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A Survey of the Regional Secure Unit Programme

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Progress in building and opening permanent and interim secure units between October 1982 and March 1984 was surveyed. Reasons for the delays in implementing the secure unit policy recommended in the 1975 Butler Report are described, and comparisons made between the different Regional Secure Unit (RSU) designs, staffing policies, and Regional Forensic Service models. The development of this Health Service innovation has now reached the stage where the limiting factor to further progress is not building but finding suitable staff and paying their salaries. The secure unit programme will highlight another group of underprivileged patients who will require further Health Service innovation.

The current evolution in psychiatric care, which began during the 1950s with the introduction of the 'open door' policy, psychotropic drugs, and less restrictive patterns of care, gradually eroded the traditional skills of both medical and nursing staff in dealing with difficult and dangerous patients. These changes were recognised in the Mental Health Act, 1959, now superseded by that of 1983.

However, as early as 1961, a Ministry of Health working party (Emery Report, 1961) recommended that secure arrangements should continue to be provided by NHS hospitals, so that each Regional Health Authority (RHA) would have some such facilities. A further suggestion was that special diagnostic units be set up for difficult patients who required security, to be involved with assessment, treatment, and research. Although these recommendations were accepted by the Government that year, only one unit (the Northgate Clinic, Hendon) actually opened, and this evolved into a specialised adolescent clinic.

Both psychiatric hospitals and the new District General Hospital psychiatric units became increasingly reluctant to admit patients who were difficult or dangerous, and as a result, the Special Hospitals and prisons admitted increasing numbers of patients who would normally have received care in the NHS. There thus arose a shortfall in care for difficult patients and in recognition of this, two separate Government-sponsored groups began working to examine the problem. The DHSS report on security in NHS psychiatric hospitals (Glancy Report, 1974) and the Committee on Mentally Abnormal Offenders (Butler Report, 1975) both recommended the provision of secure units to fill the gap in psychiatric services.

In July 1974, the Interim report of the Butler Committee had been accepted by the Government, and capital money was made available from central funds not only to build permanent units, but to fund interim secure units as a temporary solution. The DHSS publication, *Regional Secure Units—Design Guidelines* (1975) set out the Government's view on their design and discussed the proposed patients, treatment, staffing, and training. However, the final report of the Butler Committee in October 1975 commented on the disturbing lack of progress in setting up RSUs, and suggested that this could be due to difficulties that the RHAs were having in meeting the staff costs.

In January 1976, the DHSS made a special revenue allocation to each RHA to cover a proportion of these staffing costs. In 1982, the details of both the capital and revenue allocations to each RHA was published (Hansard, 1982) for the years 1976/77 to 1982/83. The most disturbing fact to emerge was that not all revenue expenditure found its way to psychiatric services, let alone secure facilities, but since 1977/78, the proportion of the central revenue support spent on psychiatric services has increased from over 60% to over 90% in 1981/82, and the proportion spent on secure facilities from 7% in 1976/77 to 60% in 1981/82.

In 1980, the official views of the Royal College of Psychiatrists were published in *Secure Facilities for Psychiatric Patients; A Comprehensive Policy*. However, it was not until November 1980 that the first RSU began admitting patients, and it then took over 2½ years for a further three units to open. Each RHA has been surveyed in order to examine the reasons for the delays and to clarify the current position of the permanent secure unit programme.

Method

All the RHAs except Oxford and Wales were visited by the author between October 1982 and January 1983, and the forensic psychiatrist appointed to each RSU planning team was interviewed. Planning documents and architectural designs were made available, and the information was updated in March 1983 (Snowden, 1983) and again in March 1984. The survey did not include details on secure provisions for adolescents or for the mentally retarded.

The particular areas that the survey set out to clarify were:

1. The reasons for the delays.
2. The current state of the RSU development programme and projected opening dates.
3. Which of the RHAs have interim secure units (ISU) and which were running forensic psychiatry services. For the purpose of this paper, an ISU is defined as *a specialised unit run by a forensic psychiatrist or consultant with forensic psychiatry sessions which provides a forensic service (in contrast to an intensive care facility, which is an integral part of a general psychiatric service)*.
4. Whether or not there were any substantial differences in RSU design.
5. Whether or not there were any substantial differences in RSU staffing.
6. The forensic psychiatry service model chosen by each RHA.

