

## Editorial

# Will Bradley lead us to New Horizons?

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Psychiatric intensive care; low secure; criminal justice system; Bradley Review

The National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units (PICUs) and Low Secure Environments were produced in 2002, and to this day they are the only Department of Health endorsed PICU and low secure standards (Department of Health, 2002). Chapter 11 of the 2002 National Minimum Standards document highlighted the need for liaison with other agencies, including legal and judicial agencies. Seven years on, it seems that the integration of PICU services within the framework of modern mental health services still remains a challenge due to the multitude of interface issues that beset the PICU (Fig. 1).

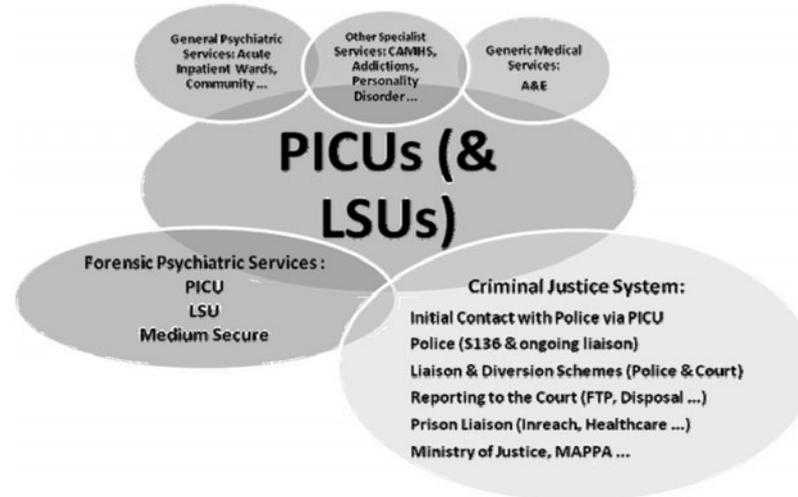
The interface between mental health services and the criminal justice system has always been fraught with difficulties with both systems generally operating at saturation point. On both sides there are limited resources in a climate of ever-increasing need leading to an abundance of potential criminogenic risk within mental health services, and mental disorder within the criminal justice system. The PICU has been, in many ways, a first entry point into mental health services for the majority of mentally disordered offenders who have, or are suspected of having, a mental disorder of a nature or degree



that requires hospital diversion for assessment or treatment.

Whether it is by design or by default, the criminal justice interface probably provides for around a quarter of the patient traffic for PICUs. In a 2008 survey by Brown et al. (2008) across seven English PICUs, 24% of admissions were from the criminal justice system or the police station; although this was heavily biased towards police station admissions, presumably via Section 136 of the Mental Health Act 1983. In his 2008 literature review, Bowers et al. (2008) wrote that the majority of PICUs accept transfers from prison, and that a minority also accept patients from courts, the police or from medium secure units. Most

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*Figure 1. The interfaces of the PICU*

PICU patients have some criminal history; the number can be as high as 59% (Eaton & Ghannon, 2000) with the majority having committed violent offences. Once on the PICU, patients are three times more likely to be violent than their counterparts on the acute general adult psychiatry ward (Brown & Bass, 2004) opening up avenues for further liaison with the criminal justice system.

In my opinion, there are features of the PICU that make it well placed to be the primary inpatient interface service for the criminal justice system. The PICU provides acute mental health care and treatment usually within a secure environment in a responsive manner. Responsivity is its key attribute; PICUs routinely provide a twenty-four hour service which responds quickly to the clinical and risk management needs of the patient. Historically, in the general adult psychiatry setting or the forensic psychiatry setting, PICU services have been strategically aligned with other inpatient mental health services or community mental health services, which by their very nature are less able to provide an immediate intensive response to critical situations. The interface work with the criminal justice system occurs through a variety of routes including police liaison, reporting to the courts, managing referrals from the prison, liaison with prison healthcare or in-reach services and working with

police station or court based liaison/diversion schemes. Table 1 illustrates some of the different types of activities that the average PICU might be involved in at the criminal justice system interface.

