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Reflections on introducing a Leavers' Preparation Group in an intellectual disability secure service

Gareth Hickman, Nicola Booth and Thuy Hoang

Abstract

Purpose – The purpose of this paper is to report on the introduction of a Leavers' Preparation Group in an Intellectual Disability (ID) Secure Service. In the context of reductions in ID inpatient beds and reductions in restrictive practices, discharge and transfers out of hospital settings are increasing. The current group was established to provide support and preparation for service users as they approach discharge/transfer from hospital. The current paper provides example outcome data and reflects on the experience and learning points in delivering such interventions in secure contexts.

Design/methodology/approach – The Leavers' Preparation Group is an eight-session preparatory, recovery focussed group intervention focussing on supporting service users as they approach discharge/transfer to lower levels of security. The intervention has a multi-disciplinary approach, focussing on psychosocial aspects of current and future risk reduction.

Findings – Overwhelmingly service users reported that they experienced the group as positive and beneficial. Personal reflections of the authors are offered on service user attitudes to discharge/transfer, the contextual impact of restrictive systems and the benefits of this type of group intervention.

Originality/value – This paper reports on clinical practice, which involves multi-disciplinary intervention, co-production with service users and relevant stakeholders, and provides a description of the group intervention. It also offers critical reflection on tensions in this area of service provision, such as control and choice, freedom and responsibility, limitations and restrictions and power imbalances.

Keywords Secure services, Intellectual disabilities, Hospital, Discharge, Reflective practice, Group programme

Paper type Case study

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Introduction

Secure Services for people with Intellectual Disabilities (ID) were established for patients whose presentation rendered their management unsafe in the community (Alexander *et al.*, 2011). Due to current recording practices it is difficult to establish the precise number of Secure Hospital inpatients with ID, however the most recent available Assuring Transformation data indicates that 1,190 patients with ID were in a Secure ward as of November 2017. What is clear is that post the Winterbourne enquiry (Department of Health, 2012) and the introduction of the Transforming Care Agenda, there has been a drive to reduce inpatient beds for people with ID. The position of Secure Hospitals within this agenda remains debated however documents such as Houlden (2015) promote the relevance of Transforming Care in this area and outline proposed national reductions in Secure beds. Despite this, some services have reported experiencing pressure to provide discharge dates for some forensic patients who continue to present levels of risk that local service providers and community teams are not adequately resourced to manage with seemingly limited alternative models of care for this population (Taylor *et al.*, 2017). However, reducing duration of hospitalisation and seeking to progress service users to lower levels of restriction, community placements and indeed discharge from Section of the Mental Health Act is expected to lead to an increase in service users leaving Secure hospitals.

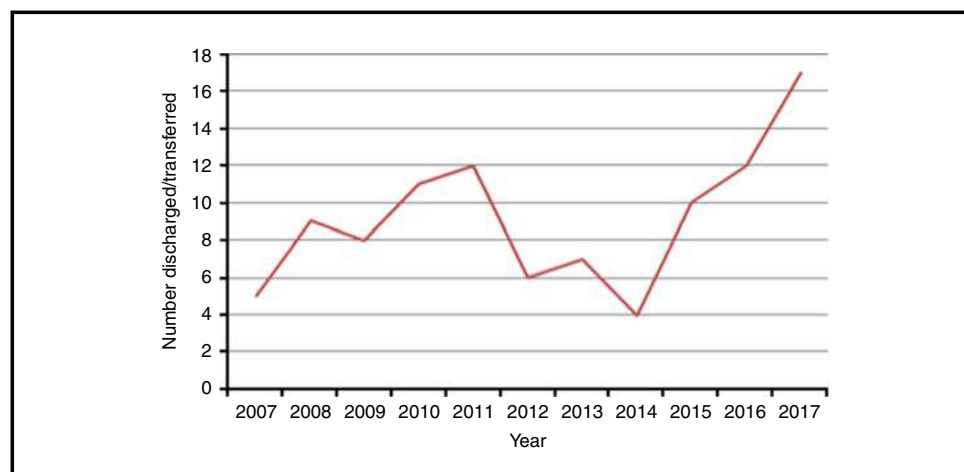
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Within the Secure Service in which the current intervention took place, which has 56 Secure beds, this effect is beginning to take hold. Figure 1 provides the number of yearly discharges and transfers over the past ten years (2007–2017) and demonstrates an upwards trajectory overall. Of note, in addition to the rise in discharge/transfers taking place in the past year there are a further assessed eleven service users for whom alternative, less restrictive placements are being currently identified having completed their outlined treatment pathways. This would represent a marked increase in discharges. This pattern is seen nationally, with some areas seeking to reduce in-patient bed usage by 50 per cent by 2019 and reports of bed closures of up to 35 per cent already having taken place with increasing focus on “new community care models” (Taylor *et al.*, 2017). However, this figure is potentially unclear with Assuring Transformation data indicating around a 9 per cent reduction in Secure beds between March 2015 and November 2017. It is also possible that this figure reflects rotation within the system, whereby people are being transferred to services closer to home rather than be discharged.