Findings

1. **The reasons for the delays**

Because of central DHSS capital funding, finance has not been a major cause of the building delays. Only two regions have no plans as yet to build an RSU. Following a regional survey of NHS psychiatric inpatient units by Oxford University Department of Psychiatry (1976), the Oxford RHA decided not to build an RSU. The Welsh Office has not yet published its overall strategy for the provision of forensic services.

The first three RSUs to be completed were in Northern RHA, Trent RHA, and the Devon and Cornwall sub-region of South Western RHA. In these cases, planning was perhaps more rapid because of the determination of local clinical enthusiasts who were keen to have an RSU in the hospitals in which they worked. Good public relations overcame objections to the plans in Northern and Trent RHAs, but in Dawlish, the local community were firmly against an RSU. South Western RHA had thus to submit to one of the first non-statutory public planning enquiries.

The planning process has not been quite as rapid in the other ten health regions because of blocks in each of the NHS administrative levels, as well as problems with the local communities.

(a) *DHSS*

The DHSS Capricode Planning Procedure has itself held up progress in building RSUs. Because the concept of these units was new, each has been designed empirically, and despite the published DHSS guidelines, a number of different design solutions have emerged, with differing implications for staffing. The proposals for nurse staffing levels proved an early difficulty, as forensic clinicians believe these are as important as physical security in the total security of the building; the proposals presented in each RSU planning document had to be considered carefully by the DHSS. There was early discussion concerning the Department's recommendations for one nurse to one patient overall, and in Mersey RHA, the plans were held up for some time until a more adequate overall nurse-to-patient ratio of 1.5:1 was accepted. Much higher levels have since been proposed in later Regional schemes, and have been accepted by the DHSS, but these are presenting severe revenue funding consequences to the RHAs, since the central DHSS revenue allocation will only meet a proportion of the total staffing costs.

(b) *RHAs*

Some RHAs were not particularly committed to the secure unit programme—RSU Project Teams were set up late and forensic psychiatrists appointed even later. However, in East Anglia, once the decision was made to build an RSU at St Andrew's Hospital, Norwich and the forensic psychiatrist was appointed, progress was rapid. Although the Project Team did not begin work until late November 1980 the RSU, which was completed in late 1983, opened ten of its 30 beds in May 1984.

(c) *District Health Authorities and NHS staff*

Many RHAs have had problems in finding hospitals willing to accept a secure unit, and this siting difficulty has contributed to the delays. It is here that consultant psychiatrists and Health Service unions have slowed the rate of progress. Even where psychiatrists were convinced of the need for secure units, disagreement and opposition among hospital staff led to industrial action in several groups of workers. Two of the first ISUs to open (at Rainhill Hospital, Merseyside and Prestwich Hospital, Manchester) were affected by industrial action for some time. However, there has recently been a noticeable shift in the climate of opinion in favour of secure units, and some hospitals even see the siting of one on their land as an asset and a positive sign, indicating that the long-term future of that hospital is assured.

(d) *Local communities and planning enquiries*

Although most RHAs have encountered opposition from local communities, in a few cases this has been extremely well organised. In East Anglia, an action group was set up, which even printed T-shirts proclaiming the slogan "No Broadmoor in Broadlands". The result of this sort of resistance was adverse press comment and lobbying of Members of Parliament and local politicians. Consequently, planning teams have had to spend time 'selling' the units and educating the public by means of meet-

ings. A number of RSU plans have also been held up by non-statutory public planning enquiries, but to date, none of these has come to a decision in which the plans were opposed outright, although acceptable modifying recommendations have been suggested.

2. **The current state of the RSU Building Programme**
The eventual total of permanent secure unit places for mental illness in England is to be 730, but this will not be achieved until the end of this decade, and the number frequently changes, as those RHAs which are still in the planning stages alter their plans. Table I summarises the progress in planning and building in each RHA. From the last column, it will be seen that the only RSU that had opened prior to June 1983 was at St Luke's Hospital, Middlesbrough.

