Should the English Special Hospitals be Closed?

John Gunn, Professor of Forensic Psychiatry
Anthony Maden, Senior Lecturer in Forensic Psychiatry
Institute of Psychiatry, Kings College, London

ABSTRACT

Great Britain has taken an international lead in developing secure hospital accommodation for many of its mentally disordered offenders. The "special hospitals" are the oldest of these services. The hospitals have been subject to a number of inquiries and reports following adverse press comments and some patient deaths. Ashworth Hospital (formerly Moss Side and Park Lane hospitals) has been a particular recent target. A Committee of Inquiry was established to investigate it in 1991, and in 1997 yet another inquiry was established this time to investigate allegations of child visitors to; paedophile patients and lapses of security on a ward. This latest inquiry is to produce a report at the end of 1998. These problems have led to a number of calls for closure of all three special hospitals. In this paper we debate the pros and cons of those calls.

The arguments in favour of closure turn on the number of adverse inquiries the hospitals have attracted. Poor standards of clinical care have been blamed on geographical and professional isolation, patient populations that are too big, poor recruitment, a penal approach, and nursing trade union problems.

The arguments against closure are that none of the official inquiries into any of the special hospitals has recommended closure of any of the hospitals. Important policy changes and improvements have been effected in recent years, at a cost of some £8 million. Three academic units have been established, one in each of the special hospitals, closure could jeopardise important research. The demand for special hospital accommodation remains high, each has a substantial waiting list. Closure would mean 6-8 new units in new sites. They are likely to be unpopular, and much less cost effective. Nursing, therapeutic, and security expertise has been accumulated in the current hospitals which would be difficult to replicate within a dispersal model. Public anxieties about dangerous patients are not best managed by the dispersal model.

Continued improvement, more research, more distance from the civil service would seem to be a better way forward than closure. It could produce high standards of care, high and long term medium security, and public support on a cost-effective basis.
SPECIAL HOSPITALS. WHAT ARE THEY?

Great Britain has taken an international lead in developing secure hospital accommodation for many of its mentally disordered offenders. The “special hospitals” are the oldest of these services. In spite of their "maximum security" image they, in reality provide a mixture of high security and long term medium security. In Scotland there is one "state hospital" at Carstairs which by policy provides both high security and medium security for the whole of that country. This discussion paper will be concerned with the special hospitals of England & Wales, which are currently the subject of much controversy and political debate. There is talk of closing the hospitals. Here we set out the pros and cons of doing that.

The hospitals began with An Act for the safe Custody of Insane Persons charged with Offences (1800), which was hastily passed in order to hospitalise a brain damaged war veteran, James Hadfield, who had attempted to assassinate King George III. The government provided the governors of Bethlem, which was about to be rebuilt, with the capital and revenue for a state criminal lunatic asylum in its new development. This new Bethlem opened at St George's fields in 1815 with two wings set aside for "criminal lunatics". There were places for forty-five men and fifteen women. The wards quickly filled and became overcrowded. The government was forced to make better provision so a new separate secure hospital was built in Windsor forest at Broadmoor, to house 500 patients. During 1863 and 1864 all the "criminal lunatics" were transferred to the new hospital and the old criminal lunatic wings at Bethlem were knocked down! This new hospital was under the direct control of the Home Office, which also looked after the prisons.

Broadmoor Hospital had only been open for 13 years when it was first under threat of closure. The Home Secretary of the day thought it was too expensive and set up an inquiry! The Committee of Inquiry were impressed with the reduction in the number of escapes compared with the previous arrangements, and so the hospital survived. Only after the Mental Health Act 1959, did the management of Broadmoor pass to the
Department of Health & Social Security. Until that time no patient detained under civil (i.e., non-criminal) arrangements had been admitted.

Rampton Hospital was built in 1910 and was also run by the Home Office. It was given to the Ministry of Health in 1947, and passed to the Department of Health & Social Security, with Broadmoor, in 1959. Moss Side Hospital was built in 1914, but it was never a Home Office establishment. Park Lane Hospital was built next door to Moss Side Hospital in 1974 as a new Department of Health & Social Security hospital to accommodate the by then burgeoning number of patients requiring high security. Thus the special hospitals have almost always been managed directly by HM government.

The influential Butler Committee reviewed the special hospitals, and made proposals for the development of forensic psychiatry services in England & Wales. They were so concerned, by the overcrowding they found in the hospitals, that they recommended that each region develop secure units to provide medium security, thus alleviating the special hospitals of significant numbers of patients and allowing them to focus on the provision of high security.

In 1989 a new special health authority, the Special Hospitals Service Authority (SHSA), was established. This put the management of the hospitals at arms length from the government, but there was still direct ministerial control and budgeting. For example, when the SHSA was established, the new authority was obliged, by government instruction, to amalgamate Moss Side hospital and Park Lane hospital into a new larger hospital embracing both of the previous ones, each of which had a different tradition and was jealous of the other. This amalgamation was ordered in the face of considerable local reservations, and with no data about the possible effects. The new bigger hospital is called Ashworth Hospital and has been the subject of much criticism and controversy ever since that time.

By the mid-1990s the management systems in the National Health Service (NHS) had undergone yet another, and this time more extensive, change.
As part of that change the SHSA was abolished. Each special hospital was given its own individual management in the form of a special health authority, and funding for the hospitals was to be directed through the High Security Psychiatric Services Commissioning Board. This board was established on 1st April 1996 with the idea that it would have powers to purchase high security services from the special hospitals. It was also to have responsibility to develop training and research within the special hospitals, and to develop a co-ordinated strategy for commissioning high and longterm medium secure psychiatric services within the NHS. One year later the government changed and the future arrangements for special hospitals are once again under discussion, and it seems likely that the special health authorities will be replaced by independent trusts.

