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# Audit in practice

## Patients in Broadmoor Hospital from the South Western region: an audit of transfer procedures

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Broadmoor Hospital is one of the three special hospitals covering England and Wales. It provides approximately 500 beds for mentally disordered patients who on account of their dangerous, violent or criminal propensities constitute a grave and immediate danger to the public, requiring treatment in conditions of special security (Section 4, National Health Service Act, 1977). It is generally recognised, however, that there are patients in special hospitals no longer requiring treatment in conditions of maximum security. These patients could probably be more appropriately cared for elsewhere if the facilities existed in general psychiatric hospitals or the community. However, special hospital consultants frequently encounter significant obstacles when attempting to transfer patients to local hospitals. Dell (1980) highlighted this problem, suggesting that 16% of special hospital patients were waiting to leave, following the agreement of the DHSS and the Home Office to their transfer. This delay appeared to be due to hospitals not wanting to accept patients who might prove to be difficult or dangerous. At the time of this current study (March 1990) these difficulties in transferring patients were particularly relevant as two of the special hospitals, Broadmoor and Ashworth (Park Lane and Moss Side) were full for male patients and therefore closed to male admissions, despite a continuing demand for beds.

The purpose of this study was to describe the group of patients from the South Western region in Broadmoor and to identify reasons for the delay in transferring those no longer requiring treatment in maximum security conditions. The study was designed to be not only a form of clinical audit, but also a training experience for the forensic senior registrar from the South Western region seconded to Broadmoor for one month.

The South Western region has two 30-bedded regional secure units (RSUs), each with two consultant forensic psychiatrists. The Butler Clinic in Dawlish covers the catchment area of Devon and Cornwall (population approximately 1.5 million). The Fromeside Clinic in Bristol serves the counties of Somerset, Avon and Gloucester (population approximately 1.7 million). When special hospital patients are considered ready for transfer, the standard procedure is for the patient to be assessed initially by their local catchment area general psychiatrist. If the consultant agrees the transfer but feels that rehabilitation through the RSU is required then the forensic psychiatrist also assesses the patient. This procedure is helpful as it clearly identifies from the start that the long-term responsibility for the patient lies with the district and ensures that patients do not remain for prolonged periods in the RSU while attempts to find a placement in the locality are made. Patients thought to require more than two years in conditions of medium security are considered not to be ready for rehabilitation and therefore inappropriate for admission to an RSU. Patients from special hospitals are initially transferred on the basis of trial leave, under the provisions of Section 17 of the Mental Health Act, 1983. This enables the patient's readiness for transfer to be tested out, and ensures a bed in the special hospital, should the patient prove to require treatment in maximum security again.

For patients detained on Restriction Orders (Section 41, Mental Health Act, 1983), the consent of the Home Secretary must be sought before transfer to conditions of lesser security. The Responsible Medical Officer (RMO) communicates with the Special Health Services Authority (SHSA) and with C3 Division of the Home Office, detailing the reasons for believing that such transfer is appropriate and explaining the plans for rehabilitation. In the case of restricted patients whose potential for serious reoffending is particularly difficult to predict, the Home Office may refer the case to the Advisory Board. This is an expert body which advises the Home Secretary on the acceptability of the RMO's proposals for the patient's transfer or discharge. It was set up following the recommendations of the Aarvold Committee (Home Office, 1973). Both these

steps in the assessment of readiness for transfer can add considerably to the waiting time for transfer of restricted patients.

## The study

A list was obtained from the Medical Records Department at Broadmoor of all patients recorded as coming from the South Western region. This was based on the patient's last address, or if of no fixed abode, the area where the offence was committed. If, however, the patient had lost contact with that area and the family were keen for the patient to live near them, the address of the next of kin was used instead. The case notes of these patients were examined. The patient and ward staff were then interviewed. Where applicable, other professionals involved in the patient's care were also interviewed.

Information on demographic details, legal status, legal classification, diagnosis, index offence, Home District and reason for currently being in Broadmoor was recorded. For comparison, lists of all South Western region patients in the two other special hospitals were obtained.

## Findings

On 1 March 1990 there were 30 patients in Broadmoor listed as coming from the South Western region. In addition to these, there were three patients on trial leave from Broadmoor and currently in RSUs who were excluded from the following calculations. As well as these 30 patients in Broadmoor, there were 67 patients from the South West in the other special hospitals (Ashworth 29, Rampton 38).

The mean age of the group in Broadmoor was 45 (range 23–83). They had spent on average 13 years in maximum security (1–38). There were 25 men and five women.

*Legal status* Of the 30 patients, 23 were subject to Restriction Orders (Section 37/41, Mental Health Act, 1983 and Criminal Procedures [Insanity] Act, 1964, i.e. patients found to be Unfit to Plead or Insane under the McNaughton Rules). The remaining seven were detailed under Sections 3 or 37 of the Mental Health Act, 1983.

