

REGIONAL SECURE UNITS*

1. RAINFORD WARD, RAINHILL HOSPITAL, MERSEYSIDE

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Following discussions with representatives of medical and nursing staff in September 1974, it was decided that each of the four mental hospitals of the Merseyside Region should make interim arrangements pending the construction of a purpose-built Regional Secure Unit. Three hospitals decided to open an Interim Secure Unit, the other to accept the monies offered to increase staffing levels on admission wards.

Rainford Ward, at Rainhill Hospital, was the first of the Interim Units to open, and started accepting patients in August 1976. This ground-floor ward is situated in the body of the hospital and was converted for this use principally by the provision of stronger window frames, unbreakable panes of glass and alteration of the locks on the external doors. These alterations made the ward reasonably secure, and cost £22,000. All patients have individual rooms and the ward can take 14 patients of either sex.

Despite difficulties raised by NUPE, it has been quite easy to recruit volunteer nursing staff from within the hospital. The nurse/patient ratio is 1.5/1 overall, giving approximately 4-5 staff on duty during the day and three at night.

Initially a senior consultant was allocated three sessions to supervise the ward. After eight months he had to retire, since when the ward has been supervised by the consultant forensic psychiatrist together with a half-share of a registrar. A senior probation officer regularly attends ward meetings, and a clinical psychologist attends on a sessional basis.

It was the policy from the outset that the ward would be run on a multidisciplinary basis, all decisions on admissions and discharges to follow as extensive discussions as possible. Only the staff of the ward were to have right of admission to the ward and the referring agents had to agree to take a patient back when he or she was considered not to require the security of the ward. As suggested in the Butler Report and Glancy Report, the length of stay of any patient was not to exceed two years. A graduated parole system has been introduced and some patients have been discharged to be followed up by the nursing and medical staff of the ward.

The criteria for admission are: that the patient's behaviour justifies it; that he or she cannot be managed on an open ward; that he or she requires treatment rather than just containment; that the

security of the ward is adequate; that an admission longer than two years is not anticipated from the outset; all patients are detained compulsorily under the Mental Health Act. After a period of approximately two weeks the patient's stay is individually planned, his or her parole status is determined and the aims for discharge set. These are reviewed at a weekly ward meeting, the decisions of which are accurately minuted. There is no formal individual or group psychotherapy; the patients are, however, encouraged to involve themselves in the treatment of each other and to care for the fabric of the ward. The patients are allowed out, or are taken out, of the ward whenever possible: some have even gone on holiday with staff.

To date there have been 28 referrals concerning 23 patients, 19 of whom were male, 4 female. The most common diagnosis was schizophrenia. The majority of the patients had committed serious violence. Seven patients have been discharged and one attends on only one day per week. Two patients who were returned to their catchment area team were subsequently readmitted; the others have been followed up successfully by the staff of the ward.

No significant conclusions can be drawn from such small numbers of patients. However, a number of lessons have been learned about the running of such a ward. With capable and enthusiastic nursing staff, the ward runs very smoothly and there has not been one episode of violence. The staff seem very happy with the type of patient admitted, and interdisciplinary rivalry does not seem to exist. The staff turnover has not been great, but there has been a gradual loss of experienced nurses with promotion. The advantages of mixing staff and patients of both sexes much outweigh the disadvantages. The locked door is an advantage in a number of ways; the staff are not preoccupied with security; all the patients consider themselves equal; a planned patient day is possible and patients cannot opt out; and the patients who have parole develop a responsibility to those who have not. There is an initial surge of admissions which must be resisted until the admission criteria of the ward are fully understood. These criteria have to be regularly repeated to medical and nursing staff, and bargains struck at a time of

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admission have to be insisted on. The ward has never been more than half full. With its small number of patients, the actual nursing staff of approximately 18 has seemed the correct number. With the full complement of patients, a nurse/patient ratio of 1.5/1 would not be adequate.

Two equal groups of patients are emerging. One group is more treatable and more dischargeable irrespective of the reason for admission, the other is much more long-stay and untreatable in that the patients periodically cause further problems. Many of

this latter group will need to be in this ward for longer than two years. Where are these patients to go? Two forms of management are also emerging, one group of patients being returned to their catchment area team, the other being retained by the staff of the ward.

Finally, difficulties in management and in relationships with colleagues which can be expected by Regional Secure Units are already being seen in this ward. It would seem unwise to contemplate opening a Regional Secure Unit without attempting to solve these locally in a smaller unit.

2. THE LYNDHURST UNIT AT KNOWLE HOSPITAL, FAREHAM, HANTS

BY DR M. FAULK

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By the 1970s three groups of psychiatric patients were receiving a particularly poor deal from the National Health Service: (a) The psychopathic patients who had never received the special facilities recommended by the DHSS; (b) A new group of patients, i.e. the difficult or dangerous psychotic patients who are now being refused admission to local hospitals, but whose behaviour is not such as to require the care of a Special Hospital; (c) The difficult or dangerous sub-normal patients who could not be managed in new style or overcrowded, understaffed subnormality hospitals.

The planning and consultation for our unit lasted from 1971 to 1977. I had the considerable support of the Deputy Regional Medical Officer right from the start. The major breakthrough occurred once the consultant psychiatrists at Knowle Hospital agreed that an in-patient unit for Forensic Psychiatry could be developed there.

Officers and their authorities at Region, Area and District had to be convinced of the need and feasibility. Locally, the nursing managers and shop stewards had to be convinced. Genuine consultation at a very early stage, both formal and informal, demonstration of case histories, visits to prisons and Special Hospitals with shop stewards and others, were all part of the process needed to demonstrate the problem and obtain support and advice on a solution.

Only when all bodies were in support of the Unit did we consult directly with the public through an open meeting, although preliminary press releases had been made right through all the planning stages.

I found the consultations with other disciplines much more than a paper exercise. I found the advice of nursing colleagues and shop stewards extremely

useful and beneficial to the Unit. The question of physical security was very taxing. I was unsure if it was necessary or desirable. The Unions insisted on there being a minimum of physical security only, i.e. just enough so that it could be used if needed. Their fear was that a permanently physically secure unit might deteriorate, especially at times of low staffing, into an old-fashioned locked back ward. They also felt, and this feeling has been echoed by local town councillors, that a fully secure unit would encourage the DHSS or others to urge the Unit to care for patients who properly should be in a Special Hospital, i.e. they felt that there would, in the end, be less risk in running a unit with less rather than more security.

This point of view was compatible with my own view of how such a unit should run to deal with the clinical problems which I was likely to meet. My experience and reading had led me to believe that patients' bad behaviour owes much more to environmental stresses from the institution than is generally recognized. It seemed to me that if patients could be helped to feel well and free of anxiety, whatever the cause, then their chances of acting dangerously would be minimized. I had come to the view that this could be achieved (a) by proper detailed clinical medical attention coupled with (b) nursing care based on the acceptance and understanding of individuals, and (c) the creation of a milieu on the Unit in which the patient could receive attention and sympathy easily and rapidly, with a minimum of institutional rules.

It seemed to me that a punitive or authoritarian regime was inappropriate in the open setting we would have. In such a setting the settling down of a patient, who might be sometimes angry, hostile or very tense and frightened, was best done, as far as possible, by reducing tension, by giving appropriate