Systems and processes that enable progress for older forensic mental health patients

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Abstract

Older forensic mental health patients have complex needs and requirements; service provision is required to address mental health, offending risk and issues associated with aging (geriatric care). This study aimed to identify the systems and processes that enable valued progress (in terms of quality of life, health, wellbeing, recovery and reduced risk) for older forensic mental health patients. Interviews were conducted with 48 members of staff working with these patients in secure hospitals or the community. Thematic analysis was used to analyse the data. Four overarching themes were identified regarding what facilitated or acted as a barrier in relation to quality of life, health, wellbeing and recovery. Multidisciplinary input, an individualised approach and implementing holistic and needs-led care was found to facilitate progress. However, lack of resources, excluding the patients in care planning, gaps in expertise and knowledge, and a lack of specialised units that could address mental health, forensic and elderly needs were found to be barriers. Extensive, multilevel and wide-ranging support is required specifically for older forensic mental health patients. Joint working is required between older adult and forensic mental health services incorporating geriatric medicine expertise in order to implement co-produced care and treatment plans.

Keywords: Forensic mental health care; Quality of life; Health and wellbeing; Multidisciplinary care; Older adults.

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Mentally disordered offenders are defined as '*those who come into contact with the criminal justice system because they have committed, or are suspected of committing, a criminal offence, and who may be acutely or chronically mentally ill*' (NACRO, 2006). The Mental Health Act 1983 (as amended in 2007) has provision for mentally disordered offenders to be placed in a hospital setting following sentencing. In the UK, the National Health Service (NHS) and private healthcare companies provide a range of secure inpatient services. 'High secure' beds are for patients who 'pose a grave and immediate danger to the public'; 'medium secure' beds for patients who 'pose a serious danger to the public'; and 'low secure' beds for those who 'pose a significant danger to themselves or others' (Völlm et al., 2017). Alternatively, where risk can be managed, support is provided in the community by specialist forensic mental health professionals. Forensic mental health services work collaboratively with other mental health professionals, general practitioners, social care staff, social workers, and criminal justice agencies.

Within forensic mental health populations, there is a growth in the number of older patients residing in secure units and the community (Chow & Priebe, 2016), although to date there remains limited research on this population. They present with complex, and differing needs compared to younger adult forensic mental health patients. This growth in the number of older patients is partly a reflection of an aging population that is globally evident and likely to continue to expand (World Health Organisation, 2017). Individuals are also remaining in secure units for long periods of time and therefore to older age (Rutherford & Duggan, 2008). In addition, there is an increase in convictions in later life for historical offences for some individuals (House of

Commons, 2013). In the UK and other Western countries around 20% of secure patients are over 50 (Di Lorito et al., 2018; Di Lorito et al., 2017; Völlm et al., 2017), and this proportion is likely to grow (Coid et al., 2002; Di Lorito, Dening, & Völlm, 2019; Lewis et al., 2006).

Forensic mental health patients commonly experience severe mental disorders (e.g., schizophrenia, personality disorder or bipolar disorder). They often present with multiple problems (e.g., substance misuse, physical ill health, cognitive impairment, intellectual disabilities), may display challenging personality traits (e.g., anger, aggression, hostility, impulsivity), and may be combined with criminal, delinquent, dissocial, self-harm, violent and sexual offending behaviours (Hodgins et al., 2011; Huband et al., 2018; Ogloff et al., 2004; Spaans et al., 2017). They may also experience social problems such as: maladaptive, inappropriate or absent social networks and relationships; issues with housing, employment and finances; and difficulties integrating into local communities or the wider society (Beeney et al., 2018; Clifton et al., 2007; Lamb et al., 2001; Ter Haar-Pomp et al., 2015).

Older forensic mental health patients (those aged ≥ 50 years) have histories that often include childhood neglect/abuse, substance abuse, poor health self-management, homelessness, violence, cognitive difficulties, mobility problems, sensory impairment, psychiatric admissions, and chronic physical illnesses (e.g., cardiac diseases, high blood pressure, obesity, diabetes, hypertension) (Cormac et al., 2013; Di Lorito et al., 2018; Lightbody et al., 2010). Many people with long term mental health disorders also experience the negative impacts and challenges associated with old age earlier and can experience a significantly reduced life expectancy (average 15-20 years) (Chesney et al., 2014). Older forensic mental health patients also have complex mental health histories with high levels of psychotic disorders (e.g., schizophrenia, schizotypal,

delusional disorder), personality disorders and co-morbidity (Di Lorito et al., 2018; Yorson & Taylor, 2009).

One of the primary aims of forensic treatment and support is to reduce risk of harm to self or others by addressing mental health issues, offending attitudes and behaviours and social issues (McIntosh et al., 2021). Forensic mental health patients therefore require valued treatment that is multimodal and personalised (Swinkles et al., 2020). It can be challenging for people to achieve progress on treatment goals set due to cognitive deficits, past failures, mobility issues, apathy, and lack of availability of age-appropriate treatment (Natarajan & Mulvana, 2017). This suggests that older forensic mental health patients require specialist care, treatment and support to manage and address their complex and multifaceted needs in valued ways, in order to facilitate progress.

To date, little is known about what service provision is available for older forensic mental health patients. A recent review by Walker et al. (2020) identified that very few studies (only eight) had examined this. They found that older forensic mental health patients' needs were not being met and that there was little intervention and treatment adapted and suitable specifically for them. It is therefore the case that research has not examined what works and what doesn't work in relation to the required systems and processes that need to be in place for older forensic mental health patients. This study sought to further our understanding from the perspective of staff working with older forensic mental health patients. The aim of the current study was to identify the systems and processes that enable valued progress (in terms of improvement in their quality of life, health and wellbeing, recovery and reduced risk) for older forensic mental health patients.