*Mental disorder* Twenty-five were classified as suffering from mental illness, three from psychopathic disorder alone and two from both mental illness and psychopathic disorder.

*Present diagnosis* A diagnosis of schizophrenia or paranoid psychosis accounted for 17 of the 30 patients. Two had a schizoaffective disorder, four a depressive illness, three personality disorder with psychotic episodes and four personality disorder alone.

*Index offence* In 14 cases (47%) homicide was the index offence. Other violent offences against the person accounted for ten cases (33%). Three patients were non-offenders who had been persistently violent and unmanageable in a general psychiatric setting but had not been prosecuted. The remaining three patients were admitted following convictions for arson, kidnapping and indecent assault on a child.

*Home district* Nineteen patients came from the Fromeside Clinic catchment area (Gloucester 3, Bristol 9, Somerset 7) and 11 from the Butler Clinic catchment area (Exeter 2, Torbay 3, Plymouth 2, Cornwall 4).

### Patients awaiting transfer

Of the patients from the South West currently in Broadmoor, eight (26%) were considered ready to leave by their Responsible Medical Officer, who had therefore initiated the transfer process. Of these, only one had been waiting more than a year for transfer. These patients fell into four groups.

(a) *Awaiting a bed in an RSU* One patient was waiting for a bed in the Bristol RSU, having been accepted for transfer. He had been waiting less than four months. This patient had been accepted for the RSU within five months of his admission to Broadmoor. He remained psychotic and without insight, and although no longer violent, still required intensive nursing care. His transfer was not therefore considered a matter of urgency.

(b) *Awaiting Home Office permission for transfer* Three restricted patients had been accepted for transfer to an RSU by the local forensic and general psychiatrists. Home Office permission for trial leave was awaited. Two of these patients were expected to move to the Butler Clinic, where there was currently no waiting list for beds and therefore no additional delay was anticipated. These patients had been waiting on average five months (range three to eight months) for a decision from the Home Office.

(c) *Awaiting decision of the Advisory Board* One patient had been referred to the Advisory Board by the Home Office, four months before the study, for decision on his readiness for transfer to an RSU. He had been provisionally accepted by the local forensic and general psychiatric services.

(d) *Awaiting assessment by RSU and general psychiatrist* Three patients had been referred to RSU consultants within the past two months, and were awaiting assessments by the local general psychiatrists. Two of these patients were on Restriction Orders. Therefore if accepted by the local service, the possibility of further delay while awaiting Home Office permission for trial leave was anticipated.

The 22 patients for whom transfer had not been initiated were classified according to the reason for currently being in Broadmoor. There were broadly four groups:

(a) *Transfer being explored* Two patients were considered by their consultants to no longer require treatment in conditions of maximum security, but future plans were still being formulated. In one of these cases, the patient had twice been returned to Broadmoor after unsuccessful trial leave in medium security facilities. Both these patients were on Restriction Orders.

(b) *Patient strongly opposed to leaving Broadmoor – transfer therefore not currently being pursued* Three very institutionalised chronic schizophrenic patients who were adamantly opposed to leaving Broadmoor remained although their mental state no longer warranted treatment in conditions of maximum security. Their mean length of stay in Broadmoor was 30 years (range 27–34). Their mean age was 67 (range 53–83). These three were all restricted patients. Two of them were likely to require long-term hospital care. One was so resistant to the idea of leaving Broadmoor that he had threatened to reoffend if pressurised to leave. Rehabilitation was therefore taking place at a very gradual pace.

(c) *Patients requiring long-stay care in conditions of medium security*. Four men with chronic schizophrenia could probably have been contained in a semi-secure long-stay facility. Although all had exhibited violent behaviour in the past, this had now subsided. With firm, consistent nursing care, continued anti-psychotic medication and a structured environment, they were easily managed. Their mean age was 42 (range 31–62) and length of stay 12 years (range 6–17). None of these had, however, yet been referred to the local services. Presumably the awareness by Broadmoor consultants of the lack of such facilities in the home districts had deterred them from referring the patients. A move to less suitable facilities could risk relapse and a recurrence of aggression. Only one of these patients was on a Home Office Restriction Order. The extra control over placement and supervision provided by a Restriction Order was therefore not available for three of this group. These four men came from four different health districts.

