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DOSSIER « FORENSIC ETHICS » / *Studies*

Ethical issues of long-term forensic psychiatric care

Aspects éthiques des soins longs en psychiatrie médico-légale

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Summary Forensic psychiatry is a subspecialty of clinical psychiatry that operates at the interface between law and psychiatry. It is concerned with patients who have a mental disorder as well as having committed an offence, often serious. Forensic psychiatric institutions are high-cost/low-volume services that impose significant restrictions upon their residents. Patients may be detained in those services against their will for lengthy periods, potentially life-long. The purpose of this detention is seen as two-fold: care and treatment for the patient and protection of the public from harm from the offender. Here we review the ethical issues around such long-term detention. We base our observations on a review of relevant literature and from focus groups with professionals working in forensic psychiatric settings. Additionally, we visited three institutions in the UK where long-stay forensic psychiatric patients receive care. A number of factors have been identified contributing to long-term stay (long-stay) in forensic psychiatric care, including organisational factors (e.g., lack ~~to~~ beds in less secure settings) and patient characteristics (severity of psychopathology and offending). Long-stay in a forensic psychiatric setting — which is often longer than had the patient received a prison sentence for the same offence — poses significant ethical and human rights issues, particularly when it is unclear

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whether the treatments offered benefit the patient and when risk management considerations may outweigh the best interests of the patient. The main topics of concern identified by our participants included ''system failures'', ''avoidance of warehousing'', ''importance of hope'', ''denial'' and long-stay units and ''quality of life''. Participants were concerned that the system is set up in a way that does not allow patients with complex and long-term needs to move to more appropriate, less restrictive settings and that the issue of ''long-stay'' is met with denial. In order to avoid warehousing and maintain hope, those we spoke to felt it was important to not give up on patients and continue to deliver treatment, almost regardless of its effect. Providing long-stay patients with a good quality of life was seen as important, though we found that the stated ambitions were not always matched by the reality of the units we visited. Despite the stated need to provide something ''different'' for long-stay patients, the units were nevertheless very restrictive in their approach (e.g., prohibition of sexual expression). Professionals seemed to lack a more ambitious and creative vision to create something truly distinct. We discuss possible solutions, including explicitly maximising the quality of life of those detained, limiting the time of detention to equal the sentence length of non-disordered offenders and locating the public protection function of the management of mentally disordered offenders within the criminal justice rather than the health care system. The implementation of such radical solutions, however, might be hampered by the difficulties in changing entrenched values and procedures, to the point that diverse stakeholders join together in maintaining the status quo.

MOTS CLÉS
Psychiatrie légale ;
Criminels ayant des troubles mentaux ;
Séjour long ;
Éthique ;
Loi de santé mentale ;
Droits humains

