Out of sight, out of mind?
Long-stay in forensic-psychiatric settings

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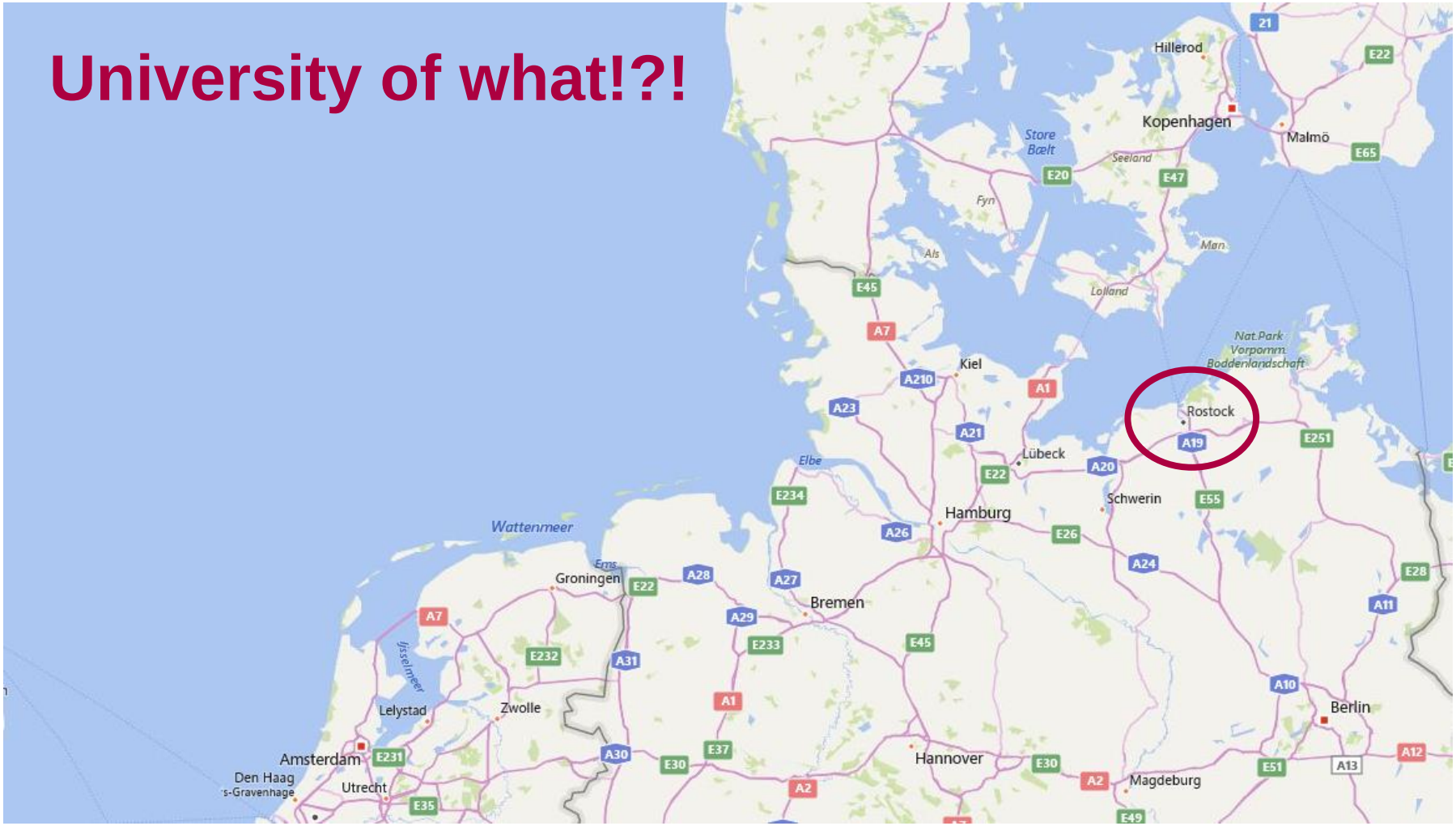
University of what!?!