Kaye & Franey⁴, two administrators who at one time had responsibility for the provision of the services at Broadmoor Hospital, have enunciated some principles of special hospital care:

i) high security services should be defined in terms of patients and their needs (emphasis added);

ii) "security" is not a way of defining patients, it is a dimension of care;

iii) most patients needing high security also need long term care (not necessarily in high security);

iv) forensic psychiatry is frontier medicine, well conducted research is essential;

v) each element of service will only be as good as the staff who provide it, they need better training and support;

vi) high security patients need a multi-disciplinary approach.

The Patients
Who then are the people that get sent to these "special" hospitals? How "special" are the patients? A major survey of the special hospital population and its needs was carried out from the Institute of Psychiatry."
Twenty per cent of the patients (241 men and 55 women) in the three special hospitals for England & Wales were studied. The table gives a few basic characteristics.

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<th>Special Hospital patient characteristics</th>
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Many (65%) of the patients came from custody, although only 10% were transferred sentenced prisoners, 12% came from regional medium security units. Fifty-six per cent of the patients were admitted following a criminal conviction, (34% because of a violence conviction, include 54 cases (18%) of homicide conviction). This means that 44% were admitted because of troublesome behaviour and/or fears of dangerousness which did not reach the criminal courts, these were almost entirely transfers from other hospitals which had deemed the patients unmanageable outside of high security. In the 12 months before the survey 120(40%) of patients had been severely threatening, 148(50%) had actually assaulted someone (half of those were serious assaults), 54(18%) patients had harmed themselves, again these figures are not mutually exclusive. These data confirm the importance of these hospitals to the NHS.
The finding which attracted most attention in the survey was our estimate of the security needs of the patients surveyed. Both the clinicians in the hospitals and we ourselves judged, in 1991, that over 80% of the patients needed medium or high security. This estimate has been seized upon to indicate that 20% of special hospital patients need low or no security, and perhaps up to half do not need high security. However, this finding is usually taken out of context, it was the patients with mental handicap that were believed to have the lowest security needs, so that it was estimated that 89% of Broadmoor patients had an immediate need for medium or high security, whereas only 68% of Rampton patients were thought to have this need. Furthermore the hospitals provide a mixture of high security and long-term medium security care.

When an attempt was made to prognose the future for the patients studied, it was thought that 80% of the patients deemed to be needing high security would continue to need high security for the next five years, and only 62 patients were predicted to be not needing secure care. Most patients in the sample were not expected to show any improvement in their clinical condition over the next five years.

A more recent survey has found that 58% of resident special hospital patients had a functional psychosis and a quarter of these also had a personality disorder; another 26% had a personality disorder without a psychosis, and 16% had learning disabilities. The main diagnostic difference between this survey and the previous one is the decline in the number of patients with learning disabilities, a decline which reflects new hospital policies.

Follow-up Studies

Douglas Acres, a member of the Butler Committee, studied 92 patients (75 men and 17 women) discharged during 1971 by interviews with them and those who knew them. At two years 4% had died, 33% were back in an institution (13% prison, 17% special hospital, and 2% NHS hospital), 5% could not be traced, but 53% were living in the community. Many of
the patients obtained work, only 17% were unemployed for two years. Fifty four per cent of the patients (50) stayed away from the criminal courts for the two-year period; 33 people (36%) served a prison sentence.

Buchanan" showed that 10½ years after discharge from special hospitals, 34% of ex-patients had been convicted of an offence, 15% of a violent offence, 7.5% of a sex offence, and 15% of any serious offence. Compared with earlier figures this indicates that special hospital patient reconviction figures have fallen from those pertaining in the 1970s.

Steels et al" used special hospital case register material. They compared the outcome of 75 men and 20 women who were restricted (Home Office controlled) special hospital patients in the legal (Mental Health Act 1983) category of psychopathically disordered (PD), with 70 men and 19 women who were also restricted but deemed mentally ill (MI). The mean length of the follow-up was 13.6 years. The PD patients had more reconvictions than the MI ones, however, the adjusted death rates within the two groups were the same, about 28% of the overall sample died in the follow-up period. The standard mortality ratio for the men was 2.1 and for the women 1.7, so the group had approximately twice the mortality of the general population.

The Services

By and large then, the special hospitals provide treatment for patients with aggressive behaviour resulting from psychoses, personality disorders, or learning disorders. The patients receive up to date medical and nursing care according to their diagnostic and behavioural needs. This means a combination of medication, specialised psychology and psychotherapy. The special hospitals are some of the few British institutions that provide therapeutic community services. Learning disabled patients receive educational and behaviour modification programmes. Specialised units are provided for drug and alcohol abusers. This list is not exhaustive.
A. INQUIRIES

Mental hospitals that are able to detain people against their will, are always vulnerable to scandal. Martin" gives a good description with significant illustrations from the general mental health services, of this process. Special hospitals are no exception to this general tendency. As other large mental hospitals have been closed they have been left as the survivors of a period of large hospitals and are now probably the main focus of such scandals and inquiries in hospitals, although the scandal process is turning away from hospitals to community care, as these new services are subjected to an increasing number of inquiries.

The special hospitals and the state hospital were subject to a House of Commons inquiry in 1968. Thirty years ago “(T)he sub-committee were appalled to see for themselves the extent of the overcrowding in the century old Broadmoor building..... by present day standards, the hospital is not adequate for more than 500 male patients, whereas the actual number of such patients was 723 in 1957 and 656 in 1966”.

