LENGTH OF STAY REPORTING IN FORENSIC SECURE CARE CAN BE AUGMENTED BY AN OVERARCHING FRAMEWORK TO MAP PATIENT JOURNEY IN MENTALLY DISORDERED OFFENDER PATHWAY FOR OPTIMAL RESULTS – PART II

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ABSTRACT

Single episode admissions in Forensic Psychiatric care have enquired into 'Length of Stay' in Hospitals, with different methods of calculating this, and the determining factors from patient data per se were reported in paper I. There is a growing recognition of the negative effects of environmental factors, interpersonal dynamics and the prolonged restrictive stay in secure care as detrimental to patient recovery. Effectiveness of treatment interventions for mental disorders and risk reduction has been lately reviewed and is a growing ground for research. Effective Patient and Carer reengagement, facilitating social return and successful collaboration between agencies and services are now recognized to enable successful discharge from secure care hospitals in addition to reducing recidivism.

In this paper (Paper II), literature review identified 7key components impacting Length of Stay which we describe as secondary factors and integrate them into a proposed framework for reporting Length of Stay.

***KEYWORDS:** Continuity of Care, Improving Outcomes, Mentally Disordered Offender, Pathway, Accommodation Model, Framework, Transitions, Key components of Length of Stay, Key determinants of Length of Stay,Treatment effectiveness, Secure Care, Forensic Psychiatry*

INTRODUCTION

Studies have so far used 'Length of Stay' in Secure Care hospitals as a proxy for reporting various outcomes of secure care delivery (clinical, recidivism and financial). Our thematic appreciation of literature on the key components that determine experience and outcomes; which in turn affects Length of Stay in secure care pathway, showed the following themes of research:

- Chronic illness care and recovery

- Patient and Carer autonomy and self-efficacy in managing their conditions and risks to the public.

- Effectiveness of interventions

- Evidence Based Medicine and Evidence Based Systemic Practise

- Evaluation of therapeutic relationship and therapeutic environments

- Challenges to smooth transitions of care upward/downward/sideways or by Age and Gender

- Continuity of care / Collaborative outcomes achieved by co working of agencies and services

It is important to consider variables related to the time before the current treatment, treatment-related variables, and variables related to the follow-up to identify patients at risk of criminal recidivism after discharge from forensic treatment (CS, n = 249) (Probst et al., 2020).There is significant literature on the rise regarding the 7 key themes identified in our review, but is currently not integrated into Length of Stay studies. The first European study on external factors impacting long term care in forensic psychiatry involved a SWOT analysis of regional representatives for long-term forensic care. They identified Care & Treatment pathways (admission criteria, discharge pathways & community integration), Resources (funding, facilities & quality staff), Legal frameworks & Systemic Factors, and Sharing Expertise (collaboration, standards & guidelines, & research) as the critical factors (Connell et al., 2019). Moreover, some of these determinants are difficult to evaluate quantitatively and establish its causative association with LoS. In this paper (Paper II), we endeavour to bring these 7 themes into a framework under study for LoS (See Table 2 in the end).

BACKGROUND

In Paper I, we provided a thematic analysis of factors identified from key Length of Stay studies in secure care. The published literature focuses on patient data per se for a given episode of admission. The 7 themes were: sociodemographic factors, criminal history, psychiatric history, index offence, clinical variables, treatment variables and risk variables (Paper I - Table 1. Factors prolonging, reducing or having ambivalent reporting outcomes on LoS). A rapid review (Vollm et al., 2017) and machine learning (Kirchebner et al., 2020) model both pointed to the nature (homicidal and sexual) and severity of index offence as the key determinants among other potential factors (we provided a thematic analysis of these 7 themes in Paper I) driving Length of Stay per admission episode. Individuals admitted in the secure care system in earlier years had slower rates of discharge compared to more recent admissions. Patients having comorbid substance use or personality disorder or neurological disorder or having committed a severe violent offence increased their stay duration in hospital (CRS, n = 2533, over 25 years) (Penney et al., 2018).Methods described to reduce LoS in secure care hospitals compiled from Nagtegaal et al., 2011 & Huband et al., 2018 include:

- Willingness to grant conditional discharge

- Extend the maximum duration legally allowed for conditional discharge

- Improve supervision & aftercare programmes on leaving secure hospital settings

- Empower & support general psychiatric services to receive ex-forensic patients earlier in care

- Design, staffing provision and activities for longer stay patients have a significant impact on social environment reducing adverse behaviours and thus facilitating discharge

However, the above data is focusing on the patient data per se in the given episode of admission, and is not able to capture the contextual, historic and settings factors, softly but probably significantly contributing to overall time spent in secure care pathway and the meaningful outcomes achieved. There is a growing recognition to triage, prioritise and focus interventions in chronic care models that considers the environment and stage of treatment. Some are advocating that Forensic treatment planning should prioritize forensic outcomes, such as restoration of trial competence or mitigation of violence risk, as the first steps in a continuum of care that eventually leads to the patient's ability to resolve forensic issues

and return to the community for recovery-oriented care (Schaufenbil et al., 2015). A lack of clear treatment standards that address all aspects of forensic care can lead to inefficient or inappropriate interventions and contribute to institutional violence; therefore, forensic interventions should be prioritised in secure care settings(Warburton, 2015).We conceived a model of throughput across providers in an interdependent manner (indicating that slack at one point can lead to congestion at another), possibly challenging the culture and boundaries of current practices, and hence advocated for a need prioritised, evidence-based provision, of tiered service across providers (Figure 4, Paper I).

METHOD

This Literature Review has attempted to gather a representative broad view of developments in Mental Illness, Recovery, Risk Reduction, LoS, Experiences (patient, carer and professional stakeholders) and Recidivism (prioritised references have often included comparative reporting from developed world countries where specialised services for Forensic Psychiatry and continuity of care exists) in order to find significant links across Services and Disciplines, and prioritised evidence in the below order (Figure 1)
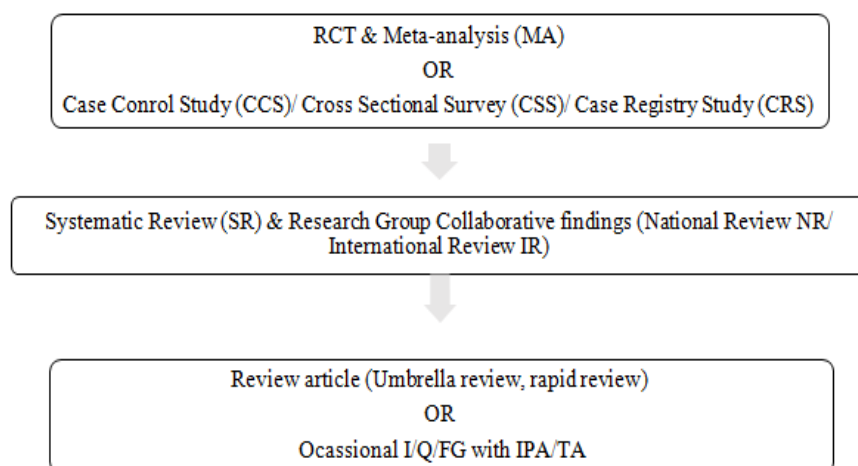
I = Interview, IPA – Interpretive Phenomenological Analysis, Q = Questionnaire, FG = Focus Groups

Figure 1: Studies included in Review.

RESULTS

Chronic Illness Care and Recovery

Chronic conditions account for $^{7}/_{10}$ of primary care presentations (Veale 2003 as cited in Cal et., al, 2015) and resilience plays an important role in the process of illness and outcomes of health (SR, n = 12) (Cal et al., 2015). However, resilience is in turn made of several other personal attributes and these are already strained in patients with mental illness. About 24% of pretrial prisoners have chronic health problems (Wermink et al., 2016) but most are younger age adults in comparison to the general population where chronic illness is mostly related to increasing age. About $^{1}/_{3}$ of mental illnessis treatment resistant (multiple systematic reviews), ~ 55% of secure care patients receive antipsychotic polypharmacy (CSS, n = 142) (Farrell & Brink, 2020)and ~ 50% of patients with major psychiatric disorders are non-compliant to prescribed psychotropic medication (SR & MA, n = 46) (Semahegn et., al, 2020). Interestingly, the non-compliance estimate in children & adolescents with severe mental illness is also > 50% (Edgcomb & Zima, 2018). In contrast, non-compliance to medication in medical chronic diseases is 40 – 50% (Kleinsinger, 2018). A Swedish National registry study of postmortem

toxicological analysis showed 46% adherence to prescribed medications with ~70% for antidepressants and ~ 21% for cardiovascular drugs (Forsman et al., 2018). Fixed dose combination, dosing frequency, reminders, refills, pill-counts, depot injections have all shown improved adherence to medications.

Health literacy improves adherence to treatment by ~ 16%, higher reported effect size by subjective measures, and the effect size is even higher in disadvantaged groups (Miller, 2016). Insight into mental illness has a complex interrelationship with disease characteristics and health outcomes (Lysaker et al., 2018). Unawareness of illness/symptoms (anosognosia/lack of insight) is common in neurological and psychiatric conditions especially with neurovascular or brain injury damage and secondary neurodegenerative changes of functional mental disorders (David et al., 2012). Please refer to (Thirioux et al., 2020) for a detailed discussion on insight (into mental illness, index offence, offending behaviour, remorse, empathy, Theory of Mind, reflection, metacognition etc) as the interrelated concepts are all crucial determinants of compliance to medications and engagement in psychosocial interventions for illness and risks, impacting on the duration of secure care delivery.