Résumé La psychiatrie légale est une sous-spécialité de la psychiatrie clinique qui travaille à la croisée entre droit et psychiatrie. Elle s'occupe de patients ayant des troubles mentaux et ayant commis un crime, souvent grave. Les institutions de psychiatrie légale sont des services à coût élevé et à petite structure qui imposent à leurs résidents des restrictions importantes. Les patients peuvent être retenus dans ces services contre leur volonté pour de longues périodes, potentiellement à vie. On considère que cette détention a une double visée : soigner et traiter le patient et protéger le public du mal que pourrait causer le criminel. Ici nous prenons en considération les questions éthiques d'une telle détention sur le long terme. Nous basons nos observations sur une étude de la littérature spécialisée pertinente pour cette recherche et sur le travail de groupes de réflexions avec des professionnels travaillant dans des contextes de médecine légale. De plus, nous avons visité trois institutions au Royaume-Uni où des patients de psychiatrie légale qui sont là pour des séjours longs reçoivent des soins. Un certain nombre de facteurs qui contribuent à un séjour sur le long terme (long séjour) ont été identifiés dans les soins de psychiatrie légale, notamment des facteurs d'organisation (par exemple, le manque de lits dans des endroits moins sécures) et des caractéristiques des patients (sévérité de la psychopathologie et du crime commis). Le séjour long dans un cadre de psychiatrie légale — qui est souvent plus long que ce que le patient aurait reçu comme sentence de prison pour le même crime — pose d'importantes questions éthiques et de droits humains, particulièrement quand le bénéfice du traitement offert au patient est incertain, et quand les considérations de gestion du risque priment sur les intérêts du patient. Les principaux sujets d'inquiétude identifiés par nos participants incluent « les défauts du système », « le danger de l'entreposage », « l'importance de l'espoir », « le déni » et les unités de séjour long et la « qualité de vie ». Les participants s'inquiétaient du fait que le système est établi d'une façon qui ne permet pas aux patients ayant des besoins complexes sur le long terme de s'orienter vers des structures plus appropriées et moins restrictives et que la question du « séjour long » se heurte au déni. Dans le but d'éviter l'entreposage et de maintenir l'espoir, ceux à qui nous avons parlé ont estimé qu'il était important de ne pas perdre espoir pour les patients, et de continuer à administrer le traitement, presque sans tenir compte de ses effets. Fournir aux patients de séjour long une bonne qualité de vie a été considéré comme important, même si nous avons trouvé que les ambitions affichées n'étaient pas toujours honorées par la réalité des unités que nous avons visitées. Malgré le besoin établi de fournir quelque chose de « différent » pour les patients de séjour long, les unités étaient très restrictives dans leur approche (par exemple interdiction de l'expression sexuelle). Les professionnels semblaient manquer d'une vision ambitieuse et

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créative pour créer quelque chose de vraiment distinct. Nous discutons des solutions possibles, incluant maximiser explicitement la qualité de vie de ceux qui sont détenus, limiter le temps de détention pour qu'il soit équivalent à la sentence de criminels n'ayant pas de troubles mentaux et situer la fonction de protection publique de la gestion des criminels ayant des troubles mentaux à l'intérieur de la justice criminelle plutôt que dans le système de santé. La mise en œuvre de telles solutions radicales pourra cependant être gênée par les difficultés inhérentes au changement de valeurs établies et de procédures, au point que les différents acteurs unissent leurs forces pour maintenir le statu quo.

Introduction

Forensic psychiatry

Forensic psychiatry is a subspecialty of clinical psychiatry that operates at the interface between law and psychiatry. Practitioners therefore require not only experience in the treatment of (complex) mental disorders but also legal and criminological knowledge. Forensic psychiatry is concerned with patients who have committed an often-serious offence and are frequently detained in secure and mostly highly restrictive settings. The purpose of this detention is seen as twofold: care and treatment for the patient (for their own sake as well as in order to reduce future risk) and protection of the public from harm from the offender. This dual role can cause dilemmas for the practitioner who has potentially incompatible duties to the patient, third parties and the wider community [1–3]. As Robertson and Walter [4] observed: ''In psychiatric ethics, the dual-role dilemma refers to the tension between psychiatrists' obligations of beneficence towards their patients, and conflicting obligations to the community, third parties, other healthcare workers, or the pursuit of knowledge in the field''. They noted further that these conflicting obligations create a conflict of interest because the expectations of psychiatrists, aside from those related to the best interest of the patients, are quite ''compelling''. This tension illustrates that the narrative in psychiatric ethics is ''embedded'' in the sociocultural context of psychiatrist–patient encounter. Robertson and Walter continued that ''It appears that as society changes in its approach to the value of liberal autonomy and the 'collective good', psychiatrists may also need to change''. This quote reminds us that the social and political context is crucial in medical decision making, even more so in the field of psychiatry, particularly forensic psychiatry. For example, several authors have noted the current risk aversive narrative in society in general and within the psychiatric profession in most European countries, in particular, driving practice to be more and more restrictive in nature and leading to increasing lengths of stay (LoS) in forensic psychiatric institutions [5], [though this pendulum may have just begun to swing back again towards a more rehabilitative approach with the rise in recovery informed care [6] and increasing concerns about ''blanket'' rules (e.g. [7])].

