#weareNHFT

NIHR | National Institute for Health Research

The University of Nottingham

NHS Northamptonshire Healthcare NHS Foundation Trust

ENHANCE project - Older adult forensic mental health patients: defining needs, barriers, facilitators, and 'what works'

Dr. Chris Griffiths 1; Dr. Kate Walker 1; Dr. Jen Yates 2; Dr. Jack Tomlin 3; Professor Birgit Völlm 4; Professor Tom Dening 2
1 - Innovation and Research department, Northamptonshire Healthcare NHS Foundation Trust (NHFT) , Northampton, UK
2 - University of Nottingham, Nottingham, UK. 3 – University of Greenwich, London, UK. 4 - Universitätsmedizin Rostock, Rostock, Germany.
Contact: chris.griffiths@nhft.nhs.uk **website: https://www.nhft.nhs.uk/research**

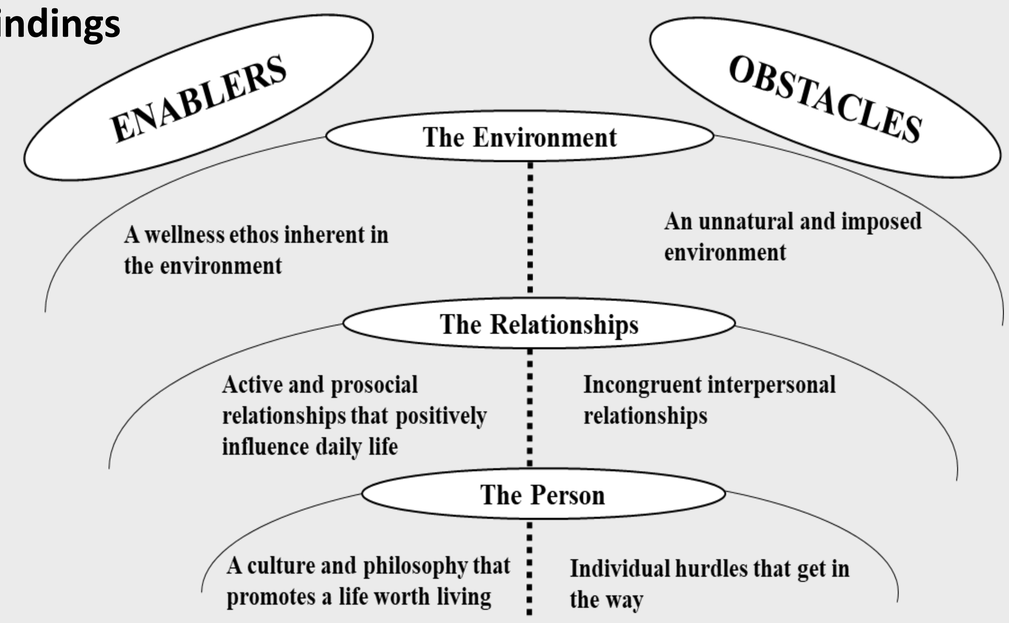
Introduction

The remit of forensic psychiatric services is to respond to patients' individual treatment needs to enable recovery and better levels of health, wellbeing, and quality of life, and lower levels of risk to themselves and others (Anderson, 2011). Compared to younger adult forensic inpatients, older adults show no or fewer improvements at discharge on measures of severe disturbance, emotional well-being, or risk (Girardi et al., 2018). Little is known about the perspectives of older forensic mental health patients related to their needs, experiences, and what they value (Di Lorito et al., 2018; Parrott et al., 2019).
The project's overall aim was to produce recommendations for best practice and service provision for older adult (aged 55 or over) forensic mental health patients.

Methods

This project employed a mixed methods cross-sectional design, conducting in-depth interviews and psychometric self-report assessment (wellbeing, recovery/health related quality of life, cognitive functioning, and restrictiveness with 37 (34 male and 3 female) forensic mental health patients (55 and over). Forty-eight staff working with older adult forensic patients were also interviewed. Thematic analysis of interviews data was employed. The project recruited participants from NHS low, medium, and high secure hospitals and community forensic mental health services. Project recruitment, interviews, analysis, interpretation of results, and development of recommendations were made with the involvement of a lived experience advisory group (LEAP).

