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Older adult forensic mental health patients' views on barriers, facilitators and 'what works' to enable better quality of life, health and wellbeing and to reduce risk of reoffending and harm to self and others

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ABSTRACT

Introduction

Research evidence that can inform service provision and treatment requirements for older (aged 55 years and above) forensic mental health patients is lacking, particularly that which is based on patients' own preferences and experiences. This study aimed to gain an effective understanding, based on patients' perspectives, of the service provision in forensic mental health inpatient and community services; investigating what could improve or hinder their quality of life, health, wellbeing, progress, and recovery.

Method

A qualitative approach was taken to examine the accounts of patients. Interviews (semi-structured) with 37 older forensic mental health patients either residing in secure units or in the community were conducted. Data were analysed using thematic analysis.

Results

Two global themes: 'Enablers and Facilitators' and 'Threats and Barriers' were identified; these were at three levels: environmental, interpersonal and individual. Results indicated

that: the physical and social environment should be adapted to accommodate the needs of older patients (e.g., for physical health, frailty, and poor mobility); prosocial interpersonal relationships with family, other patients and staff needed to be promoted; and hope and positive future focus needed to be embedded to aid recovery.

Discussion

Findings suggest that multilevel and comprehensive support, that is individualised, is required for this population. This is needed so that: patients are residing in suitable environments that address their physical, mental, and criminal justice needs; social connectedness forms part of their recovery journey; and hope, purposefulness and personal agency is facilitated.

INTRODUCTION

In England, forensic psychiatric services provide treatment and care for mentally disordered offenders in high, medium and low secure inpatient units as well as in the community. High secure units are provided for patients detained and who require treatment under conditions of high security on account of their dangerous, violent or criminal propensities, and are those who pose 'grave and immediate danger'; medium secure units are for those who 'pose a serious danger to the public'; and low secure units for individuals who 'pose a significant danger to themselves or others'[1]. Forensic mental health services aim to reduce this risk and offer specific therapies across emotional, mental health, cognitive, physical health, interpersonal skills, criminogenic, spiritual, creative skills, rehabilitative, self-management, self-care, vocational and educational domains[2].

Demographic trends (ageing population, longer life expectancy)[3], and changes in sentencing practices, e.g., increased number of life sentences, use of indeterminate imprisonment, augmentation in mandatory sentencing[4] and more convictions being seen in later life, e.g., for historic offences[5], have resulted in greater numbers of long-term and newly admitted older forensic mental patients[6,7]. In the general population, defining an age threshold to identify people as 'old', 'geriatric' or 'elderly' is arbitrary, and the same is true for older forensic mental health patients[8]. It is commonly suggested that those in secure settings with forensic histories experience 'early ageing' or 'accelerated ageing' because of risk taking behaviour in earlier life, lack of preventative health care, long-term medication, poor diets, and stress associated with being in secure units[8]. Those in restrictive settings have been evidenced to undergo an earlier ageing process of around 10 years in comparison with the general population, and so those aged 50 years plus may be deemed to be categorised as 'older' or 'aged'[9]. In the UK and other Western countries around 20% of patients in secure settings are over 50 years old[6,10,11], and this proportion is likely to grow as people live longer[9,12]. Little is currently known about the perspectives of older forensic mental health patients in secure settings; what are their perceived needs and requirements, and if these are being met[7]. There is a need to effectively address needs which cross over 'forensic' or offending behaviours (criminal justice services), mental health services, and older people/geriatric services[13].

Older forensic mental health patients have complex needs due to mental health difficulties, physical health needs, risk profiles and security needs[14,15]. Older patients

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commonly experience complex mental health problems (including severe mental illnesses: personality disorders, schizophrenia, bi-polar disorder), co-morbid difficulties with substance misuse, they are likely to have experienced negative effects of these over a long period of time and higher rates of psychiatric disorders have been found in older offenders compared to younger ones[15,16]. Compared to younger patients, older patients have more needs in relation to chronic physical illnesses (e.g., cardiac disease, high blood pressure, obesity, diabetes, hypertension) experienced as they age[9,15,17,18]. A high proportion of these patients are prescribed antipsychotic medication, which is associated with an increased risk of weight gain, cardiovascular diseases, and diabetes[19], as well as cerebrovascular disease[20]. Older patients are also more likely to experience dementia and other organic cognitive diseases[16,21,22]. Unhealthy lifestyle health behaviours (smoking, problematic alcohol consumption, physical inactivity and a high-calorie diet of poor nutritional value) are prevalent[23]. Weight control is problematic, with a high proportion of forensic patients being overweight or obese[24]. Older forensic mental health patients therefore have complex and unique needs regarding their treatment and their mental and physical needs, and so the support they require[9].

Dedicated forensic settings for patients provide a therapeutic environment where they can access mental health care, reduce their risk (of reoffending, and harm to self and others), and address their criminogenic needs[25]. Some of the settings that patients reside in can be highly restrictive, nonautonomous, coercive, and risk averse in nature[26,27]. Some patients can be managed in the community if the right expertise and service provision is available[28], although older peoples' forensic community psychiatric service are less well developed than in-patient services[29].

A lack of patient perspective research has been undertaken to date regarding what works and what does not work for older forensic mental patients within these environments. As a result, little is known about what is likely to facilitate or be a barrier for their progress[30]. It is important to understand how to maximise positive outcomes and determine what features of treatment are most beneficial for whom[31]. Forensic in-patient units can meet many of the needs of older forensic mental health adults; however, more understanding of the age balance, safety, sociability of the ward, and patient agency is required[30]. Interviews to capture the views of forensic service users are essential to understanding and improving current services[32]. This research therefore aimed to understand, from the older forensic mental health patients' perspectives, what needs to be in place to enable them to progress in relation to quality of life, health, wellbeing, recovery, and reducing risk.

METHODS

This study was part of the ENHANCE project (Grant Reference Number PB-PG-1217-20028) to examine from staff and patients' perspectives, what works and what does not work in relation to improvement in quality of life, health, wellbeing, recovery and reducing risk, and to identify the barriers and facilitators associated with this process. This article examines the patients' perspectives.

Design

A qualitative design was used in this study. Underpinning ontological and epistemological assumptions were constructivist; this approach seeks to understand individuals' internal processes: attitudes, interests, beliefs, values, perspectives, and identities as they interact and influence behaviour in personal, work or social settings[33]. Constructivism recognises multiple realities, as reality for an individual is personally constructed, within a social context. Constructivism focuses on the role of relational, linguistic and social factors in the development of the individual person[34,35]. Constructivism therefore sits within a relativist ontological perspective, which subscribes to the paradigm that reality is unique to each individual, so a person's reality and 'truth' is therefore individually defined[36, p.68]. A relativist perspective is appropriate for research that looks to examine individual meaning, focusing on the realities and experiences as defined by the individuals themselves. The knowledge claims that emerge from qualitative research are therefore constructed by those interviewed and the interviewer[37].

Participants

In total, 38 participants were recruited across 8 NHS Trusts in England, from high (HS), medium (MS) and low secure (LS) units or the community (C). To be eligible for inclusion in the study, participants had to be aged 55 or over, under the care of forensic mental health services, able to complete self-report questionnaires and semi-structured interviews, understand written and oral English and have the capacity to consent. If people were 55 years and above they were contextualised as 'older people in these secure settings' as those in restrictive settings have been evidenced to undergo an accelerated ageing process in comparison with the general population[9]. Exclusion criteria included if participation was considered by care team to be a significant risk to the well-being of the individual or others, if patients lacked capacity to provide informed consent, and if participants were unable to complete the data collection process. Thirty-seven participants were included in the analysis, as one participant (P06(LS)) age 53 was excluded from the research due to the age criteria. The demographic information on the participants is presented in Table 1.

