in the Barnet area of London. These should be able to respond quickly to a request for assistance. The police should be able to call for and routinely rely upon their attendance before employing any police power of arrest or removal;

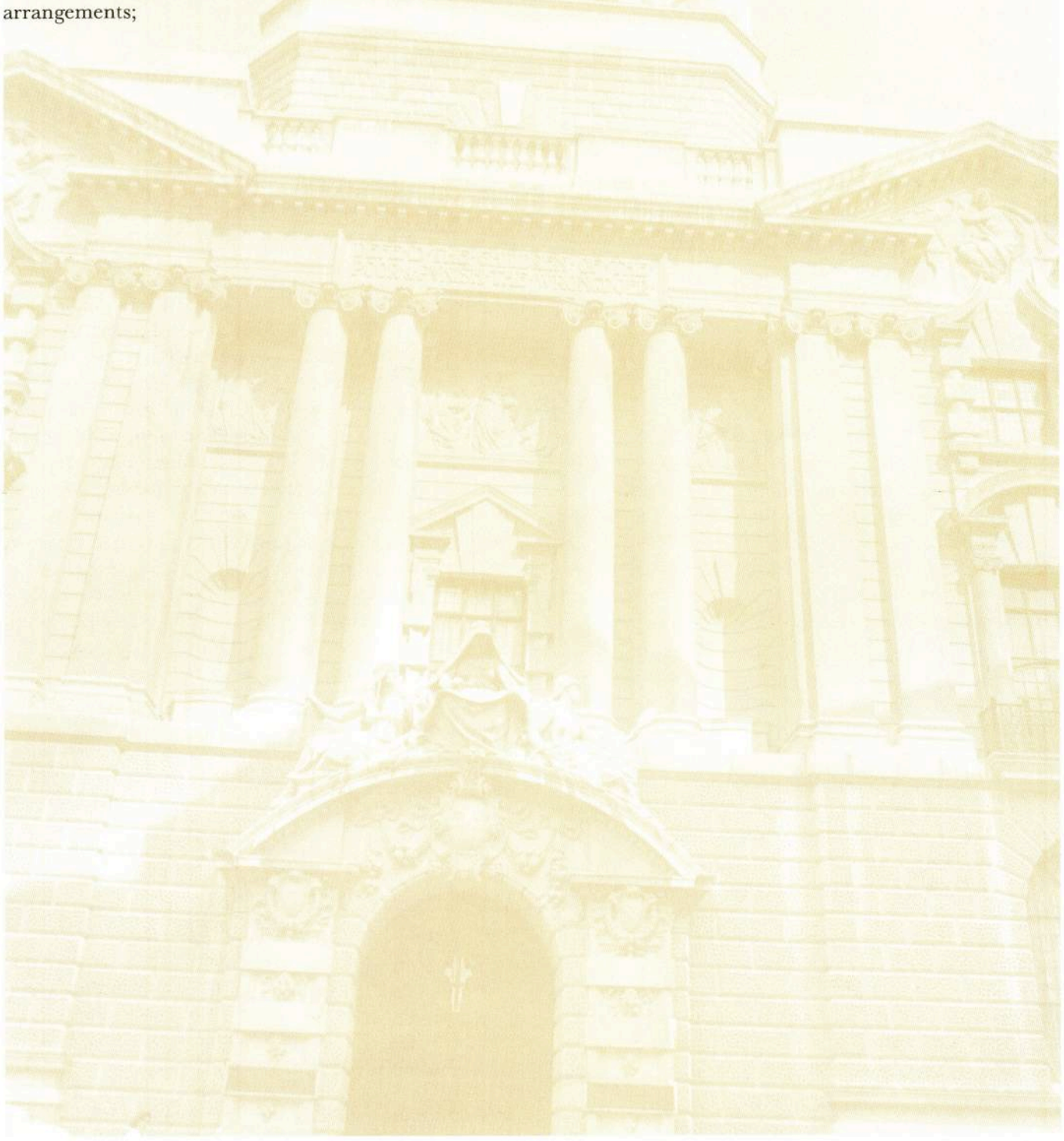
(e) detailed practical arrangements should be agreed between the police, the health and social service authorities and the probation service within the policy already required by Chapter 10, Mental Health Act Code of Practice, for the use of informal procedures to arrange a person's assessment in order to avoid unnecessary use of s.136 Mental Health Act 1983;

(f) a community based health or local authority facility should be established for each area as its 'preferred' place of safety for the purposes of s.136 to avoid the inappropriate use of either police cell accommodation or a hospital ward;

(g) interagency and interprofessional liaison are essential if the objectives mentioned above are to be met. A

formal structure for this should be created. This particularly needs to link up the probation service — which is firmly placed in the criminal justice system — with local authority social work located in the health and community services. It will be necessary to secure interagency cooperation — especially to provide quick access to voluntary sector services — by the creation of a dedicated project, run by seconded or newly appointed staff with responsibility for local work directed to diversion from custody. The main proposal of the Telethon Inquiry Report,'Revolving Doors'[46],was for such an approach. The pilot project it is hoped to establish in a part of Inner London will test the viability of such collaborative working. Rural or suburban conditions may dictate a different approach but it is essential that each locality establishes firm, working arrangements;

(h) in MIND's publications, 'A Place of Safety'[47] and 'Out of Harm's Way'[48] difficulties in the law and practice concerning s.136 Mental Health Act 1983 were outlined. When an opportunity arises to amend the Mental Health Act, then s.136 should be altered to incorporate some of the requirements now given as guidance in Chapter 10 Mental Health Act Code of Practice. In particular, the potential period of detention under this section(72 hours) should be reduced to, say, six hours; the police should be required to complete a standard prescribed form describing how and why the police power was employed and why informal measures were insufficient; and amendments to the section should discourage the use of inappropriate facilities for the purpose of detention.



The court: bail, custody and sentencing

A primary role for the court is already determined by its pivotal position in deciding who should enter the treatment system and who should not. In this, it has often been frustrated. It has had insufficient information on which to make a fair and proper decision and noncooperation from health and social services leading, at best, to delays in the provision of assessment or treatment options for defendants[49], at worst to the refusal of help, where this is nevertheless considered to be necessary and available within the law. Furthermore, when courts have wanted information about a defendant's mental state they have had to look, largely, to the prison service to supply this when they have not been willing to grant bail. In the absence of local NHS facilities prepared to provide the necessary assessment, courts have routinely used the Prison Medical Service for this purpose.