Outline

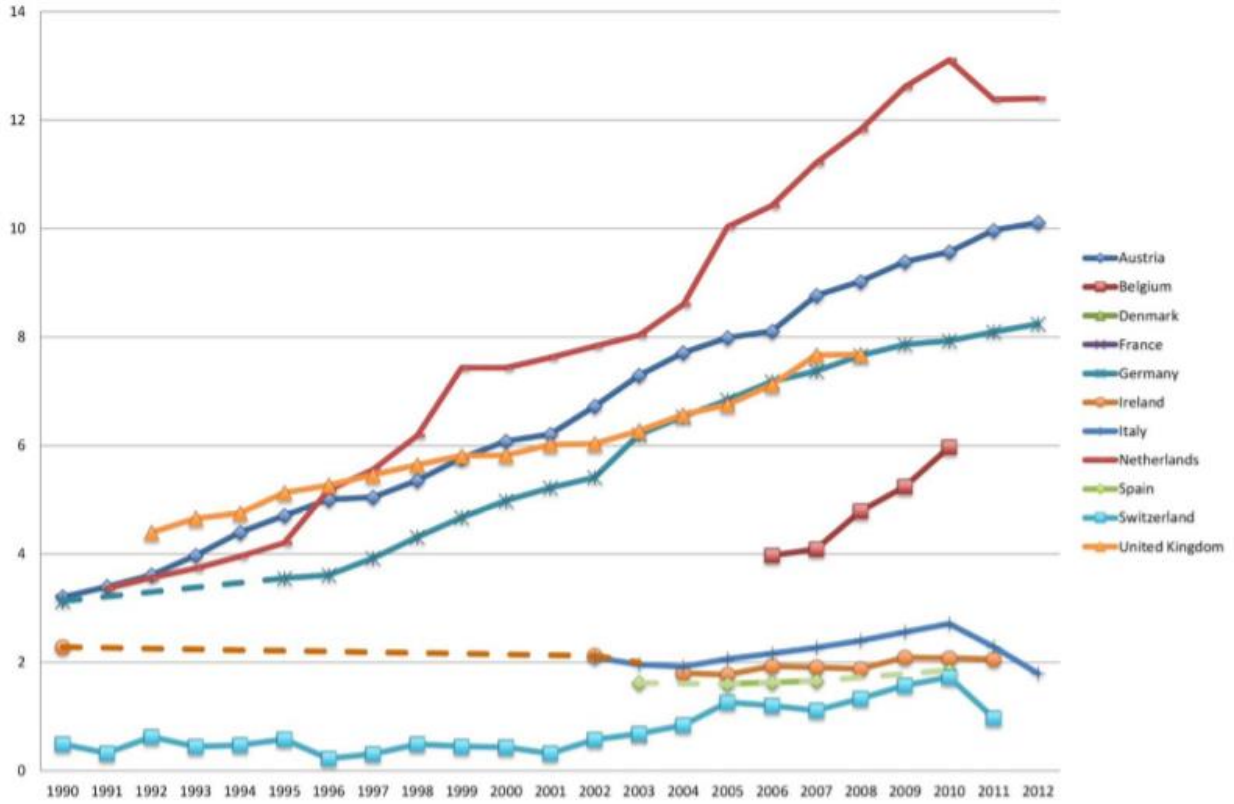
- Long-stay?
  - Definition
  - Measurement
- UK study
  - Prevalence of long-stay
  - Characteristics of long-stay patients
  - Patient experience of long-stay
  - Staff views on long-stay
- Key ethical issues
- Long-stay in different European countries
- Discussion

How long is (too) long?

- No generally accepted definition
- Should it be …
  - An actual time period (X years) – advantage: easy to measure, but comparison?
  - Be related to the average of this country / hospital / patient group?
  - A more general definition?
- E. g. COST Action
  - *“Forensic psychiatric inpatients with needs for security and care who are not able to safely progress to a level of lower security due to internal and/or external factors ”* – but: difficult to apply, e. g. in research

Bed numbers over time

Figure 3 Forensic beds per 100 000 inhabitants from 1990 to 2012.



Chow & Priebe, 2016

Does LoS increase?

Table 2 Median duration of admission of patients in the medium secure unit in each of the years included in the study. The minimum and maximum duration of stay are also included

	Year			
	1985	1995	2005	2012
Median duration of admission, days ± s.d.	167 ± 299	114 ± 425	110 ± 566	580 ± 453
Minimum duration, days	1	1	3	3
Maximum duration, days	1662	1952	2297	Unknown[a]

a. The maximum duration is unknown for this cohort owing to ongoing admission.

(Earnshaw et al., 2019)

Need for long stay?

