Secure Facilities for Mentally Impaired Patients

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Regional Secure Units are already in operation in many Regions in England and Wales and in others secure units are either in the planning stage or are being built.[1] Interim units are available in most of the Regions without a permanent unit. Almost all these developments appear to favour the mentally ill, and the placement of mentally impaired patients is not receiving sufficient consideration.

The Glancy Report[2] recommended that subnormal patients requiring medium security should be treated together with the mentally ill, and severely subnormal patients should be excluded from the service. The Royal College of Psychiatrists in their official document, *Secure Facilities for Psychiatric Patients: A Comprehensive Policy*,[3] recognised three groups of mentally impaired patients in need of secure facilities. Those who are borderline or mildly handicapped would fit in secure units designed for the mentally ill while the moderately handicapped would need a special secure facility, more appropriately accommodated in mental handicap hospitals. Severely handicapped patients should be in highly staffed wards in mental handicap hospitals.

The extent of the problem presented by mentally impaired patients is probably greater than appreciated. One survey[4] found 37 mentally handicapped patients, as opposed to 26 mentally ill patients, in need of secure facilities in one Region. The special hospitals also experience more difficulty transferring mentally handicapped than mentally ill patients, and mentally handicapped patients are on a waiting list for transfer to local hospitals for longer periods.[5]

The secure units functioning at present do not appear to have made any specific policies for mentally impaired patients and they tend to avoid admitting patients with any degree of mental handicap.[6] In many Regions there are discussions in progress regarding the problem of mentally impaired patients, but none has come up with conclusive answers.

We conducted a study in the Interim Secure Unit at Leavesden Hospital to ascertain the nature of the problems presented by mentally impaired patients and to assess their needs. Four wards, with 56 beds, in this hospital are designated by the North West Thames Regional Health Authority as an Interim Secure Unit for mentally impaired patients. The Region is currently working on reorganising this unit into a 25-bedded Regional Intensive Care Unit which will provide secure accommodation for mentally impaired patients. The rest of the patients from the interim unit will be accommodated in locked wards.

The Interim Secure Unit at Leavesden Hospital developed from locked wards due to the interest shown by the late Dr Eric W. Shepherd, a former consultant at this hospital. Consequently, whilst some of these patients would be appropriately placed in a secure unit, others need intensive nursing care. These patients provided an opportunity to study the problems presented by mentally impaired patients with different needs.

Of the four wards studied, one female ward is allocated for severely mentally impaired patients with behaviour problems. As all these patients were considered to need a locked ward and not a secure facility, the 16 patients from this ward were excluded. Thirty-nine patients from the other three wards were seen individually and assessed using a checklist.

The characteristics of the patients are shown in the Table. Severely mentally impaired patients formed only a small group of eight. It should be noted that 16 others were excluded from the study. Almost half the patients studied were in the borderline or mild range. The majority of patients were admitted compulsorily under the Mental Health Act, and all the eight informal patients were severely mentally impaired. A third of the patients were admitted through Courts, and a quarter from special hospitals and other hospitals in the Region.

More than half the patients had a history of criminal offences. The crimes committed by them were relatively minor. However, recidivism was common in that the majority of the offenders had committed offences more than three times, and different crimes at different times. Sexual offences were particularly common, as noted in other studies, which showed increased prevalence of sexual crimes among mentally handicapped people. Almost all the severely mentally impaired patients were non-offenders.

Most of the patients had a psychiatric disorder in addition to mental handicap. Personality disorder was diagnosed in 43% of them. The proportion is higher than that found in secure units dealing mainly with the mentally ill.[6] One possible explanation for this is that mentally impaired patients with personality disorder are readily admitted to our unit because, in our experience, personality disorder associated with mental handicap responds to treatment better than in those with normal intelligence.

Eight patients had schizophrenia in addition to their mental impairment and only one had an affective disorder. Three other patients with psychotic features were unable to describe their experiences adequately enough to enable a specific diagnosis to be made. Even as adults, three patients with mental impairment were diagnosed as suffering from autism.

