

LETTER

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A comparative study of healthcare and placement needs among older forensic patients in a high secure versus medium/low secure hospital setting

It is predicted that there will be a significant growth in the population aged over 65 years in the U.K., from 15.9% in 2000 to 23.3% in 2050, with the fastest growth rate being among the oldest old (United Nations, 2005). In line with such growth, there will be a commensurate increase in the population of older people suffering from psychiatric conditions. This will lead to a demand for increased health care services and the need for reorganization and prioritization of resources channeled into health care for this group.

An area in healthcare provision for older people which is both under-researched and suffers from a lack of adequate services in the U.K. are services for older psychiatric patients with a history of offending or forensic patients (Nnatu *et al.*, 2005). The older forensic offenders are more likely to have complex medical problems, complex psychopathology with much co-morbidity and a high degree of alcohol misuse and dependence (Lewis *et al.*, 2006). Studies from the U.K. examining older patients referred or admitted to forensic psychiatric services (Coid *et al.*, 2002; Curtice *et al.*, 2003; Tomar *et al.*, 2004) report that whilst the numbers are low, there is high prevalence of psychiatric morbidity, and there is no proper service provision for such a population. The authors suggest that their needs may be met in health care rather than in criminal justice services. Neither health care nor criminal justice services, however, have made adequate service provision for this group. Services for older forensic psychiatric patients are in their infancy with most such services being in the private health care sector (Yorsten and Taylor, 2006).

Recent literature on assessment of needs, and placement requirements in a forensic population in high secure hospitals in the U.K. (Harty *et al.*, 2004) conclude that it is possible to assess needs and future placement possibilities reliably in such a population. The literature review highlights a lack of understanding of the care needs of older forensic psychiatric patients.

An audit of a specialist old age psychiatry liaison service to a forensic psychiatric unit (Shah, 2006) noted that placement advice was the most difficult

to provide with a paucity of facilities willing to accept older patients with a forensic history, and the author stressed the need for a comprehensive model of specialist forensic old age psychiatry service at a regional and a supra-regional level. We believe that understanding the care needs of an older forensic psychiatric population will assist in developing and planning services for this group.

An exploratory study was conducted with an aim to compare healthcare and placement needs of older forensic patients (over 60 years) from a high secure hospital and medium/low secure hospital. An additional objective was to assist in service planning for older forensic patients.

All patients aged over 60 years and deemed able to provide informed consent in the units were approached, and those who provided valid and informed consent were included in the study. Fifteen patients each from the high and medium/low secure setting were examined using the Camberwell Assessment of Needs in the Elderly – Short Version (CANE-S) (Orrell and Hancock, 2004) and Camberwell Assessment of Need – Forensic Short Version (CANFOR-S) (Thomas *et al.*, 2003). Placement options were also compared using forensic adaptation of the Nottingham Acute Bed Study questionnaire (NABUS) (Beck *et al.*, 1997). Sociodemographic and clinical data were collected from the medical notes.

This study supports the hypothesis that there are significant differences in healthcare and placement needs of the older forensic patients in a high secure hospital compared to those in a medium/low secure hospital.

More than half of older patients in a high secure setting were transferred from prison compared to the majority of the patients in medium/low security hospital who were admitted from high secure hospital setting. Whilst the older population was relatively younger in the high secure hospital (61.5 years) than in the medium/low secure hospital (73.4 years), review of the clinical notes suggested that the former group had more physical health problems – notably poor eye sight, obesity and musculoskeletal problems. The older group in the high secure setting was more likely to be on antipsychotic medication compared to the group in the medium/low secure setting.

When the needs of the two older groups were compared using the CANFOR-S in the “user” and the “staff” subgroups, the group in the high secure setting complained of more unmet needs than the group in the medium/low secure setting, especially

in relation to healthcare, psychological distress, company, sexual expression, basic education and treatment. When total needs were compared between the two groups using the CANFOR-S, the older group in the medium/low secure setting had more met needs than the older group in high secure hospital. When the two older groups were compared using the CANE-S, the group in the high secure setting complained of more unmet needs in relation to physical health needs, memory and personal security compared to the group in the medium/low secure setting.

The two groups were significantly different in placement needs in that half of the older forensic patients in the high secure setting were deemed not to require continued high secure placements but actually needed other placements. The older group in the medium/low secure hospital almost all needed low secure placement.

Given the significant findings above, we argue that it is important that the staff who look after older people are trained to identify and monitor their needs using standardized measures. The findings call for careful evaluation of medical histories and physical health monitoring in older patients in forensic settings. Patients in secure settings may be prescribed one or more classes of psychotropic drugs and in higher doses. An appropriate screening tool to identify “metabolic syndrome” should be put in place to plan treatment.

This study shows the existence of significant unmet healthcare needs among older forensic patients in high secure settings compared to those in a medium/low secure setting. Hence it is worth asking whether the issues of unmet healthcare needs pose a barrier to a care pathway to low secure conditions. Poor health may impact on risk, compliance and recidivism; these are relevant factors when placement is considered. This study highlights the requirement for age specific services.

References

Beck, A., Croudace, T. J., Singh, S. and Harrison, G. (1997). The Nottingham Acute Bed Study: alternatives to acute psychiatric care. *British Journal of Psychiatry*, 170, 247–252.

- Coid, J., Fazek, S. and Kahtan, N.** (2002). Elderly patients admitted to secure forensic psychiatry services. *Journal of Forensic Psychiatry*, 13, 416–427.
- Curtice, M., Parker, J., Wismayer, F. S. and Tomison, A.** (2003). The elderly offender: an 11-year survey of referrals to a regional forensic psychiatric service. *Journal of Forensic Psychiatry and Psychology*, 14, 253–265.
- Harty, M., Shaw, J., Thomas, S., Dolan, M., Davis, L., Thornicroft, G., Appleby, L. and Jones, P.** (2004). The security, clinical and social needs of patients in high security psychiatric hospital in England. *Journal of Forensic Psychiatry and Psychology*, 15, 208–221.
- Lewis, C. F., Fields, C. and Rainey, E.** (2006). A study of geriatric forensic evaluatees: who are the violent elderly? *Journal of American Academy of Psychiatry and Law*, 34, 324–332.
- Nnatu, I. O., Mohamed, F. and Shah, A.** (2005). Is there a need for elderly forensic psychiatric services? *Medicine, Science and Law*, 45, 154–160.
- Orrell, M. and Hancock, G.** (2004). *CANE: Camberwell Assessment of Needs for the Elderly*. London: Gaskell.
- Shah, A.** (2006) An audit of a specialist old age psychiatry liaison service to a medium and a high secure forensic psychiatry unit. *Medicine, Science and Law*, 46, 99–104.
- Thomas, S., Harty, M. A., Parrott, J., McCrone, P., Slade, M. and Thornicroft, G.** (2003). *CANFOR: Camberwell Assessment of Need – Forensic Version. A Needs Assessment for Forensic Mental Health Service Users*. London: Gaskell.
- Tomar, R., Treasden, I. H. and Shah, A. K.** (2005). Is there a case for a specialist forensic psychiatry service for the elderly? *International Journal of Geriatric Psychiatry*, 20, 51–56.
- United Nations** (2005). *World Population Prospects: The 2004 Revision and World Urbanization Prospect*. Population Division, Department of Economic and Social Affairs of the United Nations Secretariat. New York: United Nations. Available at www.un.org/esa/population/publications/WPP2004/wpp2004.htm.
- Yorston, G. A. and Taylor, P. J.** (2006). Commentary: older offenders – no place to go? *Journal of American Academy of Psychiatry and Law*, 34, 333–337.

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