Preparing service users for discharge/transfer is recommended in the National Standards for Low Secure Units. It is considered that both practical preparations for life outside of hospital is necessary and also that supporting service users with creating appropriate endings to the relationships that they have formed with services, peers and staff members is essential. It has long been established that inpatient staff members can become significant attachment figures for inpatients (e.g. Adshead, 1998; Murphy, 2014) and as such significant consideration to the discharge/transfer process is warranted specifically due to uncertainties and anxieties engendered when moving on (see Main and Gudjonsson, 2005; Madders and George, 2014). Further, the existing literature contains a wide range of estimates of recidivism rates for this population and whilst providing accurate data on this is challenging, what is clear is that this population has high levels of support needs even following “successful” treatment and discharge (Wooster *et al.*, 2016, cited in Chester *et al.*, 2017). As such, preparatory work with service users including a focus on the realities of community life, needs and expectations following “successful inpatient treatment” should be a critical aspect of inpatient treatment pathways in Secure ID Services.

There are limited reports in the literature regarding interventions targeting the preparation of service users for leaving Secure Care. Adshead *et al.* (2017) outline data from the Broadmoor High Secure leavers’ group, which focusses on preparing individuals for transfer to Medium Security. They report on 109 males who attended their programme between 2003 and 2011. Notably, they report that there was a tendency for rate of return from trial leave back to High Security for group completers to be lower than that of patients who did not attend the leavers’ group (although not significantly), indicating some effectiveness of such interventions. This paper outlines some of the core concepts covered in the group (e.g. relapse prevention, mental ill health, anxiety and excitement) but does not describe the intervention in detail. Whilst this study

Figure 1 Yearly discharge/transfers from secure service (2007–2017)



did not include those transitioning to Low Secure or Locked Rehabilitation (two received community discharge), there appears to be a value to such programmes.

Within the Secure Services in which the current intervention took place, the existing practice for the preparation of service users leaving Secure hospital has been to provide this on an individual basis and this was appropriate given the number of service users in the “exit planning” stage of their treatment pathway at any given time. However, given the increases in the volume of individuals in this stage of their care pathway it became apparent that this process required revision. The current article documents the development of a group intervention aimed at enhancing certain aspects of psychosocial and practical preparation for life after hospitalisation in Secure Services and also creating appropriate and contained endings to the inpatient stay. Outcome evaluation data on a significant scale for the current group is in its infancy and therefore the current paper offers evaluation through a measure examining the impact of participation on perceived intensity and frequency of focussing on the problem, obtaining qualitative feedback from group participants and reflections from group facilitators.

Method

Group rationale and aims

The Leavers’ Group was designed as an eight-session preparatory, recovery focussed group intervention focussing on supporting service users with mild ID as they approach potential discharge or transfer to lower levels of security external to the hospital (i.e. people leaving the hospital). The intervention has a multi-disciplinary approach, focussing on psychosocial aspects of current and future risk reduction.

Predominantly, the group seeks to raise awareness of, and consolidate learning in relation to, psychological, occupational, and communicative and relational risk factors that are likely to be of increasing relevance in a community setting outside of hospital. The focus is not necessarily on teaching and developing new skills, but rather consolidating skills learned through inpatient treatment and then drawing attention to how these skills will be of transferable relevance when exposed to additional further risk in conditions of lower security and the community. The sessions aim to support group members to better understand and link the factors that have contributed to the development and maintenance of offending behaviour to the experiences and environment they will encounter in a community setting. The group also seeks to establish and model appropriate endings and gives the group members an opportunity to reflect on their time as an inpatient in Secure Services and the achievements and progress they have attained.