Patient experience and engagement in the improvement of chronic care needs changes at the macro (systems), meso (organizational) and micro level (patients' involvement in their own care and how to manage deep-rooted expectations and ideas about who does what and how) (Granström, 2021). Chronic illness care requires therapeutic relationship (patient perspective on their illness, transference, individualised care plans), effective team dynamics (appreciation of roles & boundaries, interpersonal behaviours & attitudes, openness to ambivalence), and focus on wider system (disease prevention & health promotion, empowering patients & carers, developing services, & effective interagency/department liaison). In forensic psychiatry, mismatch between healthcare providers' and patients' beliefs and expectations, may undermine collaborative care. Reflective practice directed at understanding personal and system responses to chronically ill patients may optimise collaborative care (Campbell & McGauley, 2005).

An Australian study of patient working party on recovery experiences in forensic psychiatry showed denial, despair, hope, acceptance, willingness, responsible action and a meaningful life contributing in a community as the key steps to recovery (I, MM, DS) (Davey & Dempsey, 2012). Patient's perception of recovery in forensic mental is about their experience of connectedness, treatment, sense of self, past experiences, freedom, hope and health. The adoption of a recovery tool 'My Shared pathway' was examined in UK where patients described care in secure hospitals as a journey, their vulnerabilities in it, their relationships with staff, loss and hope (SR, TA & IPA, n = 11 for SR & n = 6 for IPA) (Clarke, 2014). Patients identified safety and security as a necessary base for the recovery process, the dynamics of hope and social networks in supporting the recovery process and work on identity as a changing feature in the recovery process (SR & TA, n = 5) (Shepherd et al., 2015). Patients described knowing what they needed in order to recover: to find meaning in existence, to be treated as a person given the impersonal context, and to be empowered in their restricted life (I & TA, n = 11) (Marklund et al., 2019).

Coproduction is considered as central to delivering person-centred care (National Institute for Health and Care Excellence, 2016 as cited in Webb et., al, 2021), defined as a process of multidisciplinary collaboration between patients, staff and stakeholders as equal partners with complementing knowledge (Webb et., al, 2021). There are several best practice examples for collaborative and coproduced care (ex: QNFMHS aggregated annual reports in England and Wales)

Since addiction is a major problem in secure care pathway, both causative and maintenance, for mental illness and recidivism; this area of patient experience was measured in Addiction services in Canada. It identified patient-centred care, treatment effectiveness, staff behaviour, availability and coordination of care, and communication as the key patient requirements (Q, FA, n = 1222) (Currie et al., 2020). Treating substance misusing patients involuntarily, led to their lower health and social functioning, and they sought discharge against medical advice twice as frequently as voluntarily admitted substance misusing patients, and their treatment against their wish is not sustainable (CRS, n = 608) (Habermeyer et al., 2018). Patients needed specific work assistance in each aspect of a Norwegian recovery model rather than each domain of recovery sorting itself out (CCS, MM, n = 20 patients & 141 staff) (Hauso et al., 2021).

Patient and Carer Autonomy and Self-Efficacy in Managing their Conditions and Risks to the Public

In General Psychiatry detentions, patients' perceived autonomy and participation in decisions for themselves, their feeling of whether or not they are being cared for, and their sense of identity were expressed both positively and negatively when detained (SR & TA, n = 5) (Katsakou & Priebe, 2007). Patients had ambiguous experiences in their judicial trajectory (I & TA, n = 11) (Aga et al., 2017). They experienced barriers to admission, felt without a voice, passive in the decision-making process with little support during transitions and the indeterminate duration of care trajectories, contributed to overall negative lived experiences. The balance between a criminal justice and mental health approach in forensic mental health care is questioned (I & TA, n = 23) (De Pau et al., 2020). In order to answer some of this negativity of patients in secure care, their perceptions of coercion, fairness and legitimacy impacting their level of treatment engagement, risk for adversity and progress in recovery is being investigated (MM, n = 120+) (Simpson et al., 2020).

Coercion in psychiatric care may seem intuitive due to compulsory admissions needing treatment and care for severe mental illness, likely impact on capacity to make decisions, risks to self and others; however, up to three-quarters of psychiatric patients, including individuals with serious illnesses such as schizophrenia or bipolar disorder may have capacity to make medical decisions in the context of their illness, have capacity to judge risk-reward situations, and to adequately decide about the important treatment outcomes, and most are able to make rational decisions about their healthcare. Decisional capacity impairments in psychotic patients are temporal, identifiable, and responsive to interventions directed towards simplifying information, encouraging training and shared decision making (Meta-review, n = 11 SR)(Calcedo-Barba et al., 2020).There are many types of coercive measures in psychiatric practice – covert, oral medication, physical restraint, chemical restraint, mechanical restraint, and seclusion. Covert measures can range from subtle suggestions to alarms, special observations, medications mixed in food etc and are difficult to measure. The other overt measure rates differ across countries, and mechanical restraint and seclusion are banned in some countries. The data measured are heterogenous and not all categories are reported, making comparisons difficult. If the coercive practice in one domain is lower, practices in other domains are usually higher. However, most countries have measured their coercive practices in psychiatry. The range of practices is shown in Table 1 below.

(Q) (Horvath et al., 2018), *(SR, n = 13) (Steinert et al., 2009),*(SR, n = 48)*(Muir-Cochrane et al., 2020)*

Table 1: Range of Coercive Measures Across Countries as a Percentage of Psychiatric Admissions

Covert Measures	Oral Coerced Medication	Physical Restraint	Chemical Restraint	Mechanical Restraint	Seclusion	Any coercive measure (excluding covert and oral medication)
X - 70%	Unknown	2.5% - 7.3%	2.7% - 7.6%	1.2% - 8%	0.03% - 15.6%	8% - 36.3%

In General Psychiatry, patients' experience of coercive measures depends upon the provision of information, contact and interaction with staff, adequacy of communication with professional, humane treatment, respect, staff support, debriefing, quality of the working and physical environment, and some individual and treatment variables (SR & TA, n = 34) (Aguilera-Serrano et al., 2017). Physical restraint is more common in intensive care environments. The likelihood of physical injuries in restraint process is 0.8 - 4%, commonest cause of death is cardiac arrest by chest compression or strangulation, and pulmonary thromboembolism(SR, n = 67) (Kersting et al., 2019). Seclusion episodes are more common with female patients, younger age of patient, and early in admission, in addition to behaviours leading to seclusion episodes (CRS, n = 990) (Cullen et al., 2016).

In Forensic psychiatry, 70% of patients report experiencing coercion to take medication and this was influenced by their attitude towards medication and the degree of insight into illness, to a lesser extent by symptom severity (Q) (Horvath et al., 2018). Theyexperience5 times more overt coercion in comparison to general psychiatry counterparts (seclusion, mechanical restraint, room confinement or involuntary medication). The long duration of coercive measures in forensic psychiatry probably reflects their risk of violence (CRS, CCS & FA, n of secure care = 1,049, n of general psychiatry = 115,011) (Flammer et al., 2020). While implementing the guidelines of the Committee for Prevention of Torture, although the total number and duration of coercive measures showed a reducing trend, a few patients were not responsive to deescalating interventions, increasing the average measures of the institute due to outlier effects (CRS, n = 1000) (Lau et al., 2020). Factors affecting coercive practice in secure care when studied with a machine learning model, as many as 569 potential predictor variables were initially identified but the key determinants were: Threat of violence, (actual) violence toward others, the application of direct coercive measures during past psychiatric inpatient treatments, poor impulse control, uncooperativeness, hostility, total PANSS-score at admission, prescription of haloperidol during inpatient treatment, daily cumulative olanzapine equivalent antipsychotic dosage at discharge, and the legal prognosis estimated by a team of licensed forensic psychiatrists (CCS, n = 131 cases & 227 controls) (Günther et al., 2020).

Patients preferred intermittent observation, time out and PRN medication over other intrusive methods and they least preferred locked-door seclusion and coerced IM medication. Staff disapproval for more coercive measures increased with experience and male staff were more involved and showed higher approval in coercive methods(Q, MM, n = 2587) (Whittington et al., 2009). Personal opinions seem to be a major factor when choosing one method over the other and the measure that is most familiar to the staff is what is preferred (Laiho et al, 2016). Patients don't perceive seclusion or mechanical restraint differently but they prefer a choice (RCT, n = 102) (Bergk et al., 2011).

Most patients accept the need for involuntary treatment but mostly express negative feelings, although some described positive effects of safety and security, protection, trust, helpfulness and a decrease of stimulation. It depends on their age and gender, and their adaptation to the illness and treatment system (Soininen et al, 2016). Restrictive practices in secure care are experienced by patients from an individual, institutional and systemic level. Restrictiveness was subjective and included such disparate elements as limited leave and grounds access, ownership of personal belongings and staff attitudes. The patients could perceive these interventions as caring or custodial (SR & TA, n = 50) (Tomlin et al., 2018). In the UK, restrictions on autonomy of patients in different levels of security using Forensic Restrictiveness Questionnaire (FRQ) was negatively correlated with quality of life and ward climate. Patients described the antecedent conditions, the restrictive phenomena, how they these were enacted, how the restriction was subjectively experienced and, the consequences of these restrictions. These patient experiences encourage us to rethink the unintended effects of placing individuals within secure hospitals (I & TA, n = 18) (Tomlin et al., 2019).

