Staff perspectives on barriers to and facilitators of quality of life, health, wellbeing, recovery and reduced risk for older forensic mental-health patients: a qualitative interview study

Dr Kate Walker (corresponding author): Research Associate, Innovation and Research Department, Berrywood Hospital, Northampton Healthcare NHS Foundation Trust, UK.

Email: Kate.Walker@nhft.nhs.uk

Tel: 07849192119

Dr Jen Yates: Assistant Professor in Mental Health, Institute of Mental Health, University of Nottingham, UK.

Prof Tom Dening: Professor of Dementia Research, Institute of Mental Health, University of Nottingham, UK.

Prof Birgit Völlm: Director, Klinik und Poliklinik für Forensische Psychiatrie, University Hospital of Rostock, Germany.

Dr Jack Tomlin: Research Fellow, Klinik und Poliklinik für Forensische Psychiatrie, University Hospital of Rostock, Germany.

Dr Chris Griffiths: Senior Research and Evaluation Fellow, Innovation and Research Department, Berrywood Hospital, Northampton Healthcare NHS Foundation Trust, UK.

Abstract

Objectives: There is a lack of research informing service delivery for older forensic mental-health patients. This study explored service provision in forensic mental health inpatient and community services in England, investigating what is required for progress in terms of quality of life, health, wellbeing, recovery and reduced risk, and the barriers and facilitators associated with this.

Methods: Semi-structured interviews were undertaken with 48 members of staff working with older forensic mental-health patients in secure inpatient units or the community in England. Data were analysed using thematic analysis.

Results: Two global themes 'What works' and 'What doesn't work' were identified comprising themes representing environmental, interpersonal and individual factors. 'What works' included: positive social support and relationships; individualised holistic patient-centred care; hub and spoke approach to patient care; and suitable environments. 'What doesn't work' included: absence of/or maladaptive relationships with family and friends; gaps in service provision; and unsuitable environments.

Conclusions: For older patients to progress to improved quality of life, health, wellbeing and reduced risk, multilevel and comprehensive support is required, comprising a range of services, interventions, and multidisciplinary input, and individualised to each patient's needs. The physical environment needs to be adapted for older patients and provide a social environment that seeks to include supportive families, friends and expert professional input. A clear patient progression pathway is required; this must be reflected in policy and provision.

Keywords: Forensic mental health, older patients, service provision

Introduction

Forensic mental health services are facing an increasingly ageing population; around 20% of patients in forensic mental health settings are over 50[1,2] and, as people live longer, this percentage will increase.[3,4] Service provision and care packages for older forensic patients can be difficult. This population sits across criminal justice, forensic psychiatry and psychology, and old age psychiatric services,[5] and patients require integrated support. Older forensic patients' mental, physical and social needs are diverse and wide ranging.[2] They have complex histories that often include childhood neglect or abuse, substance abuse, poor health self-management, cognitive difficulties, psychiatric admission. They increasingly present with comorbid and chronic physical conditions, such as heart disease, hypertension, obesity or diabetes,[4,6] along with frailty, mobility problems[7] or vision and hearing impairment,[6] highlighting the multifaceted and complex health, care and social needs of this population.

In England, the National Health Service (NHS) provides inpatient and community services for forensic mental health patients who pose a risk to themselves or others and which cannot be managed appropriately in non-forensic services.[8] Services offer psychiatric assessment, treatment and rehabilitation to enable patients to progress towards living independently.[9] Interventions include a wide range of services to improve mental health and reduce risk, through for example psychoeducation, cognitive behavioural therapy, violence prevention, sexual offending treatment programmes, along with occupational, vocational and recreational opportunities as well as physical health support through assessment, monitoring and care planning and management.[10,11] The overarching aim is to improve quality of life, recovery and mental health, and reduce risk and offending behaviours.[10] However, it remains unclear to what degree these services meet the specific needs of older adult forensic patients.[4]

Existing guidance for forensic mental health services recommends that patients must be the centre of their recovery; individual recovery and independence must be promoted; safe environment for therapeutic work are provided; integrated pathways of care are developed;

and safe and effective transitions between settings are implemented.[12] There is a need for relevant policy and best practice to address the complex and multifaceted needs of older forensic mental health patients specifically. This study aims to contribute to fill this gap by identifying the barriers and facilitators to achieving better outcomes for older forensic mental health patients from the perspective of staff working with this population.