Forensic psychiatric services may be provided in different levels of security, in the UK, e.g., in high, medium and low secure in-patient facilities as well as in the community, to allow treatment provision according to security need and to facilitate movement along a ''treatment pathway'', in which, ideally, individuals should move to less restrictive settings as their risk reduces. This is paramount not only for ethical but also for financial reasons: forensic psychiatric services are high-cost, low-volume services: in the UK bed costs for high secure provision are approximately £ 275,000 per annum (approx. € 390,000) per patient; in medium secure care this figure is about £ 175,000 (approx. € 250,000); in total, forensic care consumes £ 1.2 billion per annum (approx. € 1.7 billion), 1% of the entire budget of the National Health Service (NHS) in England and Wales, or 10% of the mental health budget [8].

Long-stay in forensic psychiatric care

Clinical experience and research suggest that secure forensic services are not always used in the most efficient way with patients staying for too long in too restrictive settings, no longer needing or benefiting from the interventions offered. In England a number of studies in the 1990s and early 2000s highlighted that between one third and two thirds of patients resident in high secure settings did not require that level of security [9]. Inadequate provision of medium secure beds was thought to be a significant factor in the delayed transfer of patients to more appropriate levels of security; these findings led to the ''accelerated discharge programme'' with an increase in medium secure capacity, while bed numbers in the high secure estate have reduced. Nevertheless, concerns regarding the lengthy periods patients remain in secure settings are ongoing.

Research identifying LoS in forensic settings, factors associated with long-stay and the characteristics and needs of those who stay in secure care for extended periods of time is limited, though some important insights have been gathered. Firstly, not surprisingly, LoS in forensic psychiatric settings far exceeds that in general psychiatric services, though only few studies have compared these two settings directly. A recent study [10], based on a one-night census of a catchment area of a 1.2 million population in North London in 1999, found a median length of stay of 79 days in non-forensic beds whereas, for forensic settings, this figure was 1367 days. In total, 23.4% of general psychiatric patients stayed for more than one year, and 17.9% for more than 5 years, whereas the corresponding figures for forensic patients were 81.2 and 39.1%, respectively. For high secure

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care, research in England has found an average LoS of about 8 years, and about 15% stay for 10 years or longer [11]; for medium secure settings, a similar percentage stay for 5 years or longer. International studies [12] have found figures — at first glance — of comparable magnitude, with an average LoS at discharge of around 10 years, though these figures are based on the endpoint of discharge into the community whereas in the England LoS in settings of different security level have to be added up to calculate overall LoS in secure care. Despite these difficulties in the comparability of data and a lack of consensus as to how long is ''(too) long'', it can be concluded that offender patients spend a significant part of their life in secure care with very limited control over their own lives. Patients with ongoing severe psychopathology, non-engagement and dependency needs, with long psychiatric histories, more serious offending and those subject to ''restriction orders'', i.e., the mandatory involvement of Ministry Justice in decisions about their care, are disproportionately affected by lengthy care episodes, and some may remain incarcerated for their entire life [13]. The mental health, psychosocial and service needs that this long-stay population may have and how they could best be met remains unclear. Furthermore, despite ''long-stay'' being a reality in current forensic provision, the discourse about this patient group is challenging, in particular, for the medical profession used to ''treat and discharge'' rather than provide long-term care in which medical treatment in the narrow sense may only play a minor role.

The legal context

It would go beyond the scope of this article to review the legal frameworks governing forensic psychiatric care in different jurisdictions, and others have done this comprehensively before us [12,14,15]. Briefly, the detention of mentally disordered offenders (MDOs) is regulated by mental health legislation and criminal law. All European legislations recognise the concept of criminal responsibility as a prerequisite for punishment and recognize capacity to engage with the criminal process (''fitness to plead'') as a prerequisite for trial. Individuals who are found unfit to plead or are found not guilty by reason of insanity are, therefore, not punished but instead may be detained in a psychiatric facility for treatment.

In most European countries, such reduced responsibility is a prerequisite for entry into the forensic psychiatric system. In England and Wales, by comparison, admission to forensic psychiatric care is independent of criminal responsibility and solely determined on the basis of the mental condition at the time of sentencing. Even if found fit to plead and convicted of offences, people may therefore be detained in the forensic system if ''the offender is suffering from a mental disorder... of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment and appropriate medical treatment is available'' (Mental Health Act 1983, s 37).