Rampton Hospital was the subject of a major inquiry (the Boynton Report) at the end of the 1970s. This followed a television programme called The Secret Hospital, which made a number of serious allegations of ill treatment of patients by staff. The review team made 205 recommendations, including such hopefuls as "the media themselves should be prepared to report Rampton in a straightforward and balanced way"! Many of the recommendations were, however, carried out over the next two or three years. Nevertheless there were more enquiries in the 1990s. In 1992, in Rampton Hospital, a 42yr man, Brian Marsh, died during a control and restraint incident following an argument with a nurse. An open verdict was returned by the coroner, and an unsuccessful attempt was made to prosecute members of staff for conspiracy and manslaughter. Kaye & Franey also recounted how a patient escape in 1994 showed serious deficiencies in the ward regimes at Rampton Hospital, for example, there were no coherent multidisciplinary teams.
Three deaths of black men in Broadmoor Hospital each triggered an enquiry. In 1984 Michael Martin was found dead in the intensive care unit. He had been restrained for threatening behaviour, stripped and put in seclusion; then he was forcibly removed, with more violent struggles, to the intensive care unit. He vomited and inhaled his vomit during this movement. An inquiry conducted by Miss Shirley Ritchie QC recommended more qualified nursing staff and occupational therapists, proper training in physical control and restraint of patients, and better medical supervision of the administration of heavy sedatives, this last recommendation was not accepted by HM government. Four years later Joseph Watts died in the hospital following an incident in which shields and helmets were used by nursing staff to control him, following which he was given an injection. Recommendations were made about control and restraint procedures and the development of a proper seclusion policy. Orville Blackwood also died (in 1991), following an injection which was to restrain him.

In 1987 the management of Moss Side Hospital suspended a nurse after a number of allegations that he had hit a patient. The nurses' union, the Prison Officers Association (POA), balloted for industrial action and then staged a lock-in of all patients for about 10 days. Hate mail, threats and intimidation followed. Mawson gives an account of this episode, describing the Mental Health Act Commission, who had statutory responsibility to protect the interest of detained patients, as gliding silently through the hospital like "the ghost of Lady Jane Grey"; they took no public stand on the dispute. The Department of Health set up an inquiry attended by representatives of both the local and national POA, but not by local managers. The managers were found wanting and the nurse was returned to non-nursing duties.

The following year all of the special hospital managers were called to the Department of Health to discuss the problem of complaints investigations. The POA resisted management's claim to be allowed to investigate serious complaints, they insisted that the police be called in. The police would

*The Prison Officers Association is one of the trade unions which special hospital nursing staff can belong to. Its presence in the special hospitals is a legacy of the days when the hospitals were managed by the Home Office.*
usually fail to prosecute on the grounds that patients were not credible witnesses. The POA argued that it would be wrong to investigate further locally, as this would be double jeopardy! "This absurd state of affairs came to an end during the tenure of the Special Hospital Service Authority\textsuperscript{3}.

In 1991 a Committee of Inquiry was established to investigate a new set of complaints, this time about Ashworth Special Hospital, Ashworth being the result of the enforced amalgamation of the two Liverpool special hospitals (previously called Moss Side and Park Lane hospitals). This inquiry was established by the then Secretary of State for Health, Virginia Bottomley, in a strange manner. The Mental Health Act Commission, established by the Mental Health Act 1983 has special responsibilities for the protection of patients detained under the Mental Health Act. It has for example to visit and interview patients detained in hospitals and nursing homes to investigate individual complaints. Regular visits are conducted to all institutions that detain psychiatric patients. Since the need for an inquiry at Ashworth Hospital arose from yet another television programme alleging improper care and ill-treatment at Ashworth, it was widely assumed that all of the parties responsible for patient care at Ashworth (including the Mental Health Act Commission would be investigated. In the event, the man chosen as chairman of the inquiry, the then Mr Louis Blorn-Cooper QC, was also at that time chairman of the Mental Health Act Commission!

Overall there were ninety recommendations from this first Ashworth inquiry, including the abolition of mechanical restraints and the phasing out of seclusion.\textsuperscript{18} The inquiry did, however, have a number of important flaws, eg it angrily picked on one nurse for his refusal to give oral evidence and suggested that information should be laid against him. It published as an appendix to the report a series of four case studies, one on a patient who had died, another who alleged physical ill-treatment, a third who complained of a sexual assault, and the fourth on a patient who committed suicide. These case reports included all the personal details that were in the patients' files, together with the patients' undisguised photographs, and thus removed all the confidentiality which patients had expected from the authorities caring for them. Being a public document
this appendix did of course find its way to the patients' library at Ashworth hospital.

In 1997 another inquiry was established at Ashworth Hospital, this time to investigate allegations of child visitors to paedophile patients and lapses of security on the ward which had been set up to treat and manage patients suffering from personality disorders. Evidence given to this new inquiry, chaired by Judge Fallon QC, has once more induced speculation about the future of the special hospitals, and the debate of which this discussion document forms a part. It will report to HM government, after a very expensive inquiry lasting over two years, to a different political party than the one that set it up, at the end of 1998.

