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Commentary

Low secure care: a description of a UK service, six years on

Mathew J Page

Service Director: Child and Adolescent Mental Health Services, 2gether Foundation Trust, Gloucester, UK

Abstract

This article describes the development of a low secure service in Gloucester, England. It uses the structure of the service user journey to analyse practice and innovations which have been implemented within the service. The article refers to evidence and discusses the implications of the changing market place within which low secure services are positioned.

Keywords

Low secure unit; physical environment; recovery model; discharge planning

INTRODUCTION

In 2006 the author published an article in this journal describing the service provision of the Montpellier Unit, a low secure ward for male service users in Gloucester (Page, 2006a). The article outlined the operational specification of the unit which opened in 2003. As the team and service reached its sixth anniversary, it seemed a good time to take stock and reflect on how the service has developed. This article will consider why certain changes have come about and what the impact has been on service user care.

PHYSICAL AND ORGANISATIONAL CHARACTERISTICS OF THE SERVICE

Low secure units need to be purpose built robust physical environments; many of the lessons learnt from the commissioning and subsequent use of the Montpellier building are reflected upon by Dix & Page (2008). The building, which meets the National Minimum standards for PICUs and LSUs (Department of Health, 2002), is of an excellent design in terms of space, light and observation, however some criticisms that have emerged are principally concerned with the issue of observation. The exact structure of the building has led, at times, to a phenomenon which is referred to by Page (2006b) as the 'panoptic hub'. That is to say that the location of and internal visibility from the office are inclined to create a 'panopticon', a position from which complete surveillance over the institution can be maintained. This compounds the problem of mental health wards all over the land: the staff tend to migrate to the office! There is only one obvious response to this and that is to ensure that clinical leadership comes to the fore to enable all staff to engage with service users throughout the day, creating a regime based on relationships rather than surveillance. Further measures to address the issue of engagement are discussed below.

Correspondence to: Mathew Page, Acorn House, Horton Road, Gloucester, GL1 3PX. E-mail: mathew.page@glos.nhs.uk
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The senior nurses of the team rose to the challenge of how to positively impact on what was in effect a highly functional but slightly utilitarian milieu. The two charge nurses and senior charge nurse initiated a project in 2008 to improve the aesthetic and atmosphere of the building. This involved working with service users to develop themes around different areas. The end result is an impressive array of memorabilia and artwork, for instance in the main corridor where a travel theme was chosen, a model plane with 5ft wingspan hangs high in the air above the front door, while on the walls are clocks displaying different time zones of the world, reflecting the heritage of both staff and service users.

In 2007, the senior staff of the unit began a project to discuss with the team how the unit should be identified. The actual official identity of the unit was 'Montpellier: Low Secure Rehabilitation', but many people simply referred to it as the 'low secure unit'. It was felt that the identity should reflect the ethos and aspirations of the team. As such the name was revisited and the final identity was agreed as 'Montpellier Secure Recovery Service'. The reason for this particular name is fairly complex. It was felt necessary to retain the use of the word 'secure', but that this should be couched in a positive sense, i.e. security is something we all aspire to in our lives. The use of the term 'recovery' was felt to reflect both the most modern thinking in mental healthcare and the practice of the team. The emphasis on 'service' demonstrates the intention of the team to be outward looking and represents the fact that many of the interventions with service users occur away from the physical confines of the building.

ADMISSION AND ASSESSMENT

The admission routes for service users are clearly defined in the operational handbook. Three types of admission are envisaged: those descending the security ladder via medium security, those transferred from prison and a group described as 'new long stay', defined by Lelliot & Wing (1994).

While the admission criteria for Montpellier have remained constant, it is true to say that there is some evidence to suggest that service user characteristics have changed. An unpublished audit, completed after two years, found that of the three groups 40% were in the new long stay group, 25% were descending the security ladder and 35% were prison transfers. At the time of writing, the picture is slightly different; a summary view of admission data for the years 07/08 and 08/09, reveals that the proportion of prison transfers remains consistent at 36%, transfers from both secure and non-secure hospital environments are both 32%. There is now a fairly equal mix across the three identified groups. Many of the individuals identified as new long stay within the local services have now been treated and there appears to be a greater need for people leaving medium secure services to use low secure services as a 'step-down' which is perhaps reflective of an increase in movement across the secure sector. The same period reveals that 45% of service users were detained under Part II civil sections of the Mental Health Act (MHA) while 55% were detained under the Part III forensic sections concerned with criminal proceedings. A comprehensive survey by Pereira et al. (2006) found that in low secure units, 35.5% of service users were detained under forensic sections and that 52% of service users were detained under civil sections (the remainder being informal). The absence of any informal service users at Montpellier simply reflects the fact that data was gathered on admission whereas Pereira et al's (2006) research offered a 'current time' analysis. The two sets of data do appear to indicate that Montpellier operates more within the forensic spectrum of services than the majority of low secure units.