As is common in other European countries, prisoners in England and Wales who develop mental illnesses in prison can also be transferred to forensic psychiatric facilities when their disorder warrants it (Mental Health Act 1983, s 47). The effect of this is that the individual can be held well beyond the release date specified in their criminal sentence, if in the view of those detaining them and (if the detainee appeals) the relevant review tribunal, their condition warrants it.

For all these offenders, detention in forensic care is generally not time-limited, and discharge depends on whether or not the individual is deemed to have made sufficient progress as to no longer present a risk. The result is often a lengthy stay in forensic psychiatric settings, and mentally disordered offenders may well find themselves incarcerated for significantly longer periods than persons committing similar crimes who are not mentally disordered. This may be the case whether or not the offender is found to have criminal responsibility. Only four countries within Europe (Croatia, Italy, Portugal, Spain; [16]) currently restrict the length of stay in forensic psychiatric care to the length of imprisonment a non-mentally disordered individual would have been sentenced to serve if convicted for the same offence.

All of these issues, of course, raise human rights concerns. The European Court of Human Rights has in the past been relatively generous to state parties in their interpretation of the European Convention on Human Rights and Fundamental Freedoms. When the detention is justified on the basis that the person is of ''unsound mind'' (ECHR, Art 5(1)(e)), it may be justified either with reference to the individual's need for treatment or their dangerousness: *Hutchison Reid v the United Kingdom* (2003), 37 EHRR 9. If, however, if there had been an indeterminate sentence based on a person's prior criminal conduct (ECHR Art 5(1)(a)), the Court has held that some rehabilitative programmes must be available: *James v the United Kingdom* (2013), 56 E.H.R.R. 12, para 221. That raises thorny questions, not yet adequately addressed in the jurisprudence, as to whether the detainees in forensic facilities in the circumstances described above are detained based on their mental state or are detained, in effect, on indeterminate sentences flowing from their criminal history. The James case has in any event been read narrowly so far by the English courts. A sex offender on an indeterminate sentence, for example, has been held not to have a right to sex offender treatment programmes: *R (H)v Secretary of State for Justice* (2015) EWHC 1550 (Admin).

In principle, for people detained because of unsoundness of mind, the question of availability of programmes is dealt with by the legislation: detention in a forensic psychiatric facility is permitted only if ''appropriate treatment is available'' (MHA, s 36(1)(b), 37(2)(a)(i), 45A(2)(c), 47(1)(c)). In practice, this requirement would appear to be met in some cases by a very low level of treatment. It may be met when, for example, the patient refuses to engage with the therapy, so long as the therapy would be appropriate if he did choose to engage with it: *Reid v Secretary of State for Scotland* (1999) 1 All ER 481. It may even be met if the patient is unable presently to engage with the treatment. In *MD v Nottinghamshire Healthcare NHS Trust* (2010) UKUT 59 (AAC), for example, it was held that the patient's psychological defence mechanisms prevented him from engaging with therapy, and therapy was not, therefore, appropriate in his circumstances, at least in the short- to mid-term. The patient was, however, held to have the potential to benefit from ''the milieu of the ward both for its short-term effects and for the possibility that it would break through the defence mechanisms and allow him later to engage in therapy'' [para 39]. This was

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sufficient to meet the requirement that appropriate treatment was available. Some more recent case law has begun to accord some stronger meaning to the requirement that treatment be available (see, e.g., *DL-H v Devon Partnership NHS Trust and Secretary of State for Justice* [2010] UKUT 102 (AAC)), but it remains difficult to see that it provides much of a safeguard to the patient.

The European Court of Human Rights has, however, held that any unwarranted use of force may constitute inhuman or degrading treatment under Article 3 of the ECHR: see, e.g., *Van der Ven v. the Netherlands* (2004), 38 EHRR 46. This is sometimes used in what, on their face, seem quite minor uses of force as, for example, shaving a prisoner's hair (*Yankov v. Bulgaria* [2005] 40 EHRR 36), or strip searches conducted in an unduly invasive manner (*Valasinas v. Lithuania* [2001], 12 B.H.R.C. 2). While the Court has tended to be generous in its view of the use of force in a psychiatric context, there are some indications now that it is looking more closely.