Method

Setting

Recruitment of staff was from eight NHS trusts across England, from low, medium, and high secure hospitals, and community mental health services. In total 13 participants worked at low secure sites, 19 at medium secure sites, eight at high secure sites and eight for community forensic mental health teams across England.

Design

A qualitative design was implemented, and semi-structured interviews were conducted to illicit detailed narratives. The ontological and epistemological assumptions underpinning this research were subtle realism and interpretivism. Subtle realism (Hammersley, 1992) acknowledges that the social world exists independently of the participants understanding, but this is only reachable through the participants' interpretations (which are then further interpreted by the research team). The interviews involved interpretation to understand participant's narratives, perspectives and meanings, within the context, conditions and circumstances of their experiences. Emphasis was placed on the interpretations made by the participants themselves and how their unique understandings, experiences, and viewpoints are embedded in these.

Forty-eight individual semi-structured interviews were conducted. The interview questions were developed with input from a professional advisory panel and a lived experience advisory panel (LEAP) (older adults who had experience of forensic mental health services). Interview questions were piloted with two LEAP group members. The interview questions were structured around quality of life, health and wellbeing, risk, interventions and activities and age/aging. Staff were asked about what they felt was needed to address '*older*' '*forensic*' '*mental health*' patients' mental and physical

health, and about the different care and treatment that they felt they required. They were also asked about specific intervention (e.g., psychological, offence related), activities (physical, mental and social) requirements of these patients, what they believed was currently being successfully implemented, and where they felt omissions in service provision were evident. Of the 48 interviews, two were conducted face-to-face and 46 using video calls. Interview length ranged from 36.13 minutes to 106.55 minutes (M = 63.20, SD = 13.04). Interviews were audio recorded, transcribed verbatim, anonymised and uploaded to NVivo software program.

Data Analysis

Thematic analysis (TA) was used to analyse the data, a research strategy for identifying, analysis and reporting identifiable patterns (or themes) in a data set, such as commonalities or contrasts to provide an illuminating description of the phenomenon of interest (Smith & Firth, 2011). It involved inductive and deductive coding of qualitative data into clusters that comprised similar entities or conceptual categories, then extracting consistent patterns and relationships between the themes in order to come up with explanations and theorise about the subject matter being examined (Figgou & Pavlopoulos, 2015). TA enabled the researchers to identify and isolate salient themes within the text and thematic network analysis (TNA) (Attride-Stirling, 2001) facilitated the development of basic, organising and global themes from the data.

The process of analysis undertaken followed six steps (Braun & Clarke, 2006) and incorporated TNA (Attride-Stirling, (2001). Steps comprised: (i) reading and re-reading the data and coding data line by line; (ii) identifying themes by grouping codes into lower-level themes; (iii) constructing thematic networks by arranging them into basic, organising and global themes; (iv) describing explicitly and exploring thematic

networks; (v) summarising thematic networks; and (vi) interpreting the patterns in light of the research aims. Using the appraisal model developed by Malterud et al. (2015) and considering the following five dimensions, (i) study aim, (ii) sample specificity, (iii) use of established theory, (iv) quality of dialogue, and (v) analysis strategy, data were considered to have high information power. To ensure trustworthiness of the data strategies as recommended by Shenton (2004) were implemented to examine and assess the credibility, transferability, dependability, and confirmability of the data.

Sampling and Recruitment

Sampling followed a non-probabilistic, accessible and purposive sampling approach in order to achieve representation from frontline and management roles. All staff worked for the NHS. Trusts were contacted following interest from Clinical Research Network teams wanting to be part of this research study. Principal Investigators were identified and recruited at each site, and they approached individual members of staff inviting them to take part in the study. To be included in the study, participants had to have worked with older forensic mental health patients aged ≥ 55 years.

Participants

Participants worked in: community (n = 8); low secure (n = 13); medium secure (n = 19); and high secure care (n = 8). Participant professions were: community registered mental nurses (n = 5); psychiatrists (n = 7); psychologists (n = 7); occupational therapists (n = 8); inpatient registered mental nurses (n = 12); physiotherapist (n = 1); social workers (n = 5); and non-clinical staff (chaplain, service user engagement worker, activity co-ordinator) (n = 3).

All participants had experience working with older forensic mental health males, and fourteen participants also had experience working with older forensic mental health females.

Ethics

Ethical approval was granted by Health Research Authority of the NHS (IRAS project ID: 258016; REC reference: 19/EM/0350). All participants provided informed written consent.

Results

Four overarching themes were established from the interview data. Two of these 'Hub and Spoke Approach to Patient Care' and 'Individualised Approach for all Patients' were made up themes that represented aspects that the staff perceived as being required to support progress pertaining to quality of life, health, wellbeing and recovery for older forensic mental health patients. The other two overarching themes, 'Gaps, Absences and Shortfalls in Service Provision' and 'Not Including Patients in Care Planning and Processes' comprised of themes which represented issues and factors that staff perceived as being barriers for these patients in relation to their quality of life, health, wellbeing, and recovery.

[Figure 1 here]

Hub and Spoke Approach to Patient Care

This theme comprised of 4 themes (see Figure 1), named after the hub and spoke model of working which is about having a core team around the patient (the hub), access to professionals, services and support (the spokes) as and when patients need or require them. This approach means access to a selection of people and resources, which provides a range of skills, expertise, and services to meet needs.