Methods

We conducted semi-structured interviews with health care professionals working in NHS inpatient or community forensic health services. We took a subtle realism[13] approach, placing emphasis on the participants' own interpretations and how their unique positioning and viewpoint as members of staff offered diverse understandings. This enabled exploration of participants' interpretation of their patients' realities, while acknowledging that such interpretations are overlaid with participants' own meanings and understandings developed through the interplay of their professional expertise and their experiences. Deeper insights were achieved through evolving interpretations and the synthesis, integration and comparison of accounts across participants' narratives.[14]

Sampling and recruitment

Participants were recruited from eight NHS trusts across England, from low, medium and high secure hospitals, and community services, with data being collected between March 2020 and October 2020. Sites were selected from those who showed an interest in participating, and where there were an adequate number of older forensic patients residing for staff to have had suitable experience of working with this population. Suitable members of staff were contacted via email by the principal investigator based at each site. To be eligible for inclusion in the study, participants had to work for NHS forensic mental health services and have experience of working with forensic patients aged ≥ 55 years; this age cut-off was selected to reflect the generally higher biological age in this population because of their

negative life experiences.[6,4] We considered a sample size of 48 as appropriate for the aims of this study based on recommendations by Malterud and colleagues,[15] which judges sample size through five dimensions of: (i) study aim, (ii) sample specificity, (iii) use of established theory, (iv) quality of dialogue, and (v) analysis strategy. The sample size selected was appropriate to ensure a range of experience was captured and evidenced.

Data collection

The interview schedule was developed from previous relevant research, input from the research team, a clinical expert advisory panel, and our Lived Experience Advisory Panel (LEAP) - comprising current and former forensic mental health service users. The interview schedule was piloted with two LEAP group members to assess if the questions were user-friendly, appropriate and understandable. Interview topics explored quality of life (e.g., are there aspects of quality of life that are experienced specifically or differently by older forensic mental health patients?); things that support patients' health and wellbeing; suitability and appropriateness of interventions and activities; age and progress in this patient group. Interviews were mainly conducted using video calls, with two interviews conducted two face-to-face. Interviews lasted an average of just over 60 minutes (36-107 minutes); they were audio recorded, transcribed verbatim, anonymised and uploaded to NVivo (V.20).

Data analysis

We used thematic analysis to categorise data and identify patterns across data sets[16] and uncover salient themes within the text, with thematic network analysis[17] facilitating the development of basic (lowest order of themes driven by the textual data), organising (middle order themes made up of the basic themes) and global themes (the principal concept in the data as a whole) from the data. We used inductive and deductive approaches, following the six steps of (i) data coding; (ii) identifying themes; (iii) constructing thematic networks; (iv) describing and exploring thematic networks; (v) summarising thematic network; and (vi)

interpreting patterns in light of the research aims and theory.[16,17] Coding was undertaken by [KW & JY]. All five members of the LEAP group also undertook initial coding and back coding (analysing transcripts for the codes developed). Trustworthiness was sought by examining and assessing the credibility, transferability, dependability, and confirmability of the data,[18] through (i) drawing on procedures based on those used successfully in previous projects; (ii) keeping detailed memos and extensive records to ensure that the findings were data-orientated and to demonstrate transparency regarding the development of the themes; (iii) implementing systematic checks to ensure that the findings were clearly supported by the data, and represented the participants' experiences; and (v) independent advisors (LEAP) examined and verified the analysis undertaken and the conclusions drawn. Data analysis and interpretation was discussed and agreed within the wider research team.

Public and patient involvement

ALEAP, comprising five current and former forensic mental health service users, contributed to designing and piloting the interview questions. The LEAP group enhanced the practical methodological processes, data accuracy, validity of results and the overall relevance of the research to service users. Ethical good practice was maintained; only fully anonymised data was shared.

