

Original Paper

Characteristics of patients exhibiting severe challenging behaviour in low secure mental health and mild learning disabilities units

Dominic Beer¹, Vicky Turk², Phyl McGovern³, Shaun M Gravestock⁴, David Brooks⁵, Louisa Barnett⁶, David Orr⁷

¹Honorary Senior Lecturer, Guy's, King's, St. Thomas & Institute of Psychiatry; ²Consultant Clinical Psychologist in Learning Disabilities; ³Specialist Clinical Audit Co-ordinator, Bracton Centre; ⁴Consultant Psychiatrist, Oxleas NHS Trust/Honorary Senior Lecturer in Learning Disabilities; University of London; ⁵Consultant Psychiatrist in Learning Disabilities, South London & Maudsley NHS Trust; ⁶Assistant Psychologist, Oxleas NHS Trust; ⁷Assistant Psychologist, Oxleas NHS Trust, Kent, UK

Abstract

Aims: (1) To ascertain characteristics of patients in low secure units; (2) To examine whether standard 5 of the National Service Frameworks was being followed; (3) To investigate reasons for any delays in discharge and how these could be addressed.

Method: Audit survey of National Service Frameworks for Mental Health standard 5 patients being treated in least restrictive environment as close to their home as possible by case notes, interviews with ward manager and questionnaires.

Results: Patients in mental health units had greater numbers of admissions to hospital than those from learning disabilities units. They had more contact with the criminal justice system and had spent time in prison. The main diagnosis was schizophrenia.

Patients in learning disabilities units were more likely to be Black Caribbean or African and to have had special needs at school. They exhibited current higher risk to others and to self, by deliberate and non-deliberate self-harm. They had diagnoses of mild learning disabilities and autism. About a third of both groups of patients were assessed as being able to move to a lower level of security. The most suitable facility for these patients was an open unit in the community staffed by nurses.

Conclusion: For a third of the patients standard 5 of the National Service Frameworks was not met because they were not 'in the least restrictive environment'. Open community facilities staffed by nurses over 24 hours was the most appropriate unit for a majority of these patients.

Keywords:

Challenging behaviour; national service frameworks for mental health; low secure mental health units; low secure mild learning disabilities units

BACKGROUND

A number of surveys looking at forensic patients in medium secure psychiatric care have identified that

a significant proportion of patients no longer require medium secure care (Audini & Duffett, 1997; Brooke, 1998; Clarke et al., 1992; Halstead & Cassidy, 1993). It was the experience of clinical leaders in centres in South London, Kent, Surrey and Sussex that the same phenomenon occurs in low secure care for both learning disabilities and for

Correspondence to: Dr M.D. Beer, Consultant in Challenging Behaviour and Intensive Care Psychiatry, The Bracton Centre, Oxleas NHS Trust, Bracton Lane, Dartford, Kent, DA2 7AF, U.K.

mental health patients who exhibit very challenging behaviour and have complex needs. Patients with very challenging behaviour who have *both* mental illness and learning disabilities have additional complex needs and deficits in terms of adaptive behaviours and social skills e.g. some are on the autistic spectrum (Reed Committee, 1992). Once the level of challenging behaviour has improved to the extent that secure care is no longer required, it is often difficult to discharge such patients because of lack of appropriate community facilities.

The present study focused on standard 5 of the National Service Frameworks (NSF) for Mental Health (DoH, 2000). The NSF encourages treatment for patients 'in the least restrictive environment to protect them and the public' and 'as close to their home as possible given the clinical need'. Similar issues were raised for patients with learning disabilities in *Signposts to Success* (DoH, 1998) and *Valuing People* (DoH, 2001).

AIMS

This study aimed to describe:

1. Characteristics of patients in low secure units.
2. Whether standard 5 of the National Service Frameworks for Mental Health was being followed and specifically whether delayed discharge occurred in low secure units.
3. If so, to examine what were the reasons for delayed discharge and what aftercare facilities were required.