OTHER COMPLAINTS

Blom-Cooper, in his covering letter about his Ashworth inquiry said “we would even question the need for Special Hospital within contemporary forensic psychiatry services”. Other commentators with perhaps greater freedom of assertion have been less circumspect. In 1980, for example, the Lancet in a leading article following the Boynton Report gave a description of a dangerous and damaging regime existing at that time in Rampton Hospital, and implied that poor management and entrenched nursing attitudes were to blame. The Lancet” suggested that the Boynton recommendations, although numerous, were inadequate, and recommended that the patients at Rampton Hospital be relocated within the National Health Service. It also complained that the root causes for poor staff recruitment were not examined and suggested that academic linkages would be a very important innovation.

Psychologists joined the “close the special hospitals" debate in 1984 and 1985, eg Pilgrim & Eisenberg argued for closure. Pilgrim was working, as a clinical psychologist, at Moss Side Hospital at that time and Eisenberg had worked there previously. They argued for closure on seven grounds; geographical isolation, organisational isolation, professional isolation, discontinuity of care, worst contingency planning, abnormalization, personal dislocation. "Discontinuity of care" was a
criticism of the then shift system worked by the nurses; "worst contingency planning" was a criticism of security being "high" for all the patients, whereas some needed lower levels of security; “abnormalization” was a comment that the environment in the hospitals would not lead to “normalization” (undefined); "personal dislocation" was an extension of the geographical isolation criticism. They believed that special hospitals functioned organisationally nearer to prisons than hospitals. They advocated that the special hospitals should be "phased out" and replaced by "smaller units", but gave no more details as to what the "smaller units" might be able to provide for the patients who have to remain there for long periods.

The next senior medical journal to take up this theme was the British Medical Journal when Professor Robert Bluglass in a leading article following the first Ashworth inquiry, suggested closing the special hospitals and substituting instead new local high security units of about 100-150 beds each, saying that these should be linked to local regional secure units and psychiatric services, close to the patients' families and friends, and geographically placed to allow smooth continuity of care into the community. It is of interest that he acknowledged that improvements were made at Rampton and at Broadmoor following adverse reports, and said that those improvements must not be underestimated or undervalued, but used as an argument instead the "more efficient use of the Special Hospital Service Authority resources". He did not, however, explain his efficiency point.

In 1991, at the time of the Blom-Cooper Ashworth Inquiry the Nursing Times published a Spotlight on special hospitals and concluded, via Lindsay Dyer, that closure was the only solution. She acknowledged that the Special Hospital Service Authority was in some conflict with the Prison Officers Association, giving as an example the statement from a POA official that the escape of a patient from Broadmoor was the responsibility of Broadmoor's new "liberal regime", and said "the SHSA will need all its reforming zeal to tackle institutionalised inertia, incompetence, and poor standards of professional practice. The Nursing Times also wished to open up a public and political debate about the best
way of providing an integrated secure mental health service. As with other critics, Dyer did not spell out how satisfactory regimes could be developed for patients who need some level of security on a long-term basis within her proposal.

The Reed Report

In the early 1990s the Department of Health and the Home Office established a *Review of Health and Social Services for Mentally Disordered Offenders and Others requiring similar services* under the chairmanship of Dr John Reed. In its main report, the review said little about high security services, although they were always accepted as a given background factor. The *Review* established three sub-committees to deal with important matters that were not central to the main *Review.*

The main *Review* had set guiding principles for the care of mentally disordered offenders as follows:

i. proper attention to the needs of individuals;

ii. as far as possible, in the community rather than in institutional settings;

iii. under conditions of no greater security than is justified by the degree of danger patients present to themselves or others;

iv. in such a way as to maximise rehabilitation and chances of sustaining an independent life;

v. as near as possible to patients' own homes and families if they have them.

The twenty-two recommendations from the high security working party endorsed these principles, added a sixth to respect special hospital patients' rights as citizens, emphasised that NHS purchasing contracts should aim to meet the needs of patients who have a longer term need for security, and then went on to suggest that high security services should be more widely dispersed than they are at present, and that units should cater for no more than 200 high security patients each. The report also
recommended that the expansion of the academic and research base for forensic psychiatry in related disciplines should be an integral feature of future strategic planning for high security services, and that the government and the NHS should take account of high security and related services in their research and development strategies.

Chiswick\textsuperscript{24} in a \textit{BMJ} leading article welcomed the "central ......message" of the report that "high security care can no longer be provided in remote institutions blighted by geographical and (more important) professional isolation, "and went on there are no queues for consultant vacancies........ Despite valiant efforts the creation of the Special Hospital Service Authority has not brought these hospitals into the body of the NHS". Chiswick acknowledged that "In the end the outcome of these proposals will depend on public confidence and political will. Secure units are about as popular with local citizens as nuclear power stations".

It is the recommendations from the Reed Committee, set in the context of the second Ashworth inquiry, that has given rise to some journalistic speculations that what should be done is to close the three existing special hospitals, and open eight new high security hospitals scattered throughout England & Wales.

We too have noted many serious difficulties in the special hospitals, 1) the tensions between unions have already been mentioned; 2) staff recruitment is a continuing difficulty; 3) even a semi-autonomous body such as the Special Hospitals Service Authority could not entirely take its own decisions, (ministers will, probably, always want some control over the fate of the country's "dangerous" mentally disordered offenders); 4) the hospitals are to some extent geographically isolated; 5) staff still do feel on occasions professionally isolated from their peers working in other hospitals within the more usual trust and regional structures. Nevertheless, it is extremely important to note, just how far forward the special hospitals have come during the last thirty years or so, to examine carefully the political and economic consequences of some of the more radical suggestions, and to ask what evidence some of the proposals are based on.
THE CASE FOR THE RETENTION OF SPECIAL HOSPITALS

Inquiries
It is noteworthy that none of the official inquiries into any of the special hospitals has recommended closure of one or more of those hospitals.