TABLE I

Details of the Regional Secure Unit Programme in each of the 14 Regional Health Authorities and Wales—March 1984

Regional Health Authority	*Site(s) of Regional (Permanent) Secure Unit(s)*	*No. of beds*	*Progress*
Northern	St Luke's Hospital, Middlesbrough	30	Opened in November 1980, only 20 beds functional
Yorkshire	Fieldhead (Mental Handicap) Hospital, Wakefield	48	Building completed December 1983. To open 48 beds in May 1984
Trent	Towers Hospital, Leicester	60	Opened in July 1983, 14 beds functional
East Anglia	St Andrew's Hospital, Norwich	36	Building completed. To open 10 beds in May 1984
North West Thames	Regional Secure Unit—St Bernard's Hospital, Ealing	40	At stage III planning, out to tender in early 1984, should open 1985/1986
	Peripheral Units—		
	1. ?Leavesden Hospital	15	Discussions still in progress concerning site
	2. ?Site	15	and policies of these units
North East Thames	Friern Hospital, Barnet	20	Because of the closure of Friern Hospital, plans are to be redrawn. Instead of a ward conversion, a new building will have to be designed on an adjacent site
	Runwell Hospital	10	This Unit is open
	Second Site	12	Early planning stages, most likely to be on site of new District General Hospital
South East Thames	Regional Secure Unit, Bethlem Hospital	30	
	Area/Peripheral Clinics		
	Canehill Hospital, Coulsdon	15	Building of these units will be completed this year and depending on revenue consequences, all should at least be partly open for patients in 1984
	Bexley Hospital, Bexley	15	
	Maidstone Hospital, Maidstone	15	
	Hellingly Hospital, Hailsham		
South West Thames	Netherne Hospital	25	DHSS considering variation to original stage I submission
Wessex	Knowle Hospital, Fareham	28*	Building in progress, should open in late 1984/early 1985
Oxford	—	—	+
South Western	Glenside Hospital, Bristol	30	State I planning submission full approval still awaited. To open in 1986/1987
	Langdon Hospital, Dawlish	30	Opened in June 1983, 10 beds functional
West Midlands	Rubery Hospital Complex, Birmingham	100	Shortly out to tender, to open in 1986
Mersey	Rainhill Hospital, Prescot	50	Opened in August 1983, 36 functioning beds
North West	Prestwich Hospital, Manchester	88	Building in progress, completion date November 1984; to open 44 beds in late 1985
	Permanent Forensic Facilities		
Wales	?	—	Planning and site of permanent forensic facilities await publication of the Welsh Office views on forensiv services. One unit will most likely be sited at Whitchurch Hospital, Cardiff

* The Wessex unit has 31 beds in total, but three beds are in a rehabilitation flat which, while within the building, has a separate entrance.
\+ See Table III

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While there will be a steady increase in the completed places, the number of functioning beds is less impressive. In April 1983, 120 places had been completed (Devon and Cornwall sub-regional, Trent and Northern RHAs) but only 18 places, those at St Luke's Hospital were open to patients. Although by March 1984 these three RSUs opened additional places, two further units were admitting patients (Mersey and North East Thames (Runwell Hospital) RHAs) and another two units had been completed (Yorkshire and East Anglia RHAs), only 90 out of a national total of 264 completed places were staffed and open to patients. As further units open, it is likely that this pattern will continue.

This deficiency is not only due to problems in nursing recruitment, but to the difficulties that RHAs are experiencing in meeting their proportion of the total revenue costs. The units that have opened and that are near to opening are currently experiencing a great deal of pressure from the RHA to cut staffing, even though the security and efficacy of the units would be compromised. As a result, units are opening but are keeping to the agreed nursing levels, with consequent shrinkage of the number of beds that can be used. The South East Thames secure service plan (SETRHA, 1976) had to undergo RHA enquiry, whose brief was to look at the possibility of making revenue savings without compromising the whole philosophy of the proposed service. However, it was reported that they were unable to find any significant revenue savings, and the RHA is now under pressure to seek some other solution to the problem.

3. **Interim secure units**

Table II indicates where the ISUs (as defined above) are to be found in England and Wales, their size, and which may have a long-term future in each RHA forensic service plan.

Although some are little more than locked wards, many have double door 'air-lock' entries, secure windows, and in few cases a secure external exercise area. The clinical experience of running interim secure units and forensic services (Faulk, 1979; Higgins, 1979, 1981) has guided RSU plans and policy decisions. In some cases, the ISUs have become so successful that if finance allows they will become a permanent part of the secure network relating to an RSU, especially in those large regions whose initial policy was to have a single RSU, but who now appreciate that it will be extremely difficult to provide a comprehensive service without making permanent use of the ISUs and the local services which they provide.