Only recently have determined and innovative initiatives in the field of diversion from custody demonstrated alternative and often simple ways of acquiring reliable information about defendants which can assist courts in making early and appropriate decisions. Future policy and the allocation of resources need to enable these schemes to develop. They must provide a comprehensive and effective means of making key information available and ensure services are available for courts or prosecuting authorities when deciding to divert from inappropriate custody or prosecution altogether. We give below some suggestions which may assist in this.

It is essential to limit the ordering of treatment only to those persons who can demonstrably benefit from it. Sometimes psychiatry has difficulties in clearly establishing the value of treatments. Recent use of the Mental Health Act 1983 for the detention and compulsory treatment of offenders considered to have a personality disorder — termed in law 'psychopathic disorder' — has highlighted not only the vagueness and difficulty of the concept but the importance, when considering the appropriateness of treatment for it, of firmly securing the consent and co-operation of the defendant. Without the latter, treatment is quite unrealistic. Evidence from the special hospitals suggests that women are over-represented in the patient group given this legal status. The 'treatability' test introduced by the Mental Health Act does not appear to have sufficiently narrowed the entry point for admission to a secure hospital and there is controversy concerning the diagnosis and subsequent indefinite detention particularly of women with this classification[50]. In Scotland and Northern Ireland the concepts are entirely excluded from the legislation permitting the detention of patients for treatment. Why should England and Wales be an exception?

Research conducted during the 1980's in Broadmoor Hospital, confirmed to many what they already feared, namely that the continued detention in high security of patients given this legal classification beyond the time this was justified on any clinical grounds was in part due to the vagueness of that definition and imponderability concerning the chances of successfully treating it[51]. In 1986 the Home Office considered the possibility of amending the Mental Health Act to remove the power of the court to detain for treatment in these circumstances and canvassed views. It decided not to do so but the problems still remain and these contribute to the inappropriate and unjust detention of patients in secure provision. What is required are measures which limit the chances of persons entering the system in the first place for other than demonstrably justified reasons. Proposals include limiting the scope for courts to order treatment only to those occasions when the defendant positively consents to what is proposed[52]. Others have argued for changes which remove altogether the court's power to order treatment, replacing this with a jurisdiction to immediately transfer for treatment a defendant sentenced to imprisonment[53].

Practical proposals

Practical proposals to achieve these objectives are as follows:-

(a) the Reed Committee[54] has already drawn attention to the need to review the legislation which permits the remand court to send defendants into the prison system when they require medical examination and assessment. This power itself encourages the inappropriate and discriminatory treatment of defendants with mental health problems needing assessment and offers a perverse justification for the prison medical wing to continue in its present role. To continue to use inadequate prison facilities in this way surely constitutes 'inhuman and degrading treatment' of prisoners contrary to Article 3, European Convention of Human Rights[55]. The statutory framework in which decisions are taken should reflect overall policy objectives. The law should be urgently amended to remove any opportunity at all for the remand court to treat the prison as an alternative inpatient assessment facility;

(b) furthermore, the Bail Act 1976 should be amended to incorporate parallel obligations on the court to consider the mental health needs of the defendant, the effect which a remand into custody would have upon these and the availability of any treatment of which the defendant may stand in need[56];

(c) a number of assessment schemes have started in various Magistrates Courts directed to improving the ability of the court and allied agencies such as the Crown Prosecution Service to effectively divert defendants from inappropriate custody. The enthusiasm, imagination and clearsightedness of those who have pioneered these schemes is unfortunately not reflected in the attitudes of mainstream financial and service management. Like many a 'new idea' the schemes still occupy marginal

territory in terms of the main budgets of service providers. The result is that schemes are operating on little or no secure funding and are having to seek initial or additional funds from charitable sources. £4m for three years from April 1992 is now available from the government, but it appears this money will be for limited professional costs. Experience with the schemes has shown the importance of multidisciplinary assessment and working. The schemes should be placed on a more rational and formal basis with secure funding and adequate staffing and liaison. Linked to this should be explicit directions from central government that schemes appropriate to their needs should be established to serve each magistrates' court area in England and Wales;

(d) for courts to be able to divert more defendants into the community then more resources for support and for housing will be needed. Many defendants with mental health problems are remanded into custody not because of the seriousness of the offence, which is often a minor one, but because of their homelessness. Furthermore, for many defendants it would be wholly inappropriate to apply the provisions of the Mental Health Act to require their admission to hospital for treatment. For those who are not admitted to hospital under a hospital order, few are imprisoned. There is an urgent need for more bail hostel accommodation which can provide bail places for such defendants and with appropriately skilled staff and close relationships with local services. There is a similar urgent and profound need for more housing to which such defendants can have quick and uncomplicated access, if cycles of antisocial behaviour and extreme disadvantage are not to be simply repeated on their leaving court;[57]

(e) the guidelines which the courts have in relation to the sentencing of the 'mentally disordered' offender are derived from Court of Appeal decisions, from circular guidance, from publications such as 'The Sentence of the Court' (HMSO) and from the training which is provided to them, especially to lay magistrates. There is a need for explicit guidance on the considerations, particularly touching 'public safety', which should influence a court's decision to employ the Mental Health Act to order the compulsory treatment of the defendant or their reception into guardianship. Professional decisionmaking is now accountable to a detailed code of practice[58]. When courts have to employ corresponding powers they, as well, should have clearer guidance from the law and a code issued under it;

(f) we have mentioned above the difficulties which courts have in obtaining the speedy assistance of health and social services. The Finance Advisory Group of the Reed Committee found the cause of this to be uncertainty as to who would finance the treatment or care envisaged by the court. This is an especial problem for a defendant who is not in the area of their own health authority and for whom there is a dispute or simply delay in agreeing the necessary financial arrangements. The Group hinted that the court should be legally empowered to order a health authority to provide a service, subject to clinical recommendations. Although he uses it rarely, the Home Secretary already has a similar power under the Mental Health Act to order the managers of a hospital to admit a prisoner from jail[59] where that person needs treatment. There is surely little logic or consistency in the Home Secretary possessing such a power but the court not having this. The courts should be given additional statutory powers to direct the provision of treatment if this is clinically recommended. The effect of this will be to require a health authority to purchase a service for the defendant, either for pretrial assessment or treatment after conviction, where admission is ordered under the Mental Health Act;

