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Commentary

Low secure versus locked rehabilitation units: a reflection

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The editorial by Roland Dix entitled 'Behind the locked doors' (Dix, 2013) could not have come at a better time. It is a most welcome introduction to a necessary debate on the care and treatment of the more challenging psychiatric in-patients. The last few decades have seen a rapid pace of development in the UK psychiatric services:

- A shift from traditional to evidence based care and treatment that remain underpinned by compassion and a strong sense of duty of care in mental health professionals;
- A change from long term care in large asylums to largely community based care;
- The development of a range of in-patient services for the minority of patients who require short term, and sometimes longer term psychiatric in-patient care and treatment;
- The development of forensic psychiatric services including medium secure units (MSUs), low secure units (LSUs) and community forensic services.

More recently, a new term 'locked rehabilitation unit' appears to be loosely used in describing an in-patient setting for the care and treatment of some of our more complex and challenging patients. Many, however, appear to confuse this term with a rather well established term, 'low secure unit' (LSU). Recent discussions with stakeholders and some clinicians have further highlighted the need to differentiate the terms.

WHAT IS LOCKED REHABILITATION?

To better understand locked rehabilitation, one would need to revisit related services, particularly acute in-patient units, psychiatric intensive care units (PICUs) and LSUs. The majority of mental disorders are treated in the community, with only a minority requiring in-patient treatment (Kessler et al. 2005). Ideally, a patient requiring in-patient treatment is admitted for a short period of time (usually no more than a few weeks) to an acute in-patient unit and then discharged back into the community.

The term PICU was first introduced in the United States in the 1970s (Rachlin, 1973) and is now well understood in the UK and many other parts of the world. Many believe that PICUs have well established purpose and practice; however most would argue otherwise, highlighting the fact that the PICU, like most mental health services, is on a journey with continued need for evaluation of purpose and practice (Dye & Johnston, 2005; Pereira et al. 2006; Beer, 2008; Department of Health, 2012; Innes & Sethi, 2012;

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Loynes et al. 2012; Bowers, 2013). PICUs provide a safe and secure environment for emergency short term care, assessment and comprehensive treatment of people with a broad spectrum of acute and enduring mental health needs, whose risks cannot be contained within an open acute in-patient unit.

LSUs branched off from PICUs in the late 1990s and have since become a distinct and mature clinical speciality. On the one hand the LSU forms the lower end of the security ladder for the care and treatment of mentally ill offenders namely: low secure, medium secure and high secure (special hospital) units. On the other hand, the LSU has also become established as a discrete service for the mentally disordered requiring similar approaches to those on the PICU, although for much longer periods of time. As a clinical speciality, the LSU has well established standards (Pereira & Clinton, 2002; Pereira, 2006; Tucker et al. 2012) that take into account the model of care, therapeutic environment, service environment, workforce, governance and equality issues. The integrity of the therapeutic environment in the LSU is maintained through three domains of security, namely physical, relational and procedural security which are developed and managed in unison.

Although 'locked rehabilitation' has so far not been officially defined in the UK, leading providers and commissioners in secure and PICU services appear to view it as having emerged from perceived gaps between the PICU and the LSU (Dix, 2013). There are subtle differences in physical security between LSUs and locked rehabilitation units, specifically in terms of the provision of air locks and the specifications for the perimeter fencing for the former. However, the full extent of the remaining domains of security (relational and procedural security) specified in the standards for low secure services (Pereira & Clinton, 2002) is the acceptable norm within locked rehabilitation services. In addition to sharing these security standards with LSUs, locked rehabilitation units are similarly proactive in the provision of comprehensive, multidisciplinary recovery-focused rehabilitation for community reintegration, resilience building and relapse prevention.

Roland Dix's prediction of changes in LSU provision is easily understood on the background of the NHS facing unprecedented financial pressures and a commitment to £20 billion efficiency savings over four years (http://www.evidence.nhs.uk/qipp; http://www.institute.nhs.uk/establishing_evidence). This was further buttressed in a report by the Centre for Mental Health (2011) putting the cost of the UK mental health secure in-patient estate at £1.2 billion. Dix's (2013) prediction is particularly relevant in the context of the average cost of a night's accommodation and treatment in a LSU being c. £500 compared with c. £300 for a similar overnight accommodation and treatment in a locked rehabilitation unit. Recent evidence of a trend away from LSU commissioning would seem to support this view.

The evidence would suggest that locked rehabilitation units have come to stay as a distinct and vital service that caters for a defined category of patients, many of whom were previously cared for, albeit not ideally, within alternative units. Typically, they are:

- Chronically disturbed patients on acute in-patient units (delayed discharges or prolonged acute admissions) whose discharge is likely to significantly compromise safety in the community resulting in prolongation of stay in an acute admission units;
- Long-stay patients on PICUs;
- Patients not requiring upper end physical security (LSU) who might benefit from care and treatment in a locked but less physically restrictive setting, in the spirit of the UK Mental Health Act 1983/2007, and/or would benefit from comprehensive recovery-focused rehabilitation with a strong community component, at reduced cost.