Access to Range of Adjunctive Health Professionals and Services. Staff discussed benefits of support from different internal or external professionals to meet physical and mental health needs. This included dentists, opticians, specialist nursing practitioners and speech and language therapists. This was available over and above their allocated psychiatrist and day-to-day nursing care. The most widespread health professionals available across all sites were General Physicians, either offering regular visits (i.e., weekly) or available onsite:

> S21(PMD): *We have an on-site GP which, her contribution is very important, and she is a very important part of our ongoing in terms of managing physical health.*

Some sites reported they had specific healthcare centres, departments or clinics. These provided quick and easy access for physical health needs - of particular value to the older forensic mental health patients who are likely to have more physical healthcare needs.

> S45(RMN): *We have like an on-site health centre. We have all the different disciplines that work here. All their physical health needs are met immediately. We have GPs coming in on-site, dentists. We have the full range; what you would get in a walk-in centre.*

Alternative, Complementary and Therapeutic Services. The staff discussed how, for older forensic mental health patients, access to complementary therapies and non-medical interventions was an important and helpful part of treatment.

> S12(PSY): *We also offer complementary therapies as well, which can be really good for physical and mental health. They will do, you know facial aromatherapy, pain management, and reflexology all sorts of various different options.*

As part of the therapeutic services, religious and spiritual input was important for patients. Access to chaplaincy was described as valuable.

S31(PMD): *I think spiritual and pastoral care seems to be more important for the older patients as well, and again, I think a lot of them have found quite a lot of support from that.*

Health Checks and Screening: Assessment and Monitoring. This theme is specifically around assessments and ongoing checks, observations and monitoring of different health issues e.g., blood tests, ECGs, hearing, vision, and health screens. As well as these medical assessments, patients are also in receipt of general nursing observations. This type of input is potentially of more benefit to the older forensic mental health patients who are likely to have poorer physical health.

S33(RMN): *On a weekly basis, part of the ward routines is physical health monitoring, so blood pressures and things like that. We do physical observations once a week on everybody.*

Linked to this, as part of their standard and routine reviews on the wards/units, patients experienced regular assessments and monitoring by the multidisciplinary team. Assessing and monitoring physical health has become more of a priority for their older forensic mental health patients.

S27(C/RMN): *There are more physical health screening tools and stuff* [for older patients]*; you look at frailty, unprotected bed sores as an inpatient, falls risks and stuff like that.*

The staff suggested that doing regular cognitive assessments and checks for older patients, through medical assessments (e.g., brain scanning) as well as

psychological assessments was helpful for assessing patients' needs. These assessments can offer a baseline measure so that any deterioration can be observed and monitored.

> P05(PSY): *We target the cognitive functioning because that is perhaps one of the most significant aspects of this group* [older] *of gentlemen, so we are not shy around testing whether that's brain scanning, whether that psychometric testing, if anything simply just to keep an up-to-date picture of, whether or not people are deteriorating or not.*

Multidisciplinary Team Aligned and Working Together Collaboratively. This theme was common across all the staff's narratives. It captures evidence around the importance of having a multidisciplinary team (MDT), who all work together, with shared goals and input; to provide consistency of care in a combined approach to meet patients' individual needs.

> S03(PMD): *Involvement of multi-disciplinary experts, from psychiatrists, to social workers, to nursing staff, provision of psychological intervention to occupational activities, sport related activities, educational opportunities, voluntary work you know, supporting them with family contact getting them to be financially independent, providing them with vocational skills*.

Individualised Approach for all Patients

The emphasis in this overarching theme is around how care and activity planning are based on the individual needs of each older forensic mental health patient. This includes tailoring activities and treatment specifically to each person, while accounting for mental health, physical health and age-related requirements. This theme encapsulates how services try to avoid taking a one-size fits all approach and strive to implement an individually driven holistic approach.

Activities in Place That are Best Suited to Each Individual's Needs.

Activities need to be age appropriate and take in to account difficulties that might come with age. Exercise and gym work needs to be modified to consider physical ability. Exercise and sport were actively encouraged for older forensic mental health patients and provided in such a way to enable them to be involved.

> S10(RMN): *There's the gym but they'll tailor the gym as well for different people…. we've got outdoor gym equipment as well which have got different levels of access people so if you've got mobility issues or if you've got somebody who's in a wheelchair they still have access to that.*

Activities were individualised for older forensic mental health patients' needs. This included factors such as skill development and individual interests. Provision of certain activities therefore was seen to have adaptations for older forensic mental health patients.

> S13(PSY): *Some of needs for the older age groups are different, so they might be more likely to join activities that cater for they age group, I don't know, bridge club or a coffee club… The older gentleman like classical music and smooth radio, whereas the younger age group like radio one, rapping and grind, the basic needs I think are the same, just how they want to achieve them are different.*

Activities and interventions were adjusted to consider cognitive decline, dementia and/or memory loss.

> S08(PSY): *A gentleman who possibly had onset of dementia that I was working with, and also some deafness, and a lot of the time it was really important that*

we made sure we adapted, what we were doing because, you know he could easily feel quite out of it in a group.

As well as being individualised for age, the activities were individualised to those that the older forensic mental health patients find enjoyable, and that they want and choose themselves to do. Staff suggested meaningful activities really contributed for many towards good quality of life.