(g) the principle was noted above of only allowing the secure part of the mental health system to admit — and, by the same token, retain — persons whose 'mental disorder' can be the subject of precise and exact diagnosis and legal definition, for whom the benefits of treatment are similarly demonstrable. For this principle to be reflected in decisionmaking and in practice then the Mental Health Act 1983 needs to be amended. Firstly, the power for courts to order a restriction order to have indefinite effect needs to be ended. Such restrictions are not justified on any grounds other than the 'protection of the public from serious harm'[60] and need to be the subject of vigilant review. In future, the Home Secretary wishing to secure a continuation of the sentencing judge's restrictions (which should not initially exceed a maximum of three years) should have to apply to an independent judicial body — perhaps modelled on the Mental Health Review Tribunal — for this purpose. It will then be for the Home Office to persuade it of the presence of 'serious risk', not the patient's responsibility to establish that there is no longer any reason to believe it exists. This is a burden of proof as unfair as it is hard to satisfy. The same procedure should apply where a long-term treatment order under ss.3 or 37 Mental Health Act is justified 'for the protection of others';

(h) in relation to 'psychopathic disorder', amendments to the Mental Health Act are required which effectively remove it as a classification sufficient to justify indefinite treatment in the absence of the patient's consent. This is not to say that persons who may be regarded as being affected by such a 'disorder' cannot benefit from treatment. It should be available to them, if need be, in NHS facilities. However, this should be on the basis of their agreeing to its provision and without reference to any indeterminate period of detention. If the seriousness of the defendant's offence justifies a sentence of imprisonment and this is imposed, the sentencing judge should then have the power to direct the prisoner's immediate transfer into hospital on their consenting to

the making of such an order. On the completion of their treatment they will then enter the prison system or, if still in hospital on completion of their sentence, will then be released.

Inpatient treatment: 'fluid security' and a comprehensive service

A number of pressing issues need to be resolved before inpatient services can develop according to the principles outlined above.

- ☐ Substantial additional resources must be committed to the full range of services if standards of care and quality of life for detained patients are not to be compromised, prisons still used to improperly detain hundreds of prisoners, and community options not to be developed.

- ☐ The future location, style and size of 'high security' provision needs to be urgently reviewed. 'Special Hospital' care dates from 1863. Other approaches, mentioned below, are possible, should be developed and, in due course, should replace the old specials.

- ☐ Financial responsibility for treatment and care costs should entirely fall on the district authority—health or social services — for where the patient lives. Its purchasing decisions must be linked to principles preserving quality and protecting rights. We outline some in Chapter 3.

- ☐ The issues of institutional discrimination on grounds of race or gender referred to above call for detailed monitoring and consultation so that the disadvantage revealed can be faced and overcome.

- ☐ Greater clarity is needed as to the respective responsibility and role of the probation service and local authority social work service. The former has knowledge of the criminal justice system but does not work traditionally with mentally distressed people. The latter does but has little experience of work in the field of adult crime.

If ministers do not resolve these issues at the outset then the potential effects of the work of the Reed Committee and the All-Wales Advisory Group may be risked.

If institutional inpatient services are to shift towards being able to meet individual needs more effectively and problems of inappropriate detention are to be tackled then the concept of 'fluid security' must be the dominating consideration in planning and operating the service. By this is meant ensuring the ability of the patient to move easily up and down different levels of secure provision, that movement depending only on a judgement as to the measure of security which they require.

The concept should already be influencing the shape and interrelationship of services. Although it has to be acknowledged that, with resources being limited, change often reflects the pattern of existing services, this should not now inhibit planning much needed developments based on a long term projection of needs and aims. Change should not be mainly in response to the urgent requirements or priorities thrown up by short term considerations and what resources are immediately to hand. This is all the more essential when the Reed Committee has exposed the need for a great increase in the resources made available to the system[61]. Fresh resources should be devoted to innovative and imaginative developments as well as to filling obvious gaps in provision. For example, if the regional secure unit programme is to be substantially extended, some of these new resources should be employed in providing to existing or new units the capacity to provide accommodation for patients requiring high security.

Practical proposals

The outline of a service providing 'fluid security' will be along the following lines:

(a) Low Security

The primary provision for any person requiring secure inpatient treatment should be at a local level and within district hospital services. These must develop the facilities and retain the skilled staff able to meet most of their needs, and the district should only be able to refuse a place — and purchase one elsewhere — after demonstrating that the person requires medium or high security. Security is not exclusively or even mainly about physical barriers — it is achieved by providing appropriate ratios of skilled staff and establishing suitable philosophies of practice. We have seen that many districts do not prioritise local provision and an objective of policy must be to encourage a change in attitude amongst managers and professional staff to ensure that such services are seen as part and parcel of the mainstream business of local hospitals. Partly this may have to be achieved by changes in the funding mechanisms which presently discourage local NHS purchasers or providers from purchasing or operating a local service for this client group, and by the provision of regional planning structures to co-ordinate provision of such services.

The Mental Health Act Code of Practice at paragraph 18.27 advises that such a service should be provided by districts in designated facilities for which 'written guidelines are provided, setting out and clearly distinguishing between the categories of patient where it is appropriate to use physically secure conditions and those where it is not. The guidelines should include a clear policy for the practice, proper procedures and safeguards, the justification for its use and the circumstances in which it can be used.'

This advice entirely corresponds with the objective mentioned above although our view is that district

authorities should be obliged rather than merely advised to plan the service in this way[62]. If purchasing authorities require additional resources to enable them to develop the capability of dealing with this group then these have to be provided particularly for additional training.

Such accommodation should be planned to fit in with other secure services in the region. It should have the capacity to deal with many of the difficulties leading to referral of a patient to a regional secure unit. Proposals for achieving quality and protecting patients' rights are outlined below.

(b) Medium Security

The Regional Secure Unit provides, either to a regional or to a subregional catchment area, a service with intensive multidisciplinary care and treatment for the detained patient for a limited period of time, usually less than two years. The staffing ratios offered in such units, the built environment and the resources available for treatment directed to 'rehabilitation' are often superior to those found in district services, and vastly better than those on grim wards in Victorian hospitals.

However, for a number of reasons, shortage of accommodation has led to numerous examples of patients being unable to secure a place in a Unit at the time and for the length of time which they required. It is not yet known what may be the precise demand for this type of service, either delivered in the manner of existing units or according to less restrictive admission criteria, but it is likely that there is a need for at least 1,500 places at this level of security[63]. Any expansion, from the present total of 650, should be directed to ensuring that services exist in those areas where demand may be higher, some metropolitan areas, and that this level of provision is able to offer services to groups currently denied sufficient access to it. These are young people, women, those with a learning disability and those patients classified as having 'psychopathic disorder' and held in high security hospitals awaiting transfer to lesser security. As well there are those patients requiring medium security for periods longer than two years.

Additional resources have now been committed to 400 extra places and the Reed Committee recommended that a further 500 be found. If regional secure unit accommodation is to increase by nearly 150% then the opportunity should be taken to seek to integrate the service more closely into district services. As well, building a 'constellation' of small, more domestic units serving subregional areas helps patients and their families keep in touch.