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As can be seen in Table 1 participants were mostly men (92%), of white British ethnicity (81%), with a mean age of 60 years. The most frequently diagnosed mental disorders were schizophrenia, schizotypal, and delusional disorders (60%), any type of personality disorder (41%), and mental and behavioural disorders due to psychoactive substance use and mood (affective) disorders (both at 16.2%). Physical health problems were found: diabetes (49%), disease of the cardiovascular system (38%), high cholesterol (19%) (e.g., hypercholesterolemia, hyperlipidaemia, raised triglycerides) and COPD (16%). Fourteen percent had some form of visual impairment. The mean score for BMI was high (31.7), classified as 'obesity class one' by the World Health Organisation (WHO). Only two patients were in the 'normal weight' range.

Table 1. Patients' characteristics

PATIENTS (N = 37)	
Age / years, mean (SD)	59.8 (3.9)
Age / range	55-70
Gender, n (%)	
Male	34 (92)
Female	3 (8)
Ethnicity, n (%)	
White	30 (81)
Black, African, Caribbean, Black British	6 (16)
Mixed or multiple ethnic group	1 (3)
Setting, n (%)	
High secure	10 (27)
Medium secure	9 (24)
Low secure	8 (22)
Community	10 (27)
Index offence[1], n (%)	
(Attempted) murder / manslaughter	11(30)
Violence against the person	8(21)
Sexual offences	8(21)
Robbery	2(5)
Possession of weapons	1(3)
Threatening to destroy or damage property	1(3)
No offence	6(16)
Mental health diagnosis, by ICD-10 categories[2], n (%)	
Organic, including symptomatic, mental disorders	1(3)

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[1] Index offences have been categorised according to the UK Home Office Offence Classification Index. Where a patient had more than one index offence, we report the most severe as indicated by the Home Office Crime Severity Score.

[2] Observations greater than 37 and percentages greater than 100 as most patients had multiple diagnoses. *N*=37.

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PATIENTS (N = 37)	
Mental and behavioural disorders due to psychoactive substance use	5(14)
Schizophrenia, schizotypal and delusional disorders	22(60)
Mood [affective] disorders	6(16)
Neurotic, stress-related and somatoform disorders	3(8)
Personality disorders (Any)	15(41)
Dissocial	5(14)
Dependent	3(8)
Avoidant (anxious)	5(14)
Emotionally Unstable	4(11)
Paranoid	4(11)
Schizoid	2(5)
Antisocial	4(11)
Borderline	3(8)
Mixed Personality Disorder	2(5)
Disorders of sexual preference	1(3)
Disorders of psychological development	2(5)
Physical diagnoses, n (%)	
Diabetes	18(49)
Cardiovascular and circulatory system	14(38)
High cholesterol (e.g. hypercholesterolemia, hyperlipidaemia, raised triglycerides)	7(19)
Chronic obstructive pulmonary disease (COPD)	6(16)
Visual impairment	5(14)
Asthma	4(11)
Vitamin D deficiency	4(11)
Diseases of the musculoskeletal system and connective tissue	3(8)
Hearing loss	1(3)
Impaired Physical Mobility	1(3)
Medication, n (%)	
Number of current prescribed medications	7.6 (4.4)
Number of current prescribed psychotropic medications	2.1(1.5)
Anticholinergic effect of medications on cognition scores	2.4(2.1)
Obesity, Body Mass Index (BMI; n=30), mean (SD)	31.7 (4.5)
Cognitive impairment, n (%)	
Possible mild cognitive impairment according to MoCA (n=34)	
Yes	22(65)
No	12(35)

Procedure

Informed verbal consent (recorded) was obtained from the participants. To gather descriptive information on participants, their file notes were accessed, and participants completed self-report measures of physical wellbeing, mental wellbeing, and cognitive impairment.

Individual semi-structured interviews were conducted either face-to-face (n = 10), via video call (n = 26), or over the phone (n = 1). All video-calls were done over MS TEAMS, and the interviews were recorded using a handheld digital voice recorder. Interview questions were informed by prior research, input from the research team, an expert advisory panel, and a Lived Experience Advisory Panel (LEAP). The interview was piloted with a LEAP member to assess if the questions were user-friendly, appropriate and understandable. Questions focused on quality of life, physical and mental health, wellbeing, and progress. The interviews and questions were developed to enable a direct exploration of the patients' experiences while allowing for subjective narratives to be revealed[37]. Interview length ranged from 28 minutes to 80 minutes (M = 50.8, SD =10.6). Interviews were all transcribed verbatim and the data were anonymised with all identifying information removed. All recordings were securely destroyed once the transcripts had been completed and checked for accuracy.

Data analysis

Thematic analysis (TA) was used to analyse the data with both an inductive and deductive approach taken. TA is an epistemologically flexible approach to data analysis that enables the researcher to categorise data and identify patterns across data sets. TA has the ability to provide rich, detailed and complex accounts of the data[38]. Using TA, the researcher identifies themes within a given data set and can analyse them through organisation and description as well as by interpretation of the various aspects of the research topic under investigation[39]. Thematic Network analysis (TNA), an indicative process and a type of TA[40] was utilised in the current research to develop global, organising and basic themes. The procedure that was implemented is presented in Table 2.

Table 2. Process of Thematic Analysis followed

Stage[3]	Overview of process followed[3]	Step by step summary of analysis[4]
1: Code data	(i) Transcribe data verbatim	(i) Transcribe data manually and verbatim
	(ii) Read and re-read transcripts	(ii) Read through then re-read transcripts several times. If meaning is indistinct researcher to refer back to the recordings to clarify. Data then exported to NVivo software
	(iii) Coding – inductive/deductive	(iii) Develop initial codes across all transcripts (NVivo)
		Undertake some open coding, note making and highlighting of meaningful concepts and factors across percentage of transcripts (manually/paper based)
2: Identify themes	(i) Sort codes into potential theme	(i) Group codes together, name the themes (NVivo)
	(ii) Refine themes	(ii) Reduce themes further as necessary, removing and adding themes. Define the themes (NVivo)
		Send list of themes to LEAP group (name of theme, definition) with supporting quotes/excerpts to identify themes supported by data
3: Construct thematic networks	(i) Arrange themes (ii) Select basic themes (iii) Cluster basic themes (iv) Identify global themes (v) Arrange thematic networks (vi) Vary and refine thematic networks	Arrange themes into clusters and networks. Bring out the global themes, and the corresponding subthemes, Identify relationships and thematic networks
4: Describe and explore thematic networks	(i) Define the thematic networks	Develop tables for arranged themes and clusters across all transcripts
		Share tables with LEAP group to assess for sense and consistency
	(ii) Explore the underlying patterns in the networks	
5: Summarise the thematic networks		Write up the networks
6: Interpret patterns		Write up all the results
		Get comment/feedback from LEAP

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[3] This represents an overview of the stages as recommended by Braun and Clarke (2006) and Attride-Stirling (2001)

[4] This represents how the recommended stages were developed and executed in the current research

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 verbal recorded consent.