Ethics approval

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

Forty-eight members of staff were recruited comprising: community registered mental health nurses (*n* = 5); psychiatrists (*n* = 7); psychologists (*n* = 7); occupational therapists (n = 8); inpatient registered mental health nurses (*n* = 12); one physiotherapist (*n* = 1); social workers

(*n* = 5); and non-clinical staff (*n* = 3). Staff worked in: community (*n* = 8); low secure (*n* = 13); medium secure (*n* = 19); and high secure settings (*n* = 8). All participants had experience working with older males, and 14 participants also had some experience working with older female patients.

Our analysis identified two global themes: 'What works' and 'What doesn't work', with several organising themes and associated basic themes within each (Table 1). Some, but not all, of the positive factors in the organising themes for What works were the inverse of themes in What doesn't work. Organising themes captured different factors broadly across three different levels, the environmental, interpersonal/relational factors and individual. Table 2 presents illustrative quotations.

Table 1 about here

Table 2 about here

Environmental and cultural characteristics of the service

Interview participants identified various factors around the physical, social and cultural environments of older patients specifically that were seen to support quality of life, health, wellbeing and progress. Factors mentioned include the structure of buildings and internal physical environment (both inpatient buildings and in the community) and how this can enhance day-to-day living for older people ('Structural external environment conducive to older patients' needs'), such as being on one level with no stairs and providing spacious areas, as well as age related adaptations e.g., handrails, widened doors for wheelchairs. An environment that facilitated physical activities was seen to be helpful ('Environment that supports, promotes and enables physical activities'), such as providing access to spacious grounds or an onsite gym. Staff consistently identified as important that patients considered their residence as homely, friendly and safe, and not just a clinical, cold setting ('Positive

social environment: homely, safe, familiar and structured'); this included having a balanced mix of older and younger patients as this mix seemed to mean dynamics and interactions between the patients were calmer. In the community, staff acknowledged the importance of suitable accommodation, which provided necessary support, had good dynamics between residents, and promoted feelings of safety and security ('Suitable, appropriate, and safe community environment').

Interview participants recognised the importance of staff attitudes and actions as contributors to a positive environment ('Establishing a culture of therapeutic relationships with staff'). This included staff being caring, empathetic, compassionate, supportive, and inclusive, which enabled development of therapeutic alliances with the patients, good rapport and positive relationships. Staff highlighted that they had developed long-term relationships, had come to know patients, and sought to provide consistency and stability in their lives.

Conversely, study participants also reported on instances where buildings could not support older patients through age-related changes ('Physical environment not meeting physical needs'), while differences between younger and older patients were seen to create challenges for the social environment, e.g., their outlooks, their tastes and music preferences ('Conflicting dynamics between younger and older patients, incompatible environments'). Older patients were described by the staff in their experience as always being in the minority and described by staff as the 'odd ones out'. Younger patients were seen to be more 'rowdy', boisterous, lively, and prone to violent outbursts, leaving older patients vulnerable and fearful. The social environment was at times also described as a 'Restricted environment, impeded by processes' where patients were unable to do certain activities, access things, or have leave when they wanted, due to restrictions they are under. Restrictions, however, are often legal requirements imposed by the Ministry of Justice, which means this issue is difficult to address or change.

Study participants also reported that some patients did not believe in the value or efficacy of therapy, treatment, and intervention, resulting in lack of engagement ('Therapeutic nihilism'), with older patients who had remained in the system for a long time, relapsed and returned perceived to have limited opportunities to progress. For some staff this concept of how the patients perceived therapy and treatment and a belief that some did not engage, was ingrained in the social environment of the units where they were working. This can lead to a sense of complacency from the staff, and a feeling of 'what's the point' of working with these patients.