Not all medium secure places are in the NHS for the private sector has developed services in a number of hospitals and these are growing in size and importance as provider units. A minimum of about 230 places in total appear to be available in private hospitals[64].This is regrettable since it has led to patients having to be treated often many miles from their homes, their families and friends without any overriding advantage or benefit resulting from the service being purchased from the private sector. Re-establishing community links is always harder in such circumstances. The private sector operates in a niche market created by the dismal failure of the NHS to create a comprehensive service. If we were to see the development of such a comprehensive service, accurately assessing unmet needs, operating multi-level integrated provision and removing any disincentives to local service development, then remote private sector services would become less attractive to purchasing authorities. Such district purchasing authorities must become far more sceptical of the merits of remote private care. Their 'purchasing power' could also be channelled into financing local care. Their primary aim should be to seek by all possible means to secure this for their area's residents.

(c) Maximum or High Security

It has to be accepted that there will always be a group of patients whose degree of dangerousness, combined, for some, with a condition appearing highly resistant to improvement or change, calls for detention in high security at certain stages or for periods of the time they are being treated. The system of 'fluid security' outlined above most certainly takes into account the needs of the patient in this group for whom the local hospital or medium secure unit offers insufficient protection for the public.

However, maximum security accommodation is not intrinsically 'special'. It must be part of a comprehensive service and closely allied to the management, practice and ethos of the other parts of that service. Without commonly held purposes, shared values and corresponding staff skills the healthy development and operation of the system will be greatly inhibited. A necessary respect for enhancing and protecting patients' 'rights' in the context of modern standards of psychiatry and nursing will call for the system to have progressive aims. Opportunities for rehabilitation will be maximised within it and real attempts made to build security around patient/staff relationships of trust and confidence.

This required philosophy will have no time for the 'custodial' methods and culture of former times. Difficulties arise if there is a significant gap between the standards and quality of treatment and care delivered at one level of the service compared with another. Then the concept of 'fluid security' will remain elusive and the truly integrated service it requires will not be achievable.

The three special hospitals, Broadmoor, Rampton and Ashworth, provide high security accommodation for approximately 1,700 detained patients. These institutions are established under s. 4 National Health Service Act 1977 to provide treatment to those

considered to need this 'under conditions of special security on account of their dangerous, violent or criminal propensities'. They have long and complex histories. Former Home Office management has resulted in the POA traditionally representing most of the staff. They now represent 69% of the total workforce of 3,300 (1991).

Since their construction, these hospitals have been extremely isolated both in geographical and professional terms. Until 1989 this had been reinforced by DoH central management, save for Rampton which had operated under a local Board since 1980. This widely acknowledged isolation has prevented the special hospitals being influenced by other NHS developments, particularly in relation to nursing care, and as a result they continue to display characteristics which greatly limit their ability to provide modern, humane and cost effective care. These may be summarised as follows:

(i) Nursing staff attitudes

Of hospital staff, 64.5% are qualified or unqualified nurses. Their role makes them the staff group in closest contact with patients. Nearly all of these staff are represented by the POA. This union's consistent policy has been to defend present arrangements in the hospitals and oppose the numerous changes that the new management has proposed for them.

To the outside observer, such reforms aim to improve poor standards of patient care and the capacity of these highly restrictive institutions to deliver treatment in contemporary, enlightened and constructive ways. There has been no sign at all of any commitment from the POA to fundamental change in the hospitals, along the lines demanded by external critics, promoted by their new management and pursued by a small and embattled minority of dedicated and highly professional staff.

Instead, national and branch union representatives in their public statements have sought to discredit even the idea of change maintaining that this would compromise the hospitals' security. They make no mention of the urgent need to raise the standards of treatment and care given to patients, nor of the need to base future services on a clear recognition of patients' rights and a patient centred approach to planning care. A key test of attitudes will be the willingness of staff to cooperate in the investigation of complaints. To date the POA has rarely co-operated in management's investigation of complaints by patients or staff about the conduct of their members, and never when parallel investigations are being conducted by the police.

The fresh attitudes which are required cannot be created by memorandum; they must emerge from within the workplace itself. Nothing that we have learned in the last five years gives us any confidence that the transformative spirit which these hospitals lack has much chance of developing sufficiently to affect the whole philosophy of patient care and treatment. Instead, there is the overriding impression of a culture derived from outdated attitudes highly resistant even to talk of change, let alone to welcoming it with enthusiasm. Such influences constantly undermine any attempts by individual nurses to effect changes at ward level or in the manner by which their interests will be represented to management.

(ii) Institutionalisation

The 1988 HAS report on Broadmoor drew attention to a need to 'shed the unacceptable aspects of institutionalisation with its associated social and work patterns and preserve human dignity . . .'.It called for recognition of the need for patients to have a 'prominent role in determining his or her treatment' and judging that 'insofar as this is not the predominant ethos it is logical to conclude that the pervasive culture is non-therapeutic'. On any terms, the manner in which the special hospitals still provide care and living arrangements for their patients is still excessively institutionalised and depersonalising. In a very secure environment, some restrictions are bound to occur and communal life will also necessitate a degree of adaptation. However, the overriding impression gained in the special hospitals is that individual needs are constantly sacrificed to organisational ones, leading to effects which 'infantilise, create dependency and limit unnecessarily the degree of dignity and rights of individual patients' to adopt other phrases used by the Health Advisory Service. At best, this will add nothing to the therapeutic effectiveness of the hospital. At worst, it will be countertherapeutic. It is salutary to recall that the latter judgement was recently applied by managers of Ashworth Hospital themselves to one of that hospital's wards when they reported on complaints which had been made about it by MIND. Of the regime in Acacias Ward in June 1991 they said that it was 'depressingly anti-therapeutic'.

'To provide a skilled and committed nursing workforce, working in a partnership of care which recognises the needs of patients and respects their rights as equal members of society to choice, privacy and dignity.'

Nursing Mission Statement, SHSA. (1991)

'But all in all, female patients excluded, out of the 100 per cent of male patients we look after, 10 per cent need proper care as these are God's unfortunates. All the rest are the scum of the earth.'

