Centre for Mental Health

# Aiming for efficient and world class secure care

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## Caseloads and costs

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- Secure services work with between 7,000 and 8,000 people at a time
- Are a high cost, low volume form of service provision
  - Annual survey of investment in mental health services, July 2012
    - Secure services and PICU services cost £1,056 million in 2011/12
    - Remain largest single area of investment, accounting for 19% of expenditure on direct services
    - Spending has increased by 162% in real terms over the last nine years
- Expansion of spending on secure services unsustainable?
  - For first time in a decade, real spending on mental health services fell in 2011/12 by 0.1%
  - Future challenge for secure services to work with more limited resources

## Blockages in services

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- Need to address a number of blockages in the system to improve quality and efficiency
  - Current commissioning arrangements
    - Block purchasing of largely medium secure beds makes it difficult to move patients on
  - Delays to admissions and discharges
    - Duplicated assessments
    - Lack of low secure, step-down provision and community services
    - Bed capacity – high occupancy rates and relatively long lengths of stay
    - Risk aversion
    - Patient anxiety about discharge
- Also considerable variation across country in services on offer and pathways available

## Prison transfers

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- Anecdotal evidence – growth of prison inreach services led to greater numbers of prisoners being transferred into secure services
- But still subject to long delays
  - Bradley recommendation 14-day maximum transfer waiting time
  - General improvements but still delays, particularly for prisoners with personality disorder (HM Chief Inspector of Prisons Annual Report, 2010/11)
- Relationships between secure services, prison service and prison mental health services crucial
- Some areas have had greater success in transferring to low secure and PICU
  - Prison inreach teams work with the Ministry of Justice and with the units they are transferring to

## Outcomes

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- Patchy information about outcomes achieved
- Short term reconviction rates low
  - Two-year rates for those discharged from medium secure range between 10-15%
- Longer-term outcomes poorer
  - Up to 1/2 reconvicted and more than 1/3 readmitted to secure care within 20 years
- Little known about service users' and carers' experiences of secure services
- Also little known about wider outcomes such as employment

## Mental health strategy

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- *No health without mental health*
- Implementation Framework (July 2012)
- Parity of esteem for mental health
  - Section 1 Health and Social Care Act 2012 – duty on Secretary of State to promote "a comprehensive health service designed to secure improvement in the physical and mental health of the people of England, and in the prevention, diagnosis and treatment of physical and mental illness"
  - Focus on mental health within the NHS Operating Framework 2012/12 including a particular focus on improving offender health
  - Draft Mandate to the NHS Commissioning Board (July 2012) – emphasises putting mental health on a par with physical health

## Parity of esteem

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- But still a big task to secure equal investment in mental health
  - Mental ill health accounts for 23% of the 'burden of disease' in the UK yet receives just 13% of NHS funding (LSE, June 2012)
- Cost of failing to deal with mental ill health vastly outweighs what we currently spend on mental health care
  - NHS spends £8 billion extra treating long-term physical conditions among people with co-occurring mental health problems
  - £3 billion is spent on treating people with 'medically unexplained symptoms'
- Liaison psychiatry – better support for co-morbid mental health needs can reduce physical care costs in acute hospitals

## Physical health

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- MH Strategy Objective 3: "More people with mental health problems will have good physical health"
- Little research or literature looking specifically at the physical health needs of patients in secure services
- Issues likely to be similar to those relating more broadly to the links between physical health and mental health
  - E.g. people with mental health problems more likely to suffer physical health problems such as cardiovascular disease and diabetes
- Need to ensure that secure patients routinely undergo a full assessment of both physical and mental health needs
- Should have access to comprehensive range of primary healthcare services

## Diversion

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- More effective diversion at point of sentencing could help ensure people initially go to the right environment rather than prison
- *No health without mental health* and *Breaking the cycle*
  - People in contact with the CJS will have improved access to MH services by 2014
- £5 million invested in children and adult liaison and diversion services in 2011/12; £19.4 million for 2012/13
- National Development Network for Liaison and Diversion Services
- Bradley Group

## Commissioning

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- From April 2013, NHS Commissioning Board responsible for commissioning secure care – needs to be an early priority
- Need to move away from block purchasing
- Commissioning already changing
  - CQUIN incentives for providers using the new clustering tool for secure care
  - Movement towards payment by results
    - Could be part of the solution to drive improvements in quality and outcomes
    - Incentivise commissioners and providers to focus on recovery-orientated outcomes
    - Routinely use feedback from service users and carers to monitor performance and outcomes
- Clear guidance needed on roles and expectations of medium secure, low secure and community services

## Recovery

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- MH Strategy Objective 2: "More people with mental health problems will recover"
  - Key themes of recovery
    - Agency – gaining a sense of control over one's life and one's illness
    - Opportunity – building a meaningful life beyond illness
    - Hope – believing that one can still pursue one's own hopes and dreams
  - Implementing recovery through organisational change (ImRoc)
  - Need to consider promoting the recovery approach across secure care; training in this approach should be available to all staff


## Role of low secure and PICUs

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- Emphasis should be on recovery-focused care and supporting people to move towards living as independently as possible
  - E.g. Employment services should be embedded
    - Work is one of the most consistent elements in the recovery stories of service users (Shepherd, Boardman & Slade, 2008)
    - Well-implemented Individual Placement and Support (IPS) can help 50-70% of participants into employment
- Definition of low secure remains unclear
  - Centre has found that some units appear superficially at least to be very similar to medium secure
- Could play a greater role in facilitating transfers from prison; prison inreach teams could support low secure and PICUs to build confidence in working with prisoners
- Commissioning needs to ensure a better balance of investment in low secure and PICUs

## Community services

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- Degree of support that former secure patients receive in the community varies considerably
- Majority of those who receive ongoing care in community do so from mainstream community mental health services
- Need to develop the capacity of secure care units to provide outreach to mainstream community mental health services so that they can support former secure patients
- Also need to explore accommodation needs of discharged secure care patients
  - E.g. in Netherlands, TBS services estimated 15% of clients could leave secure care but remained dependent and required support – an appropriate form of supported accommodation was developed for these patients

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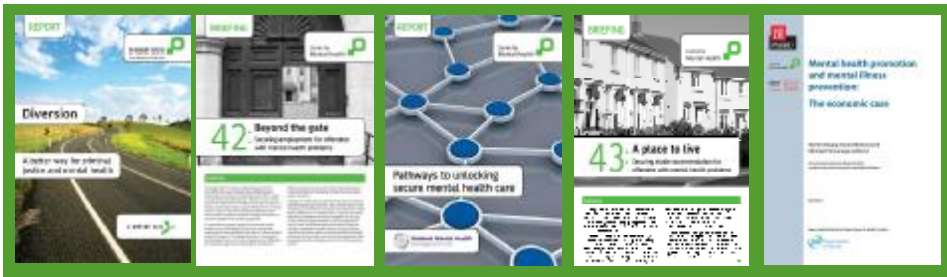


Thank you

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