Clinician Perspectives of Inpatient Forensic Psychiatric Rehabilitation in a Low Secure Setting: A Qualitative Study

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There is a dearth of research into what low secure forensic psychiatric rehabilitation means in Australia and internationally. The aim of this study was to understand clinician perspectives of forensic psychiatric rehabilitation in a low secure setting in Australia and offer insight into a model of care. A qualitative methodology was chosen with separate semi-structured interviews being conducted with staff members involved in decision-making for forensic psychiatric patients in a rehabilitation unit. Analysis of the interviews identified three domains that the questions related to: ‘defining and describing security’, ‘defining and describing low secure forensic psychiatric rehabilitation’ and ‘describing the role of staff and services in a low secure forensic psychiatric rehabilitation setting’. Where relevant, themes were abstracted from the questions that related to these domains. This study revealed that clinicians had a varied understanding of definitions for security but a similar understanding of what low secure forensic psychiatric rehabilitation means, what patients are suitable and the general goals of rehabilitation in this setting. Further research is needed on low secure rehabilitation and specific models of care. There is also a need to develop clear definitions for both security and rehabilitation in low secure forensic psychiatric settings.

Key words: forensic mental health; forensic psychiatry; forensic rehabilitation; low secure; models of care; rehabilitation; security; recovery.

Introduction

Forensic psychiatry focuses on the interface between psychiatry and the law, particularly in relation to the management of the mental health of people who have committed serious crimes and are being treated in settings such as prisons, hospitals or the community. Hospital-based rehabilitation in forensic psychiatry is provided in graded secure facilities that are aimed at optimising treatment for patients prior to their transition into the community.

In order to develop an insight into hospital-based forensic psychiatric rehabilitation, it is essential to understand how inpatient security is defined.^{1–4} This is because rehabilitation offered within different inpatient settings, whether they are general or forensic-specific psychiatric facilities, reflects both the level of security and the acuity of the patients.^{1–4} In the Australian forensic psychiatric system, there are three tiers of security that precede the final transition of a forensic

patient into the community: high, medium and low secure. Current security definitions are based on Kinsley's⁵ stratified definitions, which include:

- Relational security: quantitative (staff-to-patient ratio and contact) and qualitative (staff-patient trust);
- Procedural security: policies controlling risk; and
- Environmental security: design and maintenance of the physical environment.

Kennedy⁶ concluded that as patients transition through the system, environmental security is gradually replaced by relational security as the most important feature of security to facilitate therapeutic progress. Furthermore, low secure settings rely more on relational and procedural security than environmental security.⁶

Rehabilitation has been broadly defined as 'a process where the outcome is the result not only of the sum of individual contributions within the treatment system, but also of the interacting effects of these various efforts'.¹ To date, the general principles of psychiatric rehabilitation for civilian patients have been applied to forensic patients.^{7,8} There are limitations, however, with translating general psychiatric models of care to forensic psychiatric patients. This has become apparent more recently with the shift in general psychiatry from a biomedical to a recovery-focused model,⁸⁻¹¹ which has presented various challenges in forensic psychiatry where the interplay of political and legal factors significantly influences the provision of care. Albeit limited, Australian research is consistent with international findings with regard to high and medium secure forensic psychiatric rehabilitation; however, there is a dearth of research into how low secure forensic psychiatric rehabilitation is defined.^{1,2} Historically, this is partly due to the segregated development of forensic psychiatric services, which was reflected in Mullen's¹²

comments: 'The history of forensic mental health services, until recently, was marked and marred by isolation: geographical isolation in the insane asylums and prisons; professional isolation ... and institutional isolation'.

There is limited knowledge in general about hospital-based forensic psychiatric models of care in Australia and internationally with a significant research gap on low secure forensic psychiatric rehabilitation services.² The principles of the treatment of mental illness (psychopathology paradigm) and the assessment and management of risk (risk paradigm) have guided modern forensic psychiatric interventions.² That said, the limitations of applying traditional risk-centred models, such as the Risk-Need-Responsivity Model, as the central model of care to all forensic psychiatric settings have been recognised.² Although other models such as the Tidal Model and Good Lives Model have seemed promising, as they are strengths-based and fit within the holistic recovery-based approach, there is currently limited evidence supporting the use of these models in forensic psychiatry.² Nagi and Davies¹³ commented that in 'low secure forensic mental health services, it is clear that a robust evidence base for the treatment of offending behaviours is absent'. Also, multidisciplinary teams are often faced with the challenge of effectively addressing the rehabilitation needs of forensic patients as clinicians have individual frames of reference that frequently lead to conflict in management.¹⁴ The need for low secure settings to identify the appropriate patient population and develop individualised specialist interventions has thus been emphasised.¹⁵