Anonymous letter from member of nursing staff, Ashworth Hospital. (March 1992)

Such a situation calls for a root and branch approach which, for the reasons, given at (a) above we have no confidence the hospitals are capable of adopting convincingly. The SHSA believe that ward level change will come about because of three developments. Firstly, a fresh nursing mission document and policy has been published. Secondly, ward management is being introduced. Thirdly, every patient is to have a written 'patient care plan'. In theory each of these have merit. However, the history of these hospitals shows that good ideas sooner or later have to encounter their idiosyncratic nature. Thus, 24 of the ward managers recruited at Ashworth took part in the 1990 strike. This meant they were prepared to walk off the wards, leaving no emergency cover for patients at all and that, for those who are registered nurses, the SHSA has complained to their professional body of their misconduct. What had been the justification for this unprecedented action? Their own national chairman told union members that the 'issue [a dispute about travel payments] was difficult to defend'.

(iii) Complaints of abuse and maltreatment

These will range from serious assault to psychological taunting and oppression — 'the wind up'. It may be a complaint of repeatedly being threatened with seclusion or being constantly referred to as 'wop' or 'half brain'.

They cannot be ignored when the hospitals' long term future is being considered. Broadmoor Hospital is now the subject of yet another independent inquiry into the sudden death of Orville Blackwood, the third black patient to have died in similar circumstances since 1984. The Committee of Inquiry into Ashworth Hospital will shortly give its judgement on care of patients there. In relation to Rampton Hospital, the concern is that, because of staff solidarity, the police will be unable to obtain corroborative evidence of abuse when they need this to establish the truth of an allegation. This sits uncomfortably with statements about the hospital's 'obvious and general improvement'. If the majority of staff still reckon colleagues' interests to be more important than patients' interests, what hope can there be that patients' will be protected from abuse? That allegations of maltreatment continue to be raised by patients in special hospitals — the Ashworth Inquiry heard of 121 serious complaints over five years — demonstrates some telling facts about these places. Firstly, that the efforts or influence of good practitioners are unable to eradicate such conduct. Secondly, that the complaints and review systems, also, have wholly failed to do so.

Whatever may now be promised for them, such deepseated resistance to change puts in doubt assertions that these hospitals can ever achieve acceptable standards of care. In any event, their geographical inaccessibility will always seriously detract from any improvements which are made. The SHSA is allocated approximately £90m pa revenue and roughly £16m pa capital . According to the Reed Committee this equates to a yearly cost per patient of £65,000. Presenting the Authority's five year plan on 8th October 1991, its Chairman, Dr David Edmond, conceded the difficulty of the task of reforming these hospitals. He said, 'I am under no illusion that we have done nothing but scratch the tip of the iceberg of what needs to be done in special hospitals'. The question this statement naturally begs is for how much longer should his authority be permitted to attempt it.

With imagination, a planned allocation of the fresh resources which may be available for secure provision, and a commitment to innovation it is possible to envisage the creation of high security accomodation away from the special hospital sites. These will demonstrate the feasibility and gains of a system offering truly 'fluid security' when they are integrated with regional secure units and developed, initially, to serve supra regional catchment areas. In order to offer specialist services and flexible and diverse care, expansion would have to occur in the larger RSU sites where space is greater and recreational facilities are extensive. Furthermore, this plan assumes that RSUs broaden their admission criteria to allow for longer stays than two years.

'During the last six years to the best of my knowledge not one staff member in Rampton Hospital has been prepared to openly acknowledge the fault or wrongful actions of another.

No staff member has ever made a statement to the Police which would be construed as supportive of a Patient's complaint against another staff member.'

Detective Inspector Christopher Barnfather. Notts Police. (March 1992)

Such progress would, for the first time, offer comparisons between the traditional special hospitals and other ways of delivering care and treatment in maximum security. It would provide a model for application elsewhere. The SHSA claims that, despite its difficulties, it can reform the Specials. Instead, what it should be planning, in collaboration with regional health authorities, is the development of alternative resources altogether. These should be established on modern principles, fully and 'seamlessly' integrated into a local and comprehensive service. This provides the only long term guarantee that patients' interests and rights will be given the importance which modern

expectations and their civil rights demand. We hope that it will lead in due course to the ending of separate, central management of high security provision after the SHSA has enabled the transfer of responsibility to a regional management structure. The development of these alternative resources will permit the gradual reduction of places in the present hospitals and enable future plans to include the possibility of rational closure.

If high security accommodation was being planned and built today it is unlikely three large, remote, inaccessible hospitals would emerge. The priorities which led to their construction are not those of our age and it is time that planning for the needs of this patient group finally emerged from under the shadow cast by their long history.

Inpatient treatment: rights and standards

Policies which determine how patients experience the secure health system must aim to render this encounter one that is as positive as possible. Treatment which is provided must be as effective as possible and a patient's civil rights need to be clearly stated and then fully respected. Their formulation must lead to practical measures which enhance a patient's ability to retain a degree of control over their life whilst treatment is undertaken.

Proposals can be linked to a set of various 'rights' for the inpatient. Their complexity will limit the use or opportunity of successfully listing these in a single document or code. Some of them, however, could be grouped in a collection of enforcable minimum standards. This is not a novel idea. Already attempts have been made in the Mental Health Act Code of Practice to define certain expectations which detained patients are entitled to have fulfilled. Further, some secure units have sought to draw up charters or codes to have a similar purpose.

The rights which should concern us are as follows:

(1) a right to information
Patients are entitled to have information about a range of matters including their treatments. A hospital should have an information policy and should disseminate information on drugs, on legal rights (for example, under the Access to Health Records Act 1990) and other relevant issues. Patients and their representatives should be consulted about what information is needed and how it may be communicated so as to be relevant and accessible.

(2) a right to consultation and to self advocacy
The Code of Practice (para. 1.3) requires respect for patient autonomy. The provision of treatment and the operation of inpatient services need to encourage a 'culture of consultation'. Partly this will be built on giving to patients practical means and every assistance to express their views both individually and collectively. It will lead to the creation of patients' councils and will ensure that where patients require assistance with communicating their wishes, for example by employing interpretation, then this will be readily available to them.

(3) a right to representation
An inpatient is drawn into many situations in which they need the advice, assistance or representation of an independent adviser or advocate. Various types of representative advocacy have been developed in psychiatry, particularly citizen advocacy and legal advocacy. The latter is seen in the Advice and Law Centre providing legal casework services to patients in Springfield Hospital, Tooting. A service such as this is essential in the Special Hospitals for as long as they

remain open. It should be introduced there without delay. Detained patients in RSUs and local hospitals also should have easy access to professional advocacy assistance. When the Mental Health Act is reviewed a statutory right to advocacy should be created for detained inpatients.