That is particularly clear in the case of the provision of medical treatment without consent. It is now clear that involuntary admission on its own is insufficient to justify compulsory treatment, even when the need for treatment is a part of the detention criteria. A separate process for compulsory treatment must be provided: *X v Finland* (2012) M.H.L.R. 318. No such processes exist in England and Wales, and there can be little doubt that, in that respect, its law is noncompliant.

Ethical issues in forensic psychiatry

A number of authors have examined forensic practice with an ethical lens, either using an ethical framework applied to forensic care or highlighting particular issues. Adshead [17], for example, applied Beauchamp and Childress' ethical principles — autonomy, beneficence, non-maleficence and justice — to forensic settings. Konrad and Völlm [18] identified a number of matters as particularly relevant ethically in forensic psychiatric care: firstly, the role of the forensic psychiatrist as expert witness differs from that of a treating physician — the psychiatrist ''changes sides'', being accountable to court rather than to the patient, even if his actions and recommendations have negative or harmful consequences for the individual, such as long-term incarceration because of ongoing risk. Related are the issues of confidentiality and risk assessment. Professionals working with offenders are increasingly expected (either implicitly or explicitly by law) to disclose information related to the risk their patients may pose to others, though countries vary in the degree to which they have protected medical confidentiality from this erosion. Risk assessments are carried out routinely by forensic psychiatrists and psychologists. They are supposed to determine future risk, and such assessments may inform decisions around release and ongoing restrictions. The ethical issues in the applications of such instruments are evident and are even more concerning, as recent research [19] has highlighted their limited reliability and validity, in particular in making long-term predictions. Further issues of note relate to the limited evidence of effective treatment in forensic populations (e.g., [20,21]). Nevertheless, patients in these settings are expected to engage in psychological treatments and accept psychopharmacological interventions in order to be considered for discharge and may be forced against their will to do so, in some countries even if they have capacity and make an informed choice to not consent to treatment.

As far as we are aware, few authors have addressed the ethical issue of long-stay in forensic settings. The aim of this paper is therefore to examine in more detail the ethical issues arising from the lengthy incarceration of mentally disordered offenders in forensic psychiatric settings, mainly based on focus groups with practitioners and those planning services. This work is part of a larger, multicentre, three-year study ''characteristics and needs of long-stay patients in high and medium forensic psychiatric care: implications for service organisation'', funded by the National Institute for Health Research in the UK.

Method

Focus groups

We conducted focus groups to generate data on long-stay in forensic settings. A focus group is defined as ''a group of individuals selected and assembled by researchers to discuss and comment on, from personal experience, the topic that is the subject of the research'' [22]. Focus group participants were recruited from conferences on forensic psychiatry in 2014 and 2015. The study was advertised to conference participants in advance by the conference organisers as well as through leaflets at the conferences. Three focus groups were facilitated, with 4, 5 and 7 participants respectively. The largest professional group of participants was (forensic) psychiatrists (eleven, three of which additionally had senior management duties); one participant was a psychologist and four were from other professional backgrounds (one pharmacist, two forensic psychiatric researchers and one individual who worked for the regulatory body Care Quality Commission). Most participants worked in the UK at the time, but four were from different European countries, seven participants were male and nine were female. Focus groups were facilitated by two researchers, BV as the Principal Investigator as well as another collaborator or research assistant. A topic guide was devised and used in each group, although discussions were allowed to progress naturally. The main topics included in the focus groups were prevalence of long-stay, patient and non-patient factors associated with long-stay and services for long-stay patients. Focus groups were held at the conference sites. Each group lasted around one hour.

Site visits

In addition, we visited three sites, two NHS and one independent sector unit, providing care specifically for long-stay patients. On each occasion we had the opportunity to speak to staff from different backgrounds, including medical, psychological and nursing, as well as visiting the actual facilities. Conversations during these visits focused on the history of the long-stay service, differences compared to other parts of the service and challenges and opportunities in the running of the service. Visits took half a day on each occasion.