Findings



Social, economic, and physical influences (environmental factors), relationships with significant others and therapeutic relationships (interpersonal factors), and a sense of self, hope, purpose, and personal agency (individual factors) need to be taken into account to promote recovery and facilitate recovery orientated practice. 'What works' for forensic mental health patients is provision of individualised interventions, safe/supportive/appropriate environments, supportive social alliances, therapeutic relationships, learning from others, reducing hopelessness, promoting autonomy and fostering motivation.

Older forensic patients rate their mental wellbeing at a similar level to general population samples (Stewart-Brown et al., 2009), and their recovery-related quality of life similar to general population samples but better than samples of adults receiving general mental healthcare (Keetharuth et al., 2018). There were high levels of possible mild cognitive impairment (MCI) diagnosis in this population.

Recommendations

Patient involvement in service provision

1. Take into account the views and preferences of older forensic mental health patients in service provision. This includes the built environment, access to meaningful activities, and plans for transition to other facilities or the community. Co-production tools and resources should be applied.

Service organisation

1. Hospital/ward/unit rules, regulations or routines should accommodate the needs of older patients.
2. Provide a comprehensive range of structured activities (chosen with patients' input) in inpatient wards and the community, and offer at a range of participation and intensity levels.
3. Connect older patients to each other across multiple wards or facilities for activities and socialising, taking into account vulnerability and risk issues.
4. Provide activities that fit with patients' interests and life course, that give them a sense of identity, purpose and meaningfulness.
5. Adapt the physical environment to accommodate older patients' needs and risks (e.g., mobility, sensory impairment, disabilities).
6. Provide healthy lifestyle choices: access to physical activities, exercise facilities, and healthy food options.
7. Staff levels and retention should be appropriately funded and fully adequate to support older patients' needs, so that patient leave and going off the ward is possible and does not get cancelled.
8. Enable patients to easily connect (face-to-face and via technology) with external family and friends and support new social connections, taking into account safeguarding.
9. Assess whether specific older adult interventions and services are required.

Evidence-based care

1. Quality of life can be enhanced by addressing patients' depression, cognitive impairment, anxiety, pain management, ability to perform usual (work, study, housework, self-care, social or leisure) activities, and mobility issues.
2. Quality of life and well-being can be enhanced by providing efficient and easy access to specialist healthcare services, including occupational therapists, physiotherapists, opticians, dentists, and dieticians.
3. Offer preventative assessments, medical screenings, and check-ups, and address issues identified appropriately and timely.
4. To reduce levels of obesity and diabetes, seek to improve patient physical activity levels, diet, and sleep quality.
5. Make allowances for cognitive impairments in needs assessment, risk assessment, interventions, and treatment.
6. Provide interventions and occupational therapy that supports cognitive functioning and functional abilities to enable people to live well and manage cognitive changes.
7. Provide evidence-based psychological interventions with options of group or one-to-one sessions.

Transition and discharge

1. Offer suitable housing/supported accommodation in the community
2. Provide consistent support and supervision throughout transition into the community.
3. Support access to appropriate meaningful work/activities/education for older patients to engage in after discharge.
4. Provide easy and fast accesses to community forensic mental health services so that patients have a safety net for support and to avert offending or a mental health crisis.

Staff training

1. Provide staff training in the care and treatment of older people with mental health problems; such as bereavement counselling, transitioning to the community, identifying indicators of dementia, and identifying predictors of mental disorder exacerbated by growing old in secure services, e.g. loneliness, social isolation and deaths of friends/family.
2. Provide staff training to support patients and their carers' management of age-related health needs, such as cognitive difficulties, physical health conditions, mobility issues, sensory impairment, frailty, and incontinence.

Language and communication

1. Eliminate stigmatising language, labels, and stereotypical beliefs about older persons.
2. Communicate acceptance of whom patients are now, rather than the person they were at admission or when they committed their index offence; acknowledging that patients and their risks change over time.
3. Provide information in a manner and format that reflects the range of cognitive abilities: adjusting vocabulary, grammar, imagery, spacing, pacing, text, font, and other communicative methods.
4. Ensure communication is a two-way process: patients' voices are heard, and they are empowered to be part of decision-making processes.

This presents independent research funded by the National Institute for Health Research (NIHR) under its Research for Patient Benefit (RfPB) Programme (Grant Reference Number PB-PG-1217-20028). The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.