In a follow-up to the Boynton enquiry, Dick et al\textsuperscript{25} considered whether Rampton should be closed and what other methods there might be of managing mentally disordered offenders. They found a number of points in favour of keeping Rampton open - the varying levels of security within one hospital, the wide range of occupational and recreational facilities, the expressed wishes of patients who preferred the comparative freedoms within the perimeter to the cramped conditions of a regional security unit, the cost of smaller units, and the planning blight and demoralisation of a closure decision. They also noted the isolation of the hospital, the then relative lack of domesticity for patients, and the bad publicity and stigma, but they concluded that on balance the hospital should remain open.

Changes in the hospitals
The SHSA review for 1995\textsuperscript{26} listed some important policy changes achieved during the brief reign of that authority. The first was to establish a round the clock hospital. "Hospitals by day: prisons by night. That was the situation which the SHSA found when it took over management of the special hospitals in 1989."\textsuperscript{27} By April 1995, all wards at Broadmoor Hospital had implemented a 24-hour care regime, and 19 of the 26 wards at Ashworth, and 25 of the 28 at Rampton, had done the same.

In 1993 patients' councils were introduced into the hospitals. A special hospital patients' charter was introduced in 1994, as a variant of the general NHS patients' charter. It gave, for example, patients considerable rights of access to their consultant psychiatrist, as well as to a physically healthy lifestyle with access to fresh air, exercise, recreation, adequate sleep and a good diet. "High on the list of patient care issues which
needed to be tackled when the SHSA was set up, was the over-use of seclusion for disturbed patients in the special hospitals. The SHSA report said that some wards no longer had seclusion rooms, and that although seclusion was still in use, it was used less and it kept to the new guidelines which had been laid down by the SHSA.

Frank Powell who was Head of Nursing Services for the SHSA at that time, gave a good account of the culture change that occurred in the special hospitals in the early 1990s. He observed punitive and coercive approaches in the amount of locking up and physical restraint being used together with threats and sanctions. A custodial approach was common with passive acceptance and resignation to the working environment, little or no enthusiasm for a structured approach and individualised care, so that nurses became reactive rather than proactive. Seclusion was used very commonly. In special hospitals nurses had five types of seclusion available!

This was all changed at a cost to the SHSA of £8 million; the cost being mainly in the provision of adequate and safe nursing cover. Each ward was forced to review its operational policy for each 24 hours, these issues were discussed at ward meetings with patients. Day and night staffing were integrated with internal rotation managed by each ward manager.

Thus it has been possible to slowly improve attitudes in the special hospitals. The SHSA introduced a 24 hour regime, against some staff opposition in all three special hospitals, in switched nurses from uniforms that looked like prison officer uniforms to uniforms more in keeping with the nursing profession, in introduced new patients' complaints procedures. No doubt the current inquiry at Ashworth Hospital will suggest that at that particular site these measures have been far from successful. The simple fact that two public inquiries have been necessary within five years indicates this must be so. However, a carefully considered report by the new inquiry may bring as much beneficial change to Ashworth Hospital as the Boynton report brought to Rampton Hospital some fifteen years ago.
The special hospital patient population peaked at 2522 patients in 1956, and has been falling steadily since that time. Its most recent high was 2108 in 1977, by 1987 it was 1724 and it currently stands at between 1400 and 1500. There are, however, substantial waiting lists for all three special hospitals which is a clear indication of demand. The falls in special hospital patient numbers have been achieved partly by extra provision of medium security and other specialist units within the NHS, partly by more stringent criteria for admission to special hospitals, and partly by the virtual abandonment of provision for patients suffering from learning disability.

All this means that the current special hospitals are different from those inquiries into previous decades, and are, with suitable management, susceptible to improvement.

**Research**

When the government set up the SHSA it followed the advice of the critical enquiries and made one of its six objectives for the new Authority, the promotion of research in forensic psychiatry. Three academic units have been established, one in each of the special hospitals. A steady flow of research is now coming from the special hospitals. Such a research and teaching atmosphere is beginning to show results, and, for example, the number of consultant whole time equivalents at Broadmoor is now 15.93, encompassing 21 forensic psychiatrists (including 5 senior lecturers), and 4 psychotherapists (including 1 senior lecturer), the number of specialist registrars whole time equivalents is 8.6, there are trainee lecturers in forensic psychiatry attached from the Institute of Psychiatry, Southampton University, and St Bartholomew’s Hospital. Oxford university sends two senior house officer trainees. The psychology department has one joint appointment with the Maudsley Hospital and academic links with Reading University; speech and language therapy is linked to the academic department at University College London.

It is imperative that more knowledge is obtained about the rare combinations of diseases and circumstances that lead to seriously
dangerous behaviour if prevention and treatment are to advance. Dispersal of such patients may seriously reduce opportunities for acquiring that knowledge.

**Recruitment**

In many ways recruitment is the key to better services. The knowledge, skills, attitudes, and enthusiasm of the staff determine the quality of a hospital much more than other factors, such as buildings. Recruitment to the special hospitals has been very difficult in the past. However, recruitment, particularly of nurses, is not easy in any part of the psychiatric services. There is no evidence that recruitment at new sites would necessarily be better than recruitment at old sites. Our own hospital, the Bethlem Royal Hospital, one of the most prestigious mental hospitals in the world has serious recruitment difficulties in respect of nurses. Hence, a serious question for new small high security units would be the acquisition and retention of the necessary nursing and other medical skills which are required for the management of a relatively rare group of patients. We believe it would be uneconomic and probably not feasible to keep 6-8 geographically separate pools of such expertise.