(4) a right to freedom from interference and unjustified restriction

A priority here is the need to clearly define when physical restraint, including seclusion alone in a room, can ever be justified. The Mental Health Act Code of Practice has failed to alter practice on restraint sufficiently, particularly in the special hospitals. It is necessary to strictly limit the legal powers of staff to use restraint and this should be achieved by law rather than guidance. Seclusion has been implicated in many sudden and avoidable deaths in psychiatry and can no longer be accepted as a routine response to behaviour perceived to be dangerous or threatening. Other methods of care and risk management should take its place and seclusion as a practice should be phased out over a set period of time, giving staff and management time to adjust their practice.

(5) a right to privacy

A patient should be entitled to privacy and minimum standards of care to ensure they have the fundamental amenities for civilised living, namely washing, toilet and other facilities. They should be able to choose a single sex space in which to stay if this is their preference and there must be arrangements which enable them to have private time away from the noise, anxiety and intrusion of ward life. Hospital policies and procedures should be drawn up which recognise women patients' potential apprehension about mixed wards and which attempt to tackle and prevent the incidence of sexual harrassment and assault on women when they are in hospital.

(6) a right to contact with family and friends

Visiting rights and the ability for a patient to have contact with friends, relatives and others must be clearly formulated and must be standard throughout all inpatient settings.

(7) a right to adequate care and treatment to include the right to obtain a second opinion

A patient's right to a written treatment and care plan will be an important contribution to enhancing the adequacy of that care. The provision of a code of ethics for staff will also assist. It should include specific prohibition of racist conduct or language to ensure that the culture of inpatient facilities is one which challenges racism. A patient should be encouraged to exercise their right to seek a second opinion when in doubt about proposed treatment or diagnosis.

(8) a right to complain to an effective and independent investigator and adjudicator

Hospital complaints procedures need to be clear and comprehensive. They must be administered with speed, efficiency and independence. Much experience with such procedures is lamentable and the wider framework for their use is generally unsatisfactory. Until a fairer and more effective system is introduced, hospital managers should review present arrangements to examine their impact and the scope for improvements. Currently, the detained patient is entitled to complain to the Mental Health Act Commission about their treatment. However, Commissioners are most effective when they are able to frequently visit the wards on which patients are detained and have many opportunities to meet them and learn of their experiences. For the Commission to discharge its statutory function it must make regular visits to all hospitals and resources should be provided to it to enable this to happen.

(9) a right to review by an independent, judicial body whose powers can effectively improve the patient's position where this is justified

Mental Health Review Tribunals considering applications, particularly from special hospital patients, often find that their restricted powers do little to help the patient move through or out of secure care. They should be given power to order a patient's transfer to lesser security; to hear an appeal from a patient objecting to being moved in to maximum security; and, also, the Tribunal should have power to order health and social services authorities to comply with s.117 Mental Health Act 1983(by which they are obliged to provide aftercare for certain discharged patients), in ways directed by the Tribunal.

The prison: a health service for prisoners

The object of policy in relation to health in prison must be to ensure that the service is not inappropriately detaining those who should be receiving specialist treatment and care in the NHS. In addition, policy should be aiming to raise standards within the service so that those who remain in prison have access to improved levels of treatment and care.

'Employees should at all times establish courteous and respectful relationships with patients. Employees are duty bound to be at the service of the patient. . . .

Employees should protect patients from any abuse, exploitation or degrading or discriminatory treatment. . . .

No departures from this Code of Ethics will be tolerated. Any such departure should be immediately brought to the attention of the appropriate authority, and may result in administrative or disciplinary measures.'

Code of Ethics for employees. Douglas Hospital Centre, Montreal, Canada

Greater use can still be made of the Mental Health Act powers which can be used to transfer a prisoner from prison in to psychiatric hospital. This should be applied particularly to the suicidal prisoner whose needs can never be met in the custodial and impoverished environment of the jail. S.48 should be amended to remove altogether the ambiguous and misleading phrase 'urgent treatment', that a prisoner must need in order to obtain a transfer when on remand. S.27(2) Criminal Justice Act, 1991 should be implemented as soon as possible to reduce the time for which prisoners are kept in prison as a 'place of safety' pending admission to hospital. The Home Office in collaboration with the Department of Health should agree a date when the prison will cease to be used in this way as a psychiatric facility.

Contracting with the NHS for future psychiatric services for prisoners will require careful formulation of minimum standards. A clear policy for mental health in prisons must be published for consultation and must form the basis for detailed agreements. The prison department should plan the provision of another therapeutic prison such as Grendon Underwood. Consideration should be given to establishing a separate and independent health inspectorate for prisons.

Prisoners leaving prison with continuing mental health problems should be entitled to a care programme to plan with them the provision of after care and treatment which they need.

Community services: prevention and aftercare

The role of community services will be to provide practical options to a person who may need to be diverted from custody. Further, they will need to render support and assistance to a person following their release from prison or discharge from hospital.

There are many priorities for action in this area since it is so little developed as a comprehensive service able to offer choice, continuity and high quality care. Mostly, there is a need for social services authorities to provide staff and accomodation equipped to work with people in crisis, who may not fit the criteria of the Mental Health Act for admission to hospital. In any event, the provision of support in the community should remove the need for such action even to have to be considered.

Section 117 Mental Health Act provides aftercare rights to certain former detained patients. It is vaguely drafted and unclear. It should be amended for the precise obligations of the health and local authorities to be specifically defined and it should be extended to cover any patient discharged after one month's admission whether voluntary or under the Act. There are too many examples of authorities which have avoided their responsibilities by exploiting these uncertainties including one health authority which simply refused to provide any service at all for a patient discharged from special hospital conditionally on his receiving outpatient aftercare from the local district service.

Homelessness is the single most important factor contributing to risk of remand into custody and inappropriate imprisonment. New initiatives are required to provide for the needs of those whose homelessness causes these results. Each housing authority should review its homelessness and housing allocation policies in the light of the Reed Committee and All-Wales Advisory Group reviews. Each should collaborate with all other relevant agencies, particularly voluntary sector providers, in producing an objective assessment of unmet needs and a detailed strategy for meeting them.

5
Summary of Recommendations

1. Principles

(a) In the long term, the Mental Health Act 1983 should be amended to incorporate a set of core principles to which any decision taken under the Act would have to be clearly accountable.

(b) In the interim, amendments to the Mental Health Act Code of Practice should incorporate these principles in the guidance which it gives to medical and other professionals using the Act.

2. Practical proposals — General issues

(a) Present and future unmet need for health and social services needs to be accurately and effectively assessed as soon as possible.

(b) A national forum to overview policy and developments in the field of secure provision should be created as soon as possible. It should include members with diverse and relevant experience.

(c) Substantial additional resources will be needed if policy objectives are to be achieved, especially for community services where current spending levels are so low.

(d) Research or practical investigation must be promoted and positively encouraged.