Another area where Montpellier has seen significant change is around the provision of services to individuals outside of Gloucestershire. For various commissioning reasons there is a need to 'sell' a minority proportion of bed days to commissioners outside the county. For the unit leadership this creates a number of critical challenges, the management must engage in some kind of marketing of the service and clinicians must be shrewd and incisive in assessing those referred; out of county assessments being, by their very nature, logistically complicated and there being more difficulty in

developing an accurate clinical assessment. Page & Dix (2007) refer to many of the difficulties associated with the need to provide services on a competitive basis.

ONGOING CARE AND TREATMENT

Recovery focus

The concept of 'Recovery' is in common parlance in mental healthcare at the moment. Many teams and facilities define the service they provide in terms of 'Recovery'. As well as changing the name at Montpellier, the team aspire to the central tenets of 'Recovery'. NIMHE (2005) described it as:

a process of changing one's orientation and behaviour from a negative focus on a troubling event, condition or circumstance to the positive restoration, rebuilding, reclaiming or taking control of one's life.

For many of the service users who come to Montpellier, these ambitions are highly appropriate. The circumstances which result in an admission to a low secure unit often have very negative associations. From the point of admission, the care planning and interventions of the clinical team strive to provide opportunities to change and improve circumstances, engender a sense of hope and develop the skills to improve one's own situation.

Repper & Perkins (2003) described three components of Recovery focussed practice:

1. *Developing hope-inspiring relationships*

   There is a great emphasis on staff/service user interaction at Montpellier, a range of activities, some of which are described below, provide opportunities to develop such relationships.

2. *Facilitating personal adaptation*

   Therapeutic interventions are aimed at enabling service users to understand their condition and develop ways of coping.

3. *Promoting inclusion*

   The ethos of the service is outward looking, wherever possible service users are supported to use mainstream facilities such as colleges and leisure centres. Programmes are organised on the basis of creating a 'normal' day, so that service users access opportunities and activities at the same time as the rest of the population.

Maintenance of a recovery focus requires the constant cognisance of the team leadership. Poor or inadequate leadership will quickly lead to the institution perpetuating itself as only institutions can. This phenomenon can be seen in many mental health inpatient settings, where there is an aversion to risk taking and service user centred practice, there are prohibitive rules for everything and a milieu of low morale amongst all parties.

Initiatives which are recovery focussed necessitate a good deal of motivation and well managed use of resources. An example of how this ethos is manifested at Montpellier is the creation of a worker's cooperative using the medium of horticultural therapy. Page (2008) described the conception and implementation of this scheme. The principles are that all service users at the unit have the ability to become members of the cooperative providing they contribute a minimum amount of labour to the scheme. In exchange for this they receive a small amount of remuneration (a dividend commensurate with the amount of labour they have invested) and voting rights on how the business is run. The service users have, with the assistance of staff and an expert volunteer gardener and mentor, grown and sold nursery plants at the former horticultural therapy site in the hospital grounds. Horticultural therapy as an intervention is well established and is proven to be effective socially and psychologically (Fieldhouse, 2003), undoubtedly it also has physical health benefits as well. There is an increasing energy associated with such initiatives partly accounted for by the publication of *Ecotherapy: The Green Agenda for Mental Health* (MIND, 2007), the beauty of such projects is their tiered sophistication. Service users can engage in simply keeping a few plants on or outside the ward, or they can become involved in a much more ambitious project, but there can scarcely be a hospital in the UK where it is not possible to have some kind of horticultural type activity.

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The provision of family work at Montpellier has yet to be formally evaluated, although feedback from service users and their families is very favourable. The disabling nature of serious mental illness means that many of the people coming into Montpellier may have experienced a degree of estrangement or complete breakdown in family relationships. Given many of the challenges of resettling people in the community after an extended inpatient stay, engagement with families has moral, clinical and organisational imperatives. Through family interventions (FI) (Kuipers et al. 1992), several families have experienced a degree of reconciliation, and through improved relationships it is hoped that the family support provided after discharge will enable and sustain the service user in the community.