A detailed audit at each special hospital might reveal that, for example, provision of married accommodation, or cheap home loans, might be useful. The only data we know that purports to show how recruitment is related to a particular hospital policy comes from the USA. Knesper produced figures which suggested that the one way to improve recruitment for a large mental hospital is to improve its academic status and linkages. We have indicated that recruitment to Broadmoor Hospital is improving and that this has coincided in time with the academic developments that have taken place there.

**Size of Hospitals**

One of the criticisms of the special hospitals has been that they are too big. Big seems to be equated with impersonal regimes, with poor staff/patient ratios, and tricky staff management relationships. However,
small does not in itself overcome those difficulties. Further it is perfectly possible on one site to have separate units which would collaborate for some activities, for example the use of educational and workshop facilities, but which for living arrangements, therapeutic community developments, and the provision of a domestic milieu, would be organised in small independent sub-units. Thus the impersonal disadvantages of large wards and distant management could be largely remedied within an overall larger structure. One proposal we would like to see considered is the splitting of Ashworth Hospital into two again. This could, for example, give a high security hospital and a long-term medium security hospital on the same site. Similar arrangements could also occur at the other two special hospitals. At a stroke three special hospitals could be turned into six smaller ones. This seems, to us, at least as viable as closing the current three hospitals and opening eight new ones, in urban areas against local opposition or on green field sites without local amenities.

A serious untested question is whether small units could offer the same level of security as larger units. They certainly could not offer the same quality of life in terms of freedom within the perimeter wall, and the range of educational and occupational activities which a larger unit could offer.

**Demand actors**

It is a remarkable fact that there is no overt provision in England & Wales for long-term medium security care. Covertly English special hospitals provide that function. One of us (AM) was involved in a study of this service gap and concluded that around 1,000 long term medium security beds for England & Wales are required. The 1993 survey identified between 400 and 500 such patients already in the special hospitals.5

Another factor which needs to be taken into any numerical calculation of the number of special hospital beds required in England & Wales, is that a number of patients are currently inappropriately placed in prisons. In other surveys we have found that at the end of the 1980s perhaps 300-400 patients requiring high security care were inappropriately located in
prisons. It is common clinical experience to find severely psychotic patients in prison. (See footnote p.28 for example). A further group of prisoners require long term medium security.

One of us (AM) has recently undertaken a further needs assessment survey of special hospital patients from south east London as part of a clinical audit to determine how many patients could be moved from high security to the medium security services of the South Thames (East) Region, and has found that the proportion from that zone is now 80% requiring high security, with another 10-15% requiring longterm medium security. This change reflects changing admission policies, eg few admissions for patients with learning disabilities who were noted in our survey to less often require high security care.

A forthcoming paper pulling together three surveys, of sentenced prisoners, of remanded prisoners, and of special hospital patients, estimates that the nation requires something like 1500 high security beds, a further 1500 medium security beds, and perhaps 1000 specialised forensic psychiatry beds in low security. Currently pressures are building up in other parts of the health system as the current stock of special hospital beds fails to meet this requirement. Waiting lists for patients to move into special accommodation grow, some patients now have to wait for more than a year for a place; the private sector is expanding, particularly in provision of longer term medium security beds; the prisons remain repositories for individuals who should be in special hospital accommodation. In the face of these facts, closure of one or more of the special hospitals is surely not an option for a long time to come.

**Politics and Public Reaction**

Policy decisions in the world of forensic psychiatry are rarely rational, but are in response to public panic, punitiveness or opprobrium. As Chief Executive to the SHSA, Kaye came to understand how the British press views forensic psychiatry and its hospitals. "Broadmoor cutbacks could set killers free", "Daily Mirror catches Broadmoor pervert mingling with
PM’s wife on VIP day out”, “The loonies have taken aver the asylum”. Kaye analysed the press reactions to Ashworth Hospital during the difficult period of its first inquiry and discovered that the SHSA press office could make some difference in determining the type of stories the newspapers would print, so that in a twelve month period 1994-5 an analysis of cuttings showed an increase in positive coverage by 15%, while negative coverage remained constant. During the inquiry there was a ratio of five negative reports to one positive one, but by 1994-5 the ratio had evened out to 1.4 positive reports to one negative as the reporting of the inquiry had come to an end.

At a personal level, away from the glare of the media, one of us (JG) was involved in the early 1980s in establishing a series of medium security units for mentally disordered offenders in southeast England. At every hospital where this was discussed we encountered two groups of opponents to any development, the nursing staff who would sometimes be orchestrated by their trade union, and local residents. The team presenting the proposal would take bets as to how long it would take before a member of the audience would jump up to announce something like "we are not having Myra Hindley here" (she was almost always mentioned). Painstaking explanations that Myra Hindley had not been deemed mentally disordered and remains a prisoner, not a hospital patient, cut no ice. There were no less than three public enquiries concerned with the five small medium security units built in the then South East Thames (Health) Region.

Proposals to close the three special hospitals and open six new ones have to take facts like these into account, as well as the data on patient numbers, and the evidence on the provision of safe, therapeutic and humane regimes. Some of the enthusiasts for such local provision of high security services have probably not experienced the difficulties of setting up new secure psychiatric services. Public terror of mad axe men and predatory sex offenders and other unrealistic bogeys, has to be dealt with. It is very hard to overcome such irrational fears with reasoned argument, and the finding of sites where new high security services would
be placed is likely to be both expensive and difficult, and may well end up with a provision which is as detached from the community and other medical services as are the special hospitals today.