- 1990ies: one to two thirds of high secure patients do not need high secure care – inadequate provision of medium secure beds? (e.g. Maden et al., 1993; Reed, 1997; Dept. of Health, 2000) → accelerated discharge programme
- Average LoS at discharge: about 8 years – mostly to medium secure care
- Initially recommended for LoS of up to 2 years (Butler, 1975)
  - BUT: LoS increasing, 10 – 20% over 5 years
- Do some patients require long-term (life-long?) forensic care? Who are they?
  - Clinical experience: subgroups with different needs
- Need for strategy / designated units?

Why does it matter?

- Quality of Life
  - High secure care = highly restrictive
  - Same procedural and physical security for those just admitted and those resident for decades
  - ? Interventions / Environment offered not appropriate for long-term care
- Economic Case
  - Cost per patient in medium secure care: £175 000 per year
  - Cost per patient in HSS = £275 000 per patient/year; over 10 year period = £2.75 million
  - 1% of the entire NHS and 10% of the mental health budget (Rutherford & Duggan, 2007)

UK Long-stay study

- Collaborators
  - Birgit Völlm (PI)
  - Vivek Furtado (quantitative)
  - Tim Weaver (qualitative)
  - Ruth McDonald (economics, service change)
  - Peter Bartlett (legal, ethics)
  - Jeremy Coid (epidemiology)
  - Conor Duggan (private providers)
  - Julie Hall (NHS management)
  - Eddie Kane (policy)
  - Peter Bates (service user involvement)
- Research assistants
  - Rachel Edworthy
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  - Shazmin Mazid
  - Jessica-Rose Holley
- Stats support
  - Boliang Guo
  - Laurie Hareduke
- CRN staff
- Study Steering Group
- Service User Reference Group
- Participating sites

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Crash course on UK forensic services

- High, medium, low secure
- Criminal responsibility not entry criterion
- No substance abuse disorder as main disorder
- Can be admitted without offence

Definition

- ‘Long-stay’
  - > 10 years: high secure care
  - > 5 years: medium secure care
  - > 15 years: mixed settings
- Continuous stay in medium/high secure care
- From admission to 1.4.2013

Participating units

- All 3 high secure hospitals

Broadmoor	196
Rampton	329
Ashworth	190
Total	715

- About 2/5 of medium secure units

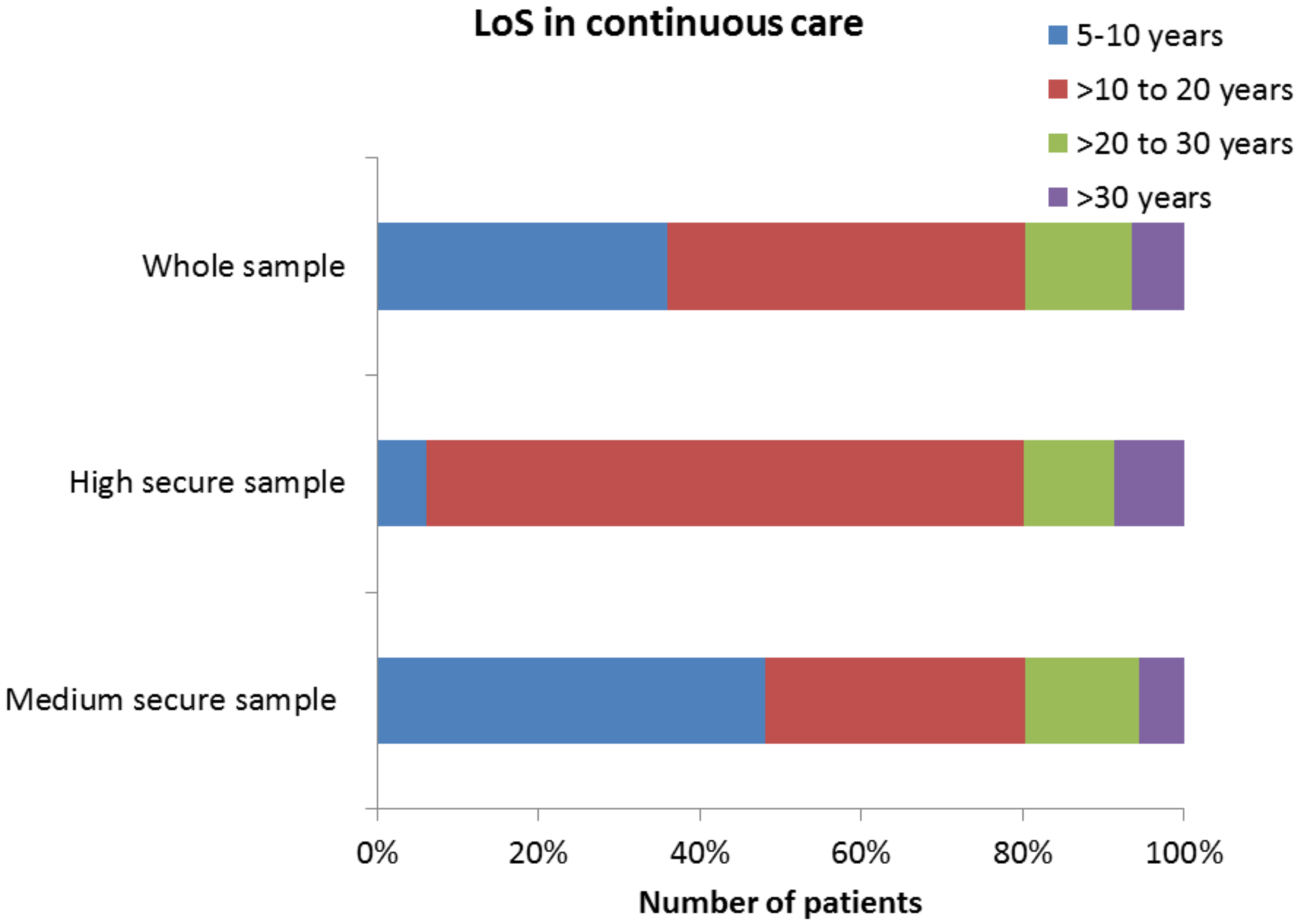
NHS (14)	1093
Independent (9)	479
Total (23)	1572