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On two occasions we ~~taped~~ the conversations, while detailed field notes were taken during the remaining visit.

Analysis

Group discussions were recorded and transcribed verbatim. Transcripts were read and re-read to ensure accuracy of content. The data were analysed using thematic analysis [23]. Both BV and RM read the transcripts carefully and devised initial codes. In doing so, we concentrated on material relevant to ethical issues. Initial codes were then organised into overarching themes – recurrent ideas within the group – by consensus between these two authors.

Results and discussion

Focus groups

Participants raised a number of ethical issues during the groups. Responses could be categorised in terms of five main themes as follows.

System failure

The inefficiencies of forensic psychiatric systems were often referred to in the focus groups. This becomes an ethical issue if the system is organised in a way that makes it very difficult for patients to move on to other, potentially less restrictive, settings. Participants were clearly of the view that this was the case and that the system was too inflexible to respond to the complex needs of long-stay patients. This problem has also widely been recognised in the literature (e.g. [24]).

> *One is like if you don't have places where you can send.*
> Matthews[1]

> *Because there's a disincentive... to fund discharges now.*
> Andy

> *... but no supporting home or any care home has touched him because he has extensive fire setting. So no insurance would cover it... So he ended up, he's 74 I think now on that ward.*
> Debbie

Participants also discussed the issue of incarceration in hospital versus prison. Interestingly, there was some ambiguity where some expressed concern that all the positive work in hospital would become undone if the patient was sent back to prison while others appeared more concerned that were left with a patient they could not move on rather than with the welfare of the patient.

> *I would have put him in jail if I could.*
> Matthews

Avoidance of warehousing

Many participants were of the view that it was important to have a mindset that assumed patients would move on. They suggested an approach that refrained from actively providing formal treatment would amount to ''warehousing''.

> *If we are not providing therapy, what are we really doing? It is like a prison.*
> Rose

> *I suppose the risk is that they've been given up on and maybe they still have some potential to change.*
> Leanne

Linked to this, participants suggested that there was a risk that staff would ''give up'' on patients and that wards would become dumping grounds.

> *There is a danger with this type of ward that we're talking about and it's not just expecting that they're run on low resources but I do agree on that but it's also that the dumping ground... because they're perceived as easier, lower acuity, fewer incidents and you get a rather unconfident, deskilled staff collecting in one service when actually they need support from higher functioning staff.*
> Andy

In order to avoid warehousing or a complacent mindset, it was important, according to participants, to continue to deliver therapy. This appeared to be regardless of whether treatment was effective.

> *With that patient group, it is a marathon, not a sprint. ... there is a certain responsibility on your shoulders and supervision and team support helps with that. It is still quite an intensive thing. ... I try and be aware. If I feel that numbness or complacency creeping in, to try and shake it out.*
> Rose

An insistence on treatment and the need to help people move on, together with an acceptance that often these people would not move on, was present in many responses. One might hope that the requirement for continued detention that ''appropriate medical treatment'' be available would provide a legal lever to assist in ensuring optimal service provision. Sadly, this is not necessarily the case. First, the requirement is not to provide optimal treatment; any ''appropriate'' treatment will legally suffice. Second, as discussed above, the courts and tribunals have given a notably weak interpretation of the requirement. At least so far, the European Court of Human Rights has been unhelpful, holding in *Kolanis v the United Kingdom* (2006) 42 EHRR 12 that the patient has no right to services that would result in his or her release.

The desire to provide appropriate treatment and to assist people to move on can be understood in a context of competing demands and objectives facing staff. It can also be understood in terms of professional identity and practice. The Royal College of Psychiatrists (RCP) has stated that the only reason for psychiatric intervention is for patients' health benefit, with any related public protection function

[1] All names are pseudonyms.