Although international definitions for the levels of security for forensic psychiatric rehabilitation exist, there are no specific definitions in Australia. Furthermore, despite there being an expanding research base into high and medium secure forensic psychiatric rehabilitation, there is a lack of research into what low secure forensic psychiatric rehabilitation means and the optimal models of care.

Aim

The aim of this study was to understand clinician perspectives of forensic psychiatric rehabilitation in a low secure setting and offer insight into a model of low secure forensic psychiatric rehabilitation in Australia.

Methodology

Study Type

A qualitative methodology with a thematic analysis approach was chosen for this study.

Setting

The Rehabilitation Unit is located within a tertiary psychiatric hospital in a major Australian city. Although defined as low secure, many of its features are consistent with an open ward.^{5,6} Furthermore, the Rehabilitation Unit has unique demographics, as it is a mixed gender ward with both forensic and civilian psychiatric inpatients.

Participants

Staff members directly involved in decision-making for forensic psychiatric patients in the Rehabilitation Unit were identified as potential participants. A letter was given to each clinician outlining the aim and methodology of the study and inviting them to participate. Written consent was obtained from each participant prior to the study commencing. The participants included were one forensic psychiatrist, one forensic psychologist, two forensic nurses, one occupational therapist, one social worker and one medical superintendent. Psychiatry registrars attached to the forensic team on six-monthly rotations and all other clinicians not involved in decision-making for forensic psychiatric patients were excluded.

Ethical Considerations

Ethics approval from the Human Research Ethics Committee of the local health district was obtained prior to the study commencing. Confidentiality for all participants was

maintained throughout the study. All data collected were de-identified and kept securely on an encrypted USB in a locked cabinet.

Method

A literature review was completed with a focus on understanding what definitions and descriptions existed for low secure forensic psychiatric rehabilitation in Australia and internationally.

In order to understand clinician perspectives of low secure forensic psychiatric rehabilitation, separate one-hour semi-structured interviews were conducted by the primary researcher with each of the seven participants. Each interview focused on the participant's knowledge about low security forensic care and the goals of low secure forensic psychiatric rehabilitation. Each participant received the semi-structured interview questionnaire schedule one day prior to their planned interview. This gave the participants an opportunity to consider their responses and optimise the detail of their answers. The participants were advised not to research their responses to ensure the authenticity of the interviews.

Each interview was manually transcribed verbatim against the audio recording and checked to ensure accuracy. This was completed by the primary researcher and confirmed by a data analyst specialising in qualitative research. The interviews were then analysed using the 'meaning categorisation' method,¹⁶ which extends data analysis beyond simple descriptions. The transcribed text was read multiple times and coded into meaningful text segments by the primary researcher and data analyst. Themes were then identified and abstracted from the coded text segments before being analysed and interpreted in a process known as thematic analysis.¹⁷ Although computerised qualitative data programs such as NVivo make data analysis less tedious, they often fail to capture the subtle nuances of interviews, with human input still being necessary

to identify and check characterisation. Thus, the decision was made to manually code the data to optimise accuracy of the data analysis process.

Results

Data analysis of the interviews identified three domains that the questions related to: 'defining and describing security', 'defining and describing low secure forensic psychiatric rehabilitation' and 'describing the role of staff and services in a low secure forensic psychiatric rehabilitation setting'. Where relevant, themes were abstracted from the questions that related to these domains.

Defining and Describing Security

Participants provided varied definitions on the security of the Rehabilitation Unit. The security of the unit was described as 'stand-alone low secure', 'an open ward' and 'lower than low'. All participants accepted that, based on current knowledge, the unit was a low secure setting for forensic psychiatric rehabilitation.