Patients describe seclusion mostly negatively as fear, neglect, abuse, and power struggle (I & IPA, n = 7) (Askew et al., 2019a). They express being vulnerable, disconnected and having a negative impact on their mental health (SR, n = 8) (Askew et al., 2019b). Even a year later, they describe memories of helplessness, tension, fear, and rage over the seclusion episode. However, 58% reported some positive effects such as contact with staff helping them in alleviating distress (RCT, Q, n = 102) (Steinert et al., 2013). The nature of interpersonal relationships between both parties (staff and patients) and their views on acceptability and justifiability, shapes their perception of care and treatment during their use (MM, I & TA) (Johnson, 2013). Patients rate the quality of support and seclusion environment lower than staff (Q, n = 268) (Lundqvist & Schroder, 2015). Seclusion rooms are designed poorly (SR) (Kaar et al., 2017). Recorrect in Netherlands is an IT interfaced wall screen in seclusion room that helps to calm the patient and maintain engagement(McCarthy et al., 2017).

Forensic mental health professionals should be aware of the relationship between perceived institutional restriction and psychopathology because it might influence treatment course and outcome (Q, n = 184) (Franke et al., 2019). Patients sometimes abscond from leave/escape from unit and several patient characteristics and socio-environmental factors underlying these events have been summarised (Bowers et., al 1998, 1999 as cited in Hearn et., al, 2013). Technologies such as CCTV, motion sensors and GPS tracking raise ethical concerns, patient objections and cost effectiveness considerations but have the potential to improve recovery outcomes and reduce length of stay (Tully et al., 2015)

Families of violent patients with illness feel traumatised even if they were not living with the patient. (CSS, n = 116) (Hanzawa et al., 2013). They describe raised levels of stress because of violence, dual stigma (offence and mental illness), disintegration of family relationships, public exposure due to media attention, and confrontation with the judicial system, these leading to isolation without help. They need psychosocial supports and timely access to clear and plain language information. Their strengths can be harnessed to help the patient (SR, n = 6) (Rowaert et al., 2016). They are ambivalent towards the judicial system, feel thatprison is an inappropriate place for MDO's, peg their hopes on mental health support and were fighting a losing battle, but were hopeful (I, n = 24) (Rowaert et al., 2017). In UK Secure care, theyemphasise the importance of communication and improving their knowledge of services, as methods of meaningful inclusion in treatment and recovery (FG, n = 2) (Sampson et al., 2019).

In a Swiss secure clinic, healthcare professionals felt that family was strength but most were broken families, not possible to trust; and they get in the way of patient's care. They felt that it was important to achieve a balance and control over the family; otherwise, family-oriented work would be impossible (I) (Hörberg et al., 2015). QNFMHS CCQI, quality network in Forensic psychiatry in England and Wales have produced a carer's toolkit addressing the carers needs and requirements in secure care pathway (RCPsych, 2018).

Commonly used risk assessment tools identify low risk individuals with high accuracy but their predictive validity is moderate at best. The number needed to detain is 2-4 and number safely discharged was 4-18 (SR & MA, n = 68) (Fazel et al., 2012). Shared decision making and Collaborative care in the area of risk assessment and management needs further research to identify the issues, barriers and complexities in implementing this aspect of care (Markham, 2020).

Effectiveness of Interventions

There are many knowledge gaps in forensic psychiatry and there is high risk of bias in the primary studies in secure care (SR, n = 38) (Howner et al., 2018). The European Psychiatric Association summarised the practices and effectiveness of

treatments in Forensic Psychiatry currently (Völlm et al., 2018). The relative risks are typically increased for all violent outcomes in most diagnosed psychiatric disorders compared with people without psychiatric disorders, with increased odds in the range of 2–4. Absolute rates of violent crime over 5–10 years are typically below 5% in people with mental illness (x2, excluding personality disorders, schizophrenia, and substance misuse), which increases to 6–10% in personality disorders and schizophrenia spectrum disorders (x3), and to more than 10% in substance misuse (x4) (SR & MA) (Whiting et al., 2020).Forensic Treatment Evaluation instrument in Netherlands showed that higher risk patients can show more treatment progress than lower risk patients (Q & FA, n = 240) (van der Veeken et al., 2018) and points to the need for careful secure care selection of patients to benefit from interventions.

Regarding occupation, patients expressed the need to have control over decision-making, help with motivation and support, and generating suggestions alongside as helping them (FG & TA, n = 26 patients in 5 groups) (Craik et al., 2010). The evidence base supporting occupational therapy in forensic mental health setting is relatively weak and consensus needs to be achieved about defining specific interventions, and then scientifically evaluating their intended outcomes (SR) (O'Connell & Farnworth, 2007).

There is a shortage of knowledge on the effectiveness of pharmacological treatment specifically to forensic issues within forensic psychiatry (SR, n = 10) (Howner et al., 2020). Patients who have a history of serious violence are more likely to show higher levels (in terms of frequency and severity) of aggressive and violent behaviour as compared to patients who do not have such a history. Patients with a history of violence have a greater frequency of lifetime domestic violence, a greater lifetime propensity to misuse substances, a higher number of compulsory admissions, lifetime substance use disorders, early age at the first contact with mental health services, and have a longer illness duration. Verbal aggression is significantly associated with aggression against objects, and this with physical aggression, in this progressive order of aggression in most cases. About $\frac{1}{4}$ of aggressive incidents is related to psychosis and $\frac{1}{5}$ to being under the influence of alcohol. Violence is frequently impulsive (92.4%). Victims of violence were more frequently the patients' parents or partners (28.0% and 24.6% respectively), followed by clinical staff (6.8%), patients' friends (6.8%), other relatives (6.8%), other patients (2.5%), or others (24.6%).A large majority of patients (88.8%) recognize their acts as violent, while the remaining 11.2% deny the violent nature of the offenses, and$\frac{1}{4}$ of the violent patients are arrested for the violent offenses. Social acceptability of the patients is inversely related to violence to a modest extent. About $\frac{1}{5}$ of patients with a violent history are readmitted to hospital within a year (twice those with mental illness without a violent history). Patients on enhanced close monitoring and intensive care in residential settings, that prevents substance abuse, show lower levels of violence when compared to patients living independently in the community.Violence in severe mental illness significantly shapes public stigma, increases discrimination, and places a heavy burden on family and carers (CCS, n = 247) (Barlati et al., 2019). Clozapine, olanzapine and risperidone have a weak effect on violence reduction (SR, n = 10) (Reisegger et al., 2021).

However, the prevalence estimate of Treatment resistant (TR) Schizophrenia is ~ ⅓ (Mørup et al., 2020), TR Depression is ⅓ (MA) (Jaffe et al., 2019), TR Anxiety Disorders is ⅓ (MA) (Bystritsky, 2006) and developmental disorders can mostly only achieve a reasonable QoL. Co-morbidities also make treatment more resistant such as Bipolar Affective Disorder is associated in ~$\frac{1}{2}$ the patients with an anxiety disorder (MA) (Nabavi et al., 2015) etc. Substance misuse is present in more than a ⅓ of secure care patient, more than ½ of secure care patients have had prior contact with

primary care and mental health services. Inadequate response is defined as less than 20% - 50% reduction in symptoms depending upon the diagnosis. Treatment resistance in pharmacologic interventions is defined as more than 6 – 8 weeks of failed treatment, unsuccessful response to 2 medications of different class, and hence a degree of improvement to lead a reasonable QoL is described by some as the goal, rather than absence of symptoms (Demyttenaere, 2019). However, patients wish for symptom remission. As a consequence of the above discussion, given that patients reaching secure care have a combination of these risk factors, the prevalence of treatment resistant conditions could well be $> \frac{1}{3}$ (no identified study on this issue). However, personality disorders as main diagnoses and comorbid personality disorders were associated with prolonged inpatient treatment in forensic psychiatry care. Substance dependence in addition to a personality disorder was an aggravating factor. Comorbid somatic disorders affected treatment duration of patients diagnosed with a psychotic disorder (CRS, n = 364) (Werner et al., 2014).

The prevalence of metabolic syndrome in secure care patients is about the same as for psychotic patients in the community i.e., $\sim \frac{1}{4}$ and $\sim \frac{3}{4}$ are overweight or obese (SR, n = 32) (Ma et al., 2020). Almost all patients in secure care are on antipsychotic medications (even those with non-psychotic primary diagnosis) and $\sim \frac{1}{2}$ on multiple antipsychotics. The association is stronger in those with longer stay, depot medication and on clozapine (CSS, n = 172) (Farrell & Brink, 2020). However, psychotic patients in general psychiatry are on more antipsychotic medications than in forensic psychiatry and the forensic patients differ from general psychiatry patients with psychosis, having more megalomanic ideations, animosity, affect flattening, weak will, social passivity, apathy, uncooperative behaviour, and poor impulse control (Vasic et al., 2017). Despite the increase in this risk, a 20-year cumulative mortality for schizophrenia without antipsychotics to schizophrenia with antipsychotics is 46% and 25% respectively, thus net weighting on the beneficial side (CRS, n = 62, 250) (Taipale et al., 2020).

