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Leading article

The impact of facility relocation on patients' perceptions of ward atmosphere and quality of received forensic psychiatric care

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ABSTRACT

In recent years, large groups of forensic psychiatric patients have been relocated into new medium- and maximum-security forensic psychiatric facilities in Sweden, where a psychosocial care approach is embedded. From this perspective and on the assumption that physical structures affect the therapeutic environment, a prospective longitudinal study was designed to investigate the impact of the facility relocation of three forensic psychiatric hospitals on patients' perceptions of ward atmosphere and quality of received forensic psychiatric care. Participants were patients over 18 years of age sentenced to compulsory forensic psychiatric treatment. Data were obtained by validated questionnaires. Overall, 58 patients (78%) answered the questionnaires at baseline with a total of 25 patients (34%) completing follow-up 1 at six months and 11 patients (15%) completing follow-up 2, one year after relocation. Approximately two-thirds of the participants at all time-points were men and their age range varied from 18 to 69. The results of this study showed that poor physical environment features can have a severe impact on care quality and can reduce the possibilities for person-centered care. Furthermore, the study provides evidence that the patients' perceptions of person-centered care in forensic psychiatric clinics are highly susceptible to factors in the physical and psychosocial environment. Future work will explore the staff's perception of ward atmosphere and the possibilities to adapt a person-centered approach in forensic psychiatric care after facility relocation.

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1. Introduction

The main purpose of Swedish forensic psychiatric facilities is twofold: (1) to act as places for rehabilitation toward re-entering society, for individuals who have been referred by the courts for assessment or who have been declared as not criminally responsible or unfit to stand trial by the criminal justice system; and (2) to protect society from these individuals. A recent study[1] revealed that the median length of stay for forensic psychiatric patients in Sweden, with and without restriction order, was 951 days, but patients with a restriction order stayed in hospital almost five times as long as patients without. Traditionally, institutional care for forensic psychiatric patients has been arranged according to the medical model,[2] in which emphasis is given to the treatment of the underlying pathology that causes the disease.[3] In recent years, however, large groups of forensic patients have been relocated into new medium- and maximum-security forensic psychiatric facilities in Sweden, where a more psychosocial care approach is embedded. In this new perspective, the care is person-centered and conducted in close cooperation with the patient and the patients' family.[2] The design of the physical environment is regarded as more than simply decorative.[4] This is based on the notion that a person's dwelling – her or his ‘home’ – is of importance for that person's sense of identity, health and well-being, given the home's fundamental role in supporting the basic needs of its occupants.[5] The physical environment can be described in terms of architectural, ambient and interior design aspects. Architectural aspects are relatively permanent, such as a building's layout, room size or window placement. Examples of interior design are furnishings and colors, while ambient aspects comprise lighting, temperature and noise.[6]

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As research focusing on the relationship between the physical health care environment and patient well-being[7] grows, the environmental design has become known as a therapeutic resource to promote well-being and functionality among patients. In light of this insight, many of those involved in the design and delivery of forensic care endorse the use of non-institutional design features to promote well-being among patients. This endorsement is supported by research findings, where more personalized and home-like caring environments are associated with improved intellectual and emotional well-being, enhanced social interaction, reduced agitation, greater preference and pleasure, and improved functionality of individuals with mental illnesses.[8–12] A growing body of research suggests that the caring environment should also support patients' perceptions of quality of care.[13,14] Quality of care is a multi-dimensional construct, composed of several related domains, including those of physical, emotional and social functioning, as well as a person's overall evaluation of his or her well-being and possibility to participate in the care.[15] The provision of good quality of care can be accomplished in person-centered care environments that are known to acknowledge the resources, needs, personality, preferences, habits, and cognitive, sensory, and physical limitations of the patients.[5,16]

Within the context of forensic psychiatry, the relocation of patients into person-centered care environments aims to promote their quality of care in the process of moving towards rehabilitation and re-integration into society. Although there is little evidence on the effects of person-centered environments in forensic psychiatry found in the literature, there have been several approaches presented of how to change the environment in forensic psychiatry to meet the needs of the patients and emphasize the individual's right to define what steps need to be taken in order to achieve health and well-being. Some of these approaches suggest that different aspects of the environment in forensic psychiatry – such as the unit layout, supportive features and finishes, access to outdoor spaces and sensory stimulation – may be linked to better outcomes, including improved sleep, better orientation, reduced aggression and disruptive behavior, increased social interaction, and increased overall satisfaction and well-being.[13,17]