Resources

The economic disadvantages of closing the special hospitals are considerable. First, there has been large-scale capital investment in the special hospitals that currently exist. Park Lane hospital, now part of Ashworth, was built in the 1970s and Broadmoor has been partly rebuilt in the 1980/90s. Staff recruitment to all three hospitals is difficult, but is probably improving, particularly at Broadmoor where its status and international prestige are currently rising. The precious resource of nurses and doctors is unlikely to transfer easily to other sites. Broadmoor, for example, is an important local industry to Crowthome, Berkshire, and a new pocket of unemployment there coupled with perhaps even greater difficulties of recruitment on a new green field site somewhere else does not make economic sense.

Furthermore, if, as is proposed, any new hospitals to be built are smaller than the current three hospitals, then there will be an increase in costs due to a reduction in the economies of scale which occur as numbers are reduced. Critics argue this is an expense well worth paying, but who will pay, where will the funds come from? As the SHSA was beginning to show when it was disbanded, it is possible to reduce unit size within current structures.

Isolation

Part of the argument against the special hospital is that they are isolated, (geographically, culturally and professionally). These problems, it is alleged have brought a legacy of bad practices and an anti-therapeutic culture. Closure it is believed would solve all this.

Geographical isolation can be a problem in some cases. Broadmoor hospital is some 30–40 miles from London, Ashworth hospital is just outside Liverpool, Rannpton hospital is not near a big centre of
population, and cities such as Birmingham are a long way from any of the special hospitals. How then, runs the argument, is it possible to rehabilitate patients back into their own communities?

Several points merit consideration. First a modern network of roads has shrunk Britain to a considerable extent. Second, the hospitals have introduced geographical zoning to try and reduce distances from patients' homes. Third, it is important to recognise that for at least some of the time, distance between a local community and someone who has committed a serious act of violence is a useful therapeutic device. It is not necessarily a good idea to nurse someone who has killed a parent or a neighbour close to their old home. It is commonly the position that rehabilitation of such an offender needs to be to a new setting, perhaps in a completely different area. Such patients are not the majority, but they do exist and the fantasy that all services should be provided down the street is unrealistic and may be damaging to patients, their families, and victims alike. It may make more sense to develop stronger links between each of the special hospitals and each of the regional services. Broadmoor drew up a service agreement in September 1993 with Fromeside Regional Secure Unit in Bristol, and the Butler Clinic near Exeter. The agreement included standards such as "Broadmoor should admit patients within three months of the original request, the regional unit should admit patients within six months of the Home Office approving their transfer, and consultants in the south west unit should attend a case conference, at least annually, for the patients who belong to them."33

Cultural and professional isolation are more difficult. People, and that includes professional people, do not like the concept of mentally disordered offenders. The patients are doubly stigmatised. In an era when “liberal” is a dirty word and all politicians boast that they are hard on crime, it is all too easy to be critical of those who are seen to be soft on criminals, even though effective treatment is very hard on crime. As patients are stigmatised, so are those who care for them also stigmatised. This type of isolation will probably occur in any setting caring for mentally disordered offenders, whatever its size and placement.
Professional isolation can also develop in a culturally separate world when there is too much work to do. This is certainly the situation in present day psychiatry and its subspecialties. However, there is no evidence that doctors and nurses in special hospitals are more professionally isolated than their peers in, say, community psychiatry. Deliberate policies to get people to meetings, and to outside courses can be implemented.

At Broadmoor Hospital there are regular multi-disciplinary teaching sessions, inviting many non-special hospital staff into the hospital. If staff-patient ratios can be increased, more opportunities of this kind can occur and will be welcomed. An increased level of research activity will open special hospital practices to greater outside scrutiny and will bring fresh and different perspectives, in the form of research staff, into the hospitals.

**CONCLUSIONS**

Until 1989 all of the English special hospitals were run directly from Whitehall. This must have been comforting to ministers, but it meant that the hospitals did not have the advantages of professional management. Management styles lagged behind the rest of the NHS and were vulnerable to the more immediate political pressures of government. Even when the SHSA was created at arms length from Whitehall, the new authority was still subject to civil service/ministerial whim. Thus it was decided without research or consultation, to amalgamate Park Lane and Moss Side hospitals to form the new Ashworth Hospital. The SHSA were instructed to carry out this policy. Ashworth has had particular difficulties in trying to accommodate two totally different traditions and hospital regimes, at the time one was a longstanding service for mentally handicapped patients, the other a new Broadmoor-like service for the mentally ill and personality disordered of normal intelligence. The staff from the two types of regime had never worked together easily and forcing them into one organisation was in our view a serious government mistake, which may even be at the root of the continuing problems at Ashworth Hospital. So far it has not been discussed in the inquiries.
A further government mistake may have been the abolition of the Special Hospitals Service Authority precisely at the moment it seemed to have come to grips with many of the problems bequeathed to it by the old civil service management.