Thereporting of adverse effects of psychotherapy has failed to progress in trials of psychological therapies (Parry et al., 2016). A meta-analysis of psychological interventions in in-patient forensic mental health showed small effect size for increasing insight into mental illness, ameliorating symptoms, improving problem solving ability, reducing pro-criminal attitudes, & improving ward behaviour, a medium effect size was found for increasing knowledge of their mental illness. Very little research has so far been undertaken to evaluate the more commonly offered interventions (SR &MA, n = 28) (McIntosh et al., 2021). Commonly offered group interventions in HSU in UK included anger/aggression, offence-specific, enhancing insight and understanding of mental illness, thinking skills/problem solving, substance misuse, self-harm, relationships, self-esteem and well-being, relapse prevention, and moving on (SR, n = 28) (Sturgeon et al., 2018). Individual psychological interventions in secure care include CBT, DBT, MBT, psycho education, schema-focused therapy and solution-focused brief therapy, IPT and psychosocial interventions as psycho educational strategies, non-directive counselling, supportive interactions and tangible assistance (SR, n = 9) (MacInnes & Masino, 2019). Patients completing forensic psychotherapy report the importance of trust and acceptance in therapeutic relationship, and changes in the domains of perception of self and interpersonal functioning as well as changes in problematic behaviours (I & TA, n = 10) (Yakeley & Wood, 2011)

The major predictors of recidivism are the same for MDO's as they are for non-MDO's, with criminal history variables dominating over clinical variables in effect size on reoffending (MA) (Bonta et al., 1998). A model for central risk factors with 8 domains was introduced by Bonta. The Big four: Antisocial – cognitions, personality, behaviour and

associates, and the moderate four – substance abuse, leisure, education/employment, family/marital. The Big four are more predictive than other clinical variables for general and violent recidivism in MDO's (MA) (Bonta et al., 2014). However, only half of the C8 predict general recidivism in sex offenders and further loses relevance in older sex offenders (CRS, n = 650) (Wilpert et al., 2018). Incarceration in prison irrespective of sentence length or community sanctions are both associated with slightly increased rates of recidivism and lower risk offenders are negatively influenced by prison settings (SR & MA, n = 50) (Gendreau et al., 1999).

After discharge from secure care, the suicide rates are ~3.25/1,000/year, crude reoffending rates are 4.5/1,000/year and readmission rates are 7.2/1,000/year (Fazel et al., 2016). Substance abuse increases the hazard ratio for rehospitalisation, death and violent recidivism by a factor of x 1.3 – 2 (Fazel, Wolf et.,al, 2016). The SMR from suicide is ~ 18 times the general population and SMR for all-cause death is x 2.2 the general population (CRS, n = 966) (Takeda et al., 2019). The 3-year recidivism rate is ~ 17% after discharge from secure care and can vary with region. Those who have committed severe prior violence are less likely to reoffend (CS, n = 1,800) (Charette et al., 2015). A 10-yr follow up study demonstrated general recidivism in ~ $\frac{1}{3}$ and violent recidivism in $\frac{1}{6}$ (CRS & Q, N = 125) (Krona et al., 2016). This is in comparison to 39% of released inmates reoffending in a year, 50% within 2 years and 75% within 9 years. More recent data suggests the annual reoffending rates are ~ 30%, with higher rates among those serving shorter prison time (MoJ UK, 2010). A recent matched case control study of three groups, (1) forensic examination without court treatment order: (2) forensic examination with court treatment order: (3) matched general offenders showed that reoffending, severe offending, and recurrent offending was 1 > 2 > 3 (Bengtson et., al, 2019).There is a reported 10 – 24% reduction in re-offending rates from delivering Offending Behaviour Programmes (OBP) depending on the type of programme, age and gender of the offender, and the risk of re-offending (SR) (Samele, 2008). Accredited OBP should have an integrated model of evaluation that focuses on the climate of program delivery, cost-effectiveness, integrity, and the treatment outcomes in the short and long term. Recidivism is only an outcome in the long term (Friendship et al., 2003). As an example, the Ministry of Justice in UK provides for 14 community and 21 custodial programmes for offenders currently in England (Ministry of Justice, 2021). There has also been a move to offer OBP's in secure care settings as part of the psychological intervention's pathway. These factors imply that although the predictors of violence among MDO's and non-MDO's are the same, the outcomes after forensic treatment and risk management interventions in hospitals and other institutions reduce recidivism when compared to matched no-intervention offender groups, and also matched prison intervention groups. Psychological treatments for adult violent offenders in correctional and forensic mental health settings are effective in preventing community recidivism and institutional (hospital/prison) misconduct but their combinations with other interventions and the appropriate offender groups need further research (SR & MA, n = 27) (Papalia et al., 2019).

Neuro-cognitive Deficits or Impairment (NCD/NCI) occurs in all mental disorders and across all age groups of mental illness. NCI can occur in any of the 6 key domains of higher cognitive functioning; IQ being a part of it. There are a wide range of tools and rating scales to undertake these assessments. Mental illness is commonly associated with NCD (all cases) and Neurological soft signs NSS (75%), both of which contribute to the illness burden in addition to psychopathology. However, these aspects are currently not integrated into regular psychiatric care. IQ is also affected in mental illness (70% with low (<10 IQ points), moderate (<20 IQ points) and severe (>30IQ points) in the ratio 1:2:1 among those with lowered IQ from premorbid IQ of ~ 95). Level of insight and aggressive behaviour is also related to an extent with NCD's. Hence endeavouring to evaluate NCD/NSS/IQ/pre-morbid IQ in a long-term care patient, contrasting it

with psychopathology PANSS, understanding the overall burden to the patient's ADL and instrumental-ADL, relation to aggressive behaviour and the level of functional handicap that poses on him/her, would provide pragmatic perspectives on the extent of achievable recovery. This will inform the patient's and attending professional team's best judgements on rehabilitation pathway in Rehabilitation Psychiatry and Forensic Psychiatry (see our other paper "Role Of Neurocognitive Impairment in Patients With Chronic Mental Illness – Relevance To Patients In Rehabilitation Psychiatry And Forensic Secure Care".

Experts felt that there is some convergence and some divergence of what constitutes efficacious treatment (what is given by professionals to patients) and similarly, of care (what is received by the patient) and what is a collaborative mix (DS, n = 54) (Tapp et al., 2016). Nurses generally have a more negative perception of people diagnosed with a personality disorder and this negativity is focused more towards managing the behaviours rather than on treatment efficacy and clinical outcomes. This is more so in lower & medium security than in HSU (Q, n = 600) (Mason, Hall et., al, 2010). There is a significant nurse to other groups and other multidisciplinary intergroup variations on diagnostic labelling which would result in different perspectives on management of patients in these settings (Q, n = 600) (Mason, Caulfield et al., 2010).

Evidence for staffing levels and patient outcomes in mental healthcare specifying staff numbers and ratios is particularly weak. There is a stronger argument for an increase in registered nurse numbers and a richer skill mix. More attention was needed to training, staff wellbeing and attitudes, especially given that there are a wide range of settings where patient interventions are offered (SR) (Lawes et al., n.d.). However, another study reporting the implementation of a safe-ward policy demonstrates that Staffing levels on acute mental health wards appeared crucial in the implementation of a restraint minimization project. Both staff and service users implicate insufficient staffing for deficiencies in the relational elements of care. Organisations and policy makers ought to address environmental, contextual and resourcing factors, rather than identify problems exclusively in terms of perceived aberrant behaviour of staff or service users (I & MM, n = 130 staff and 32 patients) (McKeown et al., 2019).

ID secure care services identified their outcome domains as effectiveness (severity of clinical symptoms), patient safety (offending behaviours) and patient and carer experience (reactive and restrictive interventions, quality of life and patient satisfaction) (SR & TA, n = 60) (Morrissey et al., 2017). However, a survey of the outcome domains showed that ~ 85% of their focus was only on half of the effectiveness elements of care (DS, n = 15) (Morrissey, Langdon, et al., 2017).

Secure services only offer religious service support to patients when the patients' religious tendencies are not part of their mental illness(I) (Nissen et al., 2019). Daily patient education programmes improved patient QoL & patient satisfaction, although discharge rates or time to discharge did not show significant changes in the 1-year study period (Q, n = 22) (Schofield, 2019).An expert user group identified research priorities in forensic mental health as physical health, future plans and moving on, and causes of illness and crime (DS, n = 27) (Aboaja et al., 2020).

Forensic psychiatry patients have different types of stories describing their offence and its meaning in their lives. Illness narratives can be utilized therapeutically because they may construct patients' identity, experiences, and their situation; and they seek explanations and meanings for their plight (I & TA) (Askola et al., 2015). Patients at different stages in their treatment need a variety of approaches. At first, they need more information about their situation in addition to being treated humanely. Later, they find it hard to work through their criminal offence and it aroused negative feelings. Their identity is constantly explored and they are particularly stigmatized. Not all forensic psychiatric patients experience

personal recovery, but each patient can rehabilitate within the scope of his or her own resources (I & TA, n = 8) (Askola et al., 2016). There are up ~25% in HSU and ~ 18% in MSU of Long Stay patients with a variation of 0 – 50% in MSU. On mapping their characteristics, it was found that this category of patients showed a 4x4 structure of attribution/outlook/approach/readiness for change vs Static or Dynamic acceptance/Static or Dynamic resistance. Patients' perceptions of their situation differ in their attribution (internal/external), outlook (positive/negative), approach (active/passive) and readiness for change (CRS, I, MM, DS) (Vollm et al., 2015).