4. **RSU design**

(a) *New buildings*

While the DHSS has limited the capital costs by using formulae based on the amount of building space and cost per patient, there are variable proportions of floor space allocation to the patients, clinical and administrative staff, and occupational and rehabilitation services in each design. The overriding principle has been that each secure unit should blend in with the surrounding hospital and that security should not be obvious from the exterior. Units which will have secure external exercise areas have used the natural contours of the land, surrounding trees, and existing walls and buildings to camouflage the 12′–14′ weld mesh fence. The larger units, of around 50 beds and upwards, have been designed to enclose outside recreation and courtyard areas within the building complex. Apart from the rather individually shaped RSU in Dawlish (Devon & Cornwall sub-region), most are of a rectangular design. The patient areas are either along single corridors or are T-shaped in design, with nursing stations positioned for maximum observation. The corridors are usually wide, and in case of disturbance are able to take three abreast comfortably. Time out or seclusion rooms are usually but not always positioned within the patient areas, and are close to or next to the nursing stations.

Although some units have deliberately built small dormitory areas for patients who are likely to be transferred back to NHS units with similar accommodation, most patients will have their own bedroom, with the door opening outwards. The patients' furniture has been bought with care, as the possibility of using furniture for self-inflicted or other injuries has been appreciated. In the larger units, most of the bedroom windows face on to internal courtyard or outside exercise areas. The windows are of either polycarbonate glass or toughened laminate and have fixed or restricted opening. The patient areas are commonly divided into an admission/assessment unit (which usually affords a higher level of security), treatment, and pre-discharge units. In many cases, the design is such that the internal security may be re-arranged, allowing ward size and even the level of physical security to alter if clinical pressure so dictates. Patients will eat their meals either on the ward (in the case of many of the admission/assessment units) or in large canteen areas. Those units of around 36 beds and upwards have been able to use the increased total building space allowed to design larger rehabilitation and education areas, which may even include a gymnasium and large multi-purpose hall.

Functional secure arrangements

Entry to the secure treatment area is invariably through a single, electronic, double door, air-lock system, supervised by the security control; some units will also have a separate service entrance, which will complicate the security control. Usually, a member of the nursing staff is designated as security officer in charge of security policies and procedures, and each staff member is given a personalised identification card which, when produced at the security control, is exchanged for a key

TABLE II
Site, size and future plans for the Interim Secure Units in England and Wales—March 1984

Regional Health Authority	*Site of Interim Secure Unit(s)*	*No. of beds*	*Future plans*
Northern	—	—	Regional Secure Unit open, no further secure units for mental illness
Yorkshire	Stanley Royd Hospital, Wakefield	16*	Future uncertain when RSU opens but may become a permanent unit
	Storthes Hall Hospital, Huddersfield	20	The future of these permanent special care units is not related to the RSU opening
	High Royds Hospital, near Leeds	20	
	Broadgate Hospital, near Hull	28	
Trent	—	—	Interim secure unit at Towers Hospital closed when RSU opened, no other interim secure unit in region for mental illness
East Anglia	—	—	Agreement was not obtained to open an interim secure unit in this region. No secure arrangements for mental illness until RSU opens in 1984
North West Thames	St Bernard's Hospital, Ealing	14	Will close when RSU opens
North East Thames	Friern Hospital	10	Discussions are taking place on opening a secure unit by converting an existing ward
South East Thames	Bethlem Royal Hospital	15	Each unit will close as the central and four area clinics open in 1984
	Cane Hill Hospital, Coulsdon	7	
	Maidstone Hospital, Maidstone	6	
South West Thames	—	—	Deliberate policy decision not to have an interim secure unit
Wessex	Knowle Hospital, Fareham	14	Will close when RSU opens
Oxford	—	—	Current policy is not to develop interim or permanent secure units for mental illness
South Western	—	—	Deliberate policy not to develop an interim secure unit for Bristol, but open acute 'forensic' beds available
	—	—	RSU open for Devon and Cornwall. No other secure facilities
West Midlands	Central Hospital, Warwick	15	Although its future is uncertain this unit may continue after the RSU opens, although it may take on a specialised rehabilitation function
	Barnsley Hall Hospital, Bromsgrove	12	This unit will probably close when the RSU opens
Mersey	—	—	The two interim secure units closed when the RSU opened in August 1983
North Western	Prestwich Hospital	44	This unit consisting of two wards will close when the RSU opens
	Whittingham Hospital, Preston	24	The immediate future of this unit is uncertain, as in the next 10/15 years the hospital may close
Wales	Forensic Facilities		
	Garth Angharad Hospital	19	The future and direction of this 'open' forensic unit will depend on the final strategy decision for forensic services in Wales
	Whitchurch Hospital	16	This intermediate unit is already open. Its relationship to other units which are yet to be planned is uncertain

* Of the 24 beds in the secure unit at Stanley Royd Hospital only 16 beds are designated 'forensic', while eight beds are designated Special Care beds.