The group further aims to offer support, reassurance, education, reflection, goal setting and practical skills help. It is anticipated that this will lead to reductions in anxiety prior to discharge/transfer, to reduce potentially self-sabotaging behaviour as service users approach their move-on, to clarify misconceptions about their potential future lives and also to meet needs identified by patients, staff and community teams.

Procedure

Focus groups were held with service users prior to the development of the group content in order to ensure potential participants’ needs were identified and addressed. This provided a space for co-production in the generation of group modules and themes and ensured that service users were at the heart of the development of the sessions and content. The primary aims of these focus groups being to identify the concerns and areas that service users prioritised in regard to receiving further support and information. In addition, local Community ID Teams were contacted to generate additionally identified needs from the perspectives of the community support services.

The group was co-facilitated by a multidisciplinary team of three staff members including a Clinical Psychologist, Occupational Therapist and a Speech and Language Therapist, with a guest speaker from the local Clinical Commissioning Group present for one session. Sessions were held once weekly for eight weeks, lasting for two hours with a brief interval for refreshments. Table I outlines the group session content.

Table I Group content and structure

Module	Session	Content summary
1. Moving On	1	Introduction Introductory session to establish aims and expectations of group; and reflections on Inpatient journey and key relationships
	2	Legal aspects of discharge/transfer Review of detention, discharge and legal requirements
	3	Models of care Sharing models of care beyond hospital Sharing steps to discharge process model
2. Life skills	4	Practical community skills: Covering daily living skills (e.g. banking, travel) and constructive use of time Sharing ex-patient stories
	5	Healthy living Covers aspects of healthy lifestyles within the community (e.g. meal planning, exercise, health checks)
3. Relationships	6	Relationships Review of types of relationships, endings and new relationships Covering the law and potential risks within relationships
	7	Social media and the internet Discussed the benefits and risks associated with the internet and modern technology
4. My future	8	Endings Supporting individuals to reflect on their experience of hospital and discharge/transfer

Throughout the group, service users were supported to maintain a log of on-going concerns, questions or further information they required. This was then reviewed in nursing 1:1 sessions and at service user attended MDT and CPA meetings in order to support continued learning and consolidation.

Participants

Six men attended the group. All were inpatients in Low Secure Services detained under Section of the Mental Health Act (1983/2007) and were all adults assessed as meeting service criteria for ID. Each participant was assessed as having completed or as being within three months of completing their outlined treatment pathway and therefore within the "Exit Planning" stage of their care pathway. Participants were offered the opportunity to attend and therefore this group was non-mandatory. Table II provides demographic details, including the potential proposed future placement, that the clinical team and service user were working towards providing risk was assessed as suitably reduced.

Measures

Three main identified problems (3MIP). As a means of offering some evaluative component to assess the perceived efficacy of the group the 3MIP Assessment scale was completed with group members at pre and post intervention. The 3MIP scale is a non-validated internally developed tool (Thrift, 2014), which requires the individual to identify the three main difficulties or

Table II Demographic summary

Participant	Treatment pathway status	Index offence type	Section	Proposed future placement
1	Completed	Violence	37/41	Locked rehabilitation
2	Completed	Sexual	37	Community discharge – supported living
3	Completed	Violence	47/49	Community discharge – supported living
4	Completed	Violence	37/41	Community discharge – residential care
5	3 months remaining	Sexual	37	Community discharge – residential care
6	3 months remaining	Sexual	37	Community discharge – residential care

problems that they currently experience in their life in relation to a specific intervention target. It is a tool that enables the service user to reflect on the changes in the intensity and frequency of their difficulties on two Likert Scales. Intensity is rated 0–10 (10 is High) and Frequency is rated 1–10 (10 most frequent).

Qualitative feedback. During the final session, an open discussion was held with group members in a format similar to the initial focus groups in order to obtain qualitative feedback on the following areas: what had been helpful/unhelpful; what would service users like to be different (content added/removed/amended); would they recommend the group to others; what they would like further information on; and any additional comments they would like to make.