When asked to define the features of security important to the unit, the themes abstracted included:

(1) High relational security

'The most important we would see is relational security. That is forensic staff ideally ... to have a good understanding of the patients, good understanding of their risk assessment and their management and an ongoing relationship'. (Interview 4)

(2) High procedural security

'Policies and procedures are in place. There is the Absent Without Leave policy, Critical Incident policy, local ward-based policies ... forensic patients have their own particular policies because

obviously their restrictions such as leave are more specified from the Mental Health Review Tribunal (MHRT)'. (Interview 7)

(3) Low environmental security

'You can put a lot of invisible walls around people but it is an open ward ... The doors are locked between certain hours'. (Interview 6)

All participants highlighted the low environmental security of the Rehabilitation Unit but acknowledged the capacity to access higher security wards, such as the hospital's Intensive Psychiatric Care Unit, when required.

When it came to generally defining low security in relation to forensic psychiatric rehabilitation, the significant themes were:

(1) Patient factors

'It is really about people integrating and developing skills before being released into the community'. (Interview 2)

(2) Clinical factors

'We have a dedicated team, which increases the actual process of security'. (Interview 7)

(3) Ward factors

'I find it very difficult to put a very definite definition. Generally, a low secure unit would have locked doors but patients are allowed to have unsupervised leave from that unit'. (Interview 4)

(4) Systemic factors

'Practically, we are treating the anxiety of systems rather than clinical needs ... It is geared towards convincing the community in terms of the community representatives, the MHRT, other people within the

psychiatric care system, that people are safe to be released'. (Interview 2)

Defining and Describing Low Secure Forensic Psychiatric Rehabilitation

Participants were asked to define low secure forensic psychiatric rehabilitation in general terms. The most important themes were:

(1) Patient factors

'It is around monitoring mental state, trying to get patients to understand any change in their mental state and the impact that might have on their level of risk'. (Interview 3)

(2) Clinical factors

'I am not sure that forensic rehabilitation definitions are particularly different depending on the unit'. (Interview 4)

(3) Systemic factors

'Keeping people in a secure environment is, by definition, a form of institutionalisation ... Having institutionalised people, you then need a process to reacquaint them with the idea that they are autonomous'. (Interview 2)

(4) Transition factors

'For low secure units, it is a stepping stone for forensic patients to re-engage in community living'. (Interview 1)

The central themes identified as important reasons for forensic patients being referred to the Rehabilitation Unit and requiring ongoing rehabilitation in a low secure setting included:

(1) Clinical factors

... 'a persistence of symptomatology and that they need to have the socialisation

as well as medical observation done'. (Interview 6)

(2) Systemic factors

'It has more to do with bed flow management and bed availability than it does with certain characteristics'. (Interview 3)
'One of the main reasons patients get referred here is because of location'. (Interview 4)

(3) Political factors

'Mostly, people are referred because we need to pacify people ... we are talking about administrative legal decisions'. (Interview 2)

All participants described the assessment process as multidisciplinary with at least two members of the forensic team assessing new referrals.

In relation to describing what forensic psychiatric rehabilitation involved at the unit, participants provided substantial details that were focused into the following themes:

(1) Patient factors

'We look at different aspects of their recovery: the biological aspects, their physical health and their living skills, their functioning ... and any psychological factors affecting their mental state and their cognitive capacity'. (Interview 1)
'The rehabilitation will look at all aspects ... particularly focusing on their risk of reoffending and risk to themselves and risk to the community. With a recovery model, we would look at all aspects of that'. (Interview 4)

(2) Holistic individualised clinical care offered by a multidisciplinary team

'It is multidisciplinary and involves a number of different strands'. (Interview 4)

'It is very individual for a start'. (Interview 6)

(3) Redefining the role of care providers

'We need to reinterpret the role of psychiatrists to the patient as somebody that is managing their transition ... and will be an ongoing support in the community rather than somebody who is primarily related to the custodial setting'. (Interview 2)

(4) Transition factors

'A lot of it is about attempting to alleviate the corrosive effects of institutionalisation and ... reinterpretation of treatment in a community setting'. (Interview 2)

Participants were asked to comment on the main challenges for forensic patients when they first arrived at the unit. One theme identified was the 'adjustment to change in security' with new ward-specific procedural security measures and a reduction in the environmental security ('There is certainly a lot more temptation and potential destabilisers ... more access to the community, more access to drugs, alcohol, people'. – Interview 4). Other significant themes identified were: 'adjustment to change in the social environment' in terms of being in a mixed gender ward with civilian patients and having to understand staff expectations again, 'emotional adjustment' ('That sense of freedom they get. Sometimes they get a little bit elated by it and at other times they are quite frightened by it'. – Interview 6), 'dealing with stigma' around having a mental illness and being a forensic patient and 'dealing with social isolation' with limited family or social supports.