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for entry into the secure areas. In some cases, there is a fairly sophisticated key suiting system, in which staff are graded, and given keys which may limit access within the secure area. Other RSUs may decide to have electronic doors within the secure complex supervised by the security control. The Mersey, North West Thames, and East Anglia RHAs have designed RSUs in which the administrative and clinical office space is located within the RSU, but outside the secure envelope, limiting the number of staff requiring keys.

Design problems

The first permanent secure units to be completed were planned well in advance of the recent forensic psychiatry clinical experience in running ISUs and forensic services, and thus contain features which are unsatisfactory. The RSU in Northern Region is small, corridors are narrow, living conditions are cramped, and ventilation poor; clinical interview rooms are limited, and the space put aside for occupational therapy and rehabilitation is inadequate. The Trent RSU has two floors of clinical, administrative, and research space, but considering its size, only a small part of the building has been put aside for occupational therapy and rehabilitation. In the Devon & Cornwall sub-region, the opening of the RSU in Dawlish was delayed by the appointment of the forensic psychiatrist, who noted a number of design faults in the almost completed building; a six-figure sum was required to rectify these faults before the unit opened.

(b) *Conversions*

Not all planning teams have adopted the design solutions described above. The RSU plans chosen by the North Western and Wessex RHAs are conversions of existing hospital buildings. The Wessex unit will have a single-entry door under lock and key to each of its two 14-bedded wards. The only evidence of physical security will be the reinforced window frames and unbreakable glass, and there will be no secure external exercise area.

Although there will be some new building, mainly for clinical and administrative offices, most of the work for the North Western RHA secure unit at Prestwich Hospital, Manchester is a major adaptation of an existing two-storey hospital building. As a result, the four wards involved will retain much of their previous external structure, and will operate in some respects as self-contained units: patients will eat on their own ward and will relate mainly to the patients on that ward. The main shared facilities will be the gymnasium and the occupational therapy department.

5. **RSU staffing**

(a) *Medical*

The number of consultant forensic psychiatrists per catchment population ranged from 0.5 to 1.8 per million, with a mean of just over one per million. Each unit will have a senior registrar, either in a full-time higher training post in forensic psychiatry (which may be of limited tenure) or seconded from a local rotational training scheme. Many units will take registrars for six-monthly periods from local rotations, and those that for various reasons are unable to do so intend to appoint clinical assistants.

(b) *Nursing and Security Staff*

In most units, the nursing staff will be headed by a nursing officer, but in a small minority of cases, an assistant director of nursing will be appointed. The projected nurse–patient ratios range from 1.5:1 to a maximum of 2.8:1, with a mean of around 2:1. Variations in nursing shift systems account for some, but not all of these differences. A member of the nursing staff is usually designated as the security officer, supervising the staff in the RSU security control. The problem of staffing the control centres has been solved in three ways. In some RSUs, security (portering) staff will be appointed, while other units intend using secretarial/clerical staff or nurses.

(c) *Social Work*

Whatever the size of the RSU or RHA, most planning teams have opted for one or two jointly funded social workers.

(d) *Psychology*

Most but not all RHAs intend to appoint a principal psychologist to head the RSU psychology establishment. There is great diversity in the size of the various psychology departments, which vary from a single Principal or Senior to the extreme example of the Mersey RSU, which will have one Principal, two Seniors, two basic grade psychologists, and a technician.

(e) *Occupations*

Two divergent philosophies have governed the approach towards patient 'occupations'. Some planning teams have chosen the model adopted by general psychiatric units, in which there will be occupational therapy departments staffed by therapists. Other units have chosen to align themselves with the rehabilitation model used in special hospitals, so that rehabilitation managers, technical instructors, gymnasts, and even psychotherapists will be appointed.