Prevalence of long-stay (% long-stayers)

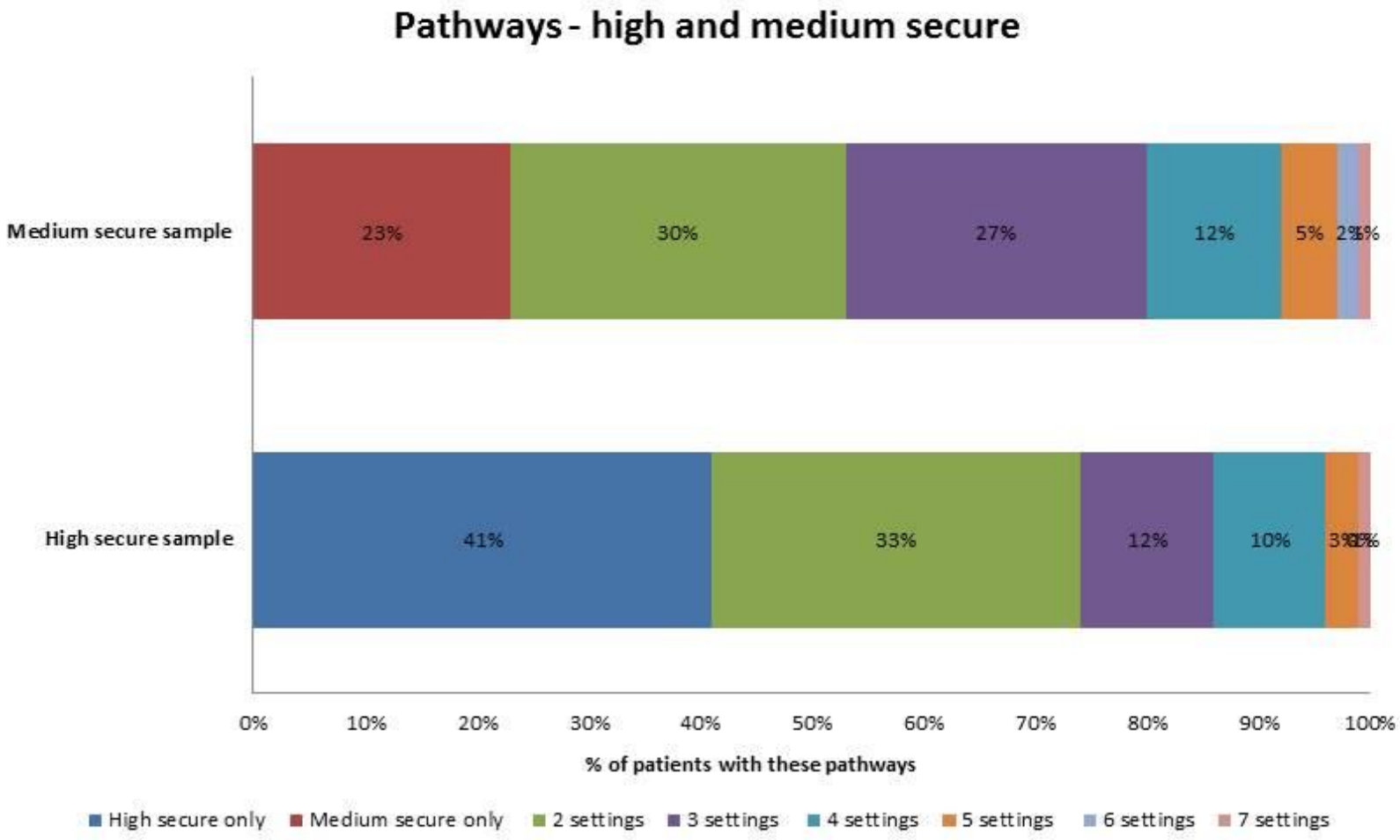
- High secure care: 168 / 715
  - 23.5% (range 21.6 – 26.5)
- Medium secure: 285 / 1572
  - 18.1% (range 0 – 50)