METHOD

The audit looked at 200 patients who were being treated in twenty low secure units in South London, Kent, Surrey and Sussex. The units were identified by contacting the Regional Office and by the knowledge of units by the steering group. It is believed that all the low secure units have been captured for this survey.

The following units were specifically excluded:

1. Psychiatric Intensive Care Units. The patients' length of stay is much shorter than on low secure units i.e. generally less than eight weeks.
2. Medium Secure Units – these had already been studied in a previous study (Sugarman & Everest, 1999).

3. Open units which can be locked for periods but are not locked for most of the time.

Permission was received from the consultant psychiatrist and ward manager/service manager to visit each of the 20 low secure units identified for the study, interview the appropriate staff using designated tools described below, search the case notes and collect the data. The data gatherer did not interview any patients within the units. Where IQ scores were collected, two psychology assistants were trained for this purpose.

The following tools were employed:

1. The Royal College of Psychiatrists Research & Development questionnaire (Audini & Duffett, 1997; Lelliott et al., 1994). This covered:
 - i. Demographic details, psychiatric, educational social histories, diagnosis, length of stay, Health of the Nation Outcome Scale (HoNOS) (Wing, Curtis and Beevor, 1996).
 - ii. Forensic and risk issues including contact with criminal justice system, criminal convictions, Mental Health Act status, reason for admission, severity of violence, current risk assessment, current challenging behaviour.
 - iii. Length of stay.
 - iv. Appropriateness of placement and if not appropriate, which facility would be appropriate.
2. Assessment of IQ. This was by means of case note IQ score. If no such score existed then The Quick Test (Ammons & Ammons, 1962) or the Wechsler Adult Scale Intelligence (WASI) was used.
3. Questionnaire to assess the level of supervision, support and resources for patients moving to a less restrictive environment (devised for the survey).
4. Patients' view of care. Questionnaire devised by Sugarman & Everest (1999). This was filled in anonymously by patients.
5. Questionnaire to assess nature, facilities and staffing of the units (devised for the survey).

All data was stored on an SPSS database in an anonymised format.

The project was submitted to the Chair of the Multi-centre Regional Ethics Committee and

MREC and LREC approval was deemed not to be necessary for such an audit project.

RESULTS

Characteristics of the units

Twenty units were identified.

There were eight learning disabilities units and twelve mental health and challenging behaviour units with ten each in South Thames East and West.

The population served by the twenty low secure units ranged from 200,000 to 1,200,000 with two units having a national intake of patients.

Eighteen of the low secure units described their unit as a separate unit/ward, one unit as part of another ward and one unit was within a Regional Secure Unit (RSU) complex.

Seventeen units had mixed patients (male and female) and three units admitted male patients only (see Beer et al., 2005 for further details regarding the units).

Nature of the patients

All 200 patients in the 20 low secure units were studied. 139 (70%) patients were in units designated as Mental Health, 61 (30%) were in units designated as learning disabilities units. 154 (77%) patients were male and 46 (23%) were female.

The age of the patients ranged from 19 to 74 years with a mean age of 39 years.

Mental health patients' marital status was 100 (72%) single, 23 (17%) married/partner and 16 (12%) separated, divorced, widow/er.

Of the learning disabilities patients 54 (89%) were single, 4 (7%) married and 3(5%) separated, divorced, widow/er.

The mental health patients were 106 white, 24 black Caribbean and African and 10 other. Learning disabilities patients were 46 white, 20 black Caribbean and African and 7 other.

Contact with social services

22 (16%) out of 139 mental health patients had been in the care of social services as children and 15 (25%) of the 61 learning disability patients. 43 (31%) out of 129 mental health patients had been identified as having special needs at school and 49 (80%) out of 61 learning disability patients.

First psychiatric contact

Patients had their first contact with the psychiatric/learning disabilities services within a period ranging from < 3 months to >10 years with a mean of 5 years.