RESULTS

Analysis of the patients' data resulted in the development of two global themes, 'Enablers and Facilitators' and 'Threats and barriers'. 'Enablers and Facilitators' represented what the patients felt promoted and afforded them good and positive quality of life, health, wellbeing, progress, and recovery whereas 'Threats and barriers' included what impeded and impacted negatively on these factors. Both global themes were divided in to three organising themes: 'Environmental'; 'Interpersonal'; and 'Individual'. Environmental factors comprised external structural and social elements, interpersonal refers to relational interactions and the individual's relationships with other people, while individual concerned the patients themselves and their sense of agency. Table 3 presents all the themes identified from the patients' narratives.

Table 3. Themes identified from patients' narratives

	Enablers and facilitators		Threats and barriers
Environmental	Comfortable environment - structural and social	Physical and structural features to address needs	Unsuitable environment for individual needs
		Promoting psychological sense of comfort	Institutionalisation
		Sense of individual purpose	Lack of things to do, boredom
	Purposive activities, occupies the self and the mind	Time fillers	Restrictions, rules and constraints
		Escapism	
		Guided towards healthy lifestyle behaviours	
	Healing and wellbeing as a function of environment	Rehabilitative and therapeutic environment	
		Effective medication to manage mental and physical health	
		Access to different health care professionals	
Interpersonal	Safety net and checks in place		
	Structure and routine		
	Camaraderie with other patients, supportive relationships		Mismatched relationships between patients
	Contact, involvement and support from family and friends		No or little contact with family and friends
	Therapeutic relationships with staff and professionals		Therapeutic ruptures
	Independence, freedom and choice		Isolation
Individual	Own space, time on own		Unhealthy lifestyle
	Future focus: Positive thinking, hope and optimism		Mental health impacting negatively
			Physical health issues
			Unmotivated, not engaging with activities
			Uncertainty and feelings of being in limbo
			Self-sabotaging behaviours, thoughts and feelings

Enablers and facilitators

Environmental

Comfortable environment - structural and social

This basic theme is comprised of two themes which relate to a comfortable, settled, and suitable environment, where individuals feel safe and content. One relates to the material structural and physical environment itself, the second relates to the way the environment makes the patient feel.

Physical and structural features to address needs. The physical attributes of the building and the structure; the design and architecture of the space helps patients manage their needs which impacts on their quality of life. For example, ensuite bathroom facilities not shared with others provided dignity and ease of access to conduct personal care.

> [5]P02(MS): *Yes, bathroom and toilet in your room, your own private shower, [gives good quality of life] we don't have to share showers with other people.*

The design of the environment created two types of areas: personal space, and shared space, both of which are important to participants in different ways:

> P03(MS): *Yes, my own room helps my wellbeing. I've got six plants in my room…. I've got my stereo in my room and I listen to music every day as part of my leisure time is listen to music.*

Adequate 'space' within shared areas was needed to give patients places where they could move about but without being constantly surrounded by others.

> P29(MS): *The environment is very well, it's more larger, where you can walk and you cannot bump into people, and you can sit down where you're not too close and all that kind of stuff.*

Next, the structure and design of the units were deemed to be appropriate to cater for older patients who possibly have less mobility, struggle to stand or may be unstable on their feet. This was a factor that was more specific to the needs of older patients in secure settings compared to younger ones. This was seen, for example, through the design of the environment itself accommodating for those with reduced mobility:

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[5] Participants are identified by a unique participant number followed by LS for low secure, MS for medium secure, HS for high secure and C for community

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P34(HS): *Yes, it's all on one level now. Steps have already went to an incline as well, yes. We had an older lad here before that in a wheelchair and he was able to go all over the ward, even outside because there's a ramp outside.*

The environment also contributed to reducing or minimising risk. Interestingly, the restriction and surveillance set up of the environment (sometimes perceived as negative by patients), was considered favourably by some because the feeling of being monitored and watched prevented patients from engaging in incidents, and also helped them feel protected because they knew other patients would not harm them whilst they could be seen.

P12(HS): *Bars on the windows, locked doors [minimises my risk]. I don't know. You're watched all the time. There's cameras, [unclear] or [person's name] who checks people going out. You're out in the open all the time.*

Promoting psychological sense of comfort. The environment evoked positive feelings in patients, such as a feeling of being at ease, feeling calm, and being relaxed in the space that they live in. Linked to this was the identification of an environment that was 'settled' and the provision of a therapeutic environment to reside in.

P23(MS): *Well, having come from [high secure] Hospital I find the environment more therapeutic. I just think on the ward it's more settled. There's something about it which makes me more settled.*

Another psychological sense of comfort for the patient was around a sense of ownership. One patient described their personal space as being 'a sanctuary' (P30(C)). The patients talked about the value of having somewhere they can go and escape to, where they can make a choice to be alone and left in peace.

Purposive activities, occupies the self and the mind

This theme is made up of three themes which envelop the available activities within the environment in terms of patients' engagement, impact on how the patients feel and think, as well as how activities provide a distraction and something to occupy patients with. These are all factors that are likely to be relevant for both older patients in secure settings and younger patients, and not specific only to those over 55, but this was found to be widespread throughout the narratives of the older participants interviewed.

Sense of individual purpose.

Activities within the environment give patients a reason and a sense of purpose for being. This sense of purpose is the motivation that drives people towards a satisfying

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future; thus, for some, chosen activities have the potential to provide purpose, which in turn is associated with better quality of life, health and wellbeing.

> P10(C): *I'd like to start on the garden… it's something nice to do. It makes me feel like I've got a purpose. Yes, a sense of well-being, then.*

This sense of purpose is intricately linked to a sense of achievement that patients receive from the activities. The patients revealed such achievement was associated with their wellbeing, improved self-esteem, feeling better in the self and as good for their mental health.

> P14(LS): *It's something that you achieve. When you make something, you feel you achieve something. I made cups, bowls. I made cards. Cards…What's good about it, it helps your mental health, because you've achieved something.*

In addition to this, the narratives of the patients suggest that the activities contribute to their sense of self and identity in that they become the 'expert' or the 'go to' person in relation to specific activities e.g., the 'book-binding person' or the 'woodwork expert'. The activities give the patients a sense of status and ownership, where they take on this social role of expert in each skill or area, and/or gain a sense of being needed by others.

> P12(HS): *I really enjoy the graphics, bookbinding. I was the one they'd come to if they wanted anything doing in the workshop. If books wanted repairing, '[Patient's name] will do it.'*

Time fillers

This was extensive across all the interviews and narratives from the patients; activities provided a way of occupying and filling patients' time. The environment provided different opportunities to do a range of activities, to pass the time and keep their day filled with things to engage with and do.

> P20(HS): *Quality of life is that I've got something to do every day to keep me occupied. I've got a stereo that I listen to and a telly that I watch. On Friday afternoons I go to the gym. I go to the garden, because I've got an allotment and I look after that and I water plants and everything. I talk to the lads; I talk to the staff. I keep myself occupied.*

Escapism

This theme explores the use of activities to take patients away from negative internal and external factors and 'escaping'. The escapism came in the form of enabling the

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patients to clear their minds, and actively avoid thinking about negative things. The activities provided opportunity to shut out their own internal voices and thoughts, preventing ruminating, focusing their attention on activities instead.

