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What does social distancing mean for patients in forensic mental health settings?

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ABSTRACT

Governments across the globe have called for social distancing measures in response to the COVID-19 pandemic. Secure settings will not be able to comply with these strictly, nor will they have the same recourse to the novel and creative solutions the general population does. Activities have been restricted in quality, quantity and scope; transfers and discharges have been halted and patient progress put on pause. Understanding how and what ways these restrictions will affect patients is crucial. This is especially salient given that large numbers of the general population have reported heightened mental health burden in recent surveys. However, it is not yet clear how and in what ways the COVID-19 restrictions will affect the mental health of patients in secure care. Past research investigating patients experiences of restrictions on autonomy in secure care that were present before the pandemic can be helpful here. Studies suggest that patient experience restrictions in care in myriad subjective ways. These include limitations on family contact, outside leave, and making hot drinks but also more profoundly on their autonomy, sense of self, and personhood. Quantitative studies have found correlations between experiences of restrictiveness and ward atmosphere, quality of life, suicidal ideation, depression and general psychological state in this patient group. This paper suggests how we can use past research exploring patient expereinces of restrictive interventions to guide the implementation of social distancing measures in light of the COVID-19 pandemic.

1. COVID-19, social distancing and forensic settings

Governments across the globe have called for social distancing measures in response to the COVID-19 pandemic. These calls typically request non-essential workers to remain at home, stepping outside0020only for exercise or to purchase necessary groceries. Individuals are asked to stand 1.5 or 2 m apart and avoid contact with others they do not live with. Secure settings will not be able to comply with these strictly, nor will they have the same recourse to novel and creative solutions the general population does. For example, depending on a patient's treatment phase and level of security, access to technology-enabled communication software will not currently be possible. Social media, used by the general population to connect with friends and family, will not be accessible to most patients.

In secure forensic hospitals, social distancing measures are marked. Activities have been restricted in quality, quantity and scope. Some hospitals have prohibited patients leaving for day trips and receiving external visitors. Therapeutic activities such as occupational therapy must be conducted on-site with regard to the 2 m requirement. This reduces the number of patients in attendance as space is limited and protocols on the number of supervisory staff will not have changed. Group therapy sessions might be moved to larger rooms or conducted with a smaller number of participants. Routine access to fresh air and exercise will need to be scheduled so that all patients safely receive the mandated hour of outdoor access as per the United Nations Nelson Mandela Prison Rules. Transfers and discharges have been halted and patient progress put on pause.

2. How will patients experience these additional restrictions?

Understanding how and what ways these restrictions will affect patients is crucial. This will be a task for everyone working in secure settings over the coming months. We already know that the COVID-19 pandemic is associated with mental health burden in the general population, frontline care workers, and individuals with lived experience (Holmes et al., 2020). A study of healthcare staff working in clinical settings during the outbreak in China found that of 1257 respondents 50.4% had symptoms of depression, 44.6% anxiety, 34% insomnia, and 71.5% general psychological distress (Lai et al., 2020). A recent representative survey of 1099 respondents in the UK was conducted between 26th and 30th March 2020 (The Academy of Medical Sciences, 2020). This demonstrated that 20% worried about mental illness in general, and 11% and 7% about anxiety and depression respectively. Respondents were concerned about having negative feelings, finances, employment, and the virus itself. One fifth identified contact with family and friends as helpful with roughly the same number using specific communication channels such as social media and video calling.

It is not yet clear how and in what ways the COVID-19 restrictions will affect the mental health of patients in secure care. However, we can look at research investigating patients experiences of restrictions on autonomy in secure care that were present before the pandemic. In recent years there has been an focus on investigating how patients experience the

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restrictiveness of their care. Hui (2017) interviewed 28 patients in a high secure hospital in England to ask about their experiences of restrictive practices. Patients described difficulties learning complex rules and struggling with the high degree of dependency upon staff. Restrictive interventions were felt to be punitive, causing fear, anxiety and negating dignity. They highlighted the importance of maintaining relationships outside the hospital.

My colleagues and I interviewed 18 patients in low, medium and high security hospitals (Tomlin, Egan et al. 2020). We asked what patients found most restrictive, why they thought these restrictions were in place, and what consequence these had for them. The most frequently reported restrictions included: having an indefinite length of stay, lack of family contact, other patients on the ward, a lack of or unclear information, meaningless or too few activities, limited access to hot drinks, and restricted leave outside the hospital. More profoundly, patients described restrictions on their autonomy, sense of self, and personhood. Pre-COVID-19, patients identified risk management techniques, a lack of resources and punitive organisational attitudes as reasons for why restriction were in place. Respondents stated that restrictions made them feel institutionalised, deskilled, bored, frustrated, and treated as an object to be managed.

Studies have investigated the empirical relationship between forensic patients' experiences of restrictions and a host of important clinical variables. Using the Forensic Restrictiveness Questionnaire (FRQ) – a patient self-report, 15 item validated measure – we found that in 229 respondents restrictiveness was negatively correlated with ward atmosphere (Spearman's Rho = −0.61, $p < .001$; EssenCES questionnaire) and (Spearman's Rho = −0.72, $p < .001$; Forensic inpatient Quality of Life questionnaire – Short Version) (Tomlin, Völlm, Furtado, Egan, & Bartlett, 2019). A separate study using an adapted version of the Measuring Quality of Prison Life questionnaire found that patient perceptions of restraint in German forensic settings was negatively associated with several clinical outcomes including hostility, depression, suicidal ideation, and psychological state (Franke, Büsselmann, Streb, & Dudeck, 2019). These studies suggest that the way patients experience restrictions implemented in light of COVID-19 will be closely linked to key clinical outcomes and that these should be considered together.

3. What does this mean for a forensic hospital implementing COVID-19 social distancing measures?

Social distancing measures might be seen as restrictive, and possibly punishing, by patients. These perceptions are likely to have a dialectical relationship with important clinical outcomes. Accordingly, any measures should be implemented cognisant of the implications on ward atmosphere, quality of life, depression, suicidal thoughts, and psychological wellbeing. Hospitals need to be mindful of these and other measures of mental wellbeing. Routinely measuring these to track patient mental wellbeing throughout the pandemic is a must. Not only does this help to monitor individual patient's wellbeing but it will also inform us of possible courses of mental ill-health in case a second COVID-19 wave materialises. Target outcomes for routine measurement should also include relevant variables identified in the general population, including anxiety and insomnia.

When implementing social distancing measures, framing and the involvement of patients is important. Our research found that restrictions were less likely to be perceived negatively by patients where they were considered legitimate (Tomlin, Egan et al., 2019). Research in prisons also indicates that the legitimacy of the governing regime is related to inmate perceptions of punishment and compliance (Rubin, 2015). Assessments of legitimacy rest upon whether information explaining restrictions is clear and timely, and whether the measures are perceived as are fair, least restrictive, and contextualised/localised i.e. not applied in a blanket manner unnecessarily. Patients need to be able to communicate with staff and have reliable and easy to understand information – information flowing in both directions. Make it clear that these measures are not the result of risk management, poor resourcing, or punishment; instead these measures are to protect the health of patients, staff, families and the general public.

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Jack Tomlin
Department of Forensic Psychiatry, University of Rostock, Germany
E-mail address: jack.tomlin@med.uni-rostock.de.