Long-stayers vs. non-long stayers

- Long-stayers are
  - older (high secure 45.5 vs. 36.1; medium secure 43.9 vs. 34.7)
  - more likely to have been admitted from other mental health setting, less likely from prison
  - high proportion of ID patients in long-stay group
- No difference in
  - gender
  - ethnicity


LoS in continuous care
5-10 years
>10 to 20 years
>20 to 30 years
>30 years
Whole sample
High secure sample
Medium secure sample
0%
20%
40%
60%
80%
100%
Number of patients

Long-stayers: Pathways



Long-stayers: Sociodemographics

Sociodemographic variable	Whole sample	High security	Medium security	Statistics
	N = 401	N = 116	N = 285	Z, χ^2 p-value
Male	345 (86%)	105 (90.5%)	239 (83.9%)	n.s.
Age [mean]	44.5	45.6	44	n.s.
Over 50 yrs	127 (31.6%)	34 (29.3%)	93 (32.7%)	n.s.
Ethnicity: White	313 (78.6%)	95 (81.9%)	218 (77.3%)	n.s.
Never married	329 (85.5%)	93 (87.7%)	279 (84.6%)	n.s.
No qualifications	241 (66.0%)	62 (69.7%)	179 (64.9%)	n.s.
Ever employed > 6 months	136 (39.3%)	27 (31.4%)	109 (41.9%)	n.s.