Evidence Based Medicine and Evidence Based Systemic Practise

Hodgins violence typology for schizophrenia patients is a useful model of 4 groups - first offender, early starter, late starter, late late starter has again received importance through a recent study. It found that early starters: late starters: late late starters is 2:2:1. The first group had more offending history, hospital admissions and higher life adversities; the second group had equivocal health and offending needs but were less severe, and the third group had less of both needs but a higher chance of using illegal drugs. The study confirmed another observation that offender characteristics are more important in violence typology associated with mental disorder. This would suggest that the Length of stay for group 1 > LoS for group 2 > LoS for group 3(CRS, n = 71) (Lau et al., 2020). HoNOS-Secure, forensic outcome tool developed in England and Wales showed an apparent lack of change over 15 months masking a more complex picture, where initial decline in ratings was succeeded by significant improvement. Results suggest that it is challenging to measure clinical and risk-related medium-term outcomes (n = 180) (Dickens et al., 2010). QNFMHS as part of CCQI (Quality Network for secure care in England & Wales) peer reviews LSU & MSU units. A case control study of 38 LSU's, a year after peer reporting, showed no change in quality of physical environment and facilities of the service. However, staff reported feeling safer after review report introduction but with more burn out. There was no change in clinical outcomes or patient satisfaction or violent incidents (CCS, n = 38) (Aimola et al., 2018).

The use of Measurement Based Care (MBC) has the potential to improve the accuracy of diagnoses and improve the outcomes of care (Aboraya et al., 2018). A similar approach is suggested for behavioural health (Lewis et al., 2019). Forensic psychiatry is described as being ideally suited for incorporating this practice (Glancy et al., 2021). Structured professional Judgement tools are already in use in secure care services for risk assessment, formulation and management. There are several clinical assessment tools in individual disciplines of secure care (Ex: CAMCOG, RBANS, IPDE, MOHOST, PANSS, AIMS etc). There are also ward climate and culture assessments in addition to several QoL, and outcomes measures which could be reported and quantified. We suggest that with the new age IT options, Natural Language Program with AI integration, use of IoT, Blockchain technology © has the potential to enable implementation of EBM and EBP, and taking on the heavy-duty administrative effort of several reports needed in Forensic Psychiatry (psychology report, psychiatric report, nursing report, OT report, Medications management, court reports, tribunal reports, MAPPA reports, ministry reports, CPA report, leave applications etc). There are also several assessment reports, clinical tools by discipline, outcomes measurements, effectiveness measurements, climate/environment measurements etc which also consumes lot of time and effort and partially, is the reason for limited uptake in practise.

Our practice suggests that there clearly is a felt need for this; but whether ethical considerations and available technology currently has answers to these problems is not known (Thieme et al., 2020). Personal wireless devices collect and integrate patients' personal physiological data, and then transmit the data to the backend of the network for related

diagnostics using Internet of Things and Body Area Network, already in use in elderly care homes(Deng et al., 2017).The ethics of autonomy, beneficience and non-maleficience and Justice is explored by Cockerill, 2020.Blockchain technology is being trialled in the cybersecurity of healthcare data. Acceptability to such interventions is not known, and barriers and facilitators to implementation need to be worked through (SR, n = 33) (Simblett et al., 2018). Nursing staff in secure care feel that it could help early identification of aggression, but are concerned about user acceptance and impact on their mental health, along with workload concerns from real time monitoring (FG & TA, n = 25) (Greer et al., 2019). See Table 1 in the end for a model range of descriptions and potential measures of data that could plausibly be used for analytics.

Evaluation of Therapeutic Relationship and Therapeutic Environments

Nursing documentational descriptions involve complex interactions between patient and staff that were linked to specific circumstances surrounding the patient. These antecedents, combined with the aggression incident itself, created stereotypic representations of patients as deviant, unpredictable and dangerous and they solely focused on the patient's behaviour. Such response would be counterproductive to managing aggression (QS, CRS) (Berring et al., 2015). Documenting the motivation for aggression (irritable, instrumental or defensive) would better inform risk management (CRS, n = 2649 incidents) (Winje et al., 2017). Use of FESAI (Forensic Early Warning Signs of Aggression lnventory) for early joint detection by nursing staff and patient of impending aggression reduced aggressive incidents significantly, more so for PD and Substance abusing patients than psychotic patients (CCS, n = 168 patients) (Albertus & Fluttert, 2010). In the UK, modified OAS (Overt Aggression Scale) is especially used in neuro-behavioural units to assess response to treatments and identify a predefined set of antecedents to inform formulation and interventions. Incidents in mental healthcare are triggered when users experience staff behaviour as custodial rather than caring and when they feel ignored. Patients identified that their mental illness and the negative aspects of the treatment environment affected the incidents (SR, n = 13) (Gudde et al., 2015). In secure care settings with a mixed forensic and civil section detained patients, 90% of the violent incidents are committed by the latter (CRS, n = 840 incidents) (Kuivalainen et al., 2013). Individuals with an ASD have disproportionately higher number of incompatibilities with other patients compared to those patients without an ASD, and experience higher and longer periods of seclusions (MA, n = 8) (Murphy et., al, 2017).Social climate in secure settings is defined by therapeutic relationship, care and treatment orientation; the secure base working in an environment created by - patient group, staff group, physical environment and system level factors (SR & TA, n = 20) (Doyle et al., 2017). Both social climate and sense of community predict incidents of disruptive behaviour as shown on a high secure ward (Puzzo et al., 2018). Some of the models and tools for social climate on secure care ward includes Safe ward model, EssenCES, See Think Act, Ward Atmosphere Scale and Forensic Restrictiveness Questionnaire.

Adult safeguarding procedures in England revealed histories of trauma, multi-factorial abuse; living with fear and stigma as well as mental distress; the effects of "psychiatric disqualification" and individual blaming needing to be addressed (MM, I, chats, n = 793) (Carr et al., 2019). Patient Safety in in-patient mental health settings is related to interpersonal violence, coercive interventions, safety culture, harm to self, safety of the physical environment, medication safety, unauthorised leave, clinical decision making, falls, and infection prevention and control (SR & TA, n = 364) (Thibaut et al., 2019). MDT staff interviews on secure wards pointed to environment, policies and practices, teamwork and support; staff experience and knowledge; and patient factors (I & TA, n = 88) (Marshall et al., 2019).

Suicidal patients in general psychiatry services described connection, protection and control as vital to their experiences of safety (SR, n = 20) (Berg et al., 2017). Majority of suicides in secure care had schizophrenia with chronic treatment-resistant illnesses, and had committed proportionally more violent offences, had a history of serious self-injury but no recognized clear depressive episodes (CRS, n = 14) (Ramsay et al., 2001). A comparison of suicide rates between prison and secure care setting in Germany revealed that there is no difference in the incidence @ ~ 130/100,000 residents. The level of mental distress is high in long term detainees (Otte et., al. 2017 as cited in Voulgaris et., al, 2018). Patients who commit suicide in forensic hospitals are, in comparison to the prison system, more likely to have committed a violent offense and have a prior history of suicide attempts. The duration from admission into the institution to the suicide event is shorter in the prison group. Also, younger people committed suicide earlier during their stay in a forensic psychiatric hospital or prison (CRS, FA, n = 519) (Voulgaris et al., 2018).The first international expert consensus study to identify research priorities in patient safety in mental health identified a. Patient contributions to their own safety b. The patient perspective on medication safety c. Perspectives on safety culture in patients who self-harm d. Good self-driven individualised safety planning e. Safety plans and safety improvement f. Factors in allowing reduction in restrictive practice including restraint and seclusion; from a set of 117 priorities obtained from systematic reviews (DS & I, n = 56) (Dewa et al., 2018).

Patient's perception of care quality increases when they are relocated to a new building with evidence-based healthcare environment design, and this view persists even three years later, especially for the seclusion room environment (I, n = 58) (Wijk et., al, 2019). Secure care Hospital design can positively influence patient experience (Mclaughlan et al., 2020). Even staff members felt that person-centred and psychosocial interventions improve after relocation (I, n = staff in 3 secure hospitals) (Degl' Innocenti et., al, 2019). An Italian study on an acute psychiatric ward demonstrated that the average noise level on the ward is ~ twice the WHO recommended levels (Berglund et al., 2000) for patients (Camuccio et al., 2019). An initial investigation of excessive sleepiness in some psychotic patients suggests the need for further research to disentangle directions of effect amongst sleepiness, mood, activity, psychotropic medication and psychotic symptoms, and investigate possible interventions for excessive sleepiness in psychosis (CCS, n = 60) (Reeve et al., 2021). The relationship between patient characteristics and ward climate in forensic settings is complex. Lower security levels are better for patient cohesion (PC), experienced safety (ES) and therapeutic hold (TH). Female gender is conducive for PC and ES. Higher perceived risk is associated with lower PC. Diagnosis of personality disorder or psychosis is associated with higher ES. Lower levels of engagement predict greater TH (n = 63) (Dickens et al., 2014). Given that smoking has been banned in secure settings, ⅓ of patients interviewed were angry and ⅔ reported gaining weight (Q & FG, n = 21) (Hehir et al., 2012).However, staff felt it easier to provide patient care with this ban and they reported lesser patient aggression (Q, n = 111) (Hehir et al., 2013).