Reflective practice. Reflective practice was also utilised as a means of monitoring group progress and impact and also to offer an additional evaluative perspective on the effectiveness of the group in meeting its aims and having a benefit within the context it was developed. The group facilitators held reflective practice discussions for 30 min following each group session, drawing on Gibbs' (1998) reflective cycle.

Results

The group was evaluated using a number of methods, a measure examining the impact of participation on perceived intensity and frequency of focussing on the problem, obtaining qualitative feedback from group participants and reflections from group facilitators.

Three Main identified problems

The data provided are idiographic and therefore the Table III provides an illustrative example.

Qualitative feedback

Additional qualitative comments were generated in a post group evaluation session:

- "Definitely run it again, it was very helpful".
- "I found the 9 Steps to Discharge diagram helpful".
- "It was very helpful looking at pictures of placements and learning about different types of placements".
- "I did not like the healthy eating session, I get fed up going over it".
- "Having a commissioner was very good and learning about funding".
- "It was good to go over CTOs and Guardianships".

Overall the group received positive and constructive feedback, however, some service users expressed frustration in discussing healthy lifestyles in regard to diet and exercise, which they believed was focussed on too heavily throughout their inpatient stay. Group members reported valuing a "9 Steps to Discharge" process map, which documented each necessary stage in identifying placements and securing funding in an accessible format, and outlined the roles of

Table III MIP summary table

<i>Problem</i>	<i>Pre Intensity</i>	<i>Frequency</i>	<i>Post Intensity</i>	<i>Frequency</i>
Getting used to the differences in the community after being locked up for 6 years	7/10 (A lot)	5/10 (A few times a month)	3/10 (Not very much)	1/10 (Every now and then)
How my relationship might change with my fiancée	2/10 (Not very much)	1/10 (Every now and then)	1/10 (Not very Much)	1/10 (Every now and then)
Learning to budget and pay bills	8/10 (A lot)	5/10 (A few times a month)	6/10 (A lot)	3/10 (Less once a week)

community based professionals such as social workers and community nurses. Overwhelmingly service users reported that they would recommend the group to fellow peers approaching discharge/transfer.

Reflections

When reflecting on the delivery of this group and the learning experiences, it became apparent that, as with almost all aspects of Secure Service provision, the presence of the wider systemic context was experienced powerfully throughout by both group members and facilitators. The following themes draw together our reflections and highlight some of the many tensions in this area of service provision, such as control and choice, freedom and responsibility, limitations and restrictions, transparency and paternalism, and the ubiquitous imbalance of power. These themes are organised into the following sections: Service user attitudes to discharge; the impact of restrictive systems; and the benefits of the group.

Service user attitudes to discharge. As group facilitators it became apparent that group members had spent limited time considering the realities of their life post-discharge. In some instances this reflected an apparent protective cognitive style reflecting pessimism and efforts to avoid “building one’s hopes up” in order to avoid potential future disappointment. Similarly, one individual withdrew from the group due to his own perceived failure following a risk incident on community leave and his subsequent anxiety that he had jeopardised his discharge. For others, it seemed that this represented learned helplessness and fatalism, and we reflected that, as is often experienced when working with disenfranchised, disempowered individuals such as offenders with ID, high levels of externalised locus of control are common in those who have historically been given little choice and independence.

It was observed that unrealistic expectations were not only negative. Some individuals displayed overly positive and optimistic expectations and were unprepared for the realities of some less positive aspects of community living, such as bill payments, and anonymity and isolation, amongst many others. Whilst we as facilitators were keen to support the group members to reconcile their fantasy of discharge with the reality, we recognised the challenges of doing so when so many of our group members did not have an identified service provider or agreed model of care proposed for discharge. Furthermore, we observed that freedom, choice and opportunity were often held up as overwhelming and anxiety provoking by service users who for many years had experienced choice and control only within defined limits. As we reflected on this we were struck by how tasks as ostensibly enjoyable as daily meal planning were sources of great anxiety and concern.