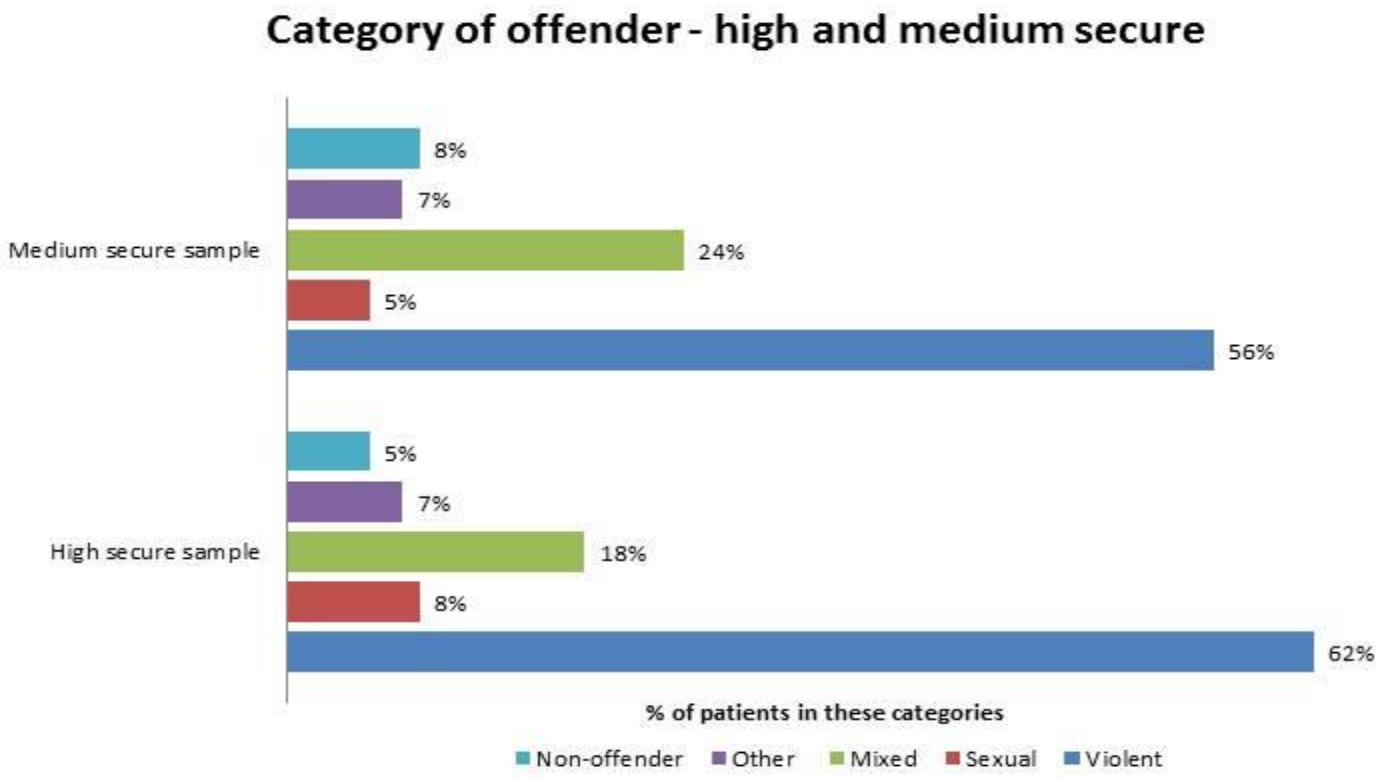
Long-stayers: Psychiatric history

Variable	Whole sample	High security	Medium security	Statistics
	N = 401	N = 116	N = 285	Z, χ^2 p-value
Age first psychiatric admission [mean]	21.8	21.3	22.0	n.s.
Previous admissions to psychiatric care	67.8%	63.8%	69.5%	n.s.
Previous admissions to secure case	46.4%	51.3%	44.4%	n.s.
Previous admissions to high secure case	13.1%	22.4%	9.3%	χ^2=12.39 p<0.001
History of self-harm/suicidal	63.8%	69.8%	61.4%	n.s.
History of serious suicide attempts	35.3%	46.1%	31.0%	χ^2=8.17 p=0.004

Long-stayers: Current diagnoses

Variable	Whole sample	High security	Medium security	Statistics
	N = 401	N = 116	N = 285	Z, χ^2 p-value
Specific diagnoses				
Schizophrenia	57.9%	53.4%	59.6%	
of which treatment resistant	32.8%	40.3%	30.0%	
Personality disorder	46.7%	50%	45.4%	χ^2=4.32 p=0.038
of which antisocial	68.3%	78.9%	63.6%	χ^2=4.83 p=0.028
mixed (two or more types)	39.2%	50.9%	33.8%	
Physical health				
Any serious physical health issue	71.7%	80.2%	68.2%	χ^2=5.81 p=0.016
Obesity	37.3%	52.6%	31.1%	χ^2=16.24 p<0.001
Diabetes	27.6%	27.6%	27.6%	
Other	26.6%	36.2%	22.6%	χ^2=7.79 p=0.005

Long-stayers: Offence types



Long-stayers: Intra-institutional behaviour and risk

Variable	Whole sample	High security	Medium security	Statistics
	N = 401	N = 116	N = 285	Z, χ^2 p-value
Any conviction for violence/sexual in institution [mean]	26.9%	41.4%	21.1%	χ^2=17.31 p<0.001
Of those in past 5 years [mean]	31.5%	31.3%	31.7%	n.s.
Serious incidents in past 5 years [mean] Assault on staff Assault on others Serious self-harm Seclusion episode	 25.7% 27.7% 11.6% 44.3%	 42.1% 33.3% 15.8% 67.5%	 19.1% 25.4% 9.9% 35.0%	 χ^2=22.56 p<0.001 χ^2=34.91 p<0.001
HCR 20 [mean] ***Total*** ***Improving*** ***Stagnation*** ***Deteriorating***	 27.0 39.4% 31.9% 28.7%	 25.5 20.7% 48.3% 31.0%	 27.3 46.2% 25.9% 27.8%	 Z=2.05 p=0.041 χ^2=11.57 p=0.001 χ^2=9.73 p=0.002