An excellent critique of the special hospitals and their future comes from one of the members of the now defunct Special Hospitals Service Authority. Dr Higgins said that when the SHSA took over the management of the hospitals from the previous civil service board, "It was all too obvious that the hospitals had been both undermanaged and overmanaged. They had been undermanaged in that no central goals had been set on standards, clinical or managerial, just on security. Decisions had often been driven by knee-jerk responses that were bureaucratic, defensive, and over conciliatory to reactionary and conservative forces in the hospital, often by concessions and the injection of further wasted resources. The hospitals had been overmanaged in that any individuality, innovation, or principled stand at hospital level, had been frustrated by central vacillation or obstruction.... The early days of the SHSA were therefore taken up with the introduction of general management of institutions far from prepared for it. The next stage, and by far the most important, was to develop a set of operational policies which would turn the hospitals in the direction of being run on behalf of the patients, eg the institution of 24 hour care:... the ending of slopping out: setting of standards for domiciliary accommodation: closure of dormitory accommodation:... seclusion policies: complaint policies: patient advocacy services, etc, and most important of all the reorganisation of the work of the clinical professionals to ensure multi-disciplinary working actually took place."

Higgins concluded that in the mid-1990s the hospitals were going in the right direction, but at that point the game changed leaving the special hospitals behind. The introduction of trusts and commissioners and the purchaser/provider split, which ultimately led to the abolition of the SHSA and the development of local management plus a High Security Psychiatric Services Commissioning Board to "purchase" the necessary high security services. Higgins went on to analyse the remit of the new
board, saying that it is abundantly clear that special hospitals are now in the mainstream of the NHS and they are but one of the providers of secure care, although it is not clear how monies will flow for secure provision to both regions and special hospitals.

We hope that by now the reader is in no doubt that we are strongly opposed to the notion that the current special hospitals be closed. The case against them is made by a succession of critical inquiries about their standards of care for patients, and a belief that high security care should be more widely dispersed across the nation, particularly in order to bring high security care closer to the areas from which the patients originated. The hospitals have had serious staffing problems including poor recruitment, and difficult trade unions. The hospitals have been accused of being isolated both geographically and culturally, and they are said to be too large. The evidence against them is thus a series of damning reports. However, none of the reports had recommended closure of any of the hospitals, there is good evidence of considerable change within the hospitals, research has been established and will provide, if nurtured, valuable information about the origins and the management of dangerous behaviour in patients. There is no evidence that smaller units are necessarily better for patients, for research, or for security, and it is possible to establish smaller working units within the current special hospital sites. Demand for high security services remains high and the hospitals have waiting lists. It is extremely unlikely that the general public would welcome the building of new high security units in their neighbourhoods. Larger units produce economies in terms of resources, may provide greater patient freedom and opportunities, and a valuable pool of expertise, both clinical and security. Isolation can be and is being reduced.

That is not to argue that no radical changes are required in the special hospital service. We believe that numbers of patients in high security are now about right, but that there is a serious shortfall in the provision of longterm medium security beds. We would urge that every effort is made to modify, adapt, and improve the current special hospital sites to recognise, as has been done in Scotland, this need for long term medium
security. Current accommodation at some of the sites could, for example, be adapted to provide a mixture of high security beds and longterm medium security beds. The hospital sites could possibly be split into two units, or even distinct hospitals providing such slightly different services.

We believe that for any change to occur there needs to be a considerable injection of new resources. We believe that staff recruitment in all the types of health care professional must be attended to urgently. In this respect we endorse the recommendations which have been made on many occasions, that academic linkages and research developments within special hospitals, making them centres of prestige, perhaps converting them into teaching hospitals, are a very significant route forward. We would particularly like to see more detailed studies of patient progress before, during and after treatment in a special hospital, including subjective information both from the patients and from their relatives. This would enhance the information available about the need for special hospital services. New ideas should also be welcomed. The notion of a further high security development, built by a regional health authority, is a fascinating suggestion. It could be tried, for example in Birmingham, and it could be thoroughly researched to see whether its establishment, its economics, and its results are worth developing further.
FOOTNOTE

We are content to leave the last word, in the form of a footnote, to two anguished parents who wrote a letter to the Sunday Times following the death of their mentally disordered son at the hands of another mentally disordered man, both of these ill people were being housed at the time in a prison system which can never be an appropriate disposal for the severely mentally disordered.

Letter to the Sunday Times 2nd August 1998

Our mentally ill son, Christopher, was killed by a paranoid schizophrenic in Chelmsford Prison in November 1994. Both men should never have been sent to prison, but to a hospital, and the subsequent enquiry report confirmed that.

Will the Health Secretary's promised reform of Care in the Community ensure that such a tragedy is not repeated?

The mentally ill have to be kept out of prison. Too many of them are now locked up - out of sight and out of mind. Official statistics show 66% of remand prisoners and 39% of sentenced prisoners could be diagnosed as mentally ill, and that the incidence of mental disorder, especially serious mental disorder, is much higher among prisoners.

We need more secure psychiatric beds and changes to mental health law to facilitate intervention to assist those in the community who do not recognise their need for treatment.

The most disruptive patients must not be reclassified with "personality disorders" to ensure that they are not regarded as mentally ill. They must - as is supposed to be official policy - be treated by the health and social services rather than the criminal justice system. No doubt these patients present very serious challenges to the mental health service, but to send them to prison is surely unacceptable.

The need to achieve a culture change in the mental health profession should not be underestimated. Minimum intervention rather than positive outreach has been the policy for many years. Poor record keeping and failure to liaise with other agencies have become a way of life for some.

Making professionals accountable and subject to sanctions for inadequate performance - as Ministers are - would be an important step in bringing about this culture change.

Paul and Audrey Edwards, Coggeshall, Essex
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ACKNOWLEDGEMENTS
We would like to acknowledge the assistance given by Mr Martin Butwell, for providing information about current Broadmoor staffing, and current special hospital patient numbers. We are also grateful to Broadmoor Hospital archives for allowing us to reproduce the Richard Dadd drawing "The Turnkey" for our cover.