Impact of restrictive systems. Throughout the reflective process a consistent theme emerged in relation to the restrictive nature and practices of Secure Services and how this creates impediments to preparing people well for life after hospital. Despite pursuing ongoing drives to reduce restrictive practices consistent with Department of Health (2015) guidance, the Mental Health Act code of practice, the British Institute of Learning Disabilities (2014) and the Care Quality Commission (2014) guidance, balancing control and power with choice and independence served to highlight the power imbalances between services and restricted patients. One such example of this was observed when service users discussed their involvement in identifying community placement options available to them. Frequently service users were asked their preferences and then provided with impressions of choice and options from external agencies that were often incompatible with their needs in relation to risk. Ultimately, final decisions were being taken in the best interests of the service user, their needs and the needs of society, that were perhaps not consistent with the service user’s ambitions. In addition, the reality of the often limited service options available in local areas was not consistently communicated to service users, leading to frustration and dissatisfaction. Such dilemmas serve to illustrate the fundamental importance of honest transparency at all stages of the discharge/transfer process.

Restrictions placed upon people in Secure Services in order to maintain security and safety can make the transition to community living difficult and anxiety provoking, particularly in the context of some of the rapid societal changes we observe; the speed of technology development is an

example of this. Anxieties and concerns raised by group members encouraged us to further reflect on the importance of progressive practices to prevent institutionalisation and to press for progressive policies and practices that keep service users updated on social developments, specifically in the age of the internet, smart phones and increasing advances in technology.

Whilst group members were overwhelmingly positive about the group, there was a distinct lack of appeal and negative feedback regarding sessions on healthy lifestyles, healthy eating, smoking cessation, alcohol consumption and gambling. This further prompted reflection on how the ideals and values of Healthcare services are communicated to service users with the expectations that they will adhere to these going forward.

Fundamentally, the perception of disempowerment and lack of control for our group members stemmed from their uncertainty within the discharge process following the completion of their prescribed treatment pathway. Throughout the group programme service users reported experiencing distress caused by inconsistencies in information provided by different services, placements “falling through”, funding applications being not granted or delayed, changes in assigned professionals leading to changes to plans and delay and uncertainty regarding dates and time-scales for Mental Health Review Tribunals and Parole Board Hearings. On-going reflective practice provided a space to hold empathy and appreciate the experience of our service users and recognise their resilience and coping ability in the circumstances as they sought to progress this significant step in the recovery of their independent lives. Further this allowed a space to reflect on our own frustrations; as clinicians we aim to be transparent and inclusive and collaborate closely with service users in informing them of their progress through their treatment pathways and give realistic appraisals of their progress towards discharge/transfer. In addition we experience external pressures to deliver efficient treatment and streamlined treatment pathways and expedite discharge/transfer, however at the point of impending discharge/transfer, systems beyond our control can halt or delay the process. We have found that being able to contain these emotions and provide optimism and hope to patients at these times is a core role throughout this stage of Secure Care.

Since effective discharge planning relies on the co-ordination of a number of services; often external to the hospital and operating within the remit of processes outside of the NHS; and across a wide geographical area, it was not surprising that there was considerable variation between the group members’ experiences of the discharge process. Whilst this provided opportunities for service users to share and learn from each other’s experiences, it highlighted challenges for us as facilitators in terms of the timeliness of the group and ensuring that the content remained meaningful and relevant. On reflection, the group members with concrete experience of either visiting placements or living in a specific model of care prior to their hospital admission, appeared to engage more meaningfully with the resources and discussions; having “real life” experience for both them and us as facilitators, to link or “hook” some of the more abstract concepts and processes on to.

In addition, the uncertainties and delays in the discharge process experienced by our group members have meant that a proportion remain detained a number of months since completing the course; with some service users still yet to have discharge placements identified for them. This prompted reflection on how we, as a service, might support our service users in what often feels like a period of limbo in which active treatment is completed but progression towards discharge/transfer has stalled. We recognise that limited resources and the restrictive nature and practices of Secure Services often obstruct clinicians’ attempts to bridge the gap between hospital and more independent living but seek to review our processes and practices in light of this.

Benefits of the group. Our overwhelming reflections on running this group were of the value and importance of significant on-going investment in bridging the divide between inpatient and community services and furthering progressive policies which manage risk in the least restrictive manner. The importance of collaboration and co-production with service users of interventions and practices to this end is fundamental to reducing service user anxieties and contributing to positive community transitions.