Hub and spoke approach to patient care

This organising theme recognises a model of working which involves a core team around the patient (the hub) and access to other professionals and services (the spokes) providing a wide range of skills, expertise, and services to meet older patients' needs. Features of this model include that health care professionals across sites, hospitals, or external to the setting can be utilised when required ('Access to range of adjunctive health professionals and services'), including general practitioners, dentists, opticians, podiatrists, specialist nursing practitioners, and speech and language therapists. However, this need to access a range of services on an ad hoc basis was seen to be difficult to balance with perceived resource constraints. Linked to the access to the range of health professionals, was provision of '*Health checks and screening – assessment and monitoring*', i.e., ongoing checks, observations and monitoring of patient health implemented as part of older patients' care plans. This included medical assessment from a range of professionals and services (the spokes) who provided blood tests, electrocardiograms (ECGs), blood pressure and weight measurements and physical health checks, such as screening, offering 'health MOTs' and 'well man clinics'. Potential cognitive decline associated with ageing was monitored and evaluated with provision of cognitive assessments.

Non-clinical input was seen to be important to enhance patients' quality of life, health and wellbeing, recovery and reduced risk. This included 'Advocacy support service' involving the provision of formal advocates to represent and support patients which was deemed to be important for older people who may have cognitive impairment or lack capacity, along with 'Alternative, complementary and therapeutic services', including services such as head massages, aromatherapy and mindfulness. Staff viewed spiritual/pastoral support from chaplaincy as helpful and therapeutic, as it provided a 'friendship' which they believed made patients feel they are listened to; also a chaplain as non-clinical professional was seen as someone who staff felt patients would feel comfortable that they could talk to openly.

The majority of interviewed staff highlighted the need for joined up and consistent approach to care to enable the creation of a comprehensive coproduced care package to meet patients' individual needs ('Multidisciplinary team, aligned and working together collaboratively') and this was seen to be relevant to younger and older patients.

Gaps, absences and shortfalls in service provision

Study participants highlighted a range of gaps in service provision, noting that even if activities were available, they were not always suitable/appropriate for older patients, such as physical gym sessions, football, or work placements ('Specific, suitable and appropriate activities and support for older opposed to younger patients'). Staff also reported gaps in their own skill sets for older populations ('Omissions in staff expertise, knowledge, awareness and education'), in particular in relation to knowledge around chronic and severe physical illnesses (e.g., heart conditions, respiratory disease, cancer), screening needs (e.g., breast awareness and well men clinics), age-related concerns and understandings of general cognitive age-related decline and specialist cognitive issues such as dementia and Parkinson's, or end of life care.

Participants further highlighted service inadequacies in relation to staffing levels, time and financial resources (‘Insufficient resources for older patients’). They reported lack of staff on inpatient wards, resulting in inadequate staff/patient ratios and, in turn, unmet patient need, along with struggling to provide adequate amount or quality of time to older patients to address physical health, mobility and frailty issues.

Participants further highlighted budget cuts and lack of funding to support suitable supported accommodation to meet the physical health and social care needs typically required by older adults, as well as support for specialist staff, and this were reported to occur along the care pathway (‘Lack of specialist units, suitable accommodation and placements’), with specialist and designated 'older ', ‘forensic’ and ‘mental health’ services to be rarely available. There were also reports of ‘Services unwilling or unable to take 'forensic' 'mental health' and or 'older' patients’ because of patients’ histories, having a 'forensic' and a 'mental health' label, and perhaps also requiring elderly care. The forensic label was seen to be particularly problematic, perceived to be a generic label and not something based on a specific type of offence.

Individualised approach for all patients

There was a general view that care and activity planning needed to be organised around the individual needs of each patient, striving to implement an individually driven holistic approach, and that this requirement applied to all the age groups alike (‘Activities in place that are best suited to each individual’s needs’). This included ensuring that activities were age appropriate for the individual or tailored to the specific needs of those who were older while recognising that activities needed to be meaningful and important to that individual, and something they actively choose to participate in.

Staff discussed the importance of ‘Holistic, coproduced, needs-led care’, with study participants referring specifically to individualised, patient-centred care and holistic

approaches. Coproduction, that is patients having a choice and say in their treatment needs, and in the services that they require and receive, was seen to be an important part of the process, with staff emphasising patients' desires, situation and needs as they work with patients to provide care to promote individual patients' physical, social and emotional wellbeing. There was recognition that care needed to be informed by the individual's needs and preferences rather than age as such ('Treatment and care informed by individual need not age').