BME's are overrepresented in Secure care in UK and their care was found to be more coercive and less needs fulfilling and discriminatory (DoH, 2005 as cited in Rahul Bhattacharya et al., 2010, pp. 222–231). There is a call to shift from cultural competency to ethnographically informed formulation where patients' lived experiences in their psychosocial and cultural contexts need to be understood and the information used in treatment planning (Kleinman & Benson, 2006 as cited in Rahul Bhattacharya et al., 2010, pp. 222–231).

Sexual dysfunction with long-term psychotropic use is prevalent in 30 – 80% of patients (Montejo et., al, 2018). On interviewing experts from European Forensic Psychiatry, it was found that no country had a national policy on patient

Length of Stay Reporting in Forensic Secure Care can be Augmented by an Overarching Framework to Map Patient Journey in Mentally Disordered Offender Pathway for Optimal Results – Part II

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sexuality in secure care, although many had local policies or shared practices. Progressive approaches were evident in 9/14 countries, and practices in UK appeared most prohibiting and excluding (QS & I) (Tiwana et al., 2016). Disgust is a common experience for healthcare professionals, yet it is not talked about. Professionals cope with it usually by the defence of empathy (SR, n = 11) (Hadjittofi et al., 2020).

It was observed that specialist knowledge and skills for forensic nursing were not documented inn literature. In order to achieve specialty status, nurses have to consolidate their role in the containment and care of patients, they have to return to the nurse–patient relationship as the foundation of psychiatric nursing practice, then, within that relationship, nurses must expand their practice to include dealing with offence issues (SR and TA) (Martin, 2001). Staff burn-out in secure care is mostly due to interprofessional conflicts, workload, and lack of involvement in decision-making (SR) (Dickinson & Wright, 2008).Forensic patients were more likely to give negative feedback on mental healthcare services than non-forensic patients. The service's level of security-impacted patient's willingness to engage with giving feedback (Q & MM, TA, n = 906) (Mottershead et al., 2019).

In frustration, some patients abscond from the ward. In general psychiatry, the patients attributed this to stigma, mixed experiences with caregivers, poor resources and services, and mental illness symptoms (I, n = 10) (Kaggwa et al., 2021). In secure care, half of the patients return voluntarily within 24 hours of leaving. Over 50% of them had drunk alcohol or taken drugs while away from the unit. Escapees were more likely to be transferred prisoners and to have planned their escape, less likely to return to the unit voluntarily, and were away for longer. Offending was rare during unauthorised leave. Motives for absconding included: wanting freedom or drink or drugs, family worries and/or dissatisfaction with aspects of treatment (CRS, n = 77 incidents of absconsion) (Mezey et al., 2015). Between this study and Wilkie et al., 2014, 30-50% were repeat absconders. Improvements in therapeutic communication between patients and clinical teams could be helpful. Patients want to find relief, to regain power and control over their lives and/or to address unmet needs (SR, n = 8) (Voss & Bartlett, 2019).

Challenges to Smooth Transitions of Care Upward/Downward/Sideways or By Age and Gender

Persons with severe mental illness are responsible for ~5.3% of all violent crimes (Walsh et al., 2002). This includes ~ 35 – 50 homicides/ year by SMI patients in England and wales (~ 10% of all homicides per year) (38 years homicides registry study) (Taylor & Gunn, 1999). Repeat homicide by released prisoners is ~ 7.3% and grave offence is ~ 20% (CIRN, n.d.). However, in comparison, the pooled estimate for homicide recidivism in schizophrenia is 2.9% given that they have received treatment interventions (Golenkov et al., 2014) and violent recidivism is ~ 40% (Fazel & Wolf, 2016). Severe violence in SMI is mostly towards family and familiar people, except in psychopathy. There were many previous studies that reported 3 – 10fold increased risk of homicide in schizophrenia patients compared to normal population, but a meta-regression study attributed this mainly to comorbid substance abuse; stating that schizophrenia patients have no more risk of homicide than the general population (Fazel et al., 2009). However, despite these findings, the public response and professional pathways to reintegrate offender patients into the community is significantly more risk averse and slower.

Offenders in custodial or hospital settings need to adapt their masculinity differently in relation to the setting and transitions between these settings brings to focus this required transition. In hospital, they need to primarily focus on illness and recovery, whilst in prison they have to learn to desist (CCS, T, n = 20) (Haddow, 2013). Secure care patients reoffend violently more often than normally sentenced individuals, suggesting the need for continua of services, independently of

medicolegal status. It is dependent on male sex, younger age, pre-index violent crime, personality disorder (*vs.* schizophrenia spectrum and other psychiatric disorder), substance use disorder, and 5+ hospital admissions (CCS, FA, n = 1062) (Bengtson et al., 2019).

Patients felt that suspension of responsibility, collaboration in care, learning from others, supportive alliances, specific interventions (medical and psychotherapeutic), a safe environment and opportunities for work is what enables them to reach discharge (I & TA, n = 12) (Tapp et al., 2013). Loneliness for the secure-unit patients was a more unpleasant experience and more associated with difficulties in forming close attachments (CCS, TA, n = 61) (Murphy, 2000). There is an ongoing study on effectiveness of social network coaching on post discharge outcomes (Q, RCT, n = 105) (Swinkels et al., 2020).

Transitions in adolescents involve emotional and developmental readiness to moving onto adult-oriented settings (I & TA, n = 34) (Livanou et al., 2021).On being discharged from hospital, adolescents feel the need for close connection to at least one person, to receive practical help with regard to finances, work and housing; and to be able to experience pleasure and joy in their lives (I & TA, n = 25) (Van Hecke et al., 2019). Life after discharge for most young adults from secure services was characterised by close friends and a high quality of life, but also by substance abuse, professional support, debts, and delinquency. Because of persistent problems, residential treatment and aftercare should focus more on patients' long-term needs (Q & FA, n = 46) (Janssen-de Ruijter et al., 2019). On release from prison, female adolescents with more resilience displayed higher QoL and less offending, while more support was associated with higher QoL only; thus, demonstrating the importance of internal and external resources as can be achieved by a Good Lives Model (Q & FA, n = 49) (Van Damme et al., 2021). A qualitative analysis of female adolescents' experience of transition to adult secure services showed that they are sensitive to the behaviour of others throughout the transition process (negative impact of aggression from other patients, relationships with staff and other patients, and the need for informed involvement) (Q & TA) (Wheatley et al., 2013).

Older Mentally ill offenders feel better in prison rather than secure care settings but wanted to live independently, despite previous failed attempts (I & IPA, n = 8) (De Smet et al., 2014). During side-ways transition, patients find the uncertainties hard to bear and are concerned about tangible and practical issues (I & IPA, n = 17) (Parkes et al., 2014). When stepping down in secure care, they relate to feeling free, one step at a time, having to prove oneself, and being open to assistance that comes in many forms. They describe the need to be connected throughout the process for successful transition (I & TA, n = 5) (Kinney, 2011). Some patient feel that transitional housing is a good trial opportunity. They could improve their social participation, self-esteem/efficacy, community integration and renewal of daily living skills, community living skills, cultivate self-confidence and grow their personal resilience (I & IPA, n = 6) (Heard et al., 2019).

Offender patients found incompetent to stand trial were patients with chronic mental illness, had lesser charges on index offence, were more disturbed in presentation during early part of admission, and took a longer time to restore competency to stand trial. They also had lower Global Assessment of Functioning and lower IQ on admission. Their LoS in secure care was also eventually longer (CRS, n = 71) (Colwell & Gianesini, 2011). Important aspects influencing the patients' transition to the community as described by providers were a well-planned care plan, together with a suitable non-institutional dwelling (see Figure 2 for an author conceptualised model of accommodation arrangements) and a tailored occupation. They also felt that having a well-functioning and trusting social network and a good relationship with a contact