Table 1 is not exhaustive, and there are significant variations in the amount of such work done by PICUs. PICUs are not alone in engaging in the activities described in Table 1. General adult psychiatry services of most varieties interact at some level with the criminal justice system and perform to some degree many of these activities and more. Forensic psychiatry services, which include some PICUs, are by definition that part of psychiatry which deals with patients and problems at the interface of the law and psychiatry. In recent years, it has become clear that there are no hard demarcations between adult and forensic psychiatric services, a view that has been echoed by the report of the Royal College of Psychiatrists' Working Party on the Interface between Forensic and General Adult Psychiatry in England and Wales (Royal College of Psychiatrists, 2006).

However, this blurring of boundaries has left both PICUs and Low Secure Units (LSUs) in difficult territory. NHS Trusts have utilised PICUs and LSUs to soak up the need for urgent forensic beds over the past decade, and changed the nature of these services. Patients who do not

**Table 1.** Activities on the PICU relating to the criminal justice system (CJS)

Interfacing with:	Some examples of activities within a PICU service
<b>Police</b>	<ul style="list-style-type: none"> <li>• Admission of S136 patients who need secure intensive care</li> <li>• Ongoing collaboration with police liaison officers to consider risk in light of criminal history</li> <li>• Issues around fitness to be interviewed and detained</li> <li>• Admissions via or collaboration with the Police Liaison &amp; Diversion Scheme and the Involvement of PICU team members in assessments at such schemes</li> </ul>
<b>Courts</b>	<ul style="list-style-type: none"> <li>• Issues around fitness to plead and stand trial</li> <li>• Issues around disposal/sentencing options (e.g. hospital order +/- restriction order)</li> <li>• Other more complex legal issues regarding mental condition at the time of the offence</li> <li>• Attendance at court to give verbal evidence in relation to the issues described above</li> <li>• Admissions via or collaboration with the Court Liaison &amp; Diversion Scheme and the Involvement of PICU team members in assessments at such schemes</li> </ul>
<b>Prisons</b>	<ul style="list-style-type: none"> <li>• Assessments of remand prisoners that may need a S48 admission</li> <li>• Assessments of convicted prisoners that may need a S47 admission</li> <li>• Assessment of prisoners that may need later diversion to hospital via the courts</li> <li>• Working with the prison mental health team to transfer PICU patients back to prison (healthcare) if they no longer need a PICU admission</li> </ul>
<b>Other</b>	<ul style="list-style-type: none"> <li>• Working with the Ministry of Justice to improve patient transfer times</li> <li>• Working with the above agencies and others such as probation and MAPPA to inform risk assessment and management</li> <li>• Guiding less secure services in the processes utilised by the criminal justice system</li> <li>• For those PICUs that sit on the interface of general adult psychiatry and forensic psychiatry, they can help overcome the barriers faced by the CJS through effective liaison between different branches of psychiatry</li> <li>• Most PICUs serve an informal gate-keeping function into less secure, less acute and less intensive mental health care environments, which helps overcome barriers faced by the CJS.</li> </ul>

present with acute serious mental disorder or high levels of behavioural disturbance, but require secure provision due to the nature of their offence, are routinely being directed to these services. The PICU philosophy which aimed for a discharge at the point at which intensive care was not clinically indicated is being eroded by this practice, primarily due to the legal restrictions that impede the progression of such patients and a culture in mental health services that is now obsessed with risk management.