Psychiatric hospital admissions

Of the patients in learning disabilities units:

- 58 (95%) patients had 0–10 previous hospital admissions; and
- 3 (5%) patients had >10 hospital admissions.

Of the patients in mental health units:

- 100 (72%) patients had 0–10 previous hospital admissions.
- 39 (28%) patients had >10 hospital admissions.

Of the patients in learning disabilities units:

- 36 (59%) patients had spent 0–10 years; and
- 20 (41%) patients had spent >10 years.

Of the patients in mental health units:

- 91 (65%) patients had spent 0–10 years; and
- 43 (35%) patients had spent >10 years.

Mental Health Act status

103 (51.5%) patients were on Section 3 Treatment Orders; 54 (27%) were informal and 27 (13.5%) were on Section 37/41 Hospital Orders with Home Office restrictions; other Court Sections 5 (2.5%).

- 97 (48%) patients had past contact with the criminal justice system:
 - 22/61 (36%) of patients in learning disabilities units.
 - 75/139 (54%) of patients in mental health units.
- 49 (25%) patients had prison sentences ranging from 1 to 10 sentences:
 - 7/61 (11%) of patients in learning disabilities units.
 - 42/139 (30%) of patients in mental health units.

Diagnoses

109 (78%) mental health patients had a primary diagnosis of schizophrenia; 13 (9%) bipolar affective disorder; 11 (8%) personality disorder; 6 (4%) other. Learning disabilities patients had the following primary diagnoses: mild learning disabilities 32 (52%); schizophrenia 16 (12%); bipolar affective disorder 6 (10%); psychopathic disorder 3 (5%); autistic spectrum disorder 3 (5%); Down's 1 (2%).

Secondary diagnoses: mental health patients – autistic spectrum disorder 14 (10%); personality disorder 9 (6%); mild learning disability 7 (5%); substance misuse 6 (4%); bipolar affective disorder 4 (3%); schizophrenia 2 (1%). Learning disabilities patients – mild learning disability 21 (34%); personality disorder 7 (11%); bipolar affective disorder 3 (5%); autistic spectrum disorder 3 (5%).

- 34/51 patients were recognised autistic from the case notes:
24/61(39%) patients in learning disabilities units.
10/139 (7%) patients in mental health units.

Measurement of IQ plus case notes analysis found the following:

Table 1. IQ measurements

IQ band	Patients in mental health units	Patients in LD units
<40	1	3
40–59	6	9
60–69	8	16
70–85	16	9
>85	25	1

Forensic and risk issues

Categories of offending for current admission

The following are the categories of offending for the current admission and the number of patients who have committed the offences.

Manslaughter (2), attempted murder (2), threats to kill (1), ABH/GBH (8), assault/wounding (7), sexual(rape/child abuse) (1), sexual(other) (4), arson (2), criminal damage (2), theft (1), burglary (1)).

Severity of violence for admission offence/acts

- 56 (28%) patients were reported to be non-violent
*18 patients were in the learning disabilities units.
36 patients were in the mental health units.*
- 17 (8.5%) patients were reported to have minimal violence (eg verbal aggression)
*4 patients were in the learning disabilities units.
13 patients were on the mental health units.*
- 54 (27%) patients were reported to have moderate violence (eg attack on person resulting in no serious injury)
*18 patients were in the learning disabilities units.
36 patients were in the mental health units.*
- 60 patients were reported to have moderate severe violence (e.g. an attack which resulted in serious injury)
*16 patients were in the learning disabilities units.
44 patients were in the mental health units.*
- 13 patients were reported to have severe violence
*4 patients were in the learning disabilities units.
11 patients were in the mental health units.*