Engagement with external social support outside of clinical care and provision

On an interpersonal level, narratives about social connections, such as befriending and peer support and having access to family and/or friends in the community featured strongly among study participants. Befrienders and peers within the patients' secure settings or units were identified as a good source of support and friendship for the patients ('*Social support from befrienders or peers*'). Peer group associations with those of a similar age were deemed as more meaningful and so likely to improve quality of life. Befrienders, volunteer visitors, and social groups were also perceived as preventing feelings of isolation and loneliness, offering opportunities for people to develop social connections and relationships, particularly for those without any family in their lives. For some, 'Supportive and actively involved family and friends' was beneficial when family, and friends were actively and positively involved in patients' lives and often provided a central support mechanism.

Absence of or maladaptive relationships with families, friends and or peers

Conversely, a lack of supportive relationships was deemed to have negative impacts, with some patients (inpatients and community) often found to not having suitable peer or friendship groups, particularly those similar in age ('Absence of positive friendships and peer groups'). Staff reported that such patients tended to become isolated, and a lack of social interactions would ultimately impact on their progress and outcomes. At the same time,

unhealthy family relationships were equally seen to be concerning in terms of a patient's quality of life, health, wellbeing and progress ('Broken, estranged, and disconnected family relationships'). Family estrangement was seen to be pertinent for some older patients due to the length of time being separated, and for some patients, family relationships were seen to be outright damaging, such as in case of abusive family members or where patients were shunned or rejected.

Having a sense of control, ownership, hope and purpose

This organising theme, comprises three basic themes, relating to individual factors that revolved around patient autonomy. Staff reported how they worked with patients to set future-oriented goals in order to provide a sense of hope and a positive focus ('Hope and a purpose for the future, forward planning'). Patients were encouraged to be autonomous and actively involved in choices and decisions about their care ('Patient given a voice and choice, involved in decision making') rather than having decisions imposed upon them. Study participants further highlighted the importance of patient empowerment, of taking on roles and responsibilities of their own choice to promote feelings of being valued, respected, and doing something worthwhile ('Taking on responsibility and being valued'), which, in turn, was seen to positively impact on patients' wellbeing.

Feeling of being done to not worked with

Conversely, disempowerment, particularly when others make choices and decisions on behalf of patients, implement activities against individual patients' wishes or fail to acknowledge preferences were seen to be unhelpful for progress and wellbeing ('Being 'done to' through pressure and force from professionals'). Staff described a 'sense of elitism', whereby professionals perceived themselves as the expert, that they know better and should therefore determine a given course of action. In this scenario, the patient takes on a passive role in their care and treatment; they are 'done to' rather than actively coproducing their care. Staff

suggested a lack of collaboration with patients and not taking a patient-centred approach and making decisions and choices for the patients without their input ('Excluding and leaving out the patient') to be counterproductive to achieving better outcomes.

In addition to above themes associated with What works and What doesn't work in relation to older forensic patients' outcomes, our interviews identified three further themes solely associated with What doesn't work (Table 1).

Security, routine and familiarity preventing patients from moving on

This organising theme is made up of three basic themes, which represent how some patients do not necessarily want to move on from where they are or feared moving on. In their current situation they feel safe, familiar and comfortable; it is what they know and are used to, and they may feel unable to cope with, or lack skills needed for an ever changing and evolving outside world ('Changing outside world, unrecognisable and unfamiliar to patients'). Study participants also referred to 'Institutionalisation and fostering a sense of dependency' where patients were seen to have become accustomed to a prescriptive structure and being told what to do, hindering their ability for self-sufficiency. Staff suggested that some patients believed that staying where they are affords them a better quality of life ('Don't want to leave, preference and choice is to stay') and that patients would see the hospital as their home, a safe place, and somewhere that can offer them more than if they were in community. These themes were particular to the older group, who generally have been in units for long periods of time.