person/advocate is helpful. They also need to be able to manage their own finances (FG & TA, n = 12) (Gustafsson et al., 2011). Consultants felt that those patients who had residual psychopathology, risk, personality traits, those who were more institutionalised and their anxiety struggled in transitions. Lack of suitable facilities and media attention were judged to be less important (CRS, I, MM, DS) (Vollm et al., 2015). The successful rehabilitation of people through forensic inpatient services relies ultimately on there being places and support available for them to return to in the community (gov.scot, 2021).A range of accommodations and supports will help locate the offender patients in appropriate environments as in Figure 2 and allow feasible discharge plans; helping reduce LoS in the secure care pathway and potentially discharge some Long Stay patients.
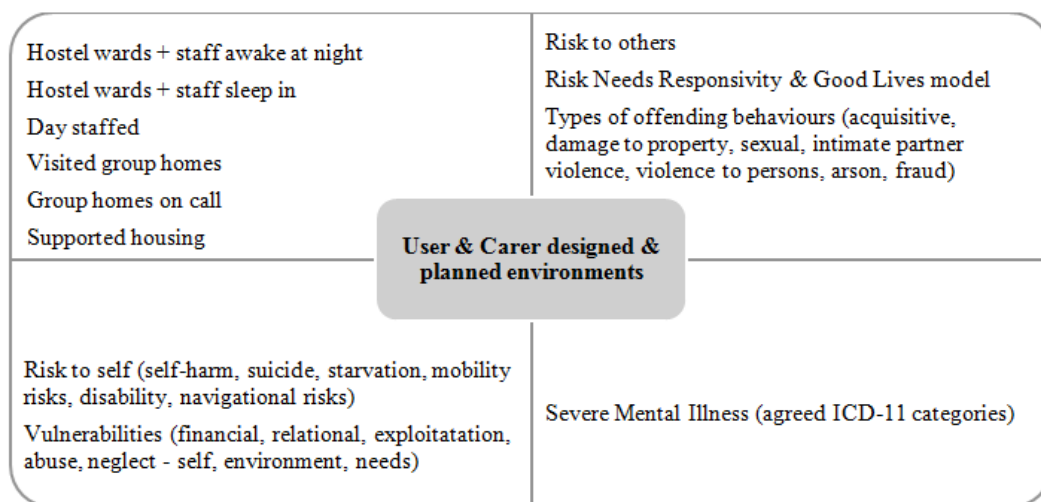
Figure 2: © Range of Accommodation Arrangements to Suit Various Offender Patient Groups.

Continuity of Care/ Collaborative Outcomes Achieved by Coworking of Agencies and Services

Quality of mental health care in prison estates were found to be related to working effectively in MDT's, having good communication, balancing care with security, and an expressed positive staff-prisoner relationship. They identified numerous shortfalls in service provision across the prison estate and called for reform with mental health as a key priority (TA, n = 42 inspectorate reports) (Glorney et al., 2020). ID prisoners on release reported unsettling conditions on return to community (I, n = 9) (Chiu et al., 2019) (I, n = 38) (Murphy et al., 2017).There are more typical criminogenic needs among those with early onset crime. Those with crime onset after mental illness show fewer criminogenic needs and have better outcomes on release, than those who had crime onset before mental illness. Individuals with no prior contact with mental health or criminal justice have higher functioning prior to their crime and have a lower risk of reoffending (CRS, n = 1800) (Crocker et al., 2018).

About $^3/_4$ of forensic patients have a prior general psychiatry admission, $^1/_4$ of general psychiatry patients with schizophrenia have offending history, and $^1/_5$ of general psychiatry patients with schizophrenia are at some point admitted to forensic psychiatry units. The authors recommended risk targeted management interventions in general psychiatry for this subgroup of patients (CRS, n = 232) (Hodgins & Müller-Isberner, 2004). On comparing general psychiatry and forensic psychiatry schizophrenia patients over 2 years follow up, general patients displayed higher levels of positive and negative symptoms than forensic patients, and more of them engaged in aggressive behaviour towards others. Aggressive behaviour was associated with positive symptoms and Antisocial Personality Disorder. Rates of readmission were similar

for the two groups. The forensic approach that includes assessing and managing risk of violence as well as treating symptoms of schizophrenia led to better outcome than that of general psychiatry (CCS, n = 248) (Hodgins et al., 2007). A 5-month follow up of acute psychiatry patients after discharge showed that 25% were violent and the factors underlying violence were the same as is in a representative forensic patient group (Doyle et al., 2011).The evolution of specialisation in all areas of occupation, is also relevant to the field of Forensic Psychiatry. The interface with General Psychiatry has its tensions but with cooperation and communication, patients' continuity of care can be optimised (Khosla et al., 2014).

A retrospective cohort study over 15 years in Sweden, of discharged forensic patients identified that ~ ⅓ have schizophrenia spectrum disorders, $\frac{1}{4}$ have personality disorder,$\frac{1}{6}$ substance abuse as primary diagnosis and $\frac{1}{4}$ have other primary diagnoses. Substance abuse increased the hazard ratio of rehospitalisation, death and violent recidivism by a factor of x 1.3 – 2. The mean age of discharge is ~ 36years, ~ ⅓ die at a mean age of 52 (suicide ~ 1/4, accidental death $\frac{1}{6}$ and cardiovascular deaths are the commonest cause), ⅔ are re-hospitalised within an average time of 5.3 years and$\frac{2}{5}$ violently reoffend over a mean time of 4.2 years (retrospective cohort, n = 6520)(Fazel, Wolf, et al., 2016). In contrast, another study found that men died ~ 15 years and women 25 years earlier than normal population but found no increased rates of suicide or accidental deaths in their 20-year cohort study. They instead identified respiratory/cancer and cardiovascular events as the main cause in their cohort's premature death (Rees & Thomson, 2020). This discussion demonstrates the need for long term mental, physical and risk management care (in whatever service models available in a country) over at-least 10 – 15 years following discharge from forensic secure care hospitals. In general psychiatry, there is no evidence of patient benefit from current CTO outcome studies. In addition, it increases readmission rates, length of stay in hospital, the duration of compulsory treatment, while minimally reducing the patients becoming victims of crime (Metareview, n = 53) (Rugkåsa, 2016).Childhood adversity is known in ~ 80% of secure care patients with physical abuse being the commonest (CRS & Q, n = 422) (Karatzias et al., 2019). It also demonstrates that violence and mental illness history usually commences by mid adolescence for many, as these offender patients graduate from criminal justice or mental health or both sets of services before landing in forensic psychiatry hospitals. Efforts to provide early interventions in both these groups could potentially alter the trajectory and length of stay for offender patients.

Most LoS studies report per admission episode only and not the up/down/side transitions of patient stay in hospital and the periods of community restrictions and treatments a patient receives. These are also important so as to evaluate interventions, triage interventions for right-place right-intervention strategy, minimise duplication, identify treatment resistance factors, improve patient motivation and engagement in interventions, and reduce restrictions earlier by identifying continuity. An Independent Forensic Mental Health Review in Scotland provides information on the Forensic Network reporting of mean length of stay durations. This for a high security patient turns out to be HSU (6yrs) +MSU (2.75 yrs) +LSU (4.3yrs) = 13 years. They found that if actions are not taken to address the issues of hospital and accommodation capacity, and the impact it is having on people moving through the system, the system is in danger of grinding to a halt. People must have access to the care and treatment they need in the correct level of security. There are two areas that require immediate attention: the pressure on medium secure beds and delays in the discharge process that are creating a bottleneck of people waiting to leave low secure service. In all, they made 21 recommendations across services and agencies to improve coworking among agencies and services (gov.scot, 2021).

There is a lack of evidence for the effectiveness of interventions for PD and related recidivism in prison, hospital or community settings. However, there is a global trend to consider non-institutional care to this group considering holistic

approaches to target trauma and relationship building, early identification and sentence planning, and the importance of workforce development and relationships (SR) (Skett & Lewis, 2019) in whatever settings the offender finds himself/herself in. There is ample evidence that higher PCL-R score, presence of ASPD with or without primary functional mental illness has higher, earlier and more severe reoffending for both general psychiatry and forensic psychiatry patients (n = 136) (Shepherd et al., 2016). Improving the clinical and risk management factors on HCR-20 in forensic psychiatry admissions does not reduce the risk of reoffending in patients with psychopathy (n = 40) (Mastromanno et al., 2017). There is also no published literature on how to effectively deliver mental health care in Probation (SR, n = 44) (Brooker et al., 2020) and this group of offender shave very high-risk for completed suicide - reasons for this include drug overdose, mental health problems, and poor physical health. They suggest good quality partnership working between probation and mental health services, in addition to appropriate investment in services(SR, n = 13) (Sirdifield et al., 2020).

Norwegian Knowledge Centre for Health Services collated the first set of international data on Patient Experience in healthcare based on OECD and WHO requirements. Patient satisfaction in General Psychiatry is related to the extent of improvement in mental health, food provided, and patients with prior admission; showed greater satisfaction, and those who were secluded & experienced poor therapeutic alliance, showed lower satisfaction (CSS, n = 270) (Zendjidjian et al., 2014). In Australia, the move is towards patient-centred care, redesigning systems architecture, shift from activity-based funding to results/outcomes-based funding and redistribution of resources from downstream to upstream mental health interventions to live contributing lives, and participate as fully as possible, as members of thriving communities (NR) (National Mental Health Commission, 2014). The only independent correlates of low satisfaction in mental healthcare were schizophrenia diagnosis and low psychiatrist to patient ratio, and they recommended examining expectations formed by previous experience of treatment, service-related knowledge, stigma and patients' disempowerment, and power imbalance (CSS, n = 8250) (Krupchanka et al., 2017). It is also related to insight, satisfaction with physical health, self-efficacy, family support, and social anhedonia (QS, n = 125) (Ratner et al., 2018). A study using ~ 75 different PREM tools in mental health with a massive 1932 items; showed that the key experience measures were interpersonal relationships (22.6%), respect and dignity (19.3%), access and care coordination (14.9%), drug therapy (14.1%), information (9.6%), psychological care (6.8%), care environment (6.1%) & patient satisfaction (6.7%) (SR, n = 86) (Fernandes et al., 2020). Patient experience work is insufficiently embedded in most mental health trusts and there is a need to gather, analyse and interpret this data and triangulate it with outcomes and safety data (CSS & MM, n ~ 270 +, 47 hospital sites + conference) (Weich et al., 2020). It has been emphasised that quality improvement is applicable to corporate, strategic and support services, in addition to clinical services, in order to influence the clinical realm (Shah & Fitzgerald, 2018).