> P12(HS): *Keeps my mind off things. Doing my jigsaws. Concentrating on that, it helps me a lot. It's about keeping my mind occupied.*

In addition to internal voices and thoughts, the patients described how activities provided a way of blocking out external stimuli and other people, a valuable outcome in an environment where they are continually surrounded by others. Part of the escapism was identified as being able to remove themselves from the ward itself. Not being contained within their usual environment enabled them to engage with nature and fresh air, offering a therapeutic environment and a sense of calm, peace and tranquillity.

> P20(HS): *We went out for a walk yesterday and listened to birds singing and all different things; smelling plants and grass and everything. I really enjoyed it yesterday…. You're not stuck in a rut.*

Healing and wellbeing as a function of environment

This theme is comprised of four themes founded upon how the environment governs health and healing, a result of access to health-related activities and facilities. Herein, the removal of barriers to 'being well' is explored, as the environment facilitates or enhances healing and wellbeing.

Guided towards healthy lifestyle behaviours.

This theme relates to the provision of an environment that guides people towards and encourages healthy behaviours which could be seen as relevant for patients of all ages. This includes factors such as exercise, diet and smoking cessation. Healthy opportunities are 'on a platter' for patients, who more specifically are exempt from barriers to accessing health interventions that are typically experienced by the general population. One such example is free and easy access to gyms and different types of sports to facilitate healthy lifestyle behaviours.

> P23(MS): *Going to the gym. Now, we've got an hour-and-a-half session now. Going down to the gym, on my exercise bike and also doing the weights. I also go and play outdoor sports, play cricket and tennis, so that's helping me.*

An example where the environment dictates a healthy lifestyle, relates to smoking. Many of the secure environments are non-smoking sites, meaning patients are forbidden or unable to smoke anywhere.

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P22(MS): *Well, to maintain my physical health, I used to be a smoker, any smoker, so coming to an environment where I can't smoke, has helped tremendously.*

A different way that the environment guides individuals towards a healthy lifestyle was in relation to diet and healthy eating. This was achieved through: options to cook healthy food, access to healthy food and menus geared towards healthy choices, the provision of specific diet advice, as well as plans and options individualised for the patients' needs.

P22(MS): *Healthy cooking as well. We get the opportunity to do healthy cooking. You're either doing your groups which improves your quality of life, or you go down to the gym to improve health and well-being, or you're cooking a healthy meal.*

Rehabilitative and therapeutic environment.

This theme was widespread and refers to formal interventions over and above day-to-day activities previously discussed such as the provision of psychological, therapeutic, and rehabilitative support and intervention. It was clear from the patients' narratives, that psychology was found to be one of the most helpful and widely accessed therapeutic services, as evidenced through the following extracts: 'I think psychology is a major one' [P09(C)]; 'Psychology's helped a hell of a lot' [P12(HS)]; and 'I'd say psychology has helped the most' [P02(MS)].

In addition, specific offence related interventions and therapies such as for knife crimes; drug rehabilitation; sexual offending; violence reduction; and social skills, problem solving, and goal setting were intrinsic to the environment. This was offered both in a group format:

P03(MS): *It's [quality of life] improved over the years because of a lot of therapy… a lot of group work in many, many, many different groups… I wanted to go on those groups. I liked doing those groups;*

and one-to-one format based on the patients' preferences:

P23(MS): *I would say I have regular psychology sessions; they help me. Having one-to-ones helps me.*

Effective medication to manage mental and physical health.

Part of the environment is having a safe place to store and administer medication, and the carefully timetabled nature of forensic settings lends itself well to encouraging

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medication compliance. Staff themselves, also an inherent part of the environment, provide additional support in medication taking and monitoring. This tended to be particularly effective in relation to mental health:

> P02(MS): *Well, as I said, mine has changed for the better really, because before I come in here, I was really, really manic, but I never realised this until they give me the depot and it sorted me out.*

As well as medication to manage mental health, there was also effective medication for physical health issues and problems. This may be particularly important for older patients in secure settings, who may experience more physical health problems. Again, it was a function of the environment in which patients had access to health professionals for physical conditions, and they then provided appropriate and suitable medication for them.

> P34(HS): *Physical, I'm diabetic, so I have diabetic medication and that's working well. That's working well, it's brought my bloods right down, so I'm quite happy.*

Access to different health care professionals.

The final emergent theme was around access to a range of different healthcare professionals. While this is something of benefit for all patients, this is required more by the older patient in secure settings, whose physical health is likely to be worse than and deteriorate more than younger patients. Beyond their day-to-day care on the ward/unit, patients benefitted from easy and quick access to a range of health care professionals such as physical health doctors, dentists, physios, opticians, GPs etc.

> P19(HS): *Oh, yes, I was at physio yesterday, because I've got a bit of a back strain…it's pretty good the medicine that we have got and all that. If you've got any ... whatsoever, you're straight there, whether it's dentists, opticians, anything.*

One of the services that seems to be easily and readily accessible is physical health care. It is well known that as forensic patients age this is associated with greater deterioration in physical health and co-morbid health issues. Specific treatment for physical illness is readily available and so patients' needs in relation to this are quickly and efficiently addressed.

> P20(HS): *I've had cancer twice, bowel cancer, and this hospital saved my life. I've got a lot to thank this hospital for. I've also had five heart attacks where*

they've saved my life, so I've got a lot to thank these nurses and psychologists and doctors for.

Safety net and checks in place

This theme acknowledges the value of perceived support that acts as a safety-net or back up for the patient if it is ever required. Beyond the day-to-day, regular input or service provision, patients valued additional ad-hoc care provided in response to their needs. Embedded in this theme, is the psychological value placed on the security of accessible support. This theme was by far most prevalent in the narratives of the community patients.

> P04(C): *A feeling of security and that you're not going to come to any harm, that if there's anything that you can't cope with you've got someone to turn to for help, but you're very independent even so, and you're supported in your independence as well.*

This theme therefore does not relate to access of concrete activities and care, but instead explores the abstract security derived from the availability of support in the background. The patients observed this as a safety-net or described it as back-up care that can be provided.

> P31(C): *Yes, it is, it is like a safety net, because at night when the staff… Sometimes I have staff in for the night. I don't know why; I don't have staff really up at night. I shut the door and that's it, that's me done for the night.*

Knowing that staff monitored patients and offered support if help was needed in the event of relapse, deterioration, or other problems contributed to the perceived back-up or safety net.

> P09(C): *Overall factors that can cause to relapse, they can inform the required authorities and I can be put in hospital, which is a guidance and a help… so monitoring me and see what I maintain and when I deteriorate.*

Structure and routine

Some patients valued the element of structure, regularity and routine in their lives. Routine is internalised as a positive thing which contributes to quality of life. Patients find it helpful to have a structure to their day that is pre-planned and organised, they can anticipate what they are doing and when.

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> P05(LS): *Looking at it from a funny kind of way, the system, the structure of the day the way it functions, it helps. Well, it's getting up, getting your dinner, getting your pills, getting out on the grounds, watch a bit of telly.*

The key element herein is that structure and routine is a mechanism that keeps patients occupied and busy. It is linked to one of the previous themes, where it was found that activities provided patients with a way of filling their time.

> P22(MS): *I think if you've got something in place, if I know I'm doing something that particular day, then it makes me feel happy, that I'm not always going to be sitting around doing… Structure is very important. Doing activities and having a structure and plan in place.*

Interpersonal

Camaraderie with other patients, supportive relationships

The patients expressed the importance of having good relationships with the other patients with whom they currently reside; this is likely to be relevant across all age groups. The older participants, noted for them, how a feature of this is that their relationship with other patients is a positive, and a supportive one. There is a feeling that the patients will help each other establishing a sentiment of 'we are in this together'.