Reasonable confusion can arise between FI (also called family work: FW) and family therapy. The distinction is best drawn by Kuipers et al. (1992): family therapy may either be psychoanalytic or systemic in nature. Psychoanalysts consider schizophrenia to be a psychological disturbance brought about by earlier experiences, while systemic practitioners view the presence of schizophrenia in one individual as indicative of a sick family. FI proponents believe schizophrenia to be a biological illness for which the family are not responsible. Most advocates of FI appear to broadly agree on its constituent parts. Barrowclough & Tarrier (1992) pointed to three key features: education, stress management, and coping responses and goal setting. Gamble & Brennan (2000) cited education and problem solving as the aims of FI. Kuipers et al. (1992) in their model, advocated the use of psycho-educational component and cognitive behavioural therapy.

The evidence for FI supports its use in serious mental illness (Kavanagh, 1992; Barrowclough & Tarrier 1992; Lam 1991). The experience at Montpellier suggests that it can be applied in cases where a multiplicity of complex needs are present, where mental ill health may only be one constituent part.

Managing disturbed behaviour

The problem of managing acutely or chronically disturbed behaviour is not solved by nursing service users within a low secure unit. What happens to service users who become disturbed in an LSU environment is as pressing an issue as it is on an open ward.

Extra Care Areas (ECA) have developed from a number of methods of managing disturbed behaviour: seclusion, 'come alive' intensive care units and simply isolating a service user in one part of a ward or hospital. Kinsella et al. (1993) first discussed the use of an 'intensive care area' within a medium secure unit. This facility appears to be what is now referred to as an ECA.

The modern ECA is a sophisticated structure which should be appended to all PICUs and LSUs (Department of Health, 2002; Dix & Page 2008). Montpellier is fortunate enough to have a well designed area of generous proportions separated from the main ward by a set of magnetic locking double doors. The area is essentially: a large shower/w.c., bedroom/day area, large corridor and a de-escalation room with the ubiquitous Rampton mattresses. An ECA may also contain a seclusion room. The Montpellier Unit has a de-escalation room which was designed to meet this purpose if required.

Design considerations for ECAs include access to natural light and fresh air and room for recreation and exercise. Furnishing an ECA is difficult; suitable fixtures and fittings are necessarily expensive and there is a limited range available. It is worth considering how furniture might be installed at the design stage.

Curran et al. (2005) gave details of what characteristics should be included within a seclusion suite; their proposal amounts to what this author would consider to be an ECA.

The Montpellier Unit ECA is installed with closed circuit television (CCTV) in the three main areas. Its purpose being for staff in the main ward to monitor the situation in the ECA, the recording system also provides documentary evidence of what has occurred while it has been in use. An ECA is the area where the most contentious interventions are undertaken

and CCTV may be seen as a protector of service user's vulnerability and staff integrity. CCTV in mental health units is discussed by Warr et al (2005), Page (2006b) and Page (2007). Communication from staff in the ECA to staff in the ward is made using two way radios and an alarm system.

The team have used this facility on a number of occasions usually only for a few hours at a time. One episode where a service user required care within the ECA for what amounted to several weeks caused significant reflection amongst practitioners. It became apparent that once the use of the ECA was initiated, if the service user's behaviour did not demonstrably and dramatically alter then there was no rationale for moving them back into the main ward. The ECA if unchecked becomes an institution within an institution. In the case in point only proactive decision making by practitioners led to the service user being moved out. Once it became obvious that the service user's behaviour (which included multiple assaults) was not going to change then the only course of action was for the staff to change theirs. Using a controlled and graded approach re-integration was achieved and the behaviour improved accordingly. The lesson learnt from this episode was that an ECA has great benefit as a short term means of stabilising a situation and improving safety; but beyond a few hours, it takes on a life of its own, which if unchecked will become the centre of not just the ward but of the entire hospital. It will be the 'tail that wags the dog' dictating the agenda of the entire ward population.