The national minimum standards for PICUs and LSUs published by the Department of Health (Pereira & Clinton, 2002) to address among other things, layout of the buildings, multidisciplinary team working, therapeutic activities, patient and carer involvement and clinical audit, was quickly embedded in units around the country (Dye & Johnston 2005; Dye et al. 2005). These national standards were later reviewed and re-emphasised by the NHS

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Institute for Innovation & Improvement (2008). They include guidelines and recommendations for:

- A well-trained and well-motivated multidisciplinary workforce (including occupational therapy and clinical psychology);
- An ethos that is user and carer centred (and highly responsive to feedback);
- Good and consistent leadership exercised within a well-managed organisation;
- A physical environment that is modern, in good order and fit for purpose with regard to managing risk;
- Clear lines of communication, in relation to the processing of referral and discharge;
- Widely accepted and adhered to criteria for admission and discharge.

These guidelines have become the norm in the development of locked rehabilitation units. In addition, one of the greatest strengths of a good locked rehabilitation unit is its recovery-focus; the ability to operationalise a multidisciplinary, comprehensive and recovery-focused model of care to facilitate community re-integration, resilience building and relapse prevention. Deegan (1996) emphasised that the goal of recovery is not to become 'normal' but to embrace the human vocation of becoming more deeply and more fully human. Recovery is 'a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life, even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness...' (Anthony, 1993). Recovery-focused rehabilitation is underpinned by mutual understanding that individual patients are experts in themselves and can be empowered to direct their own future by becoming experts in their own care, treatment and welfare (Roberts & Wolfson, 2004). There must be a recognition of the need for individual drive and flexibility; patients have the potential to become autonomous learners and can be mentored to structure their own learning and therapeutic activities within and outside of the unit, thus promoting self-directed learning and acquisition of skill that becomes transferable on discharge. A recovery college, for example, empowers patients through training and courses in three important domains: well-being, understanding your diagnosis and returning to work courses. A linkage into a local or regional recovery college could facilitate recovery within a locked rehabilitation unit.

Local communities also play a vital part in the process of recovery and rehabilitation (Leff, 2006). Locked rehabilitation units should therefore establish strong links and working partnerships with their local community and agencies who share in the commitment of improving the lives of mental health patients. Working with local community recovery partners (LoCoRP), locked rehabilitation units are able to reduce stigma and facilitate inclusiveness, resulting in increased self-esteem, self-worth and self-confidence as well as increased self-fulfilment in mental health patients. Such partnerships may include voluntary and statutory agencies, local employers and apprenticeship schemes, local community mental health teams as well as local adult education colleges, football clubs and places of worship to name but a few.

COMMISSIONING AND REFERRALS

Recent clinical opinion has emphasised the important role that PICUs and LSUs play in providing a bridge between forensic and general mental health services (Beer, 2008). Given that many patients who would ideally be cared for and treated in locked rehabilitation units are currently distributed across various (and largely more expensive) services, including acute inpatient units, PICUs and LSUs, it is expected that most referrals to locked rehabilitation units would come from these services. This brings to mind the difficulties inherent in the current parallel commissioning pathways for secure services (including LSUs) as opposed to the acute care pathway (including locked rehabilitation units).

The current situation is that locked rehabilitation units appear to be commissioned as part of the acute care (and PICU) pathway by clinical commissioning groups whilst LSUs are commissioned as part of the secure services pathway by

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NHS England, and it would appear that this structure is not especially cohesive and can give rise to undue delays in placements. For referrals made from acute in-patient units and PICUs, the commissioning pathway into locked rehabilitation is seamless. However, the same cannot be said of referrals made from LSUs (or indeed other secure services) as these face undue delays largely attributable to the split commissioning system and the lack of cross commissioning. In discussions, many stakeholders have expressed frustration with the current parallel commissioning pathways, and suggested the need for collaborative commissioning between clinical commissioning groups and NHS England. They cite the fact that locked rehabilitation units appear to provide a vital service that bridges the gap between PICUs and LSUs and should also form the commission bridge between clinical commissioning groups and NHS England.

Having reflected on these discussions and the available evidence, one wonders if anyone could justifiably be criticised for championing collaborative commissioning between clinical commissioning groups and NHS England. Indeed, it is arguable that such cross or collaborative commissioning has become imperative for the NHS to make the most cost-effective use of its resources and achieve best outcomes for the patients in its charge.

The World Health Organization considers the English mental health service to be the best in Europe (Beer, 2008). Over the years, questions have been raised by leading providers, commissioners and policy makers to drive the continuing development and quality improvement in mental health services. Zigmond (1995) asked the question: 'Special care wards: are they special?', and went on to assert that 'Patients on special care wards are usually the sickest in the service; surely they deserve the highest standard of care'. The subsequent development and growth of PICUs and LSUs was partly driven by Zigmond's question and subsequent discussions as highlighted by Beer in his (2008) editorial: 'Psychiatric intensive care and low secure units: where are we now?' It is hoped that Dix's (2013) editorial will similarly inspire necessary discussions among providers, commissioners and policy makers in mental health services, to further improve the quality of care delivered within PICUs and LSUs, as well as clarify the way forward for and benefits and cost-effectiveness of locked rehabilitation units.

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