S05(PSY): *So I've got a lovely service user whose quality of life is, if I could spend time out in the garden and in the vegetable allotment area we have at our hospital, and work with you, alongside you I'm quite content, that brings a quality of life for me.*

Linked to this, the staff discussed how it was fundamental that the activities gave the older forensic mental health patients a sense of purpose and of being valued. Again, the emphasis is on ensuring the activities mattered to that individual patients and were explicitly important to them.

S17(RMN): *Coming back to placements, whether they can get onto a rehab ward or not. Having meaningful activities, something they enjoy doing, so that - to thrive and give them that sense of purpose.*

Holistic, Co-Produced, Needs-Led Care. Staff referred specifically to '*individualised care*', '*patient-centred care'* and '*holistic approach'*. Embedded in the individualised care was patient inclusion so they identified what they needed. The older forensic mental health patients therefore take ownership in their care and are not simply passive.

S38(SW): *We need to be really keeping the patient central to their treatment and their decision-making about them… so that, actually, they can take ownership of things that are important to them as an older adult.*

By including the patients in decisions about their care, co-production was an important part of the process.

S13(PSY): *What, what works very well is that we are a very collaborative team, a co-production team… we are very much driven by what the clients tell us and if we are able to help, we will.*

Treatment and Care Informed by Individual Need not Age. This theme moves away from focusing on age as a factor determining what assessment, treatment and care is required, to the premise that assessment is based on each individual patient's needs and requirements, regardless of age. All patients, young and old, are individually assessed for their specific needs, and based on this the appropriate intervention and treatment can be identified and implemented. This was predominantly the case for assessment of cognitive status and decline which is done on an individualised basis, no matter what age.

S27(PSY): *Across the board no matter what age, if we think someone is changing or deteriorating in cognitive functioning we look to investigate regardless of age.*

Gaps, Absences and Shortfalls in Service Provision

Themes here revolve around the omissions in provision specifically for older forensic mental health patients, which participants perceived as impacting negatively on patients' quality of life, health, wellbeing and progress. This is represented by five themes.

Insufficient Resources for Older Patients. Resources identified as being in short supply to properly support older forensic mental health patients and give them the care they need included time:

S01(C/RMN): *Well on the elderly wards, if your patient is on there, which are the 65s plus, there is a lot more physical healthcare delivered on the wards, that is going to dictate the time you have got to be therapeutic;*

staff:

S42(OT): *If you have a number of patients who - and I'm thinking of people at the moment, actually, where things can be really unsettled, and particularly where staff numbers have been quite low, staff will focus on those people who are presenting as more challenging;.*

and money and finances:

S25(PSY): *Because of the cost cutting and that, there are less opportunities for all the patients and this impacts on the elderly patients…there's not enough going on for meaningful activities at the moment. There's been so many cutbacks, we have lost so many different workshops.*

Specific, Suitable and Appropriate Activities and Support for Older Forensic Mental Health Patients. This is describing how some activities are not always suitable and appropriate for older forensic mental health patients. Some activities are more suitable for the younger patient and staff felt that more activities were required specifically for the older forensic mental health patients, especially in the context of physical health and exercise.

S03(PMD): *It is challenge, again you have, you know, one older adult in a ward with younger people, and the gym, or the in-house gym is catered for young*

people, who bump into, I can see an 80-year-old or 70-year-old getting quite apprehensive.

Lack of Specialist Units, Suitable Accommodation and Placements. This theme is related to an identified gap in service provision of specialist and designated services that catered purposely for '*older'* patients, the different needs that this population have, and one that also provided '*forensic*' treatment.

A lack of suitable placements and support in the community hindered progress for the older forensic mental health patients. Such omissions in service provision mean that these patients stayed in hospital much longer than necessary; this means some older forensic mental health patients are potentially enduring more restrictions (and for longer periods of time) than they actually require.

S22(OT): *Sometimes with enough support in the community that could be achieved, and unfortunately that's just not always possible… for many patients, if there is better support in the community they wouldn't necessarily need to be in hospital for as long as they are.*

A lack of service provision was also noted in that several services are unwilling to take these patients because of their histories, and their complex needs due to them having a '*forensic*' and a *'mental health*' label and requiring '*elderly*' care. Another issue around willingness for placements to accept these patients was age cut off points. Staff commented that age 65 is a cut of for forensic services and so not open to those over 65, but then older age services are not setup to take forensic patients.

S09(PMD): *They come of an age where the forensic services no longer look after the patient beyond 65 and older age services might not be very used to having a patient with significant forensic histories.*

Omissions in Staff Expertise, Knowledge, Awareness and Education. This theme refers to gaps in expertise and specific knowledge for '*older*' and '*elderly*' populations. Areas such as physical health, cognitive deterioration, elderly nursing care needs, and understanding older people's interests and requirements were where staff had missing expertise, knowledge and awareness. The staff consistently referred to a '*lack of awareness*' in relation to older forensic mental health patients' needs and how to care for them in valued ways. The staff identified training and educational requirements to enable them to work with older populations in more valued ways.

> S37(PMD): *A general nurse on a ward is not trained in manual handling in the way that the wheelchair user would require, or someone who needs a hoist, or someone who's got a trachy that needs suctioning, or a long-term catheter.*

Processes and Restrictions Impeding Patients. This theme contains examples of where older forensic mental health patients are unable to do certain activities, because of the processes and restrictions that are in place. These process and restrictions are often due to legal requirements, policy and practice and are in place for reasons of safety and risk minimisation. This however was identified as impacting negatively on older forensic mental health patients' quality of life.