Community living

The development and sustaining of a suitable programme of activity within any ward environment is highly resource intensive. Montpellier's four occupational therapy staff work in conjunction with other disciplines to deliver a seven day a week programme in which service users engage to various degrees. The debate around the extent to which any activity should be mandatory is often had amongst clinicians. Even the most socially libertarian individuals can be heard arguing that there is a moral imperative for staff to ensure that service users are participating in activities, which will ultimately assist in their swift discharge into the community. Over several years the team have developed a philosophy around these issues which is encapsulated within an explicit document entitled *Community Living Arrangements*. This ensures that service users at the unit know that they are expected to participate in available activities, but the onus is on them to take responsibility. It was observed that clear parameters also needed to be in place for staff and as such it was considered essential to ensure that there are allocated times when leave can occur. When groups are in operation, service users are not normally permitted to take leave. There is free time allocated at the beginning, middle and end of the day which ensures ample opportunity for unescorted exercise, shopping etc.

The combined community meeting (CCM) serves the function of both the service user's meeting and the staff meeting. Excepting issues pertaining to security etc., most issues discussed at staff meetings can be discussed with service users too. A cursory check of agenda items for staff meetings suggests that many of them are shared concerns: maintenance of a clean environment, good stewardship of the unit vehicle, ensuring that group activities take place etc. In this guise, the meeting has had its successes: negotiation between individual service users around many of the issues associated with sharing a living space is the most obvious way in which this format is really effective. The CCM is also the arena in which some of the most controversial issues of managing the service have been resolved. Montpellier was the first unit locally to become completely smoke free. When the NHS smoking ban was enforced in April 2006, efforts to negotiate a middle ground by the author were roundly dismissed as unworkable by service users who opted for a complete ban. Overnight the internal ward environment was dramatically improved.

The issue of diet has also been a bone of contention for both staff and service users. Service users often complain about the quality of food provided and some clinicians concern themselves with the dangers of weight-gain associated with psychotropic medications such as atypical antipsychotics. Through the CCM a number of initiatives have developed: the organising of

catering within the ward for several meals a week, the encouragement for individuals to be provided with a budget to 'self cater' on the unit, the agreement of staff to become good role models in terms of healthy diet (the consumption of large cooked breakfasts from the canteen and takeaways in front of the service users is not encouraged!) and agreement that the hospital will only provide the healthiest options. Discussions with medical colleagues revealed a high degree of concern around a number of physical health related issues most notably constipation associated with antipsychotics and tachycardia associated with high caffeine consumption. Through the CCM, agreement was obtained to switch to only provide wholemeal bread and de-caffeinated drinks. The effects in the case of constipation were palpable and rapid, the unit went from almost all service users requiring laxative treatment to almost none. Sebastian & Beer (2007) found similar concerns with physical health in their research noting the importance of health promotion activities in order to improve prognosis, a view supported by Brown (2007).

Solomons et al. (2008) discussed a number of challenges perceived by service users in running such meetings. This author would concur with this research, which finds that service users consider the attendance of senior staff essential in providing meaningful opportunities for issues to be aired. The success of enabling service users to organise the meetings themselves alluded to in the research suggests development potential for Montpellier where such efforts have only ever been sporadically successful.

The CCM is thus an essential component in maintaining the ward as a therapeutic environment. It is operationally useful but more importantly contributes to the Recovery focus and promotes harmony within the community of staff and service users.

PRE-DISCHARGE PLANNING

Getting paid

The development of so-called 'Payment by Results' (PbR) commissioning of services remains an enigma to many professionals in front-line practice. Quite often confusion emanates from the very name and from the many complex proposals that have been developed over the years. Those working in mental healthcare have generally, and quite rightly, viewed with some scepticism, the notion that a PbR methodology could be implemented, simply the based on the fact that treatments in mental healthcare have much less predictable components and outcomes than other areas; compare perhaps the relative certainties of hip replacement procedures with the hospitalisation of someone with acute symptoms of psychosis.

The first point of clarification worth making is that in most senses, at the present time, PbR is not literally payment by results but rather payment by activity. That is to say hospitals are paid only for the work they do, they are not generally paid for the outcomes they achieve, although that is likely to be developed. The traditional 'block contract' style of commissioning where all of the beds within a PICU or LSU would be purchased by one commissioner, normally the local Primary Care Trust (PCT) may change and managers and clinicians alike should begin to familiarise themselves with PbR with some urgency.

The Department of Health (DoH) has made a commitment within the Darzi review (Department of Health, 2008a) to develop a currency for mental health for national use by 2010/11. Currency can be described as a common system of taxonomy where users of services will be placed into a group and service providers will be remunerated accordingly. Various possibilities have been considered but the DoH has now committed to a system developed in the north of England entitled *Care Pathways and Packages* (Self et al. 2008). Service users will be placed into one of twenty one clusters based on their needs and characteristics. The identification of the correct cluster is achieved through assessment, and transition between clusters is achieved through Care Programme Approach reviews.