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being secondary to this [25]. For clinicians working in this sector, an emphasis on treatment helps to maintain their identity as a competent professional. This is not an atomistic identity but involves recognition from one's peers. In other words, shared norms in relation to what it means to be a professional are important in relation to feelings of self-worth and fulfilment [26]. However, because these norms relate to active treatment, making decisions that involve explicitly scaling back or stopping such treatment is not an easy process. This may also explain why clinicians — similar to the law — appeared to settle with the delivery of treatment rather than its actual effectiveness. At one level, these responses are contradictory and may appear irrational. However, within the context of a system that imposes contradictory demands on individuals, the responses are perfectly understandable.

The importance of hope

For the focus groups, one way of coping with contradictory demands and a mismatch between aspirations and reality was to preserve hope. Many participants emphasised the need to maintain hope, both for patients and for themselves as staff.

> *We don't really give up on them. . . . and we will just try again and again to offer them. Sometimes successfully, sometimes not.*
>
> Andrew

> *I think it's remembering to keep up your professional standards when you are working with these patients when you are seeing them day in day out for years and potentially for decades. Making sure you. . . maintain hope, not give up even if they've given in. . . hope is just so important, just keep them going.*
>
> Leanne

> *Something to hope for. And if you have something to hope for. . . I'm guessing quite a protective factor in stopping from becoming a long-stay patient.*
>
> Rose

At the same time, some participants stressed the importance of being open with patients, and having realistic expectations. However, maintaining a balance between hope and realism was not always easy.

> *We need to be careful because it is a fine line what's keeping that [i.e., hope] up and being realistic that some of our patients may not get out and may never have a relationship. So it is really difficult. That is a very small minority in my experience, who may never get out. Unfortunately probably more are going to fit into that box. So it is kind of like having some hope that we are working towards and towards a better life, I guess is what the challenges would be for me.*
>
> Michael

> *There's one ex-patient, I can't remember his name now, he's quite big on service user involvement and he goes round doing talks about Rampton [one of the three high secure hospitals in England] and how he feels it saved his life basically. . . . he's gone on to university as well. . . so it just goes to show that it does work if you're in the right frame of mind to take that work on.*
>
> Stephen

Denial

While maintaining hope was clearly important in the view of participants, some also cautioned about giving false hope, and a number of people felt there was a denial in society as well as within the professional regarding the need for long-stay institutions.

> *I think there is a little bit of denial actually in society because there is a need for long-term institutional care.*
>
> Andy

> *Well, there's a certain humanity to it in that it manages expectations more realistically. Because I think you could call it cruel to allow them to be in expectation of release. . .*
>
> Andy

It was also acknowledged that being on a ward catering for long-stay patient and not having the pressure to move on can be positive for some patients though what such ward should be called was a matter of considerable debate.

> *. . . seen every other patient kind of come and leave, it gets very demoralising. Somewhere where they don't feel that pressure of the need to move on.*
>
> Oscar

> *. . . so that they're all on a journey and I sometimes want to say, you know what? You've arrived and you're not on a journey now and we're not allowed to say that. It is seen as unprofessional or lazy or giving up, where actually, it might be the most humane thing to say.*
>
> Joe

> *But there was a big debate about the names there as well [Name of the unit]. Long stay was not allowed.*
>
> Oscar

Long-stay units and quality of life

Whilst staff stressed the need to continue active treatment, they also suggested that for this group of patients a focus on quality of life was very important and more important than for other patient groups. Some staff described being involved in service developments in which dedicated facilities had been created for this group of patients.

> *So we do look more sympathetically at how we can facilitate more for them to be enabled to go out into the community supervised but engage with activities in the community. You know, recreational activities, sports and gym and that kind of thing. You know, escorted trips out*

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and that. We try and provide quality of life that is safely managed, as much as possible.

Peter

Staffed to give good quality of life. I suppose, that was the biggest ethical concern. It had to be a positive, I would say, homely environment really. ... making it a live place, not a place of deadness, ok, you're long stay but no... Ok, you're in care for special people now and it's going to feel a bit different but this is how it's going to be and won't that be lovely?

Joe

It's more about quality of life, stimulating environment, those... you don't have the young patients you know disturbing them, not vulnerable, so they're more like at ease on that ward. Actually the decoration of the ward is like more retro!