(e) The Mental Health Act, 1983 should be reviewed with a view to its reform to improve the legislative position of offenders with mental health problems.

(f) Issues of discrimination on grounds of race or gender must be given the highest priority and regarded as justification alone for fundamental reform of the system of secure treatment and the pathways by which patients arrive in it.

3. The police: crime and crisis intervention

(a) Police training should equip operational staff with legal information and skills needed to successfully secure diversion from custody.

(b) A liaison officer should have defined responsibilities for promoting and encouraging 'diversion' at a divisional level.

(c) Each police force should have published policies on cautioning and on prosecution with detailed guidance on considerations affecting the prosecution of the offender with mental health problems.

(d) Health and social services authorities should form multi-disciplinary crisis teams to respond to police requests for assistance to a person in crisis.

(e) Interagency arrangements must secure informal means of dealing with a person needing assessment to limit the use of s.136 Mental Health Act, 1983.

(f) A community based health or local authority facility should be established for each area as its 'preferred' place of safety for the purposes of s.136.

(g) Interagency cooperation should lead to the creation of formal structures for such joint working, aimed at providing a single referral point for health, social services, and probation services.

(h) The Mental Health Act 1983 should be amended to improve practice in relation to s.136.

4. The court: bail, custody and sentencing

(a) The Bail Act 1976 and other relevant legislation should be amended to remove the power for a remand court to send a defendant into prison custody solely for the purposes of obtaining a psychiatric assessment.

(b) The Bail Act 1976 should be amended to require a court considering a remand into custody to have regard to the mental health needs of a defendant and the effect of penal custody upon this.

(c) Duty psychiatric rota schemes in magistrates courts should be placed on a rational and formal basis and arrangements should cover each court area in England and Wales.

(d) Bail hostel accomodation should be expanded to provide for defendants with mental health problems and their ordinary housing needs recognised.

(e) Courts should be given clear statutory guidance on the exercise of their powers to divert defendants from custody.

(f) Courts should be given the power to direct a health or social services authority to purchase a service for a defendant.

(g) The crown court's power to make an indefinite restriction order should be ended and replaced with a power to make a determinate order, renewable by Home Office application to a judicial body.

(h) The law governing the treatment of psychopathy, should be amended to limit the circumstances in which a defendant will be ordered to be treated to determinate

periods equivalent to the sentence of imprisonment which their offence attracts.

5. Inpatient treatment — general services issues

(a) Substantial additional resources must be committed to the full range of services if standards of care and quality of life for detained patients are not to be compromised, prisons still used to improperly detain hundreds of prisoners, and community options not to be developed.

(b) The future location, style and size of 'high security' provision needs to be urgently reviewed. Alternative approaches to 'special hospital' provision should be developed and, in due course, should replace the specials.

(c) Financial responsibility for treatment and care costs should in future entirely fall on the district authority — health or social services — for where the patient lives. Its purchasing decisions must be linked to principles preserving quality and protecting rights.

(d) Issues of institutional discrimination on grounds of race or gender call for detailed monitoring, consultation and action.

6. Inpatient treatment: 'fluid security' and a comprehensive service

(a) District health authorities should be obliged rather than merely advised to plan a local secure provision service as required by the Mental Health Act Code of Practice.

(b) Such accommodation should be planned to fit in with other secure services in the region with clear means for achieving quality and protecting patients' rights.

(c) Medium secure provision should be increased to at least 1,500 places with expansion directed to ensuring services are available to groups formerly excluded or disadvantaged by existing Regional Secure Unit policies and practices.

(d) Resources should be allocated to the planning and establishment of new high security accomodation away from the sites of the present special hospitals. This should be integrated with Regional Secure Units, established on modern principles of nursing and be fully integrated into comprehensive local services. The development of such units would make possible the reduction of conventional 'special' hospital accomodation and enable future planning to include its rational closure.

7. Inpatient treatment: rights and standards

(a) Hospitals should disseminate standard information on treatments, legal rights and other relevant issues.

(b) Hospitals should promote forms of selfadvocacy and aid in the establishment and maintenance of patients' councils.

(c) A professional advocacy service should be provided for inpatients modelled on that running in Springfield Hospital. Citizen advocates should be available for those who value assistance in speaking for themselves.

(d) Law must define lawful and unlawful forms of restraint since guidance is not adequate to protect the interests of the patient. Seclusion should be phased out in psychiatric practice with alternative methods being used for the management of dangerous or threatening behaviour.

(e) Hospital accomodation should be designed or adapted and operated so as to secure practical respect for patients' rights to privacy and freedom from sexual harrassment.

(f) A patient's right to contact with friends and family must be clearly formulated and enforced.

(g) A Code of Ethics for hospital employees should be introduced. A second opinion should always be sought where a patient has doubts about their treatment or diagnosis.

(h) Hospital complaints procedures need to be kept under constant review to ensure their effective operation. The Mental Health Act Commission needs to obtain sufficient resources to be able to regularly visit hospitals where patients are detained.

(i) The powers of the Mental Health Review Tribunal should be extended to enable it to order transfers of patients, to prevent a patient's inappropriate admission to high security accomodation and to guarantee adequate and effective aftercare arrangements following discharge of a patient.

8. The prison: a health service for prisoners

(a) Greater use should be made of the Mental Health Act transfer powers.

(b) Section 48 Mental Health Act should be amended to remove its ambiguity and s.27(2) Criminal Justice Act 1991 should be brought into force without delay and the Home Office and Department of Health must agree a date when prisons will no longer be employed as a 'place of safety'.

(c) A clear policy for mental health care is required in the prison service.

(d) The Prison Department should plan the provision of another psychiatric prison.

(e) An independent health inspectorate is required for the service.

(f) Prisoners with mental health problems leaving prison should be entitled to care programmes and the services linked to them.

9. Community services: prevention and aftercare

(a) Each social services authority should provide staff and accomodation aimed specifically at crisis intervention and diversion from custody.

(b) Section 117 Mental Health Act 1983 should be amended to define precisely the obligations of health and local social services authorities to provide aftercare and to extend the duty to every patient discharged after one month's admission.

(c) Each housing authority should review their homelessness and housing allocation policies in the light of the Reed Committee and All-Wales Advisory Group reviews and collaborate on producing an assessment of unmet needs and a strategy for meeting them.