As has already been described, the complexities of implementing such a system in mental healthcare are significant and while it is possible

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to see how a standard cognitive behavioural therapy course for uncomplicated anxiety might be costed, those familiar with the multiple needs of most PICU and low secure service users will be aware that there is a direct proportionality between complexity of need of the service user and complexity of costing for the service provider. The provision of certain care pathways, of which PICU and low secure are two examples, will provide some further clarity and it seems likely that these will be costed and commissioners will be invoiced accordingly. There appears to be an acknowledgement that the issue of costing inpatient episodes is not fully resolved as yet (Self et al. 2008), and the move towards clustering service users is one step on the journey. It may be necessary to resort to more traditional costing tools for this type of treatment in the short term.

Commissioners will increasingly be requiring that providers meet certain performance criteria, usually referred to as key performance indicators (KPI). The exact nature of these KPIs may well be left to local negotiation. Experience so far suggests that they are often based on administration and systems rather than actual interventions with service users, such as percentage of staff with appraisals or compliance with statutory and mandatory training. No standard appears to exist for PICUs or LSUs as yet, although there may be an argument for providers cooperating to develop some indicative quality measures, preferably associated with the experience of service users. The adage that 'services tend to make important what's measurable rather than finding a way of measuring what's important' should be heeded by any such innovators.

Commissioning for Quality and Innovation (CQuIn; Department of Health, 2008b) is a means of commissioners encouraging providers to improve the quality of their services. The premise is that a proportion of the overall budget is withheld until certain targets are met. The exact nature of the targets is to be negotiated locally, but they are anticipated to be 'stretching'. An example of one possible CQuIn target for PICU/LSU would be for services to meet AIMS standards (Page et al. 2010).

Measuring progress

The use of outcome measures (OM) in mental health is well established and most clinicians will be familiar with the principle. The most universally used is the Health of the Nation Outcome Scale (HONOS; Royal College of Psychiatrists 1996) which forms part of the mental health minimum data set and, as such, all teams should be recording this data. Other assessments which give quantitative data may also serve the purpose of OMs, but it is the clinical relevance of such processes that should be the foremost concern. The development of assessments which are intrusive solely to serve the purposes of the organisation is highly ethically questionable.

Beer et al. (2007) made some pertinent observations of the use of OMs within one LSU. The importance of baseline assessment is obvious in order to assess progress at discharge or any other interval, but the study noted other relationships with outcome, such as what types of interventions are engaged in. The authors also drew a correlation between longer length of stay and physical health problems. The paper in question demonstrated the importance to all services of using reliable OMs in order to better understand the service provision and work towards improving outcomes. These measurable tools are also important to clinicians and service users (providing they are appropriately engaged in the process) to demonstrate improvement and reduced need.

There are now examples of systemic approaches to outcome measurement which are highly sophisticated and do not concentrate so much on clinician rated tools as actual service user experience. A good example of this is the Sainsbury Centre's *Outcome Indicator Framework for Mental Health Day Services* (2008), which includes such factors as whether individuals were helped to become volunteers, develop work skills etc. PICU and LSU leaders would do well to consider developing such a framework for their services.

Obstacles to moving on

Provider organisations will be increasingly cognisant of length of stay (LoS) statistics. Such data

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is of interest to commissioners who will seek to minimise cost on the basis of shorter LoS. This will of course only be effective if it is married to other outcome measures such as a low readmission rates; no data can be viewed in isolation! Through performance reporting service providers will need to demonstrate cost effectiveness in order to ensure sustained commissioning. LoS though is not as straightforward as it sounds and ward managers are well advised to work with their colleagues in information departments to ensure they understand what data is being collected. The important data is the length of time between admission and discharge, although occasionally figures are quoted which are simply the LoS to date of service users on a ward on a given day. Given that most wards are small the sample population is small and as such average figures for LoS can be significantly skewed by one individual. Other factors such as where the service user moved onto should also be considered; someone may only be on the ward for a few nights but if they are remanded to prison after a significant assault then it is disingenuous to cite this as a favourable LoS. With only 12 beds, the Montpellier team has sought to understand LoS, but for some of the reasons discussed the reality can be elusive. Favourable outcomes are evident in the majority of cases but making sense of average figures is very difficult indeed. As the approach towards data collection becomes more sophisticated this author advocates for information which indicates LoS in conjunction with outcome, not as an isolated statistic.