> S22(OT): *In a secure service, because you have those restrictions in place for a reason, and that doesn't necessarily mean that they can fully fulfil or engage with what they want to. So that can be one of the barriers for quality of life.*

Blanket restrictions that are in place prevented older forensic mental health patients from having access to opportunities and engaging in activities that might have been of benefit. This includes examples such as being able to leave the unit and have freedom of movement:

S43(OT): *The fact that it is locked and secure and they can't just go for a walk when they want, they can't just go to the gym when they want;*

and the limits in place around access to technology and the internet:

S03(PMD): *Security regimes, means that we can't have any Wi-Fi devices, we have some people who are in the older age group, they're in their 50s, who love to read, and they have requested me to get them Kindles, so they can download books on to them, we have struggled with that, because that's getting a Wi-Fi enabled device within the building.*

As well as the physical restrictions that are in place, staff discussed how policy and processes became another form of restriction that impeded older forensic mental health patients.

S03(PMD): *Special permission, and that can be time consuming, it can be painful, people think why bother… people say, "well I'm not going to fill out 3 forms, to justify myself again, to get this person 1 hour of leave, I won't bother doing it.*

Not Including Patients in Care Planning and Processes

This overarching theme (made up of two themes) describes how older forensic mental health patients may feel disempowered, particularly when others make choices and decisions for them, when things are sometimes implemented against their wishes, and where their choices are not acknowledged.

Being 'Done To' Through Pressure and Force From Professionals. This theme is where staff described how professionals can pressure older forensic mental health patients into doing things. It was as if professionals almost 'pulled rank' over the

patients. Professionals see themselves as being the expert, that they know better than the patient and as such what they say should go. The patients become passive in the process as they are pressurised to do things and end up engaging in things they don't really want to do. At times, skills and activities and the expectations of what patients should be doing, does not always match up to what the patients want to do and what they value. Care and input received is based on the professionals' views of the world, values and beliefs, and not an individualised, patient centred approach.

> S13(PSY): *In my experience, but the same applies to everyone, is, applying our belief in our standards, and wanted them to fit in to what we think they should be doing, they should be thinking. So, what I see is a lack of insight about what their needs might be, a lack of training and professionals who do not work in a client centred way.*

Excluding and Leaving Out the Patient. Older forensic mental health patients can be excluded from decision making and care planning and denied being given a choice. Patients seemed to lack a voice in the process and because they are 'being done to' they are not empowered and have no autonomy around their decisions, choices and care.

> S12(PHY): *The doctors go 'well we will try it again it will be fine', and kind of overrule them. I think sometimes I don't think their voice is always heard….it takes away that autonomy and that you know, that drive in them, it's like what's the point of me having a voice if everyone else is going to make that decision for me.*

Discussion

This study investigated the processes and systems that enable valued progress (in terms of quality of life, health, wellbeing, recovery and reduced risk) for older forensic mental health patients. Based on 48 interviews with members of staff who have worked with this population, this study revealed how a comprehensive and multimodal level of support is required to facilitate progress, in terms of improved or good quality of life, health and wellbeing, and to address the complex needs of these patients. This support needs to be individualised and tailored to the needs of each patient considering issues that are experienced as the patients age. Older forensic mental health patients need comprehensive multidisciplinary team input that can offer specialised care and treatment. Mental health and cognitive decline need to be addressed as these issues can become more problematic as patients age. In addition, physical health and general physical decline (i.e., frailty, mobility, hearing and sight) associated with aging needs to be assessed and monitored and suitable treatment and care provision from multiple sources needs to be implemented. Treatment implemented must be age appropriate and meaningful to each patient so that they are able to engage with it and therefore benefit from it. The research also identified barriers and obstacles for older forensic mental health patients, regarding the gaps and omissions in service provision. It was found that omissions included lack of suitable activities for the older forensic mental health patient, that staff had gaps in their knowledge particularly in relation to physical health needs and elderly care needs, and that there were very few specialist units available that could accommodate '*older*', '*forensic*' and '*mental health*' requirements. It was also found that failure to include the older forensic mental health patients in their care planning and service provision was a barrier to valued progress (in terms of good or improved quality of life, health, wellbeing, recovery and reduced risk).

It was clear that provision for older forensic mental health patients should include a wide and comprehensive range of services and professionals. Although it could be argued that a comprehensive range of services and professionals are required for forensic mental health patients across all ages, the need is perhaps more notable and required for older patients; they tend to have more complex, numerous and chronic physical and mental health issues associated with aging and the aging process. As these patients often have comorbid difficulties and complex treatment and care needs, multiple formal and informal sources of support need to be identified, offered and provided. Mental health services that deliver clinical care, treatment and primary acute psychiatric response (acute impatient unit or community-based), secondary care services (including GPs, dieticians, physical health care specialists), and non-clinical services (e.g., advocacy, religious/spiritual) are all required to make sure there is appropriate support and parity of input to address both mental and physical health needs and improve wellbeing. MDT must therefore be established, including psychiatrists, psychiatric nurses, psychologists, social workers and occupational therapists as this provides comprehensive treatment and care (Haines et al., 2018). Physical and mental health are closely interconnected through several pathways (Prince et al., 2007), and need addressing through an integrated approach (Mental Health Taskforce, 2016). Older forensic mental health patients can have extensive offending histories, severe mental illness, poor physical health and general deterioration in function (e.g., sight, hearing, mobility, and cognitive) (Di Lorito et al., 2018; Huband et al., 2018; Spaans et al., 2017), all which requires appropriate treatment, management and support.