> P20(HS): *Yes, everybody helps me on the ward. They talk to me, they play cards with me, play other games. They're always asking me if I'm all right. If I'm looking down, they come and talk to me or make me a brew.*

This camaraderie, unity and friendship is identifiable in the language used by the patients as numerous of them referred to the other patients as 'the lads' (e.g., P12(HS): Probably being with all the lads [helps wellbeing]. Being with the lads on the ward; P08(LS): Talking to the lads. That's it. Talking to some of the lads and that's it). This suggests they are part of a group with social dynamics and fellowship and talking to people within the group that all leads to connection.

Within these interpersonal relationships, patients suggest that they genuinely get on with the other patients. This was evidenced though the 'banter', 'teasing' and 'having a laugh' interaction with other patients:

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P23(MS): *Sometimes it helps just to have a bit of banter… I get quite a bit of stick sometimes because I'm 58, or 59, but it's just harmless banter. Someone called me an old git, and I said, 'Cheeky bugger', you know.*

Contact, involvement and support from family and friends

Positive and supportive contact with certain family members and friends, who have an active involvement with the patients is important. Patients reported they received support from a range of different family members, including their children, parents, and siblings. Children particularly were identified as a source of support facilitating quality of life and wellbeing for patients.

P01(C): *Yes, the relationship I've got with my kids. Yes, that's essential for me. Well, for a while I didn't speak to them, because I was in hospital. Then they came and saw me, and that uplifted me. That keeps me going.*

In addition to or in the absence of family, the patients discussed the role of friendships in providing support. These were intentional friends who provided a prosocial relationship and a support mechanism, superior to the role played by peers or circumstantial friends with whom they resided.

P20(HS): *My mate is supportive of me. He said, 'When you get out you can come through here and stop for the weekend or a week or whatever. We'll go out to the park or go shopping' things like that. He's going to help me when I come out.*

Therapeutic relationships with staff and professionals

A final interpersonal facilitator for the patients was the relationships formed between the patients, staff and other professionals. The patients are not simply being offered care and input on a practical level; but it was suggested that staff were 'caring' people who fostered a connection on an emotional level.

P20(HS): *I feel cared for, I feel understood, and my quality of life is very good here. The staff on this ward help me every day. The difference is I'm cared about.*

There was widespread narrative across the patients' descriptions of their relationships with staff, viewing them as approachable and someone who they readily could talk to. This 'talking' with staff was outside of formal sessions and comprised casual and impromptu interactions.

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P16(HS): *I think talking to staff. The only way to make me feel better is when I talk to staff and get all me frustrations out. Well, there's a couple of staff nurses I like talking to.*

Some patients may lack family and friends, under which circumstances staff and professionals may fill this gap and provide a substitute 'family' or 'friendship' for the patients. This community is reliant on the relationships built between the patients and staff.

P07(LS): *Everybody, the patients, the staff, my key worker, the other patients, or just staff. They're just one big family, we get on all right.*

Individual

Independence, freedom and choice

This theme is about patients gaining independence within their environment and having an element of freedom and choice day-to-day. In many ways this relates to how the removal or reductions of restrictions inherent within their environment could enhance patients' wellbeing, quality of life and progress. The patients in secure units discussed their desire for more freedom and how the lessening of their current restrictions would help their quality of life and wellbeing.

P13(MS): *Being out of hospital. I'd be in a flat. I think more freedom I'd like, like going out shopping and things like that. I'd like to be free of hospital. Just freedom, my own flat.*

It was seen that patients experienced more freedom, independence, and choice as they moved through levels of security. They positively identified with the easing of restrictions that came with moving through security levels, affording an element of freedom and access to things that were previously prohibited.

P35(MS): [Moving down restrictions] *You've got your own mobile phone; you've got your own TV. To a degree, you can cook more. They don't allow you even to make a cup of coffee over there. It's down to having slightly more freedom and less restrictions, that has and is what has made quality of life better.*

Own space, time on own

Patients positively identify the occasional importance of personal space, away from other people, gaining time on their own. Time alone was valued when it was an active choice, and therefore not associated with feelings of isolation and withdrawal. Given the nature

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of secure units and continually being surrounded by people, not necessarily through choice, time alone is important for patients.

> P32(LS): *I do like time by myself because I can go off and I can think. I haven't got all the noise round me; I've got people chatting at me all the time do you know what I mean? It's like total calm, serenity, so I can just walk or sit there and think, yes, this is nice, this is what is needed.*

Patients valued having a space that they could call their own, and in effect have control over. They felt they 'owned' certain spaces and decided who could enter it.

> P35(MS): *You get peace and quiet* [in your own room] *and get away from it. Having your own TV is a big thing. You've got your own room to go to. That's just nice and gives you quality of life. Well, it's your spot. It's your place in there. You dictate who comes in and who doesn't.*

Future focus: Positive thinking, hope and optimism

This theme is about the individual characteristics, personal thoughts, perceptions and attitudes that promote good quality of life, health and wellbeing. Some seem to choose to take a positive mindset and attitude, coupled with a sense of optimism which has a positive effect for them. This is an active decision and choice that is made, that seems to benefit the patients.

> P04(C): *The main thing is optimism and a positive state of mind. A positive frame of mind. I'm happy to be alive. I just I enjoy being alive.*

Depicted in the narrative is a future focus in the thinking and mindset of the patients, and a move away from the past. There is a practice of a positive attitude orientated towards desires and plans for a preferred positive future.

> P34(HS): *I think it's attitude. It doesn't pay to ruminate about what happened in the past and what bad things have happened. You can't change it, what's done is done….Looking more forward in the future.*

This theme is underpinned by a sense of hope for the future within the individual. It revolves around the patients having an expectation of fulfilment or success as well as a sense of happiness and optimism and something to look forward to.

> P35(MS): *Yes, having this hope for getting out and that you've got a future. Well, if you thought you were going to be stuck in here for the next ten*

years, you'd give up, wouldn't you? I look forward to the fact that I'm - hopefully, I'll be on my way fairly soon.

Threats and barriers

Environmental

Unsuitable environment for individual needs

The theme examines the impact of an unsuitable environment - encompassing both physical (structural) and social factors - on the patient. The patients discussed structural and physical elements of the ward that were not suitable for them as they aged; for example, those with mobility issues found they struggled and were unable to take a bath. One of the older patients, aged 70, expressed how they were unable to take a bath due to their mobility issues:

> P18(LS): *At other hospitals you have got baths that invalids can use, you know, with a hoist. I like getting in the bath, I like getting out the bath but it's standing up after I've sat down. I cannot stand up again. I have to be lifted up. I can't reach. Because of everything I don't get to have a bath. I don't like showers or strip-washing down.*

Another patient with poor eyesight, that had deteriorated as he aged, found it difficult within the unit, finding his way around and the light not being good enough for him to be able to see well enough. In both these instances, this highlights barriers that are more specific to the older patients in secure settings, influenced by the fact that the ageing process has resulted in physical health deterioration and issues such as frailty, poor mobility and sensory decline.

Patients often commented on the lack of space in their environment, frequently combined with a feeling of the space being overcrowded with other people.