Participants were asked to describe how rehabilitation helped overcome these challenges. In regards to security, 'optimising relational security' with close monitoring and building rapport, and 'strict enforcement of

procedural security' to minimise temptations such as drugs, alcohol and gambling while ensuring adherence to Mental Health Review Tribunal leave provisions were recognised as important themes. In terms of clinical care, 'holistic individualised clinical care offered by a multidisciplinary team', 'gradual exposure to potential destabilisers' through the slow titration of leave, 'preparation for dealing with stigma' such as when to discuss their forensic status with other people and 'gradual transition into the community' ('A very supportive approach to early exposure to the community, a lot of assistance with learning new skills'. – Interview 4) were also emphasised as significant themes.

In an attempt to understand the duration of rehabilitation for forensic patients in the unit, participants were asked to comment on the average length of stay, which was estimated to be between two and four years. The following themes were abstracted as influencing the length of stay:

(1) Patient factors

'Response to medication ... The cognitive profile of the patient ... significant personality features ... antisocial personality ... narcissistic personality'. (Interview 3)

(2) Systemic factors

'Some of it would be the appropriateness of the referral ... people who come here directly from court because they were already here, they would be the long-stayers ... they have not had much rehabilitation elsewhere'. (Interview 4)

(3) Resource factors

'One of the biggest issues is to actually have a decent community network for forensic patients ... To monitor in the community is almost always where it falls down ... Community Mental Health

Teams (CMHT) are really under-resourced'. (Interview 7)

(4) Influence of victims

'With a few it has been victims. The position of families who influence'. (Interview 6)

Given the nature of the unit with both forensic and civilian patients, participants were asked whether forensic rehabilitation differed from civilian rehabilitation. Forensic rehabilitation was identified as being more resource-intensive, prescriptive and individualised ('In terms of the group program, it is one program for everyone. In terms of forensic patients, we have to tailor the program to fit their stage of recovery'. – Interview 1). There was also emphasis placed on the importance of relational and procedural security as well as the greater influence of political and legal factors on forensic patients.

Describing the Role of Staff and Services in a Low Secure Forensic Psychiatric Rehabilitation Setting

Participants varied in the duration of their work experience at the Rehabilitation Unit with a range from three months to eight years.

The main responsibilities of each participant were described as expected, with the themes identified as:

(1) General clinical skills

'Assessments. Being part of the forensic team in terms of reviews'. (Interview 3)

'For all patients, it is to monitor their mental state ... you put more emphasis on their transition because it is more of a prolonged exercise'. (Interview 6)

(2) Discipline-specific clinical skills

Each participant identified their discipline-specific roles within the team as

expected. The medical superintendent emphasised that their primary role was to provide clinical governance. The forensic psychiatrist identified their role as the team leader who also managed 'medical aspects, particularly the pharmacological and ongoing assessment of mental state'. The forensic psychologist described their role as being indirect through the supervision of clinical psychology interns. The forensic nurses emphasised their role in building rapport with patients and managing procedural security such as monitoring leave provisions and substance use. The occupational therapist's role was to assess the level of function and cognition of patients while making recommendations about support needs. The social worker's role was to support independence and engagement with community resources.

(3) Multidisciplinary teamwork

'We all bring our observations together as a team to make decisions, to make a precise and sound risk assessment and management plan for the patients ... each member of the team contributes to the final MHRT reports'. (Interview 1)

Participants described a variable range of contact with each forensic patient, from indirect contact through clinical supervision of other staff to direct face-to-face contact. Contact ranged from irregular to regular contact depending on the rehabilitation stage of the patient:

'Obviously when someone arrives here first off, we spend a considerable amount of time with them one-to-one ... The more time they spend in other areas, the amount of time we actually spend with them on the ward lessens'. (Interview 1)

Apart from the medical superintendent, all other participants described attending a

regular fortnightly case review meeting that lasted approximately four hours. Each forensic patient was interviewed directly and their management plans were discussed in detail in each meeting.