Notes and References

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8. Report on women offenders and Probation Service provision (1991) H.M. Inspectorate of Probation
9. Race and criminal justice (1989) NACRO
10. eg Its call for improved complaints procedures in the special hospital system, the full integration of the management of those hospitals into NHS structures and the belief that standards in the Prison Medical Service should be raised to NHS levels by its closer association with mainstream NHS services.
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19. Report of Interdepartmental Working Group (1987) Home Office
20. Interim Report (1974) Cmnd 5698 HMSO, Final Report (1975) Cmnd 6244 HMSO
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22. cf. Bluglass, R. *The development of regional secure units* in *Secure Provision*, (Ed. Gostin, L.) (1985) Tavistock Publications
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26. *Prejudice and Pride* (1990) DoH
27. HAS/SSI Report on services provided by Broadmoor Hospital (1988)
28. Report on an efficiency scrutiny of the Prison Medical Service (1990) Home Office
29. H.M. Chief Inspector's Report on H.M. Prison Brixton (1990) Home Office; Report of Review of Suicide and Self Harm (1990) Cm 1383 HMSO
30. CPT/Inf(91)15
31. Supra note 12
32. *The Guardian*, 19th September 1990
33. Interim Reports of Reed Committee (1991) DoH/Home Office

34. Report of the All-Wales Advisory Group on Forensic Psychiatry (1992) Welsh Office

35. Hospital Advisory Group Report (Reed Committee) para 5.23

36. Report of Official Working Group on Services for People with special needs (Reed Committee) para 8.12 paper 8

37. R -v- Ealing Health Authority ex parte Fox, QBD, *The Times*, 24th June 1992

38. For sources cf. Universal Declaration of Human Rights (1948) European Convention for the Protection of Human Rights and Fundamental Freedoms (1950) UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991)

39. cf. Article 8, European Convention of Human Rights

40. cf., for example, the discharge of Carol Barratt, above

41. Communication from Clerk to Southern Region MHRT to the Law Society Mental Health Sub-Committee 1991

42. Genn, H. and Genn, Y. *The Effectiveness of Representation at Tribunals* (1989) Lord Chancellor's Department

43. Knight -v- Home Office [1990] 3 All ER 237; cf. Bynoe, I. *The prison medical wing: a place of safety?* Journal of Forensic Psychiatry 1, 2, 251

44. Chapter 10, *The Mental Health Act 1983 — Code of Practice* (1990) HMSO; Home Office Circular 66/90

45. Serious arrestable offences are defined in the Police and Criminal Evidence Act 1984 s.116 and include offences causing serious physical or other harm

46. *Revolving Doors* (1991) NACRO

47. Rogers, A., Faulkner, A. *A Place of Safety* (1987) MIND

48. Bean, P., et al *Out of Harm's Way* (1991) MIND

49. Supra notes 11, 12 and 16

50. Allen, H. *Justice Unbalanced* (1988) Open University Press

51. Dell, S. and Robertson, G. *Sentenced to Hospital: Offenders in Broadmoor* (1988) Oxford University Press

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54. cf. Report of Prison Advisory Group (Reed Committee) paragraph 3.3

55. See observations on Brixton's "F" Wing of Committee on Torture and Inhuman and Degrading Treatment; cf. note 30 supra

56. Similar but less rigorous obligations now apply to the sentencing court contemplating a sentence of imprisonment. s.4 Criminal Justice Act 1991

57. cf. Villeneau, L. *Housing with Care and Support: A Quality Action Guide* (1992) MIND

58. Mental Health Act 1983, Code of Practice (1990) HMSO

59. ss.47 and 48 Mental Health Act 1983

60. s.41(1) Mental Health Act 1983

61. cf. Report of Finance Advisory Group (Reed Committee)

62. Report of Hospital Advisory Group (Reed Committee) para 5.37

63. This is the estimate of the Hospital Advisory Group (Reed Committee)

64. Report of Finance Advisory Group (Reed Committee) para 5.42.

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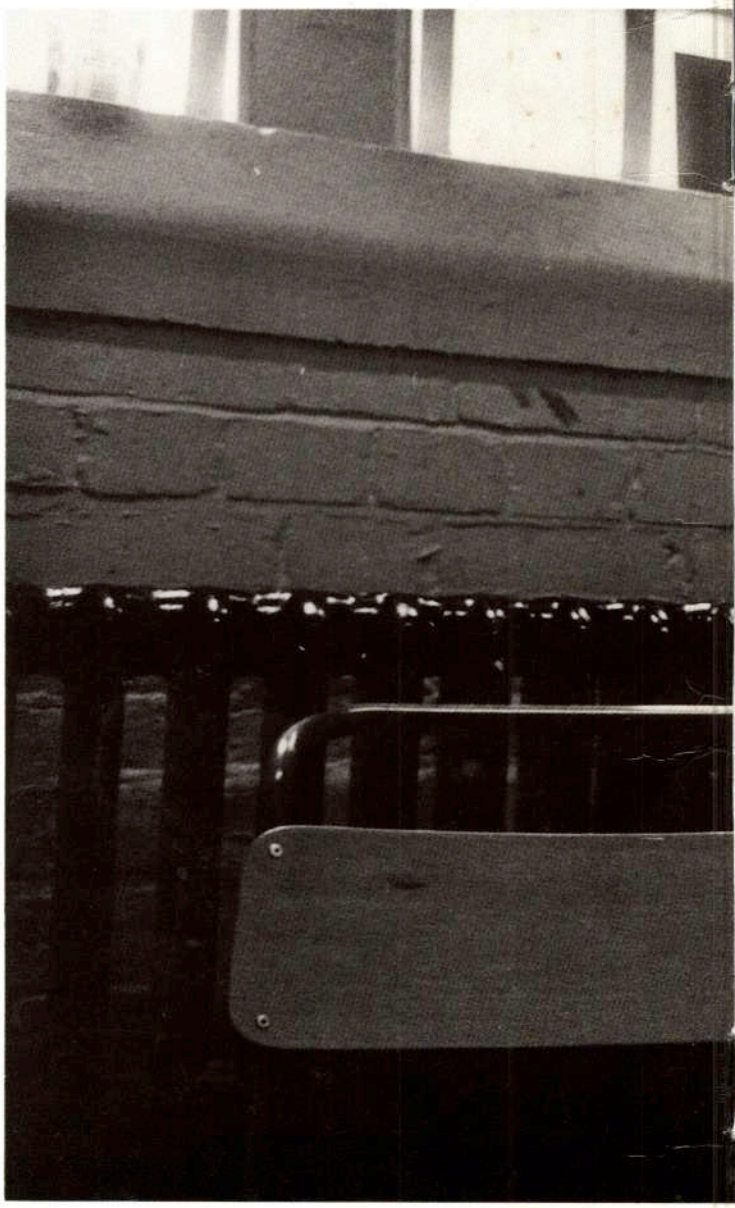

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