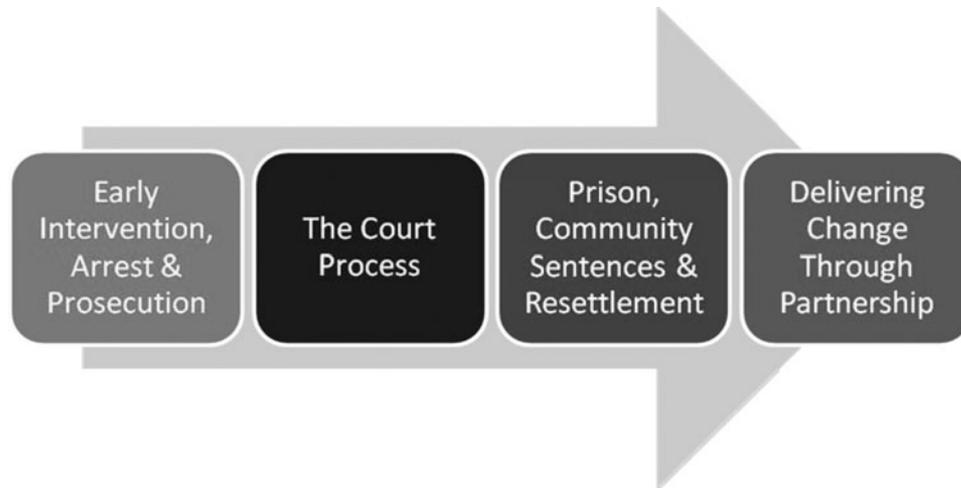
## THE BRADLEY REPORT

Over the past year, there has been a renewed focus on the processes around diversion for mentally disordered offenders into mental health services, and this debate centres on the development and management of pivotal interface services. In December 2007, Lord Keith Bradley was asked to undertake an independent review of the alternatives to prison for mentally disordered offenders. The Bradley Review, as it came to be known, included within its terms

of reference, an examination of the extent to which individuals with mental health problems and learning difficulties could be diverted, as well as the barriers to such diversion and the organisational effectiveness of such procedures. In particular, Lord Bradley was asked to make recommendations around the organisation of effective court liaison and diversion arrangements and the services needed to support them.

On the 30th April 2009 Lord Bradley published the Bradley Report (Department of Health, 2009a) and this was closely followed by the government's response (Ministry of Justice, 2009; Sainsbury Centre for Mental Health, 2009). The report utilised the offender pathway (Fig. 2) as a template and made eighty-two recommendations which related to the interventions, services and structures linked to the offender pathway.

The government's response was grouped under seven headings referring to Governance Arrangements, Children & Young People, Police,



*Figure 2. Bradley's offender pathway*

Courts, the National Offender Management Service (NOMS), Criminal Justice Mental Health Teams, and Overarching Systems.

Under Governance Arrangements, the government accepted that national accountability for the Bradley Report's agenda would be via a new National Programme Board, which in principle would be supported by a National Advisory Group. The National Programme Board would have been in place by the end of May 2009, and the National Advisory Group by the end of July 2009. The work of the National Programme Board would feed into the government's wider strategy for the health and social care of offenders further down the line.

In the response section related to the police, the government accepted that all organisations involved in the use of Section 136 of the MHA 1983 should work together to develop an agreed protocol on its use and that the police station should no longer be used as a place of safety. Furthermore, it accepted that the NHS and the police should explore the feasibility of transferring commissioning and budgetary responsibility for healthcare services in police custody suites to the NHS at the earliest opportunity. The National Programme Board is to report back on this issue by April 2010.

In relation to the courts, the government accepted that service level agreements should

be created for the provision of psychiatric reports and advice to the courts, as well as ensuring that the necessary mental health requirements for community orders are available. The government also accepted in principle the need for an investigation into the services available via the courts to defendants with a dual diagnosis (mental illness and drugs or alcohol difficulties).

Amongst other things, the National Offender Management Service (NOMS) has responsibility for the prisons, and the government has stated that it agrees with the goal behind the recommendation that the Department of Health should develop a new minimum target for the NHS of fourteen days to transfer a prisoner with acute severe mental illness to an appropriate healthcare setting. Although the government has left this recommendation under review, it is noteworthy that it has not been rejected outright.