As the management may be concerned with developing more impressive LoS figures there is a pleasing convergence with the motivation of most clinicians who seek to move their charges to less restrictive environments in the minimum time. The energy that is now being invested in improving LoS figures is in the favour of clinicians and service users. For too long it has been too difficult to find suitable accommodation for people leaving low secure care and moving into the community. Montpellier is no exception, as the team and service have established their reputation, then developing a rapport with other service providers has become vital part of moving people into the community. The last six years have seen improved transitions into nursed accommodation and social care placements, although there is a reality that as demand exceeds supply, some of the people passing through the low secure unit may not be selected for inclusion in some of these placements. This is where provider's desire to improve LoS figures may enable better transitions. For instance a provider who finds that it has unnecessary delays due to a lack of supply of either nursing or social care in the community may well decide to invest in such provision and as such the outcome for service users is improved.

All NHS Foundation Trusts are expected to minimise Delayed Transfers of Care (DToC), that is service users who stay in hospital longer than is necessary, and must ensure that no more than 7.5% of occupied bed days are accounted for in this way (Monitor, 2009). Failure to achieve this target will be a source of increasing scrutiny in the coming years and PICUs and LSUs are areas where high levels of DToC are traditionally found. The symbiotic goals of low levels of LoS and DToC may force providers to review practice and consider innovation, such as working in partnership with a social care provider, in a way that serves the interests of users of the service. There are all sorts of moral and therapeutic imperatives associated with moving people out of secure care in a timely way and while some will question the use of quantitative statistics in the qualitative world of mental health, history may judge that, in part at least, the net effect of this level of scrutiny served the needs of service users.

Cultural and political changes continue to have an impact on the way in which services are delivered. The high profile incident of absconding and serious offending from a West Country LSU had a sudden effect of increased political scrutiny of such services. The BBC made a request under the Freedom of Information Act (HMSO, 2000) for details of number of incidents of absconding from low secure units, the subsequent debate prompted a revision of the National Minimum Standards (Department of Health, 2002) which is still

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ongoing. It seems likely that the impact of this will be a greater concern with security. Legislators and civil servants should be reminded by those that work in such services, that their primary function is to guide service users through a process of Recovery, the end goal of which is some form of living in the community. It is nonsensical therefore to become overly preoccupied with high levels of physical security, when, if a service is being well run, the occupants will routinely have access to the community. Reflection and scrutiny are of course right and proper but reactions need to be proportionate and in keeping with the values of the service in question.

The current political concern with the rights of victims of crime will have a demonstrable effect on those detained under sections of the Mental Health Act (HMSO, 2007) concerned with criminal proceedings. Under new guidance arising from the Domestic Violence Crime and Victims Act (2004) the views of victims of serious offences (sexual/violent) will need to be sought prior to discharge. The arrangements are not entirely straight forward in that in the case of service users subject to restriction (S41) the responsibility for this duty lies with the probation service and in cases where a mental health disposal was made without restrictions (S37) it is the responsibility of the hospital. The effects of this have not been fully tested yet; there may not be sudden examples of service users' discharge being completely stopped by the process but it is easy to imagine how it could affect factors such as where someone might be discharged to. The complexities of this issue will be immediately apparent to clinicians who will be aware that most service users will be having leave long before they are discharged. As such, the process should be commenced early in admission as the negative effects on a victim and the reputation of the service provider could be significant if the issue is approached in a naive way.

CONCLUSION

This article has attempted to describe the operation of a low secure unit by analysing, in depth, the process of the service user's journey. Practical and philosophical perspectives have been offered. The complexities of running such services cannot be overstated. The underpinning ethos of the team has a considerable effect on the outcomes for service users and teams, and their leaders are well advised to explore and reflect on their own motivators for working in this challenging field. The Recovery Model (Repper & Perkins, 2003) offers one conceptual framework deeply rooted in the experience of service users which is usable in a low secure unit.

The politics of the time continue to have a profound impact on services especially in terms of concerns for safety and security, but perhaps it is the competitive market in low secure and psychiatric intensive care which is likely to be one of the chief determining factors of models of service delivery, quality of care and service user outcome in the coming years.

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