Patients' current assessment category

- Risk to others (through violent or otherwise dangerous behaviour)*
 - 92 patients (46%) were recognised from the study to be a current high risk to others through violent or otherwise dangerous behaviour.
*52/61 (85%) of patients in learning disabilities units.
40/139 (29%) of patients in mental health units.*
- Risk to self (deliberate)*
 - 67 patients (33%) were recognised from the study to be a high risk to self (deliberate).
*40/61 (66%) of patients in learning disabilities units.
27/139 (19%) of patients in mental health units.*
- Risk to self (non-deliberate)*
 - 98 patients (49%) were recognised from the study to be a high risk to self (non-deliberate).
*51/61 (84%) of patients in learning disabilities units.
47/139 (34%) of patients in mental health units.*

Table 2. Significant differences between patients in mental health units and those in learning disabilities units

Variable	MH = 139 patients	LD = 61 patients	Chi squared	P value
Single status	100	54	6.58	=0.01
Black Caribbean or African	24	20	5.95	<0.05
Special needs at school	43	49	41.64	<0.001
More than 10 admissions	39	3	12.32	<0.001*
More than 10 years in hospital	43	20	6.74	<0.01
Criminal Justice System in past	75	22	5.43	<0.02
Any time in prison	42	7	8.05	<0.01*
Current high risk to others	40	52	54.42	<0.001
Current high risk to self	27	40	40.53	<0.001
Current high risk to self non-deliberate	47	51	42.06	<0.001
Diagnosis of Schizophrenia	111	16	52.6	0.000
Diagnosis of mild learning disabilities	7	53	131.4	0.000*
Autism	7	24	35.5	0.000*

*Yates correction applied.

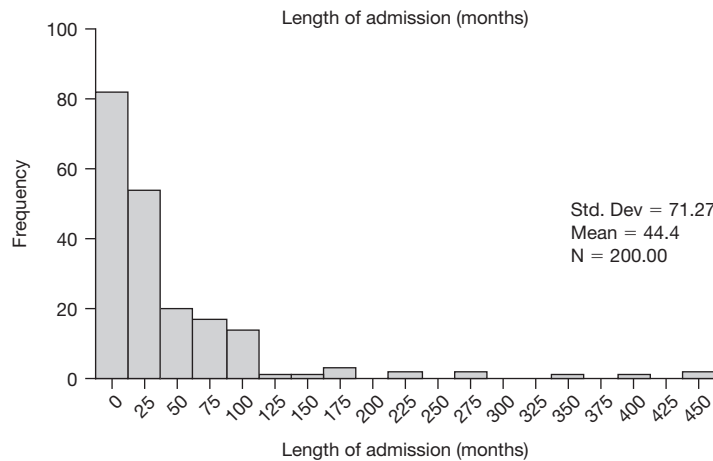


Figure 1. Length of stay.

- 6 patients in the learning disabilities units had no risks recorded.
- 4 patients in the mental health units had no risks recorded.

It is noteworthy that learning disability patients tended to be rated as having multiple risks whilst mental health patients tended to have one.

Patients’ length of stay to date

The length of stay for the 200 patients in the units ranged from 1 month – 40 years.

The above graph highlights the length of stay in months for the 200 patients

Patients’ length of stay to date in the learning disabilities units:

The 61 patients in the learning disabilities units length of stay ranged from:

1 month (24 patients) to 450 months (2 patients) with a mean of 66.4 months.

Patients’ length of stay to date in the mental health units:

The 139 patients in the mental health units length of stay ranged from:

1 month (4 patients) to 276 months (1 patient) with a mean of 34 months.

It is noteworthy that learning disabilities patients had stayed twice as long as mental health patients.

Appropriateness of placement

126/200 (63%) were assessed by ward managers as appropriately placed. 8/200 (4%) required a more secure placement. 66/200 (33%) – 48/139 (34%) from mental health units and 18/61 (30%) from learning disability units – required a less secure placement. 44 had been waiting up to 6 months and a further 22 had been waiting more than 6 months: (15 patients 6–12 months; 6 patients 1–2 years and one for three years). The most appropriate placements were assessed as being:

1. Nursing home care in the community – 41 (28 mental health; 13 learning disabilities).
2. Open hospital ward care – 12 (all mental health).
3. Hostel care – 7 (all mental health).
4. Independent living – 6 (5 learning disabilities; 1 mental health).