The government has accepted in principle that the Department of Health should expedite planned work on assessing the quality of security at low and medium secure mental health facilities. It has proposed that the National Programme Board will consider what further steps are needed to improve security, including promoting the use of standardised risk assessments. The Board will report back by April 2010.

Perhaps one of the more far-reaching recommendations which has only been accepted in principle is the development of Criminal Justice Mental Health Teams; this is essentially a new model of liaison and diversion services. The National Programme Board will oversee the development of this model, but the government has agreed that in the medium term, every police custody suite and every court should have access to mental health liaison and diversion services which must be able to carry out timely assessments and, where appropriate, refer offenders for treatment. The government will review whether the requirement for Criminal Justice Mental Health Teams should be included in the Standard NHS Contract for Mental Health and Learning Difficulties as a mandated item and therefore reflected as such in the next edition of the NHS Operating Framework.

These recommendations are just a flavour of some of the eighty-two proposed by the Bradley Report, and I have tried to highlight those that would have a significant impact on the working of PICUs and LSUs in particular. The recommendations along with the government's response map out the course to be followed by the National Programme Board, and ultimately steer the strategic direction for the government in relation to offender health and social care. There are considerable implications for mental health services, both general adult and forensic psychiatric services, in the hospital and in community settings.

## DISCUSSION

Bradley's fourteen day transfer target and the review of quality at low secure mental health facilities needs to be considered within the context of the changing political landscape. In 2002, the National Minimum Standards referred to both PICU and low secure services, and the standards formalised a relationship between two types of service with a common underlying philosophy underpinned by the principles of risk assessment and risk management. Both PICUs and low secure units deliver

intensive multidisciplinary treatment for those who demonstrate disturbed behaviour in the context of serious mental disorder. PICUs deal with acute disturbance and provide an immediate response, whilst low secure units employ a more rehabilitative model. In recent years, some lines of divergence have emerged.

In 2008, a Working Document of the Additional Guidance to the National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units and Low Secure Environments (Department of Health, 2002) was circulated. The additional document intended to develop on the security statements made in the original 2002 National Minimum Standards, and further refine the security parameters for a low secure service. Although both PICUs and low secure units have historically been considered to be low secure services, this document may have been the first clear attempt to separate the two areas.

More recently, the National Association of Psychiatric Intensive Care and Low Secure Units (NAPICU) and the Royal College of Psychiatrists Centre for Quality Improvement (CCQI) have been working on AIMS-PICU, that is, the Accreditation for Acute Inpatient Mental Health Services for Psychiatric Intensive Care Units (Royal College of Psychiatrists, 2009). It is noteworthy that there is currently no AIMS-LSU. NAPICU, which represents both PICU and low secure services, remains at the forefront of developments in the field of low secure care, but signs are emerging of a need for a clearer understanding of what is PICU and what is low secure. With the government taking an interest in the quality of low secure facilities, is there an implication that the Ministry of Justice is about to get more discerning about where it transfers its prisoners? Currently the Ministry of Justice transfers prisoners to general adult psychiatry wards, general adult PICUs, general adult low secure units and to medium secure services. If the Ministry of Justice decides that prisoners can only be moved to low secure units or medium secure services, I imagine they will need a lot more beds in these services or be forced to reconsider the proposed fourteen day transfer target.

In some respects things may well have changed since the days of the 2002 National Minimum Standards. Personally, I'm not convinced that things have changed a great deal. However, with the accumulation of better statistics and research in the area of PICU and low secure care, we are beginning to see some clearer patterns emerging. For example, PICUs that historically have an identity for dealing with those that are clinically acutely unwell, are actually dealing with a mix of acutely unwell and risky (offender) patients. PICUs that are historically characterised by the speedy transit of patients, are having beds blocked by the chronically unwell, the residually risky and those entwined in the slow pace of the court process. In my experience it is now not uncommon for PICUs to take remand and even sentenced prisoners, as long as the offence is below a certain arbitrary risk threshold (often below ABH/GBH for general adult PICUs), and this risk threshold seems to be lowering all the time.