The different staffing proposals (apart from nursing) in the RSU planning documents indicate differences in the type of service that is being planned, rather than in RSU size and design. Planning teams with a forensic clinician member have appreciated that an RSU is only one part of a comprehensive forensic psychiatry service, and in these cases the secure and non-secure forensic services have been planned concurrently; staffing proposals for the unit have been agreed with the service beyond the unit in mind. Some RSU planning documents, however, have staffing proposals which indicate that few of the disciplines other than medical will have time to work outside the units; the danger in these cases is that the staff

will become 'unit bound', inward looking, and professionally isolated. For example, some units will appoint a single psychologist, while others will have a number in post, allowing this discipline to develop and to offer a comprehensive service to the community, probation services, and Home Office establishments.

6. **Regional secure units and forensic services**
It might be thought that the service plans adopted by each Region are the result of some deep analysis of regional needs, geography, and population, but the impression gained from the survey was that RSU site, design, philosophy, and position within a regional service owed more to the unsystematic effect of the 'Prime mover' in the planning process. For example, the units which opened first were all sited where the local enthusiasts worked, and not perhaps where a regional specialist would have wished, leading to problems in the type of regional forensic service that can be provided. Those RHAs which appointed forensic psychiatrists and were running early forensic services have clinicians with strong individual views on the type and style of service, and the size, number, and functions of the secure units, though there are still Regions in which the exact service model is uncertain. Table III summarises the solutions chosen; forensic services which contain either a single RSU or one relating to satellite or sub-regional secure units.

TABLE III
Summary of the Permanent Secure Unit Models for each Regional Health Authority and Wales—March 1984

Regional Health Authority	Number of Permanent Secure Units
Northern	Single RSU
Trent	Single RSU
East Anglia	Single RSU
Wessex	Single RSU
Mersey	Single RSU
South West Thames	Single RSU relating to close supervision beds in the larger psychiatric hospitals in the region
Oxford	No units planned
South Western	Two sub-regional secure units
Yorkshire	RSU relating to three or four special care units
North West Thames	Single RSU relating to one or two sub-regional secure units
South East Thames	RSU relating to four area secure clinics
West Midlands	Large RSU relating to perhaps one sub-regional secure unit, but still some uncertainty about future policy
North West	Single RSU relating to one or two sub-regional secure units
North East Thames	Three separate sub-regional secure units
Wales	Future forensic/secure strategy still uncertain

The single RSU model would obviously work best in a compact Region with good road communications, such as Mersey, but even in their plans, it was appreciated that the central regional site of the RSU would still be over ten miles from the main population density in Liverpool. For this reason, the forensic service base has been divided between the RSU and the out-patient and assessment centre in central Liverpool. South West Thames RHA has overcome the problems of distance by setting up 260 close supervision beds in the larger psychiatric hospitals in the region, which will relate to the small 25-bed RSU. Other RHAs have settled for a single RSU, even though clinical experience suggests that this is inappropriate for large regions. The danger is that what will be provided will be a *secure unit service*, with little community service and follow-up for those patients who are best managed by what has been described (Gunn, 1977) as the 'parallel forensic service'.

More complicated service models have also been adopted, such as the special assessment and supervision service in South East Thames RHA. Here, the problem of providing a comprehensive service for a large region has been solved by building an RSU which will relate to four local secure clinics, each of which will provide a sub-regional service. The larger central clinic at Bethlem Royal Hospital will not have a catchment population of its own, but will provide a higher degree of security, which will allow greater flexibility in patient management and more specialised care.

Discussion

The results of this survey show that there is no uniform answer in any of the six areas of enquiry that it set out to investigate. Apart from Oxford RHA and Wales, multiple factors explain the delays in implementing the RSU programme; the process by which a new organisational change achieves acceptance in a complex system such as the NHS depends on factors other than central policy decisions and the availability of finance.

Barbara Stocking, in her work on health service innovations, has identified three important factors, which she calls 'the product champion, the gatekeeper and the blocker', each of which can greatly influence the acceptance and development of an NHS innovation (B. Stocking, 1985). The 'product champion' is highly motivated to develop a particular innovation, guides and encourages the planning process. 'Gatekeepers' are administrative bodies or individuals who are in a position to allow or hinder the acceptance of the innovation, while the 'blockers' are those who may be affected directly by a change of their job, work philosophy, or environment. Using these concepts in relation to the RSU programme, the local 'product champions'

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have been the forensic psychiatrists or, in those RHAs 'first off the mark', a general clinician or an academic psychiatrist. Without such a person (as in Oxford RHA and Wales), progress has been slow. It is one of the tasks of the successful 'product champion' to identify and convert the 'gatekeepers', in this case the Regional Medical Officer, administrators, and clinicians in the health region.