When asked what were the ‘very important’ factors (on a 1 to 4 scale) for a community placement to have, the following were given:

For learning disability patients (18):

1. Supervision of medication (89%).
2. Small residence (5 or less) (78%).
3. Permanent home (78%).
4. Structured recreational programme (67%).
5. Multidisciplinary team (23%).
6. Trained nursing staff (23%).

For mental health patients (48):

1. Trained nursing staff (38%).
2. Supervision of medication (36%).
3. Home for longer than five years (31%).
4. Abstaining from alcohol (29%).
5. Multidisciplinary team (27%).
6. Structured recreational programme (27%).
7. Locality close to home (25%).
8. Abstaining from drugs (23%).
9. Small residence (5 or less) (21%).

Patients’ satisfaction

There was a relatively poor response rate of 54 (27%), patients who returned the anonymous questionnaire. 37 (69%) said they saw their doctor enough; 30 (56%) saw a psychologist enough but only 18 (33%) said they saw a social worker enough.

Staffing levels

Only seven of the twenty units had more than two sessions from a clinical psychologist per week; four units had no occupational therapy input at all and only eight units had more than two sessions per week. Two units had no input from a social worker and eleven had in-reach/caseworker social work input for certain patients only (see Beer et al., (2005) for further details).

DISCUSSION

The information obtained indicates that the patients in low secure units have complex needs and challenging behaviours. Nearly half (46%) were assessed as having special needs at school and nearly half (48%) had had contact with the criminal justice system. A similar proportion (42%) had an index offence or reason for admission of a serious nature. Current risk was also assessed as being significant for violence (46%), deliberate self-harm (33%) and non-deliberate self-harm (49%).

Regarding level of IQ – ten patients in Mental Health Units had definite evidence of learning disability (including one with IQ less than 40; six with IQs 40–59). Ten patients in the learning disabilities units had IQs more than 70. The need for screening for learning disability requires further research (see Orr et al., 2004 for further details).

The diagnosis of autism is significantly high – 51 (25.5%) with 34/61 (39%) of those in the learning disabilities units and 10/139 (7%) of those in the mental health units. Further research is clearly needed on this issue and its service implications.

The main finding of the study was that 66 of the 200 patients (33%) were assessed as no longer requiring low secure placement. Predictors of prolonged length of stay are analysed and discussed in Beer et al. (2005). The main reason for delayed discharge was the lack of a suitable facility. In a majority of cases the most suitable facility was found to be a 24 hour nursed unit. For learning disabilities patients the needs identified were for supervision of medication and for a structured recreational programme with help with activities of daily living. The type of home being looked for was often a small residence suitable for at least five years.

The mental health patients' needs included those of the learning disabilities patients but also stressed the importance of abstaining from alcohol and drugs. The lack of move-on facilities may be linked to the paucity of social workers. Patients, too, commented on the lack of social workers in the units. National guidelines recommend the presence of a full multidisciplinary team including a social worker for these kind of units (DoH, 2002).

The study's strengths were that it was a comprehensive survey of all patients in all the low secure units in one region. The data was taken from case notes and then cross checked by interview with a clinician who knew the patient well.

The weaknesses of the study were that only 27% of the patient questionnaires were returned. Diagnoses were not made using strict operational criteria but by combination of case note diagnosis plus interview with a clinician who knew the patient well. Much of the information was obtained by interviewing one source alone (the ward manager).

Studies have been performed with high secure and medium secure unit patients which also show a similar proportion of patients no longer require care provided by those facilities. In comparison with other studies, no other studies have looked at this specific group of patients' needs against the National Service Frameworks.

CONCLUSION

The main finding of this study was that a third of the patients were rated as needing to be moved to currently unavailable, open community facilities staffed by nurses on a 24 hour basis.

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