Unlocking Secure Care
a pathway to climb
or a cliff edge to walk?

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The story starts ...

The **Bradley Report** presents

- a comprehensive plan
  - to reduce reoffending
  - and improve public health
  - by ending the revolving door to custody for mentally ill and learning disabled offenders

The report made **80 recommendations**

- the consensus is that overall these **did not** happen

[www.nhsccl.org](http://www.nhsccl.org)
What & who is secure care for?

- There is confusion
  - Medium secure
  - Low secure
  - Psychiatric Intensive Care Units (PICUs)
  - Locked rehab
    - No clear definition about which should be used when and lack of clarity around commissioning them

- What is commissioned?
  - Hot potato of handling s136s
  - s117 – disintegration between health & social care – personal experience of patients
  - Is that they get less than they used to

- What PICUs do has changed
  - 10 years ago more about intensity of care and therapy
  - Now more about security
An overgrown path?

• There may be a pathway
  o But it may be too little trodden – why?

• Transfer delays
  o Transfer times for prisoners to end up in medium/low secure or PICU vary from a month to many months (PICU around 20-30 days)
  o Can be 5, 6 or 7 assessments
  o Need to better connect acute general and PICU to CJS

• Commissioning difficulties
  o Lack of definition for PICU, locked rehab and low secure leading to no clear distinctions
  o Those working in them believe they have a clear distinction but when the area is overlaid & funding sources and urgency for a bed are added ... the default tends to be a PICU
An overgrown path?

- **There may be a pathway**
  - But it may be too little trodden – why?

- **Pathways out of secure and semi-secure accommodation**
  - This is the same as with general beds – accommodation, community support

- **Services in the community**
  - Multidisciplinary case management in the community is often lacking
  - Time for secure and semi-secure services to place a greater value on non-doctors & -nurses managing people
  - Many of the difficulties are more about social, cultural and other non-medical issues
Who holds the keys & carries the can?

• Decision making
  o National Offender Management Service (NOMS) and Ministry of Justice make decisions about detention
  o Mental Health Tribunals make many pathway decisions
  o often go with the judgment of the clinician but do not share responsibility if things go wrong

• MDTs across the pathway
  o Should share the decision making AND responsibility
  o This needs more attention to ensure a timely approach can work
Who cares?

• Real risk of falling (failing) between many groups ...
  o Fractured commissioners (NHSE, CJS, CCGs, Las, etc.)
  o Prisoners often have to wait until the proverbial hits the fan – only referred to MH services at point of crisis
  o Lack of secure beds – maybe because of lack of community based support services to clear beds
  o Risk aversion as it tends to sit with individuals

• What would make a difference?
  o Shared decision making by MDTs across a pathway with shared responsibility for outcomes
  o Better use of court diversion and liaison services (e.g. s37 can go to an acute general ward)
  o Early access / referral to MH input for those in prisons with better links to acute general and community services (e.g. prison transfer insists on a secure unit)
  o Improved community support services to enhance return to the community including accommodation, employment, etc.
  o New models of care with groups of providers taking responsibility for tier 4 budgets may help but only if take a true population level approach and work with local commissioners to join up pathways
  o STPs cannot ignore tier 4 services and need to grasp the nettle of joining the pathways across their footprints and beyond
Thank you

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