> P25(MS): *Well, I think there's too many people and not enough space for everybody. There's not enough space, you've got them all crammed in.*

Linked to this lack of space was that the environment was deemed to be very claustrophobic. The narratives referenced the experience of a feeling of being in a prison, a sense of people feeling they were hemmed in, enclosed and confined.

> P19(HS): *It can be claustrophobic, some of these rooms, they feel like prison cells, it's not for me really, basically, especially when you get locked up in your room from nine o'clock until eight o'clock in the morning.*

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Institutionalisation

Following prolonged stays within units, patients reported feeling institutionalised becoming over reliant on other people, support mechanisms, and help. For some of the older patients in secure settings, who have been in these units for a long duration of time, it is the length of time within the units that is likely to contribute to patterns of institutionalisation, and not the individuals age per se. While institutionalisation can happen to any age, it is likely to be particularly prominent for those who have been in units for long periods of time, and these people are also generally older. One of the factors seen in relation to institutionalisation was that patients acquired a sense of comfort and safety from their environment. Despite the positive sense of comfort from being settle in the environment, the challenge is institutionalisation becomes a barrier as people are then reluctant to move on.

> P23(MS): *I got a bit settled, a bit institutionalised and in a comfort zone there, and every time I would walk round the doctor would ask me how I felt, 'Oh, I'm doing okay'. Then I thought about it and I thought well, I've got to move on some time.*

One of the issues that seems to be associated with institutionalisation that acts as a barrier for patients progressing is that they seemed to become 'deskilled' by being in a secure unit for so long. They get used to having a structure and things being done for them. This means that they lose their independence and a sense of being able to care for themselves. Progression then becomes problematic because risk could be increased once this structure and having things done for them is then removed.

> P07(LS): *Living in a nice secure, like this one and an en suite and quality of life, food on the table, no bills to pay. I don't want to move from here, it scares me that does, it scares me moving from here, because I might put the cooker on and forget to turn it off.*

Lack of things to do, boredom

Patients found they experienced episodes and feelings of boredom day-to-day. Some of the patients described how they felt that there was a lack of available things to do, resulting in too much time on their hands.

> P15(LS): *Because there's nothing to do here gives me bad quality of life. There's nothing to do, no. Boredom. It's just whiling away the time, really, killing time. It's all life is all about anyway; it's about killing time.*

The narratives of some patients emphasised the experience and subsequent feeling of monotony alongside this boredom. The negative impact of repetition and the lack of variety and access to different activities to occupy themselves, emerges from the patients' discourses.

> P36(LS): *Well, there's precious little to do on most wards… When your entire existence consists of daytime TV it's a pretty poor quality of life… I live in a state of inertia, really. This place is Groundhog Day.*

Restrictions, rules and constraints

An environmental feature found to be a threat and a barrier was the negative impact of the system comprising of the constraining processes, rules and restrictions. This is not necessarily something specific to older patients but was something the participants in the current research discussed in detail. It is a challenge to address and resolve these restrictions, often put in place to protect patients, staff and other people. Therefore, restrictions may need to remain in place and removal may be impossible.

> P12(HS): *I know you've got to obey the rules and all that, but some of the rules are a bit stupid. I'm just saying how I feel. Not being able to do things that I enjoy* [makes quality of life worse].

In addition to the rules, processes and paperwork were an additional barrier for patients intensifying the restrictive environment. The patients' interviews indicate bureaucracy and paperwork add another layer of restriction that potentially hinders achieving further wellbeing and progress.

> P36(LS): *Just all of the bureaucracy that goes with being inside* [hinders progress]; *it's not our fault. It's down to like processes and having all of those in place and form-filling, that kind of bureaucracy.*

A paramount example of restrictions which featured within and across all the patients' interviews, was the impact of COVID-19 pandemic which coincided with the research. Patients explained how their quality of life, health, wellbeing, recovery, and progress was hampered by the additional restrictions that COVID-19 imposed; such as meaning they did not get access to activities to engage in, visits into the units were stopped, leave was prohibited as was mixing with other patients. For community patients, they found themselves restricted again, akin to being in a secure unit, but this time due to the pandemic.

P11(C): *Right, for the past 16 months, I don't do anything because of COVID. Then obviously, with the restrictions, that's made it a little bit harder as well. I spend most of my time on my own.*

Interpersonal

Mismatched relationships between patients

At times the relationships between patients were deemed poor. This theme describes the negative impact of a mismatching of people, and the wrong mix of people on the ward and units as well as the impact of problematic dynamics between patients. Patients referred to the impact of being in confined spaces with too many other people and pressure this puts on the dynamics between individuals.

P22(MS): *Yes, been stuck in on the ward, day-in, day-out, people under each other's skin, it can cause friction.*

In several of the patients' narratives, mismatched dynamics between patients were seen to arise due to age differences. The general observations were that the younger patients seemed to be rowdier and noisier, and this was not the type of interactions that the older patients wanted.

P12(HS): *Too many young ones. They're stupid. Shouting and just too many young ones. So, it's quite noisy… but there's too many young ones. Get rid of the young ones.*

Another of the concerns that the patients discussed was around the fact that they are sharing a space with other people who have mental health issues, and this can cause an unsettled ward or make interactions with others more difficult.

P21(HS): *We're getting a lot of peers that are coming from other wards that are creating havoc and they're making the ward unsafe. There's people on here that are a lot more unstable than they used to be, they're volatile, they're unpredictable, they're unruly.*

No or little contact with family and friends

The next theme moves away from the relationships with other patients, capturing relationships with family and friends external to the unit or in the community. This is namely where there is evidence of there being no relationships or there being very few relationships with family and friends. Supportive external relationships outside of the units where they were living were not evident for some.

> P15(LS): *I don't have any - my friends I've put aside. I've put my friends aside… I've got no friends that I could really consider to be worthwhile outside in my local area. My family I have very little to do with, because they've all got their own lives to lead, and they can't help me in any way, or not really. I don't really bother with friends or family.*

The other difficulty that patients discussed regarding family and having contact with them, was because, as the patients were older, many had experienced a loss of family members such as parents. They also experienced no or little contact with siblings, because they were also older and sometimes had their own mental and physical health problems, making it impossible to connect with them, thus they found themselves without a family around them who could offer support.

> P34(HS): *No, not really. I've got a brother. My mum's dead, my dad's dead, all my uncles have passed on. [Brother's name] got problems as well, he's got mental health problems.*

Therapeutic ruptures

This final theme relating to interpersonal relationships was with staff and professionals. Some patients experienced poor relationships with staff they simply felt they didn't like certain members of staff and did not get on with them. This meant there was an absence of any therapeutic alliance.

> P16(HS): *I'm not going to name staff, obviously, but I'll just say there's a couple who I don't really get on with… I don't say I don't get on with, because I can talk to them, but if you want something done don't go to them, so to speak.*

Some patients felt that the staff didn't really engage fully with them, and that they were more interested in socialising with each other and 'drinking coffee' and 'watching the television'. Some of the patients also discussed that they felt staff didn't really support them or seem to care about them.

> P13(MS): *I don't feel they'll* [staff] *help me progress? I don't think they will. They don't seem to care.*

One issue raised by the patients in relation to the therapeutic ruptures was regarding age and when younger staff looked after them, opposed to older staff who worked on the unit. Part of the issues seems to be that the older patients felt that they could not relate to the younger staff and vice versa. There is a suggestion by some that the preference

would be to have the staff of a similar age care for them, as they better understand the older patients.