Personal characteristics and intrinsic factors

Study participants identified several interpersonal characteristics and factors such as attitudes, thoughts and feeling, risk, labelling and stigmatising, and the vulnerability of patients as contributing to 'What doesn't work'. 'Negative feelings and emotions' held by the patients,

including guilt, shame, anxiety, and hopelessness were identified as barriers to good quality of life, health and wellbeing and progress as was 'Vulnerability' as a consequence of weakness and frailty related to ageing. Staff reported instances of how others took advantage of older patients such as family, friends and younger patients, seeing them as weaker due to their age. From the narratives of staff there was no consistent pattern about what happens in relation to risk over time for older patients ('Ongoing and inconsistent risk issues to self and/or others'), which was seen as problematic as ongoing risk is not predictable and so is difficult to manage. 'Stigmatised and labelling' was also identified as an issue, in particular the label of 'forensic', seen to hinder progress and limit personal opportunities. Older patients were also perceived to be 'Unmotivated and disengaged' in some instances, without enthusiasm, lacking motivation and unwilling to engage with treatment and care, with likely negative impacts. There was a feeling that older patients become stuck in the system.

Cumulative physical and mental co-morbidities

The final organising theme aligned to '*What doesn't work*' relates to the cumulative effect of long-term mental illness, physical illness through ageing and extensive medication use that was seen to be detrimental to patient outcomes. 'Cognitive decline, deterioration, and impairment' was viewed as an added difficulty to an already complex situation of being an older forensic patient with long-term mental health issues and likely physical health deterioration. Study participants highlighted how patients as they age are more prone to present with general cognitive decline or neurodegenerative disorders, such as dementia or Parkinson's disease. Patients were also reported to experience 'Physical health deterioration, complex comorbid issues as age', including heart and respiratory problems, diabetes, arthritis, and other long-term chronic conditions, along with frailty, poor mobility and risk of falling. 'Side effects and problems associated with prolonged and long-term taking of medication', such as psychotropic drugs, were reported to be common. Some patients were

thought to be taking the wrong medication or excessive doses. The long-term effects of medication use was seen to be associated physical disease, and reduced cognition

Discussion

This study examined factors that worked and did not work for older forensic mental health patients in the UK in order to improve their quality of life, health and wellbeing, recovery, and reduce risk. Identified factors acted at multiple levels (environmental, relational, and individual) These levels interact and are reinforcing, targeting them simultaneously is expected to create sustainable health and wellbeing improvements.[19] Some factors identified in our study were particularly pertinent to older patients, such as the environmental needs in relation to buildings, adaptations needed to enable physical activity, a culture suited to older patients' needs, and need for specialist care. This suggests that older forensic mental health patients require multilevel intervention and support at each level and this needs to be reflected in best practice and policy.

The environment was found to be a crucial influence on what did and did not work, particularly the physical environment, and related to social and cultural factors. Forensic mental health care should be provided in the least restrictive setting possible, while implementing appropriate levels of security,[20] but this can be challenging because of the need to balance a therapeutic environment with a safe environment. Staff in these environments have to manage complex tensions, balancing their dual role of care (and establishing therapeutic relationships) and of custody (imposing rules and restrictions), which can rupture therapeutic relationships. The architectural and physical design of psychiatric facilities can impact positively on the healing process and on outcomes of medical care, health and wellbeing[21] where provision of a safe physical environment affords intensive stabilising and suitable treatment while also providing privacy and observability.[22] The environment also needs to be homely and comfortable, but this again can be challenging as offering and

developing this type of environment may lead to older patients becoming reluctant to leave and move on and becoming institutionalised.[23] As highlighted, older forensic patients are likely to have a range of physical and mental health needs[4,6,7] and service environments need to be suitably designed (e.g., wheelchair access, stairs, levels) and equipped (e.g., hand rails, Zimmer frames, moveable beds) and provide appropriate facilities (e.g., outside space, suitable gyms, therapy space).

A 'Hub and spoke approach' to patient care was deemed of great importance for enhancing quality of life, health and wellbeing, including access to multiple and diverse health professionals who work together to deliver a comprehensive package of care (as inpatients and in the community) that is individualised, coproduced and needs led. This was seen to be particularly important for older forensic patients who require a diverse and extensive range of professional input to address their complex mental, physical and wellbeing needs associated with aging. Multidisciplinary teams can offer continuity of care, a comprehensive, holistic view of each patient's needs, a range of skills and mutual support; it is advocated as the best approach to address complex needs of those with severe mental illness.[24] This suggests that practice and policy need to adopt a holistic, well-being focused, and individualised approach, with input from MDTs who can offer expertise across older, forensic, and mental health patients.