Although there is no previous research on the impacts of relocating forensic psychiatric patients to new environments, relevant research in elderly care and general psychiatry leads to the assumption that moving into new care settings may represent a monumental life change for all long-term care patients, and that several adjustments accompanying relocation, such as imposed routines and regulations, may complicate the patient acclimatization.[18–22] Findings are, however, mixed,[23] and, according to McAuslane and Sperlinger,[24] a more pleasant environment in a new facility may lead to a more positive impact for relocated patients. This finding matches a previous study which also demonstrated that patients affected by dementia appear to suffer few or no adverse impacts from relocation when moved together as intact units of residents and staff.[25]

On the assumption that physical structures affect the therapeutic environment, a prospective longitudinal study was designed to measure the impact of the physical and psychosocial environment on psychiatric care outcomes, after the relocation of three forensic psychiatric hospitals in the western part of Sweden, in the county of Västra Götaland, to new facilities. Additionally, we aimed to study the effect of the working environment and other staff-related parameters, such as competence and experience, on the delivery of person-centered care. Finally, we measured the effect of interventions designed to ensure a secure and safe environment.

The hypothesis assumed that designed strategies such as improved access to gardens, nature window views, and quiet environment can reduce negative psychiatric outcomes and adverse events among the patients. Furthermore, it was hypothesized that increased availability of single rooms with private bathrooms and choice seating in communal spaces may increase socialization for patients and staff, perceived ward atmosphere for patients and staff, the possibility to perform person-centered care for staff and perceived quality in psychiatric care for patients.

Before relocation, the forensic psychiatric hospitals were housed in old buildings, which had been improved and altered over the years to adjust to changing needs. The design of the three old facilities faced both latent implicit and explicit architectural drawbacks, including the following: a series of standardized traditional single-patient rooms, called back-to-back, were laid out on both sides of a hallway in all three hospitals. The rooms lacked individual bathrooms and had deficient ventilation systems. Moreover, back-to-back plans created major transfer noise and vibration between rooms. The lack of windows and of controllable lighting and temperature was also defined as some of the structural failures of the facilities. Furthermore, a lack of access to the natural environment and daylight exposure, either through nature window view or by gaining access to gardens with seating areas, was also recorded. Poor placement of handrails, and inappropriate door openings and furniture heights were also some of the latent conditions registered.

In a previous paper we presented baseline data on the impact of the psychosocial and physical environment on forensic psychiatric care outcomes at the same three forensic psychiatric clinics in Sweden. The results indicated that both patients' and staff's perceptions of person-centered care in forensic clinics are highly susceptible to factors in the physical and psychosocial environment.[26]

In this paper we present results of the impact of facility relocation on patients' perceptions of ward atmosphere and quality of received forensic psychiatric care as well as how environmental and other patient-related parameters, such as literacy level and length of care, affected their views of a person-centered caring environment, placing his or her needs and expectations at the center of care as well as on the quality of care received.

2. Methods

All patients at the three clinics were informed and asked if they were willing to participate in the study. Data were collected prospectively between 2010 and 2014; before (baseline) and after relocation, i.e., after six months (follow-up 1) and after one year (follow-up 2), respectively. All patients treated at the time for baseline and at each follow-up were asked if they were willing to join the study ending up in a total of 58 patients at baseline, 47 patients at follow-up 1 and 38 patients at follow-up two. In this study we only present the result for the repeated measures, that is, only the individuals that performed both the questionnaires at baseline and at follow ups.

3. Measures

Demographic data included age, gender, place of birth, education, employment history, marital status, place of residence before admission to the forensic psychiatric clinics, previous admission to a general psychiatric ward, length of current admission, and compulsory care during current admission.

The *Person-Centered Climate Questionnaire* (PCQ-P) was employed; a validated patient-reported outcomes instrument designed for evaluating the extent to which a climate (i.e., the physical and psychosocial environment) is perceived as being person-centered (i.e., supporting the person by placing his or her needs and expectations at the center of care). The instrument

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