Characteristics and needs of long-stay patients in high and medium secure settings in the UK: Implications for service organisation

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Important

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Scientific Summary

Background

Forensic psychiatry operates at the interface between law and psychiatry. It is concerned with patients who have committed an often serious offence and may be detained in highly restrictive secure settings. The purpose of this detention is twofold: care for and treatment of the *patient* (i.e. to improve mental health and facilitate recovery) and protection of the public from harm from the *offender* (i.e. reduce the risk the patient poses). This dual function can cause tensions and dilemmas for the practitioner who has potentially incompatible duties to the patient, third parties and the wider community. In the UK, forensic-psychiatric services comprise different levels of security: high, medium and low secure, as well as community forensic services. High secure services cater for patients who "pose a grave and immediate danger", medium secure services for those presenting "a serious danger to the public". These services are expensive and highly restrictive to patients.

Detention in forensic care is generally not time-limited and discharge depends on whether the individual is deemed to have made sufficient progress as to no longer presenting a risk. There have been concerns that patients stay for too long in too high levels of security. Needs assessments of high secure patients in the 1990ies have identified that between one-third and two-thirds of patients do not require that level of security and this led to the 'accelerated discharge programme' which resulted in a move of patients from high to medium secure care.

There is currently no accepted standard for length of stay (LoS) in either high or medium secure care. For high secure care, the average LoS is about 8 years. For medium secure care, early guidance suggested an upper limit of LoS of 2 years. However, a number of studies have identified that 10 to 20% of patients stay for more than 5 years. Research on factors associated with long-stay has identified psychopathology, severity of index offence, being on a 'restriction order' and a lack of suitable facilities at lower levels of security as important reasons for extended periods of stay. However, previous research has mostly only been conducted in single units, has not taken a whole pathways approach, has been based on discharge samples (thus neglecting those who never achieve discharge) and has not explored patient experience and stakeholder views.

Objectives

The aim of this project was to provide a comprehensive description of long-stay patients in high and medium secure settings in order to inform future service developments to improve the quality and cost-efficiency of care and management of long-stay patients in high and medium secure forensic psychiatric care.

Our research questions were:

i. What is the length of stay (LoS) profile of the current high and medium secure forensic-psychiatric population in England? (Work Package 1)
ii. How many long-stay patients are currently resident in high or medium secure care? (Work Package 1)
iii. What are the characteristics, care pathways and mental health, psychosocial and

service needs of long-stay patients? (Work Package 2)

iv. Which patient and non-patient factors are associated with long-stay? (Work Package 2)

v. Are there different categories of long-stay patients with distinct needs and, if so, what are they? (Work Package 2)

vi. What are the experiences of long-stay patients in forensic care? (Work Package 3)

vii. What are the ethical and legal issues associated with long-stay in secure forensic services? (Work Package 4)

viii. Which service models could meet the needs of the different long-stay groups, improve resource use and quality of life of this patient group and what are factors potentially impeding their implementation? (Work Package 4)

Methods

A mixed methods approach was taken, including a cross-sectional survey of all patients resident in selected units on 1.04.2013, a detailed file review and consultant questionnaires of those identified as (Work Package 4) and management of long-stay patients.

Definition of 'long-stay'

We took into account total time spent consecutively in high/medium security and defined long-stay as having spent:

- five or more years in medium secure care OR

- ten or more years in high secure care OR

- 15 years or more years in continuous secure care in a combination of the high and medium secure settings.

Selected units

All three high secure units in England were included. There were approximately 57 medium secure units in England at the time of the study. A stratified cluster sampling frame was adopted with 23 MSUs, including 14 NHS and 9 independent units, drawn according to sector, geographical region, size and specialization (e.g. patient groups and designated purpose such as treatment, rehabilitation, etc.) with oversampling of units specialising in particular patient groups, including women and patients with learning disabilities. This sample represents approximately 40% of all MSUs in England.