Long-stayers: Current treatment

Variable	Whole sample	High security	Medium security	Statistics
	N = 401	N = 116	N = 285	Z, χ^2 p-value
Psychotropic medication *Any* *Clozapine* *Depot* *Three or more psychotropics* *Non-compliant*	 91.0% 44.1% 22.1% 17.3% 16.1%	 91.4% 41.2% 18.4% 17.5% 22.8%	 90.9% 45.6% 23.7% 17.3% 13.4%	n.s.
Psychological therapies ***Any current*** *Previously but not current* *Never*	 51.1% 36.9% 12.0%	 58.6% 31.9% 9.5%	 48.1% 38.9% 13.%	n.s.
Monitoring (high secure) ***Phone*** ***Mail***	N/A	 12.9% 20.7%	N/A	N/A

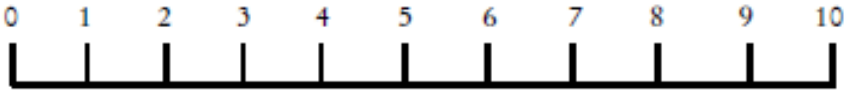
Patient views

Table 1 Summary of long stay stances

Theme	Long stay stance			
	Dynamic acceptance (14 participants)	Static acceptance (12 participants)	Dynamic resistance (nine participants)	Static resistance (five participants)
Outlook	Positive outlook towards being in secure care; believed their mental health had improved whilst in secure care	Positive outlook towards being in secure care; believed their mental health had improved whilst in secure care	Negative outlook towards being in secure care; feeling bored, restricted and frustrated	Negative outlook towards being in secure care; feeling bored, suffocated and a sense of pointlessness
Approach	Proactive approach; stressed the importance of keeping busy and making the most of their time by engaging in occupational activities and therapies	Proactive approach to occupational activities; less willing to take part in therapies that they found ineffective	Proactive approach to engaging in occupational activities and therapies that, although thought repetitive and pointless, would ultimately help them to move on	Passive approach to daily life; choosing not to engage in any occupational activities or therapies
Attribution (for their long stay)	Being unwell; their own behaviour	Their own behaviour; being on the wrong medication; being in a non-therapeutic environment	Risk-averse factors that left them feeling unable to prove themselves to staff	Interpersonal and structural factors outside their control
Readiness for change	Believed that they did not need to be in secure care; felt ready to move on to lower secure units	Believed that they were not ready to move on from their current unit	Believed that they did not need to be in their current unit but were stuck	Believed that they did not need to be in secure care but that they had no choice and so chose to remain

Consultant views: Life long medium/high secure care

How likely is it that the patient will remain in a high or medium secure setting for the rest of their life?



Highly likely

Very unlikely

- Score 0 – 5 (= greater likelihood)
  - 66% high secure (n = 31)
  - 32% medium secure (n = 37)

Moving to?

Table 3 Discharge location of patients discharged from our medium secure unit (MSU) in the 1985, 1995, 2005 and 2012 admission cohorts

Discharge location	1985	1995	2005	2012
Police custody	0 (0%)	0 (0%)	0 (0%)	1 (3%)
Prison	5 (10%)	7 (11%)	6 (16%)	3 (10%)
Low secure psychiatric hospital	5 (10%)	4 (6%)	8 (22%)	10 (33%)
Other MSU	0 (0%)	2 (3%)	1 (3%)	5 (17%)
High secure psychiatric hospital	4 (8%)	5 (8%)	1 (3%)	1 (3%)
Remained in our MSU	0 (0%)	0 (0%)	0 (0%)	4 (13%)
Supported accommodation	8 (17%)	28 (43%)	10 (27%)	2 (7%)
Home	26 (54%)	17 (26%)	9 (24%)	4 (13%)
Died	0 (0%)	0 (0%)	2 (5%)	0 (0%)
No information	0 (0%)	2 (3%)	0 (0%)	0 (0%)

(Earnshaw et al., 2019)

Consultant views: Reasons for not moving on

High secure

1. Psychopathology
2. Risk
3. Personality traits
4. Patient anxiety
5. Institutionalisation
6. Lack of suitable facilities
7. Media attention

Medium secure

1. Psychopathology
2. Risk
3. Personality traits
4. Institutionalisation
5. Patient anxiety
6. Lack of suitable facilities
7. Media attention

Senior clinicians/commissioners: Themes

- Factors preventing step down/discharge
  - Patient characteristics
  - Organisational issues (MoJ, siloed working, communication)
  - Perverse incentives
  - Custom & practice
  - Idiosyncrasies of teams
- Medical model
  - Disorder – cure – discharge
- Reluctance to accept ‘defeat’
- Importance of hope