This theme is also being taken up by clinicians in the field. In his article in the *Psychiatric Bulletin*, Beer (2008) questioned the clinical sense in mixing three types of patients: the acute symptomatic behaviourally disturbed patients from the general psychiatric wards, the prisoners who need security but may not show behavioural disturbance, and the longer-term mentally ill with chronic challenging behaviours. His view was that these streams of patients are clinically distinct and the implication is that their needs cannot be optimally met in the same clinical environment. Beer's article points to three clinical/risk axes, relating to the acuity/chronicity of the disorder, the level of behavioural disturbance in the presenting patient, and the need for security at a certain level. These axes are not orthogonal but are inter-related, and as the research base increases in the years to come, one suspects there will be more than three streams identified.

PICUs should reconsider aspects of their current role and position within the framework of modern psychiatric inpatient services in light of the Bradley Report. This process needs to start from the foundations and should begin by

looking at the definitions of both psychiatric intensive care and low secure care. In the 2008 edition of their textbook on *Psychiatric Intensive Care*, Beer and colleagues wrote that admissions to PICUs from courts and prisons should not be considered if absconding carries a serious risk to the public, and behaviours driven by symptoms of mental illness should govern admission, not a court's requirement for security (Beer et al., 2008). I would speculate that a large number of the patients that end up as a delayed discharge in a PICU are there due to a court's requirement for security.

The relationship between PICUs and LSUs is key in teasing out their individual identity and purpose. In defining the nature of low secure care, Beer and colleagues wrote that patients would be detained under the MHA and may be restricted on legal grounds needing rehabilitation (Beer et al., 2008). Intuitively there seems to be a continuum that needs to be defined and operationalised between PICU and low secure care; one that needs to account for the interface with the criminal justice system.

I am aware that a large number of PICUs do not consider themselves to be in the business of doing forensic psychiatric work, and are reluctant to take into precious hospital beds, those who are legally restricted. Some PICUs in the general adult sphere may also feel that their primary objective is to provide a PICU service to their respective general adult psychiatry wards, and those that are flowing through the criminal justice system are by default a secondary priority. These attitudes are not compatible with a healthcare service and one hopes that the Bradley Report and the future offender health and social care strategy should at least promote the principle of equivalence for offenders when it comes to access to mental healthcare.

For PICUs and low secure units, I think an opportunity for improved service delivery at the criminal justice system interface lies in strengthening the links with police and court based liaison/diversion schemes. There are of course going to be concerns around the

provision of beds required for those patients who may be diverted to hospital by well run liaison & diversion schemes. My own clinical experience and reading of the literature suggests that a very rough figure of 10% of liaison & diversion scheme assessments require hospital diversion. In London regions, where approximately 2000 referrals are assessed in such schemes over the course of a year, this would have massive resource implications. It should be highlighted that not all such diversions would need to end up in a PICU or low secure bed, but given the current climate, one would imagine that the majority would.

The Bradley Report will hopefully lead to significant changes in the provision of mental health care for mentally disordered offenders, and the focus will be firmly placed on alternatives to prison (Sainsbury Centre for Mental Health, 2009). In this respect, the consideration of a fourteen day time limit for hospital transfers, the development of the criminal justice mental health team model, and the review of the security levels of low secure units will focus the minds of service managers and commissioners at the dawn of a shrinking health economy. All service development in this area should be based on robust standards underpinned by a research base along with expert consensus.

In recent months, the government has been consulting on New Horizons (Department of Health, 2009b) which will be the blueprint for the improvement of mental health services over the next ten years when the National Service Framework (Department of Health, 1999) expires in December 2009. New Horizons makes reference to The Bradley Report and reiterates that the government has accepted the responsibility of making Lord Bradley's vision a reality. The Bradley Report however, does not opine on how the mental health services will adapt to receive the outcomes of its recommendations. The work from Bradley will take place over the years to come, and it is important that those who manage PICU and low secure services in both the forensic and general adult sphere, realise the potential.

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