

G. Escuder Romeva¹
L.G. Gomollón Rubio¹
S. Ochoa Güerre²
M.J. Ramos Miravet¹
A. González Cáceres¹
Stuart D. M. Thomas³

Clinical validation of the CANFOR scale (Camberwell Assessment of Need-Forensic version) for the needs assessment of people with mental health problems in the forensic services

¹Penitentiary Psychiatric Hospitalization Unit of Catalunya
Sant Joan de Déu- Serveis de Salut Mental
Barcelona (Spain)

²Research and Development Unit
Sant Joan de Déu- Serveis de Salut Mental
Fundació Sant Joan de Déu
CIBERSAM

³Centre for Forensic Behavioural Science
Monash University
Victorian Institute of Forensic Mental Health

Introduction. One of seven people admitted in prison has a diagnosis of a severe mental disorder and it is necessary to assess their needs. CANFOR was developed in 2004 to assess the specific needs of the forensic mental health services users. Adaptation and validation of CANFOR into Spanish was done and the psychometric properties were tested.

Method. After translation and back translation, we administered the CANFOR to a sample of 90 users of the penitentiary mental health services in Catalonia.

Results. Inter-rater and test-retest reliability coefficients for each of the 25 domains were high: moderate to almost perfect (0,44 to 1). Regarding concurrent validity a negative correlation was found between GAF ($p<0,01$); LSP in all its subscales ($p<0,01$ - $p<0,05$) and needs as assessed with CANFOR.

Conclusions. the Spanish version of CANFOR retains the psychometric properties described in the original version. It has been proved that the Spanish version is valid and reliable, so it can be considered an optimal instrument for the assessment of needs of people with a severe mental disorder admitted in prison.

Keywords:
Mental health, needs, prison, forensic psychiatry, validation, assessment

Actas Esp Psiquiatr 2010;38(3):129-137

Validación clínica de la escala Camberwell Assessment of Need-Forensic version, CANFOR para la evaluación de necesidades de personas con trastorno mental en el ámbito penitenciario

Introducción. Una de cada siete personas en el ámbito penitenciario sufre algún trastorno mental severo y

Correspondence:
Gemma Escuder Romeva (Psicóloga)
Unidad de Hospitalización Psiquiátrica Penitenciaria de Catalunya
Sant Joan de Déu- Serveis de Salut Mental
Carretera de Martorell a Capellades, Km 23.
08635 Sant Esteve Sesrovires (Barcelona)
E-mail: gescuder@pssjd.org

es necesario evaluar las necesidades de esta población. La escala CANFOR se desarrolló en el 2004, para evaluar las necesidades específicas de esta población. Se ha realizado la adaptación y validación en castellano y se han evaluado las propiedades psicométricas de la escala.

Método. Tras realizar el proceso de traducción y retrotraducción, se ha administrado la escala CANFOR a una muestra de 90 usuarios con patología psiquiátrica residentes en los servicios de salud mental del medio penitenciario de Catalunya.

Resultados. La fiabilidad entre-evaluadores y test-retest para cada ítem de la CANFOR ha presentado un acuerdo de moderado a casi perfecto (de 0,44 a 1). En relación a la validez convergente, existe una correlación negativa entre las puntuaciones del EEAG ($p<0,01$) y de las subescalas del LSP ($p<0,01$ - $p<0,05$) y las necesidades.

Conclusiones. La versión castellana de la escala CANFOR mantiene las propiedades psicométricas descritas en la versión original. Se ha comprobado que es una escala válida y fiable, por lo que se considera un instrumento adecuado para evaluar las necesidades de las personas que padecen un trastorno mental y se encuentran en el ámbito penitenciario.

Palabras Clave:
Salud mental, necesidades, prisión, psiquiatría forense, validación, evaluación.

INTRODUCTION

Over the recent years, increasing importance is being given to those suffering a mental disorder, approaching a wider view and with more comprehensive care. This has made it necessary to consider the evaluation of their needs and the basic information for their care and service planning.

With the birth of community psychiatry, especially in the United Kingdom, interest has been arising to evaluate

if besides physical needs, such as accommodations, nutrition and safety, the needs for quality of the personal life, such as self-respect, independence, maintenance of interest, contribution to the society and increased knowledge, among others, are also covered.¹ Due to the absence of instruments to evaluate needs, a group of professionals from the Institute of Psychiatry Health Services, of the community psychiatry section (PRISM) of London, created the Camberwell Assessment of Needs (CAN) scale,² in order to evaluate these needs. This instrument has been translated and validated in different languages, such as Spanish,³ Swedish,⁴ Italian⁵ and the EPSILON Group made up of different European countries that has translated it into Dutch, Danish, Spanish and Italian,^{6,7} obtaining some good psychometric characteristics.