The DHSS acts as a distant 'gatekeeper' because even where a regional planning team has presented a united front, the central three-stage Capricode Planning System sets up hurdles, which must each be negotiated. Local Authorities, District Health Authorities, Community Health Councils, the local community, and (especially) Health Service unions and psychiatrists working in hospitals alongside the proposed building sites have all exerted a 'blocking' influence, which has delayed progress in RSU planning.

It is perhaps surprising that the secure unit programme has not been delayed even further. The concept of regional secure units is a new one in English psychiatry, and there was little appropriate knowledge to help direct the development of this complicated service innovation, apart from various developments in Holland, Denmark, Sweden, and Canada (Bluglass, 1981).

Overall, there has been a surprising lack of formal liaison between the regional planning teams, although problems have been shared informally and many similar basic solutions have emerged. The fundamental design approach has been to build RSUs that are unprovocative (Ingham, 1976) and which blend in with the surroundings, but views on design and physical security differ, even when a forensic psychiatrist is part of the planning process. For example, at one extreme there will be RSUs that can, in an emergency, deal with even the most dangerous patients for short periods of time. At the opposite, some units will be little more than highly staffed locked wards. While there are some similarities in the way the RSU programme has developed in each region, there are also many differences. It is doubtful whether a single solution exists to the problems of dealings with the difficult, dangerous, or offender patient. Each RHA is different and what will work for one will not necessarily do so for another. Also, the time between laying down RSU plans and opening the units is now so great that the plans made in the mid-70s, when clinical forensic experience was still at an early stage of development, may not be appropriate now.

The RSU programme is now entering a phase where the limiting factor to further progress is not the building programme but staffing. There are difficulties in staff recruitment with all the disciplines in this relatively new psychiatric subspeciality, as few have been or are currently being trained. In consequence, suitable staff are being attracted from one secure unit to another, rotating the vacancies nationally, accompanied by only a slow enlargement of the total pool of suitable staff. A further difficulty, mentioned above, is the problem that RHAs are having in meeting their proportion of the total revenue costs. Some are taking the narrow view that the only performance indicator relevant to revenue allocations is bed occupancy, this ignores the large amount of time all staff including nurses spend developing and providing the regional services beyond the unit.

Because of the many differences, it is important when looking at the RSU programme nationally not to draw general conclusions on the effects and relationships of RSUs to the NHS, special hospitals, prisons, probation service, the courts, and the community. It is not possible to say that any one model is better than another, but what can be said is that the differences in design, staffing, and philosophy may not make each unit equipotent in all functions. There are important opportunities for research in this field: a comparative study of seven RSUs has already begun, but evaluative work is also required to assess how the units (as they open) are working and whether this new innovation in psychiatric care is fulfilling its functions.

It could well be that these permanent secure units will underline a deficiency in service for a further group of underprivileged patients, i.e. those who are not dangerous enough to require the maximum security provided for by Special Hospital but whose illness, because of its chronicity, will be unsuitable for long-term care in RSUs. These chronically mentally ill but minimally dangerous patients are not readily accepted by general psychiatric teams, and their plight must lead to further innovation, if they are not to be inappropriately admitted to RSUs, Special Hospitals, and Prisons.

There have naturally been a number of changes in the development of RSUs since the survey was last up-dated. The Secure Units in Trent RHA and in the Devon & Cornwall sub-region of South Western RHA have opened an increased proportion of their beds. The interim secure units in Wessex and Yorkshire (Stanley Royd Hospital) RHAs have closed, as these regions, with East Anglia RHA and two of the South East Thames RHA area clinics have opened a proportion of their permanent secure places, but of

the total of over 370 permanent secure places completed nationally, only just in excess of 190 beds are open to patients.

It is now unlikely that the two interim units in West Midlands RHA will remain open when the RSU opens. This unit and that in North West Thames RHA are being built, as is the one for the North Western Region, but the opening of this unit will be delayed until early 1986 because of a major problem in the almost completed building. The sub-regional units at Bristol (South West Thames RHA) and at Friern Hospital (North East Thames RHA) and South West Thames RHA are still in the planning stages. Lastly, there is now a strategic plan for secure services in Wales.

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