The role of language proficiency is insufficiently acknowledged as it is very important in mental health care (SR, n = 26) (Bauer & Alegría, 2010). This brings into focus the important role of translation and interpreter services, advocacy groups for patients and carers, easy read and watch communication-material provided by key organisations such as national professional bodies and voluntary organisations representing the interests of the patients and carers; and the role of expert user groups in shaping consensus decisions on recruitment, planning, design and delivery of secure care services. Professionals' practice is subject to bias: both Implicit (Sukhera & Watling, 2018) and Explicit (Clarke, 2018). Patient reported experiences when analysed for content over 12 years found that multiple interactions affect patient experience and perceived care quality and the care provided by an individual clinician cannot be separated from the wider healthcare team (QA & TA) (Baines et al., 2019).

In evidence-based practice, tools to measure work environment of healthcare professions (SR, n = 37) (Maassen et al., 2020), nursing cultural competence (SR, n = 44) (Osmancevic et al., 2021), Quality & Satisfaction in mental health (SR, n = 34) (Sanchez-Balcells et al., 2018) show that certain tools meet psychometric properties but they need to be suitably modified and developed further with consensus. QoL evaluation using a suitable instrument from the available multitude of scales can be useful in demonstrating the impact of mental illnesses and the possible benefits of therapeutic interventions in psychiatric care (SR, n = 159) (Berlim & Fleck, 2003).The negative impact of stigma in secure care on patient transition to the community showed that access to care and community resources, and completing identity work necessary for moral and social community inclusion, were hindered (SR & TA, n = 7) (MacMillan, 2016). In the community, they are stigmatised and not properly understood by non-specialists when they engage with primary care teams (I & IPA, n = 11) (Campbell, 2008). They may receive insufficient support in the community from staff that are overworked and under resourced (Q & TA, n = 80) (Coffey & Coleman, 2001). A national community sample of healthcare workers describe the poly-problems of MDO's suggesting the need for an integrated and comprehensive approach, which is challenged by the fragmented and diverse ideologies of the behavioural health, criminal justice, and social service systems. This diverse range of problems needs the healthcare professionals to have knowledge of many different problems, expertise to respond to them, and an understanding of how these problems interact when they co-occur (Wolff et al., 2013). There will be various such challenges for the discharged secure care patients to face in order to remain well and safe in the community.

DISCUSSION

The 7 key themes identified show possible significant relationship with Length of Stay, as both upstream and downstream systems/services/Interventions feed into LoS in a given admission episode (Paper II), in addition to factors underlying secure care stay per episode of admission (Paper I). The evidence suggests needing to consider macro, meso, micro, static, dynamic and continuity level factors in considering goals and outcomes. There is a need to design a consensus framework (for example EPA forensic guidelines 2018) and evaluate these outcomes with the ability to allow devolved implementation, but within the framework. The QNFMHS in England and Wales have aggregated annual reports for LSU/MSU with defined standards in 14 categories of physical, procedural & relational security, safeguarding, patient focus, family & friends, environment & facilities, admission, treatment & recovery, medication, leave & discharge, physical healthcare, workforce and governance. The peer review provides benchmarking and balancing practices across secure care hospitals. However, these 14 categories in the QNFMHS reporting standards are different, albeit with some overlap, to the research evidence on Length of Stay (Paper I & II). The Hoeven Outcome Monitoring method in Netherlands, currently in evaluation is a tool with emphasis on macro, meso and micro factors but relate to an episode of admission (Keune et al., 2016). MDT consideration of the whole care pathway is required to address increased length-of-stay (again in reference to an episode of admission). Further research is required to support development of evidence-based standards that can be applicable in various regions of the world and improve outcomes for patients at risk of increased length-of-stay in forensic services (Connell et al., 2019).

We have endeavoured to provide a sample representation of key determinants of Length of Stay (primary 1^0 and secondary 2^0 factors) in the entirety of the offender patient care pathway, with some examples of what to observe and measure or gather evidence for, in Table 2 below.

CONCLUSIONS

We have endeavoured to bring together the relevant discussions on how long a patient stays in secure care in the entirety of offender patient care pathway in these two papers 'Length Of Stay Reporting In Forensic Secure Care Can Be Augmented By An Overarching Framework To Map Patient Journey In Mentally Disordered Offender Pathway For Optimal Results-Paper I & II'. Paper I describes factors in a single episode of admission and Paper II identifies other secondary factors demonstrated to impact Length of Stay indirectly through various outcomes. These factors for many patients starting at High secure care begins from adverse trauma in childhood, with early onset substance use and criminal justice involvement by mid adolescence, early general psychiatry admission, graduation to high secure unit and step down for ~ 13 years to be discharged into the community at an average age of 36 years. They need follow up from services for 10 – 15 years thereafter and die in the community at a mean age of ~ 52 years. This summarises the life-long need and challenges to patient/carer autonomy/experience for this complex-needs offender patient group with severe violent offence history.

In order to empathise with the offender patient/family who traverse the secure care pathway, we provide an imaginary fully informed offender patient narrative on their journey through this pathway in our other paper to follow - *A Review Of Patients' Experiences Amidst Other Stakeholder Views In Forensic Psychiatry.* We endeavoured to identify the role of chronic illness and neurodegenerative changes across the spectrum of psychiatric disorders that would have a significant impact on the potential for psychiatric and risk rehabilitation in our fourth paper awaiting publishing titled '*Role Of Neurocognitive Impairment In Patients With Chronic Mental Illness – Relevance To Patients In Rehabilitation Psychiatry And Forensic Secure Care'.*

We hope that these four papers together capture the most relevant perspectives and challenges in determining Length of Stay in secure care pathway in any country.

CONFLICT OF INTEREST DECLARATION

There is a certain degree of overlap between Paper II and the paper '*A Review Of Patients' Experiences Amidst Other Stakeholder Views In Forensic Psychiatry',* awaiting publication. However, the purpose of the narrative is different in these papers, and in addition, have their own independent description and evidence base.

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Table 2: © Summary 10 and 20 Factors Determining Length of Stay in Secure Care

Category	Factors Identified from Literature Review	Some Examples of what to Deliver and Observe (Observations and Summary from Paper I & II Combined Literature Review)							
LoS 1° (Paper I)	Index offence	Nature	Severity	Insight	Relation to mental disorder and extent of correlation	Publicity issues	Victim issues	Carer issues	Stigma Identity Remorse
	Sociodemographic	Literacy	Criminogenic environment	Gender	Age	Race	Occupation	Family & friends	Immigration factors
	Criminal history	Age of onset	Type of offences	Relation to SMI	Relation to Substance abuse	Peer effect	Motivation for offending behaviours	Duration of incarceration	Duration of community sentences and fines
	Psychiatric history	Impact on social functioning and new learning	Careful DD and comorbidities	Prognosis and limits of evidence-based treatments available	Compliance to treatment	Treatment resistance	Age of onset	Engagement in treatment	Self-efficacy
	Clinical variables	Psychopathology	Severity of illness	Insight	Self-efficacy	Response to treatment	Clinical prognosis	Comorbid conditions	Physical health
	Treatment variables	Antipsychotic equivalence	Side effects and tolerance	Engagement in treatment	Compliance to treatment	Treatment resistance	Carer participation	Agreeableness	Suggestibility/antiauthority
	Risk variables	Types of risks	RNR plans	Good Lives plans	Carer strengths and participation	Range and effectiveness of intervention	Clinical influence of risk	Criminal influence of risk	Perception of risks
LoS 2° (Paper II)	Chronic illness & Recovery	Duration of illness	Prognosis	Self-efficacy	Insight /empathy/remorse /Anosognosia	Help & support	Engagement & compliance	Effectiveness of Rx	Neuro-cognitive Impairment
	Autonomy & efficacy (Patient & Carer)	Participation	Keenness	Motivation	ADL's	Directiveness	Responsibility	Self-management	Patient led activities
	Effectiveness of Interventions	Evaluate by discipline	Evaluate by systems	Evaluate by environments and dynamics	Evaluate by outcomes	Evaluate by feedback	Be on top of new research	Other measurements of care	Economic analysis
	Evidence Based Medicine & Evidence Based Systemic Practice	Use of clinical tools by discipline	Use of risk assessment & formulation tools	Use of recovery tools LoS data gathering Data Physical Health Outcomes' data	Data on training, CPD, supervision, research, organisational learning etc	Data – aggression, coercive measures	Data - Activity, compliance & engagement	Data on managerial & leadership systems	Data diagnosis & treatment resistance
	Therapeutic relationship & environments	Supervision	Climate evaluation	Relational security	Identity, future goals, work and relationships	Patient feedback	Carer feedback	Team mutual 360 feedback	Relationship with others
	Transitions	Referrals	Admissions	Appropriate level of security	Transfers	Discharge	Stepdown	Age/gender transitions	Diversion interface
	Continuity of care	Tiered care models	Right place, right intervention	Collaboration	Sharing of requisite data	Treatment continuity	Support continuity	Good lives continuity	RNR continuity

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