Prevalence of mental disease in the penitentiary population is greater than in general population samples, according to studies performed during the 1990s. In general terms, it can be concluded that one out of every 7 persons in the penitentiary setting have some type of severe mental disorder.^{8,9}

Few studies have been performed in Spain on the prevalence of mental disease in prisons. According to the data published in 2007 regarding the penitentiary population in Catalonia, it has been confirmed that there is a greater prevalence of mental disorders in the penitentiary setting than in the general population. A total of 40.9% of Convicted Offenders have been diagnosed of severe mental disorder (SMD), 44.3% of them being subjected to Security Measures. As a first diagnosis, the most prevalent are Schizophrenia and other Psychotic Disorders, since they are found in 44.5% of the security measures and 26% of the convicted offenders population seen by the Psychiatry Services.

Competencies in penitentiary material has been transferred to Catalonia. Psychiatric care in the prisons is performed in different services integrated into the network and located in different penitentiary centers with different levels of specialization.

On the one hand, there is psychiatric nursing, which is located in the Men's Penitentiary Center of Barcelona (Centro Penitenciario de Hombres de Barcelona (CPHB)) and in the Brians 1 Penitentiary Center (Centro Penitenciario de Brians 1 (CPB)), the Polyvalent Psychiatry Unit of the Penitentiary Center of Quatre Camins (Centro Penitenciario de Quatre Camins (UPQC)) and finally the Penitentiary Psychiatric Hospitalization Unit (Unidad de Hospitalización Psiquiátrica Penitenciaria (UHPP)) that cover all of Catalonia and is located in the Penitentiary Center of Brians 1. The penitentiary psychiatric follow-up is found within the framework of a collaboration agreement between the Conselleria de Justicia, Conselleria de Sanitat and Sant Joan de Déu-Serveis de Salut Mental.

In relationship to legal situations, we should consider that the prison inmate within the Spanish penitentiary system can be classified into 3 types of situations: preventive, convicted, and security measure. The preventive situation is that in which the person has been imprisoned while awaiting trial. The situation of the convicted subject is when there is a criminal conviction. Finally, there are those with security measures, who are imputable or semi-imputable subjects related with psychic abnormalities or alterations and the fact that the personal circumstances of the subject may lead to a prognosis of a future behavior that reveals the likelihood of committing new crimes (criminal dangerousness). The security measures that can be imposed in accordance with the Spanish Penal Code (art. 96)¹⁰ are loss of liberty and non-loss of liberty.

Initially, within the penitentiary setting, the specific needs of the patients with severe mental disorder was begun similarly to the way it was done for patients of the general population. It was concluded that there are some differential characteristics in these patients that should be taken into consideration, such as aspects linked to security, comorbidity with personality disorders, substance abuse and criminal behavior. The clinical evaluation of the cases and evaluation of their needs on admission to the prison provide information in the decision of the case management, such as type of treatment and/or most adequate facility according to the needs detected. The uncovered needs detected, such as sexual, alcohol and arson, may detain transfer to lower security levels.¹¹⁻¹³

The same work group from the Institute of Psychiatry Health Services became interested in evaluating the needs of the patients with severe mental disorders who were admitted to forensic facilities. Using the CAN instruments as a basis, a special version was elaborated for penitentiary patients, this giving rise to the CANFOR Camberwell Assessment of Needs Forensic scale version.¹³⁻¹⁵ This instrument has maintained the same format as the CAN scale, however, three new areas of evaluation have been added. Both scales have the following 22 areas of need: Accommodation, Food, Self-care, Looking after the home, Daily activities, Physical health, Psychotic symptoms, information, anxiety, Safety to self, Safety to others, Alcohol, Drugs, Company, Intimate relationships, Sexual expression, Child care, Basic education, Telephone, Transport, Money management, social benefits. The CANFOR scale also includes the following 3 areas: treatment, arson and sexual offenses. The presence or absence of need is evaluated in each one of these areas. When there is a need, either severe or moderate, the informal and formal help received by the person and whether the formal help received was adequate are evaluated. Formal health refers to that which is received from the health care and/or penitentiary services attending the patient, while informal help refers to that received from the family or friends. They detected that

the instrument was more sensitive if there was knowledge about the patient evaluated. The novelty of the CAN and CANFOR is the dual evaluation of each one of the needs, by the user and the professional, and that we can say that it is an instrument which really is two independent scales. On the other hand, the CANFOR scale has a clinical and a research version.