Staff interviewed for this study identified a range of gaps in service provision relating to activities available to patients, staff knowledge, specialist units, reluctance to provide services to this population of patients, and insufficient resources in terms of staffing, patient support and funding. The specific health and care needs of older forensic patients require higher patient to staff ratios, as well as greater support from staff. Lack of funding may mean that older patients cannot be placed in the most suitable environment, or access specialist staff and expertise, in particular combined expertise in mental health in forensic settings and elderly

care. Services tend to be offered ad hoc and in a fragmented and isolated manner, highlighting the need for specialist, tailored and age-appropriate services[8] that are integrated and bring together old age psychiatry and generic forensic psychiatry as older forensic mental health patients sit between criminal justice, forensic psychiatry and psychology.[5] Stand-alone services find it difficult to manage this group of patients.[25]

Finally, staff reported a strong sense that working with this population requires patients to be given autonomy and a sense of hope, a voice and not simply being 'done to'. It has been suggested that four key processes in recovery are: hope, re-establishing identity, finding meaning, and taking responsibility for recovery.[26] The detained status of forensic patients imposes limits on capacity for autonomy and, coupled with the duration of stay experienced by older patients, can erode hope and independence.[27] Patients therefore need support to foster a sense of hope, aspiration and control. Professionals must work with patients in collaboration, include them in the decision-making process around their care, and not implement care based solely on decisions and instruction made by professionals alone.

Older forensic mental health patients have expressed concerns over institutionalisation, reintegration into the community, and finding appropriate accommodation,[28,29] with inpatients also identifying aspects of daily life on the ward that are ill-suited to the older population, including lack of equipment such as wheelchairs,[29] increased time needed for daily activities, such as showering,[28] or lack of access to meaningful, age-appropriate activities such as gardening, art, library visits, and viewing sports with other older patients.[1,29] There is consensus in the literature that staff are not equipped with the right training and skillset to holistically support the older patient group.[1]

Study limitations

Some limitations of the present study should be acknowledged. This study did not seek to generalise beyond the type of settings in which it took place, with insights limited to NHS

forensic mental health settings in the UK. Staff interviewed self-selected to participate, which can introduce bias, as their experiences and perceptions may be very different from those who did not wish to or felt they were unable to participate. However, the large sample size, which afforded sufficient information power[15] was drawn from eight NHS hospitals across rural and metropolitan areas and the range professional disciplines suggests that our findings are representative of experiences of staff in such settings. Further, the research was based on the accounts from staff only. Staff can only offer their perceptions of patients' experiences opposed to the actual lived experiences; findings could be strengthened by gaining an insight from the patients themselves. Finally, a larger proportion of the patient population within forensic mental health services is male, and as such the experience and needs of female patients is less understood. Our participants had more experience in caring for male patients than female patients, and consequently further research should explore service provision for older females receiving forensic mental health care.

Clinical, policy, and research implications

Our findings suggest staff believe that individualised and patient-centred care in forensic mental health services is implemented, but expertise and physical environments conducive to successful ageing are lacking, and so this could constrain the extent to which care can be provided in a way that takes into account ageing. This highlights a need for adapted environments, specialist training and multidisciplinary working to provide an appropriately balanced set of skills and suitable surroundings to support older forensic mental health patients.

There is a need for clear care pathways to enable older people to progress from forensic services to independent living in the community. Our findings suggest that gaps in service provision are problematic, and particularly a lack of community placements that encourage

skill development and independence for people in later stages of their lives and for people who may be institutionalised.

Conclusion

Older people under the care of forensic mental health services require input and support from a range of different specialist services and expertise but these are generally not offered as one combined integrated pathway. This population is thus at risk of falling between gaps in service provision which then prevents them from progressing towards a good quality of life, health and wellbeing. The lack of a defined progression and support pathway creates gaps in service provision and challenges recovery and rehabilitation of a patient population already experiencing additional barriers compared to younger forensic mental health care users.

Declaration of Conflicting Interests

The authors declare that there is no conflict of interest.

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