Debbie

There was some recognition that aspiring to a different kind of service for these types of patients was important. Such a service would involve providing a stimulating environment, but also a place that was homely and characterised by stability for the patient throughout.

We need to provide them with the best environment and quality of life and they may not need what all that other patients need in terms of goals and psychology either; they need something different instead, don't they.

Barbara

Visits

However, when we visited the long-stay units, we found that although efforts had been made to separate older patients who were likely to stay for a long time, the environment was nevertheless highly regulated and there was a mismatch between the verbal accounts of aims and aspirations and the reality of life on the wards. At one site, staff described how they had visited another facility catering for ''long-stay'' patients to learn from the experiences of staff. There they noticed that despite the clinicians saying that patients were not left to lie in their rooms all day, which was seen as part of the ethos of making the place more like home, various patients were sleeping on couches in the lounge during the day. They resolved not to buy three seater couches to prevent this from happening at their new facility. Here the espoused aspirations concerned quality of life and building a long-term community, though patients' views about what constitutes a normal quality of life might be disregarded if they involved daytime sleeping.

Similarly, although staff emphasised the importance of making these facilities as homely and ''normal'' as possible, there were limits to such normality, for example, sexual activity was not permitted. There is no national policy preventing this, but in the absence of such a policy, staff members are free to apply their own judgment. Staff attitudes in the settings we visited contrasted with those in other countries, such as Germany and the Netherlands, where sexual activity between patients or with an outside partner is permitted [27]. Doctors explained the need to protect vulnerable patients and highlighted the fact that many patients were sexual offenders, implying that they saw engaging in a sexual relationship as an obstacle to recovery [28]. These responses may reflect the broader social and cultural context in which forensic units are situated, with less liberal views regarding sexual relationships in the UK than the Netherlands, for example [28].

The example of sexual relations also implies clear constraints on ''normal'' living and quality of life despite stated opposite aspirations. In one site there was an area where patients could make their own hot drinks. This was seen as a shining example of the ways in which facilities were allowing patients significant freedoms and, compared to the other sites, at which no such freedoms ~~are found hot beverages~~, this facility was unusual. However, this also suggests that even the most ambitious facilities are very pedestrian in terms of the extent of their ambition.

Conclusion

Here we gauged the views of professionals on the subject of long-stay in forensic psychiatric care with a particular focus on ethical issues. We recognise that this approach has omitted the perspective of patients — we are currently conducting a separate study interviewing 40 patients in English medium and high secure settings and these findings will be reported elsewhere.

Overall the responses and accounts of participants can be seen in the context of tensions and dilemmas created by the context in which they work. Staff members are expected to protect the public and protect patients in a context that involves incarceration. At the same time, they are also required to facilitate ''recovery'' for a group of patients who may never leave these settings. The ethical issues we identified partly arise from these tensions in which staff appeared to be providing therapy to avoid ''warehousing'' but were largely unconcerned with its effectiveness and aimed to maintain hope to the extent that it might be false hope. Attempts to improve the quality of life of long-stay patients were identified as of particular importance though, in reality, these attempts did hardly achieve their objective. While regulations and guidelines could be blamed for these shortcomings (e.g. [29]), such guidelines do leave some room for discretion; however, there appeared to be a reluctance to deviate substantially from the model of provision that was applied in secure settings generally. Staff appeared to take for granted that certain freedoms and facilities should not be permitted rather than thinking creatively about alternatives.

We suggest that a fundamental reconsideration of the task of forensic psychiatry is required to address some of these ethical issues. If that task is — as we suggest it should be — care and treatment of patients (as opposed to ~~be~~ the protection of the public), then limiting the time of detention to equal the sentence length of non-disordered offenders for the same offence and locating the public protection function within the criminal justice rather than the health care system whilst more sincerely focusing on the quality of life of those detained in health settings, would be useful

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first steps. The implementation of such radical solutions, however, might be hampered by the difficulties in changing entrenched values and procedures, to the point that diverse stakeholders join together in maintaining the status quo.

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Disclosure of interest

The authors declare that they have no competing interest.

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