> P16(HS): *One last thing. I also think that the staff that should be on that ward shouldn't be kids…It just needs more people of the same ages but older generation because you understand each other.*

Individual

Isolation

A small number of participants discussed a lack of interpersonal relationships, and how this led to feelings of being alone and experiencing isolation.

> P18(LS): *Sitting about doing nothing or laying about. Not listening to music. Staying about on my bed. Chilling out. I don't like to have to be beside myself, in I like to be sociable. I don't like spending too much time in my room unless I want a sleep. I feel a bit isolated when I'm on my own and that gives me bad quality of life.*

The issue with isolation was observed more so within the community sample. By its nature those within the units are likely to have more people around them, with staff and professionals on hand to interact with. However, in the community patients find themselves on their own more, and this can develop into feelings of isolation and loneliness.

> P30(C): *My life is empty; it can be very lonely because sometimes I don't see anybody for weeks apart from my CPN* [Community Psychiatric Nurse] *and that.*

Mental health impacting negatively

By nature of the patient group interviewed, mental health issues are a feature of their lives. This theme was identified by a few of the patients, who stated that when mental health was poor or deteriorating, this impacted negatively on them, particularly on their quality of life. As seen with P05(LS), poor mental health makes their current situation worse, and this causes negative thoughts, feelings and emotions.

> P05(LS): *I haven't got it* [quality of life] *here. I've got negativity and depression and anxiety and panic. It's more turmoil, more drudgery, a lot of drudgery. I've got no excitement, no happiness, no joy, no fun…. What*

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*upsets me is I'm suffering basically torture, terror and anguish, anxiety,
panic.*

Physical health issues

As well as mental health issues, the patients also identified how physical health issues
were a threat and barrier. This is something that differentiates older patients in secure
settings from younger patients, who although may also experience physical health
issues, physical health issues are generally more prevalent and chronic in older patients,
who also experience physical health issues as a result of ageing The patients identified a
range of different physical health problems experienced, including diabetes, angina and
heart issues, COPD, and asthma. For a few patients their physical health issues were
extensive, as they experienced some major long-term health issues.

> P21(HS): *Physical health, I'm not in good health at all. I've got arthritis… I've
> got deformity of my neck and shoulder, my spine, it's called spinal shock. I'm
> 80 per cent deaf, that's why I'm putting in a request to go to the deaf ward. I
> wear glasses, I have problems breathing, I've got a hole in the heart, I've got
> a leaky bowel…. I've got damaged liver, which is on the mend, so I
> understand. I've also got gallstones… I've got diabetes.*

The patients experience physical health issues associated with ageing and the ageing
process. The patients talked about 'aches and pains' that seem to worsen as they get
older; ones that are likely to continue to worsen. These physical issues impact on
patients' mobility, getting about and being able to do things. Some patients seemed
resigned to the fact that this was happening to them.

> P38(HS): *My disabilities, get the wheelchair over to the DRC instead of using
> my walker. It's because I'm in pain and I can't even bend my knees. Just old
> age. It creeps up on us, doesn't it? It's a case of you're bound to get wear
> and tear and arthritic hands and that.*

Unmotivated, not engaging with activities

Some patients reported that they were not engaging with or doing activities that they
felt they should be because they had no interest or motivation in these activities even if
they knew it would ultimately help them, (particularly for their physical health) and add
to their quality of life and wellbeing. Although they have access to numerous different
activities, some patients are simply not motivated to engage them.

> P07(LS): *We've got the choice of doing ground walks outside the community, ground leave, ground walks, cycling. We've got that, but I don't want that. No, we've got a gym, I don't go there because I've already tried it, I've got no motivation.*

Some of the patients suggested there was a lack of encouragement from the staff and peers to help motivate them to engage with the activities. Such encouragement could perhaps facilitate the patients to take-up and maintain certain activities which could ultimately benefit them.

> P22(MS): *I think sometimes we need to get, to be encouraged a little bit more sometimes. I've done it myself, where we, 'I don't fancy doing this today.' There could be a bit of encouragement from staff, or your peers, to egg you on a little bit.*

Uncertainty and feelings of being in limbo

This theme was not widespread but was significant for a small number of patients. These patients talked about how they were not sure what was happening, predominantly with regarding their futures. They expressed an uncertainty about their future, it terms of what the plans are, what the options are and where they are going. This seems to put the patients in a state of limbo, feeling stuck, and where they do not know what the next steps are and what this would mean for them. This causes feelings of confusion, frustration and generally that they are playing a waiting game in relation to their progression.

> P19(HS): *It can be frustrating, because you want answers, when do I move on, what's next, that kind of thing? The only answers that you get is, 'Oh, just keep going.' well, what happens next? I don't think most of the people know what the end game is anyway. it's just a kind of, that's it, it's a wait and see scenario for your next CPA* [Care Programme Approach meeting].

Self-sabotaging behaviours, thoughts and feelings

This final theme was about behaviours, thoughts and feelings of individuals that impacted negatively. One of the factors that the patients identified could impact on their quality of life and hinder progress was if they engaged in detrimental behaviours e.g., violence or drug use and abuse. As well as behaviours, the patients also talked about thoughts that could also act as self-sabotaging for them. These thoughts were negative

and debilitating and as such evoked feelings of hopelessness and fear and took patients back to traumatic pasts.

> P05(LS): *I'm afraid of what I'm going to think, I'm afraid of how it's going to be. The torture that I can suffer could send me over the top. Negative thoughts make my quality of life not so good.*

Linked to negative thoughts, patients' feelings of self-esteem and self-worth were also detrimental for them and deemed as a potential sabotage for them. There was evidence that this low self-esteem and low self-worth has negative impact on the patients' day to day living and lives. The patients develop a feeling of not deserving to move forward and progress, this then is likely to prevent them physically from moving forward.

> P04(C): *I've not got very good self-esteem, so sometimes that overwhelms me, and I just feel I'm good for nothing and life isn't worth living I sometimes feel. Just my own lack of self-esteem and the dips; when I dip down and I become very negative.*

DISCUSSION

This research addressed gaps in knowledge on what can enhance quality of life, health, wellbeing and recovery, and what is likely to enable progress for older forensic mental health patients. There were certain factors that were likely to be relevant for both older and younger patients alike, with other factors, e.g., those that address physical health and mobility, frailty, cognitive and sensory deterioration experienced as patients age that are specific to the older population. On a broad level, it was found that a combination of environmental, interpersonal, and individual factors are required, aligning with previous research[41,42]. 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[41]. 'What works' for forensic mental health patients is provision of individualised interventions, safe environments, supportive alliances, learning from others, reducing hopelessness, promoting autonomy, and fostering motivation[42]. Recovery needs to be a holistic approach across these different factors that can enable patients to maximise their health, quality of life, agency, functioning and achieve satisfying, meaningful, and fulfilling lives[42].

People "live not just in the environment but by means of their environments, and it is through embodied engagement and interaction with the world that the mind

emerges"[43, p. 31]. The environment should be designed so it can address the needs of older forensic mental health patients including their mental health needs, reducing the risk of recidivism, and catering for issues as patients age (e.g., poor physical health, mobility problems and frailty). This is best achieved within the least restrictive environment, with the goal of progressing patients down in security levels to community reintegration where possible; while at the same time effectively managing risk[44]. There is a difficult balance, as patients suggest they would like less secure confinement and more freedom (less rules, fewer restraints, less restrictive processes, more leave, easier access to outside), but at the same time (for reasons of risk, safety and rehabilitation) both physical (e.g., safety-windows, locks, perimeter walls, alarms) and procedural (e.g., policies and procedures to maintain security such as processes for leave, search protocols) aspects of security need to be imposed[45].