All participants commented on how local resources affected the provision of services within the Rehabilitation Unit and in the community. Themes were abstracted as follows:

- (1) Local resources influence service provision

‘Funding is virtually done by historical precedence rather than by need’. (Interview 2)

- (2) Lack of dedicated resources for forensic patients

‘This is a general rehabilitation service ... There should be more people involved in forensic training so they can understand the complications’. (Interview 1)

‘There are no specific resources for forensic patients ... because they are less disabled as a group than other people in a traditional setting, they get fewer resources’. (Interview 2)

- (3) Lack of community resources for forensic patients

‘There is just a dearth of appropriate resources ... Probably all patients could move out if we had the right accommodation and right supports’. (Interview 5)

- (4) Current models do not support provision of services to forensic patients

‘There is no particular funding model ... I am sure that it is quite below what any reasonable assessment ought to be’. (Interview 2)

Discussion

This study offered insight into clinician perspectives of low secure forensic psychiatric rehabilitation and about a particular model of forensic psychiatric rehabilitation in a low secure setting in Australia.

There was consensus that the Rehabilitation Unit was a low secure setting based on current security definitions.⁴⁻⁶ Although some participants were not aware of Kinsley’s⁵ stratified definitions of security, the high relational and procedural security of the unit was described as being significant given the low environmental security. This was consistent with conclusions drawn by Kennedy.⁶ Interestingly, an additional perspective was offered on psychological security, a definition not previously described in literature: ‘Really a lot of the security is in the patient’s mind. Their restriction in this particular stage is more from them as opposed to the actual physical environment’ (Interview 7).

Despite limited research to date, there was inherent consistency in how participants defined and described low secure forensic psychiatric rehabilitation. Most participants acknowledged that rehabilitation aimed to transition patients from institutional living to community living, which reflected deinstitutionalisation and a shift from the biomedical to recovery-focused model of care.⁸⁻¹¹

Participants described clinical, systemic and political factors influencing the referral of new forensic patients. Although clinical factors were identified in the outcomes of previous studies,^{3,18,19} systemic and political factors had not been described previously. The assessment process in the unit was ‘ad hoc’ (Interviews 3 and 4) at times, which differed to previous research that emphasised the importance of identifying suitable patients in order to provide appropriate and effective treatment.^{15,18,19}

When it came to describing what rehabilitation involved at the unit, central themes included: patient factors, holistic

individualised clinical care offered by a multidisciplinary team, redefining the role of care providers and transition factors. These themes reflected the findings of another qualitative study³ that emphasised medication adherence, management of comorbidities and development of financial management skills as important aspects of forensic psychiatric rehabilitation.

Most participants referred specifically to the influence of a recovery-focused model of care on forensic psychiatric rehabilitation in the unit. Although risk-centred models traditionally used in higher security settings were acknowledged, these were not considered applicable to this setting. Interestingly, this application of a recovery-focused model has not been reflected in the literature.^{2,12,13}

Many challenges were faced by patients in their transition to the low secure unit, including adjustment to changes in security and the social environment, emotional adjustment, dealing with stigma and dealing with social isolation. Overcoming these challenges required optimising relational security, strict enforcement of procedural security, holistic individualised clinical care offered by a multidisciplinary team, gradual exposure to potential destabilisers, preparation for dealing with stigma and gradual transition into the community. Similar findings were described in a qualitative study³ that explored the perspectives of caregivers towards aspects influencing the transition of forensic patients from institutional to non-institutional care.

There was agreement amongst all participants that forensic psychiatric rehabilitation differed from civilian psychiatric rehabilitation as it was more resource-intensive, prescriptive and individualised, with longer admissions. The average admission length for forensic patients was estimated to be between two and four years with patient factors, systemic factors, resource factors and the influence of victims impacting on the length of admission. Similar results were described in a service audit¹⁸ of an open forensic psychiatric rehabilitation ward in Australia, which

reported an average admission length of 15 months and explored the importance of an appropriate discharge destination. This audit also commented on other factors influencing the effectiveness of such settings, including improvement in mental state and a reduction in both reoffending risk and illness relapse.¹⁸

The responsibilities of the participants ranged from general clinical to discipline-specific clinical skills with collaboration as a multidisciplinary team. There was no fixed frequency of contact between clinicians and patients. Participants commented on the importance of conducting assessments within and outside the ward environment as this ensured more holistic assessments of patients. Participants also described how local resources impacted on the provision of services and emphasised the lack of dedicated forensic resources with current models not supporting service provision. There is limited research available to compare these service-specific findings against any Australian standards. The 'Standards for Low Secure Services'⁴ developed in the United Kingdom are yet to be translated into an Australian model.