Behaviour disorder of varying degrees is often found in mentally handicapped patients. Their behaviour disorder

should be differentiated from that due to mental illness. In the mentally handicapped, this is very often due to their inability to understand the environment they are in and to act appropriately. The Social and Physical Incapacity Scale[8] which incorporates the rating of aggressive, destructive, overactive, attention-seeking and self-injurious behaviour, is a useful scale for rating this behaviour.

Behaviour disorder, as rated above, was present in just over half the sample and was evenly distributed among all diagnostic categories. We saw no relationship between behaviour disorder and the presence of mental illness, but behaviour disorder was more common with increasing degrees of handicap. The severely mentally impaired patients had more behaviour problems than the others.

Management of these patients is similar in many respects to that of mentally ill patients. However, more emphasis is given to behaviour modification, social skills training and education. The aim is to provide a secure and structured environment that facilitates learning of appropriate behaviour and skills. Patients are given freedom on a gradual basis depending on their behaviour. It is also necessary to restrict the freedom of some severely mentally impaired patients to prevent them wandering off.

Workshop and school facilities are provided for the patients in a secure setting to prevent them being confined to the ward for long periods without occupational activities. About half the patients go to other work areas in the hospital after having made sufficient progress. Chemotherapy has a definite role for patients with mental illness, and drugs are used for some others to reduce aggressive and other disturbed behaviour which prevents them deriving benefit from treatment programmes.

The future placement of these patients needs special consideration. Most of them have hostels as the aim for ultimate placement and a few patients will need to stay in hospital for a long time to come. There should be appropriate places which gradually increase their independence and exposure to the outside world, both within the hospital and in the community, to continue their rehabilitation. An effective rehabilitation service is essential for the successful running of a secure unit for mentally impaired patients.

Over half the patients stayed in the unit for longer than the two years recommended by the Glancy Report for Regional Secure Units. In part this is because mentally handicapped patients are slower in learning and take longer to show progress. Also other wards are reluctant to take them when they have improved. By providing appropriate therapeutic programmes, an effective rehabilitation service and back-up wards, it would be possible to reduce the length of stay of these patients in the unit.

The ability of mentally impaired patients to integrate with mentally ill patients is difficult to assess. It is known that mentally handicapped patients tend to be exploited by the more able ones and they can be disruptive in general psychiatric wards. They also do not fit in with the psychotherapeutic programmes of these wards. This problem needs to be examined further if integration of these two groups is aimed at.

TABLE
Characteristics of patients

	Number	*%*
Sex of Patients		
Males	29	74
Females	10	26
Degree of Mental Handicap		
Normal/Borderline	3	8
Mild	16	41
Moderate	12	31
Severe	8	20
Legal Status		
Informal	8	20
Section 3	9	23
Section 37	10	26
Section 37/41	12	31
Source of Admission		
Court	13	33
Other hospitals	5	13
Other wards (Leavesden)	15	38
Special Hospitals	5	13
Home	1	3
Criminal Record		
Petty crime	2	5
Theft	3	8
Assault	3	8
Sexual	11	28
Arson	4	11
None	16	40
Duration of Stay		
< 1 year	11	28
1–2 years	5	13
2–5 years	10	26
> 5 years	13	33
Psychiatric Disorders		
No disorder	7	18
Personality disorder	17	43
Schizophrenia	8	20
Affective disorder	1	3
Autism	3	8
Unspecified psychosis	3	8

Severely mentally impaired patients have many features which distinguish them from the rest, and they form a distinct group. They are usually transferred from other wards for their behaviour problems and are least likely to have additional psychiatric disorder. They make very slow progress and remain in this unit for long periods. Almost all of them are non-offenders and are admitted informally. As recommended by the Glancy Report, they should be excluded from secure units and accommodated in specialised wards dealing with behavioural problems.

Mentally impaired patients who are not severely handicapped do not form such a distinct group. Although they share many problems with the mentally ill, they have some additional features which are very relevant to their management. As discussed, these features vary according to the

degree of handicap and include higher incidence of sexual crimes, higher prevalence of personality problems, presence of behaviour disorder associated with mental handicap, need for management with different emphasis, possibility of staying longer in the unit, and a need for an effective rehabilitation programme. It could be argued that these additional needs can only be met by a special unit for mentally impaired patients, linked to a mental handicap service.