(d) *Patients continuing to require treatment in conditions of maximum security* Thirteen patients fell into this category. Their mean age was 40 (23–60) and mean length of stay nine years (1–38). This group, however, contained two patients in their 50s who had spent 25 and 38 years in Broadmoor respectively, and had been turned down by RSUs in the past two years. These were the only patients in the sample whose transfer had been refused. Both were considered too dangerous for transfer by local forensic psychiatrists because of their continuing sadistic fantasies and the lack of appropriate long-term facilities in their home districts. Both had been diagnosed as schizophrenic although psychotic symptoms were no longer apparent. It is arguable that both would have been easily contained in a long-stay unit of medium security. The remaining 11 patients consisted of eight who had suffered from a psychotic illness and three personality disordered patients. Nine were currently involved in group or individual psychotherapy. There were no patients on either the male or female special care wards. These are wards for the most highly disturbed patients, requiring particularly high levels of security.

## *Comment*

At the time of this study there were 97 patients from the South Western region in special hospitals. The total special hospital population is between 1700 and 1800, indicating that, as one of 15 Regional Health Authorities, the South Western region is not making excessive use of maximum security facilities.

The patients described in this study do not differ significantly in terms of diagnosis, mental disorder, legal status or sex, from previous studies (Hamilton, 1990). As an index offence, homicide appears more common in this sample (47%) than in the Broadmoor population as a whole (30%). Other violent offences, and in particular arson and sex offences, are correspondingly less common. The mean length of stay of 13 years was much greater than previously found. However, without studying in detail all patients from the South West currently in all the special hospitals, it is difficult to draw meaningful conclusions from these differences.

One of the aims of this study was to identify the group of patients awaiting transfer to conditions of lesser security and the reasons for any delays. Twenty-six per cent of the patients from the South Western region fell into this category. This is in fact higher than the 16% described by Dell (1980) and the one in seven demonstrated by Hamilton (1990). However, in contrast to these studies which found that two-thirds of these patients had been waiting over a year, only one patient in the current survey had waited more than 12 months. With the number of steps involved in the transfer process, some delay must be inevitable. It is arguable that a delay of six months from the time the RMO first refers the patient to the local service is acceptable. In more complex cases, in particular when a referral to the Advisory Board is made, a transfer time of one year may be more realistic. Other causes of delay include problems in arranging for the local psychiatrist to assess the patient and queues for RSU beds. Except for one patient, who was awaiting an RSU bed, neither of these problems applied to the sample of patients from the South West. Therefore it would appear that although the numbers of patients

awaiting transfer were relatively high, the waiting time was not excessive and no particular deficiencies in the transfer process could be identified. The findings of this study suggest that just over half the patients in the sample probably no longer needed to be in Broadmoor. This supports Gostin's claim (1986) that between a half and two-thirds of special hospital patients could be discharged or transferred. A major factor contributing to patients remaining for unnecessarily long periods in Broadmoor appears to be the lack of long-stay medium secure facilities. Despite having two RSUs and a number of open forensic beds in the South Western region, there is perceived to be a shortage of long-stay facilities for the mentally ill. This is unlikely, however, to be a problem unique to the South West. It should also be pointed out that no single district in the region could be singled out as being particularly lacking in such facilities. The need for secure provisions ranging from the open door psychiatric hospital to that provided in special hospitals, with free movement of patients between facilities according to need, was recognised by The Royal College of Psychiatrists (1980). It would appear, however, that deficiencies in this service provision remain. RSUs are generally considered inappropriate placements for patients requiring long term care. Recently, Priest (1990) recommended the development of sub-regional "modest" security facilities for patients requiring longer term care. It is difficult to quantify the numbers of beds required by each region for such a purpose, but the numbers are unlikely to be large. In order to ensure a reasonable quality of life for patients, it is essential that such units are able to offer a full range of medical, social and recreational facilities. If, as Priest suggests, they are sited on mental hospital campuses, this might be possible. In the absence of such facilities, many patients suitable for transfer remain in special hospitals. However, the issue of infringing liberty by detaining patients in conditions of excessive security should not be overlooked. Other problems of such centralisation which should be considered include the distance from relatives and ease of eventual rehabilitation nearer home. If patients are to remain unnecessarily in conditions of maximum security, with the continuing and increasing demand for such beds, the capacity of the special hospitals will have to be expanded.

This study proved to be a useful form of clinical audit. As well as drawing attention to deficiencies in service provision, it also demonstrated that referral and transfer procedures in the South Western region appear to be working well, contributing only minimally to delay in moving patients out of special hospitals.

The Joint Committee on Higher Psychiatric Training (JCHPT, 1987) recommends that senior registrars (SRs) training in forensic psychiatry should gain experience in special hospitals. It is desirable that SRs are exposed to the full range of clinical problems encountered in special hospitals. Senior registrars used to working in the RSU setting should also be made aware of the frustrations encountered by special hospital consultants attempting to transfer patients to local psychiatric facilities. By examining all the patients in the hospital originating from their region the SR is able to achieve these goals in a practical and meaningful way, making optimum use of the secondment. Such a survey could usefully be repeated by other forensic SRs during their special hospital attachments.

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