A key finding was that in order to aid older forensic mental health patients' progress an individualised, holistic, co-produced and needs led approach is required. A particular consideration is that a particular consideration for this population is that they

have complex needs that straddle forensic (criminal justice), mental health, and elderly/geriatric care. Their needs and requirements therefore differ to those of younger adults. It has been suggested that services struggle to offer individualised and tailored service provision to older forensic mental health patients, who are numerically in the minority compared to younger patients, and scattered across different wards and units (Di Lorito, Völlm, & Dening, 2019). This means that a barrier to individualised care occurs because priority seems to be placed on rehabilitating the younger patients, which could be deemed as institutional ageism (Di Lorito, Völlm, & Dening, 2019). Services therefore need to make sure they are not adopting a 'one size fits all' approach and must recognise that individuals will respond differently to treatment and therefore these treatments need to be personalised and adapted, in this case to older, forensic and mental health patients' needs.

Additional resources are required in relation to staffing provision. A core part of recovery-focused care is therapeutic relationships, and that positive relationships lead to positive recovery (Horvath, 2000). Within forensic settings supportive relationships have been found to assist in patients' recoveries (Nijdam-Jones et al., 2015), where staff need to offer custodial and relational-based care (Martin & Street, 2003). To do this, there needs to be sufficient staff, consistent staffing and enough time for staff to spend with the patients. In addition, specific to older forensic mental health patients, there is often a lack of training with regards to understanding cognitive difficulties and lack of nursing staff with a background in managing older adults and so this needs to be addressed.

Some of the professionals subscribed to the view that more specialist units are required staffed with nurses / professional groups who have experience of working in forensic mental health units and in older adult wards. Placement of older forensic

mental health patients is difficult (Coid et al., 2002) and generally provision of this is sporadic and fragmented. Progression could be improved with provision of suitable inpatient and community settings specifically for older people as they move through the forensic system. These settings potentially exist already but may lack staff who are specifically trained or experienced to care for older forensic mental health patients, resulting in a lack of confidence to accept patients into their services, subsequently delaying transfers and preventing progression for older patients. An integrated approach is required that combines both geriatric old age psychiatry and generic forensic psychiatry services is needed for older forensic mental health patients, which can address the criminal justice, forensic psychiatric and psychological, and geriatric psychiatric needs of this population (Curtice et al., 2003).

Finally, it was found that a barrier to progress was not including older forensic mental health patients in the process and decisions around their care plans and service provision, and professionals implementing treatment based on their own autonomous decisions and not in conjunction with the patients. Service provision and care plans need to be implemented through co-production, which has been found to be an important element within the delivery of person-centred care which can contribute substantially to forensic patients' recovery (Webb et al., 2021). There is a misunderstanding among health professionals as to what co-production should comprise, and it can be a challenge in mental health services, where there can be potential issues with patient capacity (Pilgrim, 2018); both factors can be barriers to implementing valued co-production. A 'recovery approach' is required, as this focuses on supporting or empowering individuals to address their mental health, so including them in the decision-making process (Turton et al., 2011). This promotes autonomy and self-management where the patients are at the centre of treatment and care, and partners

in service development, so practice evolves to be person centred and collaborative (Beckett et al., 2013).

Some limitations need to be acknowledged. This research offers in-depth and highly applied findings relevant to NHS forensic mental health settings, which may not be transferable to privately provided services, or services outside of the UK. However, purposive sampling enabled a sample that captured a range of different professionals and disciplinary backgrounds, providing a realistic view of the myriad of services that forensic mental health patients are likely to access. Participants self-selected to take part, which can introduce bias where those who participated might be particularly motivated to make researchers aware of certain issues or successes within their working environment. The views sought were of professionals working in the settings, and so did not include the patients' voices directly.

Conclusion and Clinical Implications

Over the years, there has been significant debate in the clinical academic literature about whether stand-alone niche secure forensic psychiatric units catering to the care and mental health treatment of the older forensic mental health patient should be built and be the gold-standard in provision of treatment and care for this group (Natarajan & Mulvana, 2017). This qualitative study does not make an argument for such stand-alone units but on the contrary argues for robust and comprehensive multi-disciplinary care of the older forensic mental health patient in mainstream forensic services. Multi-disciplinary care for these individuals will need to include joined up working between older adult and forensic mental health services with geriatric medicine expertise following a co-produced care and treatment plan. Concepts of recovery will need to be revisited and tailored to this specific group, for example, to address issues such as institutionalisation, physical health, and cognitive decline.

Finally, sufficient staff and training of staff to not only recognise signs of cognitive decline at an early stage but also develop their skillset and confidence in managing this patient cohort would be vital in maximising the quality of life of this patient group whilst safely reducing their risk to themselves and others. Improved training and service investment is likely to lead to improved staff morale and better outcomes overall.