Data collection

Work Package 1: Cross-sectional survey of length of stay in high and medium secure care

Collection of length of stay data (from admission to current setting on census date) and basic patient characteristics (date of birth, gender, ethnicity, admission source, Mental Health Act section, type of current ward) of all patients resident in included units.

Work Package 2: Characteristics and needs of long-stay forensic psychiatric patients

Detailed file-reviews of all identified as long-stayer (n=401) from WP1, including pathways, sociodemographics, psychiatric history, offending history, intra-institutional behaviour, risk and interventions, consultant questionnaires on future need.

Work Package 3: Qualitative study of patient experience

Qualitative, semi-structured interviews with 40 long-stay patients in 8 units using purposive sampling.

Work Package 4: Service innovation

Description of international service models, stakeholder interviews, focus groups and workshops.

Data analysis

Quantitative data were analysed using Stata, SPSS and MLWin software. Descriptives were calculated for medium and high secure samples separately and differences between long-stayers and non-long-stayers are reported. Predictors for length of stay were computed using multi-level binary logistic regression with MLWin software. Cluster analysis was performed using latent component analysis.

Analysis of qualitative data was supported by NVivo software (QSR International, Southport, UK) and used a thematic analysis approach.

Results

Prevalence of long-stay

The percentage of long-stayers was 23.5% for high secure patients and 18.1% for medium secure care. There was significant variation in the prevalence of long-stayers in medium secure units, from 0 to 50%. Using extrapolation, we estimated the total number of long-stay patients in England to be about 730. There were no differences between long-stayers and non-long-stayers in gender and ethnicity. However, long-stayers, compared to non-long-stayers, in both high and medium secure settings were significantly older, more likely to have been admitted from other secure units and less likely from prison, more likely to be on a s37/41 hospital order with restrictions and less likely to be on a s47/49 prison transfer.

Characteristics and needs of long-stay patients

There were more similarities than differences in the characteristics of long-stay patients currently residing in high and medium secure care. The mean LoS in continuous high/medium secure care was 14.5 years with about one fifth of patients having been resident for more than 20 years. Those currently in high secure care had longer LoS though there was no difference between settings in the percentage of extreme long-stayers (more than 20 years). The largest

percentage of patients in both settings were on a s37/41 (about 60%) with the second largest group being on a s3 (about 15%). Nearly half the sample were admitted to their current unit from medium secure care, 24% from high secure care and 20% from prison. Pathways were complex with the majority of patients experiencing multiple settings; there were more moves within the same level of security than moves to less secure settings. Over one third of patients had unsuccessful referrals to less secure services in the last 5 years.

The most prevalent single diagnosis was schizophrenia with 58% with about one third considered treatment resistant. The second most prevalent diagnosis was PD (47%) with the most prevalent type being antisocial followed by borderline PD; 17% had a learning disability. Three quarters of patients had a physical health condition. Two thirds had a history of self-harm and nearly half had previous admissions to secure care.

Whilst the majority were violent offenders, 17% had no index offence and about one fifth had a sexual index offence. A high proportion of long-stayers had a history of arson and one quarter had convictions within institutions. Figures for recent incidents and seclusions were high. HCR-20 scores were high with higher figures in the medium secure group; according to the HCR-20 about one third of patients were still improving.

90% of patients were on psychotropic medication, but only 50% were currently receiving psychological treatment of any kind and completion rates for offending work were low. The majority of patients had some form of contact with their families.

We identified 5 different classes of patients, distinguished by diagnosis, offending and current behaviour.

About one third of patients in high secure care might be placed in too high levels of security; for medium secure care, according to their consultants, about one quarter each were judged to be detained in too high or too low levels of security. Only a minority of patients were expected to be in the community in five years' time. Patient factors (e.g. psychopathology) were judged to be more important in impeding movement to less secure settings compared to political or service provision factors. Few meaningful predictors were found to identify those judged to require life-long forensic care.