The architectural design and structure of the psychiatric facilities and the quality of living space is essential for the recovery process[46]. A safe environment that facilitates treatment is required, but one that also affords privacy and the ability to observe and monitor patients[47]. The environment therefore needs to be adapted specifically for older patients, so that they have privacy where possible but remain safe (i.e., through surveillance, observation, and procedures), and adapted structurally by modification to the buildings and through the provision of equipment (e.g., Zimmer frames, moveable furniture, hoists, handrails) to address any issues as they age. High quality spaces (inside and outside) should be provided to allow patients mix with others or take some time to themselves. This can promote good quality of life, health, and wellbeing.

Another factor deemed important was access to suitable and appropriate activities that occupied patients (both from a physical/behavioural point of view and in relation to their thoughts), and that filled their day, preventing feelings of boredom, but that were age-appropriate. So, while there were issues identified that would be relevant for older and younger patients, it was specifically noted that older patients need to be offered age-appropriate activities in terms of their physical capabilities, as well as their interests and tastes as an older person. A lack of activities in secure units can impede and negatively affect individuals' mental health[48]. Availability of different activities (including work, sport and social activities) has been found to be important for those in secure units as it offers them respite from thinking about their issues and being detained[42]. It is important to offer access to stimulating and meaningful activities that are age-inclusive and appropriate[6,30]. Service goals for older adults therefore need to include a range of stimulating, meaningful and age-appropriate activities, that can be embedded as part of their day-to-day structure.

It is also important to have health and wellbeing embedded within the environment and service provision. Patients discussed how important psychological, therapeutic, and rehabilitative intervention was. Treatment of forensic mental health patients is complex as it needs to focus on the intersection between psychiatry and offending behaviour and so treat mental health and psychiatric disorders while preventing criminal recidivism by addressing offence related factors[49]. The interventions offered need to reflect these dual goals, and offer interventions broadly based on psychopathological models for addressing mental illness and correctional models to manage the patients' risks, needs and responsivity[44,50].

Alongside this it is also important particularly for older patients, to provide access to a range of different health care professionals who can address physical health needs and issues such as deterioration in sight, hearing, mobility, and cognition associated with the ageing process. It is known that the physical health of patients with long-term mental health issues is poor with high rates of mortality compared to those without mental health issues[51]. Service provision that offers onsite and/or easy access for medical care and input can help address the needs of the older forensic patients and so can contribute positively to the lives of this group of people. A comprehensive package of support is therefore needed for older forensic mental health patients to address mental health, physical health, elderly care needs as well as offending behaviours and risk.

The social environment and social connectedness form an important part of the recovery journey[52]. There is social interconnectivity between patients sharing the same environment; they are involved in each other's recovery[2]. Patients must navigate complicated relationships on the ward with both peers (who they befriend through circumstances and not necessarily choice), particularly as it was seen that there were tensions between younger and older patients, as well as with professionals - who have a dual role of care and custody[52]. This is something that is likely to be problematic across all ages and needs consideration for all, but the participants in this research were vocal about these tensions they experience with younger patients and some members of staff, especially younger members of staff. The older patients in this research reported that positive interpersonal relationships (camaraderie with other patients, family and friends, and therapeutic relationships with staff) were important for them as a way of promoting good quality of life, health and wellbeing, and in aiding recovery and progress. It was found that specifically for older patients, that some did lack social contacts with family and friends due to loss through death. It was therefore important that social relationships were developed across different people such as peers, staff and befrienders.

It is vital to recognise the importance and value of the social matrix and milieu in forensic settings, whilst managing the risks[43]. Trusted alliances with others can offer a feeling of safety for patients and can provide support and protection when individuals have feelings of distress, anxiety, and isolation[53]. Forensic institutions need to become secure bases for patients and promote the development of more secure therapeutic relationships[54]. Within the sense of safety and openness enabled by a secure base the experience of benign intersubjectivity may enhance personal identity and compassion towards the self[43]. Patients need opportunities for taking personal responsibility and having valued social roles[2]. This can be done through professional, peer and family relationships and meaningful social activities.

On an individual level, it was seen that self-sabotaging thoughts and behaviours, and lack of motivation, seemed to impact negatively on the patients. This seemed to be associated with feelings of hopelessness, low self-esteem and low self-efficacy, which all contributed to negative outcomes. As older patients may have been detained for lengthy periods during which occupational and technological skillsets have changed significantly, their concerns for future employment, volunteering and social participation might be different from their younger peers. However, patients did report that positive thinking, hope and optimism, as well as feelings of independence and choice, promoted good quality of life, health and wellbeing and progress. People have the fundamental need to self-determine their own lives and goals, have hope, and believe in their capacity to grow[55].

Hope is a central tenet in patient centred recovery[56]. A collaborative model of care has been found to aid patient recovery in forensic psychiatric populations, where the emphasis is placed on collaboration between the professionals and patients; service users are empowered and have a sense of personal agency in co-production of outcomes[2,57]. For those with severe mental illness, a sense of self, hope, purpose and personal agency all make a significant contribution to recovery[41]. Facilitating hope, purpose and personal agency can be achieved by taking the focus away from problem behaviours and focusing on adaptive behaviours[58], and taking a strengths-based approach[59].

Limitations

This research does not seek to generalise beyond the type of settings where the interviews took place; the findings therefore offer in-depth and highly applied findings that are relevant to NHS forensic mental health settings (inpatient and community) in

England, which may not generalise to non-NHS and private services, or services outside England. The participants were those who self-selected to be interviewed, which can introduce bias. The interviews were mainly conducted remotely, (following COVID restrictions), using video calls, which for many of the patients was a new use of technology and so they may have found it more difficult to engage with the interview and interviewer. This might have excluded some patients from being interviewed (e.g., restrictions accessing technology), or for those in the community who might not have access to such technology. Some of the patients, for reasons of risk, were accompanied in the interviews by members of staff who work with them, and this may have influenced how the patients responded to questions. However, it was a strength of the research that 37 older forensic patients were recruited and enabled to express their views, as this population are rarely given this opportunity.

CONCLUSION

Our findings of the needs identified were consistent with other studies of older forensic mental health patients.. The older patients in this study identified many issues that would be common to forensic patients of all ages at an environmental, interpersonal, and individual level. However, there were also certain issues found that were more specific to the older population such as in relation to the physical structure of the environment (such as the adaptions needed to compensate for issues as they aged), their physical healthcare problems and needs, and tensions in relationships such as with younger peers and difficulties they may have relating to younger staff. This emphasises the need for individualise care-planning and provision to address all the needs of older patients.

Findings highlight the importance of suitable environments and care for physical health issues, as well as how ageing may leave older patients with fewer family and social contacts and how they may find it harder to establish a supportive peer group. Therefore, for older forensic mental health patients to achieve good quality of life, health, wellbeing, recovery and progress, consideration needs to be given across the environmental, interpersonal, and individual factors. These factors are interlinked and so a comprehensive, holistic and individual patient centred approach is needed within forensic mental health services.

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