References

Attride-Stirling, J. (2001). Thematic networks: an analytic tool for qualitative research. Qualitative Research, 1(3) 385-405. https://doi.org/10.1177/146879410100100307

Beckett, P., Field, J., Molloy, L., Yu, N., Holmes, D., & Pile, E. (2013). Practice what you preach: Developing person- centred culture in inpatient mental health settings through strengths-based, transformational leadership. *Issues in Mental Health Nursing, 34*(8), 595-601. https://doi.org/10.3109/01612840.2013.790524

Beeney, J. E., Hallquist, M. N., Clifton, A. D., Lazarus, S. A., & Pilkonis, P. A. (2018). Social disadvantage and borderline personality disorder: A study of social networks. *Personality Disorders: Theory, Research, and Treatment, 9*(1), 62-72. https://doi.org/10.1037/per0000234

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Chesney, E., Goodwin, G. M., & Fazel, S. (2014). Risks of all-cause and suicide mortality in mental disorders: A meta-review. *World Psychiatry, 13*(2), 153-160. https://doi.org/10.1002/wps.20128

Chow, W. S., & Priebe, S. (2016). How has the extent of institutional mental healthcare changed in Western Europe? Analysis of data since 1990. BMJ open, 6(4), e010188. https://doi.org/10.1136/bmjopen-2015-010188

Coid, J., Fazel, S., & Kahtan, N. (2002). Elderly patients admitted to secure forensic psychiatry services. *Journal of Forensic Psychiatry, 13*(2), 416-427. https://doi.org/10.1080/09585180210154470

Cormac, I., Ferriter, M., & Buchan, S. (2013). Follow-up study of an integrated weight management and fitness programme. *Mental Health Review Journal, 18*(1), 14-20. https://doi.org/10.1108/13619321311306929

Clifton, A., Pilkonis, P. A., & McCarty, C. (2007). Social network in borderline personality disorder. *Journal of Personality Disorders, 21*(4), 434-441. https://doi.org/10.1521/pedi.2007.21.4.434

Curtice, M., Parker, J., Wismayer, F.S., & Tomison, A. (2003). The elderly offender: an 11-year survey of referrals to a forensic psychiatry service. *Journal of Forensic Psychiatry and Psychology, 14*(2), 253-264. https://doi.org/10.1080/1478994031000077989

Di Lorito, C., Castelletti, L., Tripi, G., Gandellini, M. G., Dening, T., & Völlm, B. (2017). The individual experience of aging patients and the current service provision in the context of Italian forensic psychiatry: A case study. *Journal of Forensic Nursing, 13*(3), 118-125. https://doi.org/10.1097/JFN.0000000000000163

Di Lorito, C., Dening, T., & Völlm, B. (2018). Ageing in forensic psychiatric secure settings: The voice of older patients. *Journal of Forensic Psychiatry & Psychology, 29*(6), 934-960. https://doi.org/10.1080/14789949.2018.1513545

Di Lorito, C., Dening, T., & Völlm, B. (2019). Ageing in forensic psychiatric secure settings: The views of members of staff. *Journal of Forensic Psychiatry & Psychology, 30*(2), 270-285. https://doi.org/10.1080/14789949.2018.1542449

Di Lorito, C., Völlm, B., & Dening, T. (2019). The characteristics and needs of older forensic psychiatric patients: A cross-sectional study in secure units within one UK regional service. *The Journal of Forensic Psychiatry & Psychology*, 1-18. https://doi.org/10.1080/14789949.2019.1659390

Figgou, L., & Pavlopoulos, V. (2015). Social psychology: Research methods. In J. D. Wright (Ed.), *International Encyclopedia of the Social & Behavioral Sciences* (2nd ed., pp. 544-552). Elsevier.

Haines, A., Perkins, E., Evans, E. A., & McCabe, R. (2018). Multidisciplinary team functioning and decision making within forensic mental health. *Mental Health Review Journal, 23*(3), 185-196. https://doi.org/10.1108/MHRJ-01-2018-0001

Hammersley, M. (1992). *What's wrong with ethnography* (2nd ed.). Routledge.

Hodgins, S., Calem, M., Shimel, R., Williams, A., Harleston, D., Morgan, C., Dazzan, P., Fearon, P., Morgan, K., Lappin, J., Zanelli, J., Reichenberg, A., & Jones, P. (2011). Criminal offending and distinguishing features of offenders among persons experiencing a first episode of psychosis. *Early Intervention in Psychiatry, 5*(1), 15-23. https://doi.org/10.1111/j.1751-7893.2010.00256.x

Horvath, A. O. (2000). The therapeutic relationship: From transference to alliance. *Journal of Clinical Psychology, 56*(2), 163-173. https://doi.org/10.1002/(SICI)1097-4679(200002)56:2<163::AID-JCLP3>3.0.CO;2-D

House of Commons Justice Committee. *Older prisoners Fifth Report of Session 2013–14.* London: The Stationery Office Limited, 2013

Huband, N., Furtado, V., Schel, S., Eckert, M., Cheung, N., Bulten, E., & Völlm, B. (2018). Characteristics and needs of long-stay forensic psychiatric inpatients: A rapid review of the literature. *The International Journal of Forensic Mental Health, 17*(1), 45-60. https://doi.org/10.1080/14999013.2017.1405124

Lamb, H. R., & Weinberger, L. E. (2001). Persons with severe mental illness in jails and prisons: A review. In H. R. Lamb, & L. E. Weinberger (Eds.), *Deinstitutionalization: Promise and problems* (pp. 29-49). Jossey-Bass/Wiley.

Lewis, C. F., Fields, C., & Rainey, E. (2006). A study of geriatric forensic evaluees: Who are the violent elderly? *Journal of the American Academy of Psychiatry and the Law, 34*(3), 324-332.