Critical Review of the Methodology, Including Strengths and Limitations

Unlike quantitative research that focuses on numerical data analysis, qualitative research focuses on analysing the meaning of words.¹⁷ Despite historically being considered inferior to quantitative research and perceived as lacking in rigour due to its small-scale nature, qualitative research is superior for exploring the subjective perspectives of individuals and obtaining a realistic insight into their experiences.^{20,21}

The qualitative methodology was chosen as it was deemed more suitable for eliciting clinician perspectives of low secure forensic psychiatric rehabilitation. This study sought to maintain rigour by optimising credibility (truth value), dependability (trustworthiness), confirmability (neutrality) and transferability (applicability).^{21,22} Credibility and dependability were

optimised through the clear methodological approach with consistency in recruiting and consenting the participants while the use of a semi-structured interview schedule standardised the process of data collection and ensured each participant was asked the same questions. Also, cross-checking of interview transcriptions minimised transcription error, and joint coding of the interviews helped to increase inter-coder reliability, capture complex details and generate theory from empirical data leading to a 'closeness of fit' between theory and data. Supervision from a forensic psychiatrist disconnected from the research setting and the involvement of an experienced qualitative data analyst optimised credibility, dependability and confirmability while minimising researcher bias. Although the results of this study might be transferable to similar settings, they ought to be interpreted and applied with caution, given that the study participants were unable to provide specific definitions for low secure forensic psychiatric rehabilitation.

Some limitations were identified in this study. The Rehabilitation Unit where the study was conducted had a unique combination of civilian and forensic psychiatric patients with the unit being based in a general psychiatric hospital. The participating clinicians were involved in the care of both patient groups and thus were more exposed to a recovery-focused general psychiatric model of care as opposed to clinicians working in forensic-specific psychiatric rehabilitation settings. In spite of seven appropriate participants being identified, this small sample size had the potential to affect the generalisability of this study to a larger service. That said, this was unlikely to be significant, as the qualitative methodology supports smaller sample sizes. Limitations in the data collection process were identified, particularly the difficulty accounting for the varied interview lengths and differences in the quality and quantity of information obtained. Factors influencing the participants might have included: their discipline-specific roles, varied clinical training and varied clinical experience ranging from three months to eight years. An exploration of

these differences between participants might have yielded interesting findings; however, this was limited by ethical considerations such as the need to maintain the confidentiality of participants as well as the qualitative methodology limiting the ability to objectively investigate causality between different research phenomena. Other limitations were identified in the data analysis process with the potential for the results to be influenced or different conclusions to be obtained from the same information due to researcher bias.

Contributions to Forensic Psychiatry

This study specifically addressed the knowledge gap in the literature on forensic psychiatric rehabilitation and models of care in low secure settings.^{2,12,13} Although the participants had varied clinical experience, their reflections offered insight into the goals of forensic psychiatric rehabilitation and the delivery of a recovery-focused model of care in a low secure setting. Their reflections supported the proposed stratified definitions of security and the shifting emphasis on relational security for forensic psychiatric patients transitioning from low secure to community settings.^{5,6} Furthermore, the clinician perspectives highlighted the complex interplay between clinical, systemic and political factors influencing forensic psychiatric rehabilitation, which has not been elucidated in literature. That said, the participants were unable to provide a specific definition for low secure forensic psychiatric rehabilitation. Hence, this study highlights the need for further research to understand models of care being provided in other low secure settings, identify strengths and limitations of such models, develop a consistent definition for low secure forensic psychiatric rehabilitation and guide improvements in service provision for forensic patients.

Conclusion

This study offered insight into clinician perspectives of forensic psychiatric rehabilitation and a model of care in a low secure

setting in Australia. Clinicians had a varied understanding of definitions for security but had a similar understanding of what low secure forensic psychiatric rehabilitation means, what patients are suitable and what the general goals of rehabilitation are in this setting. Further research is needed in forensic psychiatry, particularly in relation to low secure rehabilitation and specific models of care. There is also a need to develop clear definitions for both security and rehabilitation in low secure forensic psychiatric settings in order to optimise the consistency of patient care.

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Declaration of Interest

The authors report no declaration of interest.

Disclosure Statement

The authors have no conflicting interests to declare.

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