

# A mixed-methods study exploring the characteristics and needs of long-stay patients in high and medium secure settings in England: implications for service organisation

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## Scientific summary

### Exploring the characteristics and needs of long-stay patients

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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 a 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, to third parties and to the wider community. In the UK, forensic psychiatric services comprise different levels of security – high, medium and low security – as well as community forensic services. High secure services cater for patients who ‘pose a grave and immediate danger’, while medium secure services are for those presenting ‘a serious danger to the public’. These services are expensive, and are highly restrictive for patients.

Detention in forensic care is generally not time-limited, and discharge of an individual depends on whether or not he or she is deemed to have made sufficient progress that they no longer present a risk. There have been concerns that patients stay for too long in settings with security levels that are too high. Needs assessments of high secure patients in the 1990s identified that between one-third and two-thirds of patients do not require that level of security. This led to the ‘accelerated discharge programme’, which resulted in the transfer 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 on LoS of 2 years. However, a number of studies have found that 10–20% of patients stay for > 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 been conducted in single units only, 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 LoS profile of the current high and medium secure forensic psychiatric population in England? [Work package (WP) 1]
- ii. How many long-stay patients are currently resident in high or medium secure care? (WP1)
- iii. What are the characteristics, care pathways, and mental health, psychosocial and service needs of long-stay patients? (WP2)
- iv. Which patient and non-patient factors are associated with long stay? (WP2)
- v. Are there different categories of long-stay patients with distinct needs and, if so, what are they? (WP2)
- vi. What are the experiences of long-stay patients in forensic care? (WP3)
- vii. What are the ethical and legal issues associated with long-stay in secure forensic services? (WP4)

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 factors are potentially impeding their implementation? (WP4)

## Methods

A mixed-methods approach was taken, including a cross-sectional survey of all patients resident in selected units on 1 April 2013, a detailed file review and consultant questionnaires of those identified as long-stay patients, as well as patient and stakeholder interviews.

### Definition of 'long stay'

We took into account the total time spent consecutively in high/medium security, and defined a long-stay patient as a patient who has spent:

- $\geq 5$  years in medium secure care *or*
- $\geq 10$  years in high secure care *or*
- $\geq 15$  years in continuous secure care in a combination of 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 medium secure units, comprising 14 NHS and 9 independent units, drawn according to sector, geographical region, size and specialisation (e.g. patient groups and designated purpose such as treatment or rehabilitation), with oversampling of units specialising in particular patient groups, including women and patients with intellectual disabilities. This sample represents approximately 40% of all medium secure units in England.

## Data collection

### Work package 1: cross-sectional survey of length of stay in high and medium secure care

Collection of LoS data (from admission to current setting on census date) and basic patient characteristics (date of birth, gender, ethnicity, admission source, Mental Health Act section and 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-stay patients ( $n = 401$ ) from WP1, including pathways, sociodemographics, psychiatric history, offending history, intrainstitutional behaviour, risk and interventions, and consultant questionnaires on future needs.

### Work package 3: qualitative study of patient experience

Qualitative, semistructured interviews with 40 long-stay patients in eight 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 (version 13; StataCorp LP, College Station, TX, USA), Statistical Product and Service Solutions (version 21; IBM Corporation, Armonk, NY, USA) and MLWin (version 2.35; Centre for Multilevel Modelling, Bristol, UK) software. Descriptives were calculated for medium and high secure samples separately, and the differences between long-stay patients and non-long-stay patients

are reported. Predictors for LoS were computed using multilevel binary logistic regression with MLWin software. A cluster analysis was performed using latent component analysis.

The analysis of qualitative data was supported by NVivo software (2014; QSR International, Warrington, UK) and used a thematic analysis approach.

## Results

### *Prevalence of long stay*

The percentage of long-stay patients was 23.5% in high secure care and 18.1% in medium secure care. There was significant variation in the prevalence of long-stay patients 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-stay patients and non-long-stay patients in terms of gender or ethnicity. However, compared with non-long-stay patients, long-stay patients in both high and medium secure settings were significantly older, more likely to have been admitted from other secure units and less likely to have been admitted from prison, more likely to be on a section 37/41 hospital order with restrictions and less likely to be on a section 47/49 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 > 20 years. Those currently in high secure care had longer LoS, although there was no difference between settings in the percentage of extreme long-stay patients (> 20 years). The largest percentage of patients in both settings were on a section 37/41 (about 60%), with the second largest group being on a section 3 (about 15%). Nearly half of the sample were admitted to their current unit from medium secure care, with 24% admitted from high secure care and 20% admitted 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 been referred unsuccessfully to less secure services in the previous 5 years.

The most common single diagnosis was schizophrenia, with a prevalence of 58%; about one-third of patients with schizophrenia were considered treatment resistant. The second most prevalent diagnosis was personality disorder (47%), the most prevalent type being antisocial followed by borderline, and 17% had an intellectual 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.

While the majority were violent offenders, about one-fifth had a sexual index offence and 17% had no index offence. A high proportion of long-stay patients had a history of arson, and one-quarter had convictions within institutions. Figures for recent incidents and seclusions were high. Historical Clinical Risk Management-20 (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.

Ninety per cent 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 five 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 a level of security; for medium secure care, according to their consultants, about one-quarter each were judged to be detained in settings with too high or too low levels of security. Only a minority of patients were expected to be in the community in 5 years' time. Patient factors (e.g. psychopathology) were judged to be more important than political or

service provision factors in impeding movement to less secure settings. Few meaningful predictors were found to identify those judged to require lifelong 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 were (1) factors attributed to long stay, (2) outlook towards secure care, (3) approach adopted in daily life and (4) readiness for change and progression. A narrative analysis approach was used to further scrutinise the way in which each participant positioned him- or herself in relation to each of the emergent themes. This 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 described actively trying to progress in order to leave secure care. The acceptance and resistance variables illustrate the extent to which participants believed that they were in hospital to be treated and that the secure care system was helping them to get better. These stances revealed differences in the 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 thereof) 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 in such countries, with patients granted greater freedoms and autonomy. Patients in these services are able to return to the 'normal' system and often do so when they feel ready to progress.

### **Stakeholder perspectives**

Tensions were created for staff in balancing the aims of rehabilitation and recovery in a context in which patients are detained against their will in a regime that applies pressure on them to comply with therapeutic interventions. 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, for a substantial minority of patients, this may not apply. Almost all doctors appeared to conceptualise the process in terms of an 'admission, treatment, rehabilitation, cure' trajectory, with little or no acceptance that not all patients would fit this model.

The incentives within the system were identified as acting as a barrier to the provision of care that would best meet patient needs. An emphasis on managing risk creates disincentives to take patients from other facilities that have higher levels of security. Furthermore, payment for capacity as opposed to hospitals being paid for their actual level of activity undertaken ('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 of patients into the community. The existing arrangements were also reported as creating little incentive for providers to innovate, particularly when 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 among themselves that some patients would not 'recover'. This is reflected in a reluctance to use the term 'long stay' for such facilities and the use of terms such as 'enhanced recovery' instead.

## **Conclusions**

A significant proportion of forensic psychiatric patients are detained in highly restrictive settings for lengthy periods of time, potentially for longer than 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 will not be met. Both the ways in which services are commissioned and funded and staff attitudes might hinder service improvements. Key factors identified in the provision for long-stay patients included a stable environment allowing for 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 stays, 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
- conduct an economic evaluation of pathways, identifying inefficiencies through delay and repetition and comparing forensic provision with that provided in other countries.

## Study registration

Comprehensive Clinical Research Network Portfolio 129376.

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