Lightbody, E., Gow, R. L., & Gibb, R. (2010). A survey of older adult patients in special secure psychiatric care in Scotland from 1998 to 2007. *Journal of Forensic Psychiatry and Psychology, 21*(6), 966-974. https://doi.org/10.1080/14789949.2010.504858

Martin, T., & Street, A. F. (2003). Exploring evidence of the therapeutic relationship in forensic psychiatric nursing. *Journal of Psychiatric and Mental Health Nursing, 10*(5), 543–551. https://doi.org/10.1046/j.1365-2850.2003.00656.x

McIntosh, L. G., Janes, S., O'Rourke, S., & Thomson, L. D. G. (2021). Effectiveness of psychological and psychosocial interventions for forensic mental health inpatients: A meta-analysis. *Aggression and Violent Behavior. 58(1),* [101551] https://doi.org/10.1016/j.avb.2021.101551

Malterud, K., Siersma, V. D., & Guassora, A. (2015). Sample size in qualitative interview studies: Guided by information power. *Qualitative Health Research, 26*(13), 1753-1760. https://doi.org/10.1177/1049732315617444

Mental Health Taskforce. (2016). *Five year forward view for mental health.* https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

NACRO. (2006). Liaison and diversion schemes for mentally disordered offenders: A mental health good practice guide. NACRO.

Natarajan, M., & Mulvana, S. (2017). New horizons: Forensic mental health services for older people. *BJ Psych Advances, 23*(1), 44-53. https://doi.org/10.1192/apt.bp.113.012021

Nijdam-Jones, A., Livingston, J. D., Verdun-Jones, S., & Brink, J. (2015). Using social bonding theory to examine 'recovery' in a forensic mental health hospital: A qualitative study. *Criminal Behaviour and Mental Health, 25*(3), 157-168. https://doi.org/10.1002/cbm.1918

Ogloff, J. R., Lemphers, A., & Dwyer, C. (2004). Dual diagnosis in an Australian forensic psychiatric hospital: Prevalence and implications for services. *Behavioral Sciences & the Law, 22*(4), 543-562. https://doi.org/10.1002/bsl.604

Pilgrim, D. (2018). Co-production and involuntary psychiatric settings. *Mental Health Review Journal, 23*(4), 269-279. https://doi.org/10.1108/MHRJ-05-2018-0012

Prince, M., Patel, V., Saxena, S., Maj, M., Maselko, J., Phillips, M. R., & Rahman, A. (2007). No health without mental health. *The Lancet, 370*(9590), 859-877.

Ribe, A. R., Laursen, T. M., Charles, M., Katon, W., Fenger-Grøn, M., Davydow, D., ... & Vestergaard, M. (2015). Long-term risk of dementia in persons with schizophrenia: a Danish population-based cohort study. JAMA psychiatry, 72(11), 1095-1101.

Rutherford, M., & Duggan, S. (2008). Forensic mental health services: Facts and figures on current provision. *The British Journal of Forensic Practice, 10*(4), 4-10. https://doi.org/10.1108/14636646200800020

Shenton, A., 2004. Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information 22*(2), 63-75. https://doi.org/10.3233/EFI-2004-22201

Smith, J., & Firth, J. (2011). Qualitative data analysis: Application of the framework approach. *Nurse Researcher, 18*(2), 52-62. https://doi.org/10.7748/nr2011.01.18.2.52.c8284

Spaans, M., Molendijk, M. L., de Beurs, E., Rinne, T., & Spinhoven, P. (2017). Self-reported personality traits in forensic populations: A meta-analysis. *Psychology, Crime & Law, 23*(1), 56-78. https://doi.org/10.1080/1068316X.2016.1220555

Swinkels, L. T. A., van der Pol, T. M., Popma, A., ter Harmsel, J. F., & Dekker, J. J. M. (2020). Improving mental wellbeing of forensic psychiatric outpatients through the addition of an informal social network intervention to treatment as usual: A randomized controlled trial. *BMC Psychiatry, 20*(1), 1-15 https://doi.org/10.1186/s12888-020-02819-2

Ter Haar-Pomp, L., Spreen, M., Bogaerts, S., & Volker, B. (2015). The personal social networks of personality disordered forensic psychiatric patients. *Journal of Social Work, 15*(3), 254-276. https://doi.org/10.1177/1468017314537425

Turton, P., Demetriou, A., Boland, W., Gillard, S., Kavuma, M., Mezey, G., Mountford, V., Turner, K., White, S., Zadeh, E., & Wright, C. (2011). One size fits all: Or horses for courses? Recovery-based care in specialist mental health services. *Social Psychiatry and Psychiatric Epidemiology, 46*, 127-136. https://doi.org/10.1007/s00127-009-0174-6

Völlm, B., Edworthy, R., Holley, J., Talbot, E., Majid, S., Duggan, C., Weaver, T., & McDonald, R. (2017). Characteristics and needs of long-stay patients in high and medium secure settings in the UK: Implications for service organisation. *NIHR Journals Library*, 5(11). https://doi.org/10.3310/hsdr05110

Walker, K., Griffiths, C., Yates, J., & Völlm, B. (2020). Service provision for older forensic mental health patients: A scoping review of the literature. *The Journal of Forensic Psychiatry & Psychology, 32*(1), 29-50. https://doi.org/10.1080/14789949.2020.1817525

Webb, E., Girardi, A., & Stewart, I. (2021). Exploring coproduction of patient care in a secure mental health setting. *Nursing Times [Online]*, *117*(4), 34-38.

World Health Organization. (2017, May 1). *10 facts on ageing and health.* World Health Organization. https://www.who.int/news-room/fact-sheets/detail/10-facts-on-ageing-and-health

Yorston, G., & Taylor, P. J. (2009). Older patients in an English high security hospital: A qualitative study of the experiences and attitudes of patients aged 60 and over and their care staff in Broadmoor hospital. *The Journal of Forensic Psychiatry & Psychology*, *20*(2), 255-267.