Patient experience

Four themes emerged using thematic analysis illustrating the different ways in which participants made sense of their experiences in secure care. These themes included: 1) factors attributed to long-stay, 2) outlook towards secure care, 3) approach adopted in daily life 4) readiness for change and progression. A narrative analysis approach was used to further scrutinise the way in which each participant positioned themselves in relation to each of the emergent themes which resulted in the emergence of four long-stay stances: dynamic acceptance, static acceptance, dynamic resistance and static resistance. The dynamic and static stances illustrate the extent to which participants describe actively trying to progress in order to leave secure care. The acceptance and resistance variables illustrate the extent to which participants believed that they are in hospital to be treated and that the secure care system is helping them to get better. These stances revealed differences in ways in which

patients made sense of their experiences which was illustrated through their experiences of moving to and from units within the secure-care system, their motivations (or lack of) to engage and progress and their perceptions of what was seen as 'risky' behaviour.

International service provision

A number of European countries have developed dedicated forensic long-stay services, focusing on quality of life rather than risk reduction with positive experiences. Regimes are much more relaxed there with patients granted greater freedoms and autonomy. Patients in these services are able to return to the reduction with positive experiences.

Stakeholder perspectives

Balancing the aims of rehabilitation and recovery in a context where patients are detained against their will in a regime which applies pressure to comply with therapeutic interventions created tensions for staff. The need for staff to manage risk means that the extent to which they can empower patients is constrained. Staff emphasised the need to maintain hope, but hope was related to treatment and 'cure' in a context where this may not apply to a substantial minority of patients. Almost all doctors appeared to conceptualise the process in terms of an 'admission, treatment, rehabilitation, cure' trajectory with little or no acceptance that no all patients would fit this model.

The incentives within the system were identified as acting as a barrier to the provision of care which would best meet patient needs. An emphasis on managing risk creates disincentives to take patients from other facilities which have higher levels of security. Furthermore, payment for capacity as opposed to money following patients might create incentives for providers to protect their bed base, rather than actively scrutinising the extent to which the setting and nature of care provided is the most suitable for the patient. Budget holding arrangements were reported as creating a disincentive to develop community services and to engage in facilitating discharge to the community. The existing arrangements were also reported as creating little incentive for providers to innovate, particularly where this would threaten their existing bed base.

Despite such disincentives, service innovation was happening, with some sites creating dedicated facilities for long stay patients. Even in these sites, most staff were uncomfortable with explicitly acknowledging amongst themselves that some patients would not 'recover'. This is reflected in a reluctance to use the term n was happening, with some sites creating terms such as 'enhanced recovery' instead.

Conclusions

A significant proportion of forensic-psychiatric patients are detained in highly restrictive setting for lengthy periods of time, potentially for longer than what is necessary and this impacts negatively on their quality of life. These patients have complex needs and pathways. Without a national strategy and service specifications for this group it is likely that their needs are not met. Both, the way services are commissioned and funded as well as staff attitudes might hinder service improvements. Key factors in the provision for long-stay patients identified included a stable environment allowing the development of long-term relationships with staff and patients, flexibility and an emphasis on quality of life, autonomy, meaningful activities and

community links.

Recommendations for future research

Future research is recommended to

- develop standardised ways of recording key patient and service characteristics and meaningful outcome measures in forensic care,
- use prospective designs to longitudinally follow up an admission cohort of high and medium secure patients to test the predictive validity of factors associated with long-stay with a view to developing instruments to predict LoS,
- investigate how different ward environments and staff / team attitudes affect patients' pathways,
- develop and pilot interventions / environments specifically catering for long-stay patients and evaluate their impact on progress and quality of life,
- develop and evaluate staff training programmes for those working with long-stay patients, focusing on engagement and quality of life in forensic care and
- conduct an economic evaluation of pathways, identifying inefficiencies through delay and repetition and comparing forensic provision with that provided in other countries.

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