Service users clearly valued the group and enjoyed the opportunity to engage in transparent, open discussion about their futures. The sense of transition, progress and optimism within the group was refreshing for clinicians more familiar with discussing distressing content regarding trauma, risk and offending. Similarly, we enjoyed the opportunity to reflect on the significant progress service users at this stage of their treatment pathway had made, the journeys they had each taken, the obstacles they had overcome and the positive changes they had made. The hope and optimism within this group was rewarding for all involved.

This group also again highlighted the benefits of multi-disciplinary team approaches in discharge planning but again also in the delivery of interventions. The unique perspectives and contributions of different professional groups adds value and learning to both service users and clinicians' experiences, specifically in Secure Services where MDT coherence and relationships are central to effective service user rehabilitation.

Finally, we reflected on the importance of endings and how often in the drive to rehabilitate and discharge/transfer people and focus on their positive futures outside of Secure hospitals, we risk neglecting appreciating how the inpatient experience can sometimes be a significantly positive one for service users. Often, this period of hospitalisation represents the most stable and safest period of individuals' lives and the relationships and trust that is built up between service users and their staff team, and indeed their fellow service users can be difficult to leave behind.

Discussion

The current paper describes the introduction of a Leavers' Preparation Group in a Secure ID Service. In the context of reductions in ID inpatient beds and reductions in restrictive practices, discharge and transfers out of hospital settings are increasing. The current group was established to provide support and preparation for service users as they approach discharge/transfer from hospital. The outcome data indicate that the group was beneficial in reducing service users' anxieties in regard to moving on from their current hospital and qualitative feedback was overwhelming positive and indicated that the group had been a beneficial experience. As reflective practice should, this experience has given us the opportunity to focus on those aspects of practice that work well and those that we strive to do better. We have engaged in the process of co-production in the development of this group intervention and have been led by the needs of our service users and relevant stakeholders along with identified clinical need.

There are evident limitations to the process highlighted in this paper. At present it has been trialled only with a small sample of male service users. The outcome data are limited by this and also by the subjective idiographic accounts of the 3MIP measure. Additionally, qualitative feedback was gathered in a group forum with the group facilitators which may inevitably have biased responses.

Following the initial delivery of this group a number of learning points have become apparent. There is an evident need for thorough discharge preparation commencing from the point of admission and this should include all involved agencies external to the inpatient hospital; the role of an internal inpatient Social Worker can provide critical support in this work. As inpatient services we should strive to pursue progressive drives to reduce restrictive practices where possible, whilst of course balancing the needs and responsibilities of risk management, if we are to ensure effective resettlement in conditions of lower security, particularly in the context of Transforming Care; this should include consideration of access to restricted items, in particular the internet and Smart Technology. We believe that there is a responsibility on staff teams to appreciate the anxieties involved in discharge/transfer and for services to be pay careful consideration to the use of language in goal planning, being mindful at all times that "getting back to the community" can for some individuals feel less desirable and more stressful than remaining in Secure Services. It should be a constant effort to foster cultures of open transparency and collaboration with service users and we should reflect on controlling practices where required and seek to truly appreciate the distress that can be engendered in the length of time taken to discharge/transfer individuals. Finally, we feel that the value of relationships people develop whilst

in Secure Services and how these endings are managed needs formal recognition in ending phases of treatment pathways. Whilst Secure Services undoubtedly strive to achieve these aims, we have found having the opportunity to reflect on these points throughout the course of this group to be a rewarding experience.

Future developments

Further groups are scheduled with the intention that this practice becomes integrated within the existing Service Treatment Pathway. Indeed, it would be recommended that the practice of actively preparing service users for discharges and transitions is a core element of exit planning in Secure Services. At present both an all-female and a mixed gender group (influenced by risk assessment) are scheduled. Whilst it is anticipated that further groups will follow the existing structure, focus groups will be held prior to their commencement in order to ensure the content covered meets the needs of prospective participants. In addition, to further enhance the multi-disciplinary approach, nursing staff are scheduled to be involved in facilitating future groups. Finally, it is anticipated that further exploration of the impact of this group, and indeed comparison of a group-based intervention with individually delivered discharge/transfer preparation, will be conducted as further outcome data are generated.

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