Some of the mildly handicapped and borderline patients from this group could very well be accommodated in a Regional Secure Unit with patients of normal intelligence. Perhaps the placement of individual patients should not depend on an arbitrary level of intelligence but on their behaviour pattern and level of social functioning.

In conclusion, we identified three groups of mentally impaired patients in need of special facilities. Severely mentally impaired patients formed a distinct group, whose needs can be met in a specialised ward with intensive nursing in a mental handicap hospital. Borderline and some mildly mentally handicapped patients could be accommodated in a Regional Secure Unit with patients of normal intelligence. The others have special needs that are different in many respects from that provided by a Regional Secure Unit. A secure unit which provides for these special needs would be necessary to cater for this group of mentally impaired patients.

References

[1]Snowden, Peter (1985) A survey of a Regional Secure Unit programme. *The British Journal of Psychiatry*, **147**, 499–507.

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[3]Royal College of Psychiatrists (1980) *Secure Facilities for Psychiatric Patients – A Comprehensive Policy*, London: Royal College of Psychiatrists.

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[5]Dell, S. (1980) Transfer of special hospital patients to the NHS. *British Journal of Psychiatry*, **136**, 222–234.

[6]Treasaden, I. (1985) Current practice in Regional Secure Units. In *Secure Provision* (ed. Larry Gostin). London: Tavistock.

[7]Hunter, H. (1979) Forensic psychiatry and mental handicap: A clinical approach. In *Psychiatric Illness and Mental Handicap* (eds. P. Snaith and F. E. James). London: Gaskell (Royal College of Psychiatrists).

[8]Kushlick, A., Blunden, R. & Cox, G. (1973) A method of rating behaviour characteristics for use in large scale surveys of mental handicap. *Psychological Medicine*, **3**, 466–478.

Awards

Dr Valerie A. Cowie has been awarded a Personal Chair in Mental Handicap by the University of Wales.

Dr Colin Shapiro, Department of Psychiatry, University of Edinburgh, has been awarded the McHarg Prize for 1986. The prize is given for original work presented by a Scottish trainee and is worth £100.

Diploma in Child and Adolescent Psychiatry

A one year course leading to a Diploma in Child and Adolescent Psychiatry will start in January 1988. This annual course is run jointly in London by the Institute of Psychiatry and the Institute of Child Health. It covers diagnosis and treatment of children and adolescents with psychiatric disorders, including those with physical illness and chronic handicap; assessment of community needs in relation to child mental health, with a view to planning or implementing psychiatric services in the participant's own country; teaching and training medical and paramedical workers. This international course will be particularly suitable for paediatricians and psychiatrists intending to set up or work in child mental health services in developing countries. Good English is essential.

Course teachers will include Dr A. Bentovim, Professor P. Graham, Dr R. Howarth, Dr P. Howlin, Dr R. Lansdowne, Dr B. Lask, Dr N. Richman, Professor M. Rutter, Dr E. Taylor, Dr S. Wolkind and Dr W. Yule.

Further details are available from Dr S. Wolkind, Children's Department, Maudsley Hospital, Denmark Hill, London SE5 8AF. Applications should be returned by 1 September 1987.

Certificate in Psychotherapy

The University of Oxford Department of External Studies in collaboration with the Department of Psychiatry invites applications from mental health professionals who have an appropriate professional qualification for a course of study and practical work leading to the award of a Certificate in Psychotherapy. The course will start in January 1988 and will last for two years, for half a day a week during term time. Further information: The Course Secretary, Department of External Studies, 1 Wellington Square, Oxford OX1 2JA (or telephone Dr Sidney Bloch, Warneford Hospital, Oxford: 0865 245651).

MSc in Family Therapy

The Tavistock Clinic invites applications for a two year, two day per week multi-disciplinary clinical training in family therapy which is for experienced clinicians who wish to develop their practice and teaching of family therapy. Upon successful completion of required academic work, including a dissertation, an MSc will be awarded by Brunel University. A general prospectus of training is available upon request. Further information and application forms (closing date 6 April 1987) available from: The Training Administrator, The Tavistock Clinic, 120 Belsize Lane, London NW3 5BA (telephone 01 435 7111, extension 313 or 469).