Senior clinicians/commissioners: Themes

- Reluctance to accept term/concept of ‘long-stay’
- ‘Language games’ (long-stay in disguise)
  - Slow stream
  - Rehabilitation
  - Continuing care
  - Enhanced recovery
  - Personality focused recovery service
- Objections to ‘long-stay units’
  - Fears about ‘warehousing’
  - Staff and patient moral
- Some positive examples with ‘long-stay’ wards
  - Smaller
  - Staff specifically interested in this group
  - High profile – staff aware
  - Less change on ward
  - Positive patient experience - improvement

Key ethical issues

- Legal
  - Discrimination against those with mental disorder (against CRPD)
  - Focus on risk to others
- System failure
  - Too complex
  - Not enough flexibility to accommodate individual needs
  - False hope
  - Effectiveness?
  - Giving up on people
- Quality of life
  - Too restrictive setting

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ORIGINAL PAPER

Check for updates

Forensic mental health in Europe: some key figures

Jack Tomlin[1] · Ilaria Lega[2] · Peter Braun[3] · Harry G. Kennedy[4,5] · Vicente Tort Herrando[6] · Ricardo Barroso[7] · Luca Castelletti[8] · Fiorino Mirabella[9] · Franco Scarpa[10] · Birgit Völlm[1] · the experts of COST Action IS1302

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Long-stay in Europe

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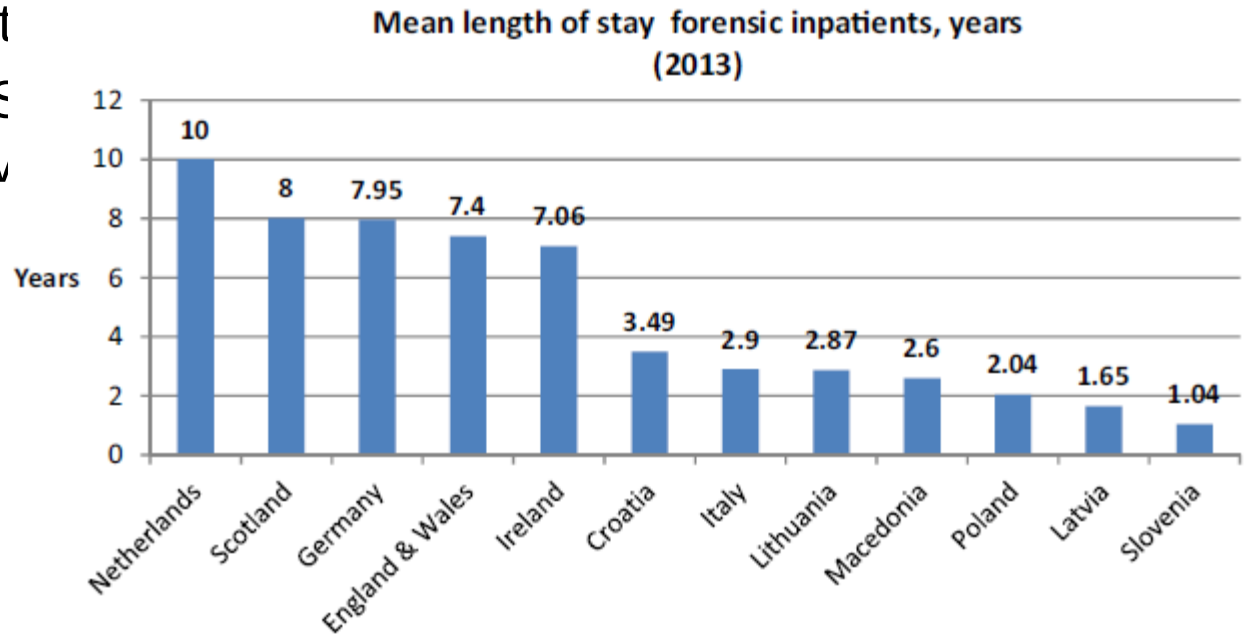

Italy

- 1978 “Basaglia law”: Closure of psychiatric hospitals, replacement by community mental health care
- 2008: Forensic services incorporated into National Health Service
- Concerns about the state of forensic hospitals (CPT)
- 2014: Law mandating the development of secure residential units for forensic patients (REMS)
- Closure of 6 forensic hospitals completed in 2017
- Currently 30 REMS with about 600 beds (about 1000 in old system)
- REMS
  - In community
  - Up to 20 beds
  - Focus on rehabilitation
  - High turn over

Conclusion: Vive la différence …