Since it has not been validated in Spain, the purpose of the present study is to carry out its adaptation and validation, considering that the evaluation of needs makes it possible to perform specific individual interventions with the possibility of monitoring the needs detected in each one of the variants.

METHOD

Translation and back translation procedure

The validation procedure was initiated by performing a literal translation of the research version of the CANFOR Scale from English to Spanish, considering that the version for research was the most adequate, since all the questions provided were closed.

After having completed the translation, some of the concepts were adapted to the reality of our setting. When the Spanish version was considered to be the final one, it was back translated into English by a native whose maternal language was English. The back translation to English was submitted to the original author of the scale, Stuart Thomas, who made some observations. After introducing the corrections proposed by the original author, the final version of the scale was approved and it was validated.

Sample

The population that was administered the scale were users with a psychiatric condition residing in the mental health care services of the penitentiary setting. Four facilities were selected and within these, a certain number of patients were randomly chosen based on the total number of places in each facility. Finally, the interview was administered to 90 patients distributed in the following way: 18 patients with Psychiatric Disease from the CPB site, 10 patients of the Psychiatric Infirmary from CPB, 10 patients of the Psychiatric Infirmary from CPHB, 21 patients from UPQC and 39 patients from UHPP-C.

A Case Report Form (CRF) was developed and included the Patient Information Sheet and Informed Consent approved by the Ethics Committee of Sant Joan de Déu-Serveis de Salut Mental and the EC of the Secretary of Penitentiary,

Rehabilitation and Juvenile Justice Services (Serveis Penitenciaris, Rehabilitació i Justícia Juvenil del Departament de Justícia) of the Local Government of Catalonia, which had to be signed by the patient or, if appropriate, by the guardian if the patient was incapacitated.

Evaluation instruments

The group making the interviews was made up of three psychologists, one family doctor and one social worker.

The information provided by the patient was compared with his/her clinical team and with the clinical history information and with that of the procedure sheet (where the procedural information and sentences or security measures of the patient are stated).

The final version of the CANFOR in Spanish, which contains 25 items (user and professional) as has been previously described, was administered to all of the patients selected.

In order to study the convergent validity, the Global Assessment of Functioning Scale (GAF)¹⁶ was administered. In this, a score of 100 implied satisfactory global activity and a score of 10, permanent incapacity in the areas evaluated, and the Life Skills Profile (LSP)¹⁷ scale, that evaluated 5 areas of the patient: self-care, interpersonal behavior, communication and social contact, non-interpersonal social behavior and independence in life, was also administered. High scores implied good performance and low ones detected the difficulty or problems in the areas evaluated.

In order to study the Test-Retest reliability, a second visit was made to half of the sample, that is, 45 patients, one week after the initial examination. In this visit, the same interviewer who had made the initial visit administered the CANFOR and GAF of activity scale again.

The inter-rater reliability was studied in 44 patients of the total number and consisted in having 2 interviewers independently score the questions of the different areas in the first visit.

Statistical analysis

A descriptive analyses of the social demographic, clinical and crime results was made by frequencies. In order to compare the inter-rater and test-retest concordance, the Kappa coefficient and weighted Kappa was used. The Kappa indexes were considered based on the criteria of Landis and Koch.¹⁸ A Kappa coefficient of 0.4 to 0.6 indicates a moderate grade of agreement, between 0.6 and 0.8 indicates significant agreement and between 0.8 and 1, almost perfect agreement.

Table 1	Sociodemographic data	
	n	%
Gender		
Man	87	96.7
Women	3	3.3
Ethnic Group		
European	71	78.9
African- Maghreb	8	8.9
Hispanic	3	3.3
Gypsy	4	4.4
Other	4	4.4
Nationality		
Spanish	74	83.1
Moroccan	8	9.0
Dual nationality	2	2.2
Others	5	5.5
Civil Status		
Single	63	70.0
Married-Significant other	14	15.6
Separated-Divorced-Widow(er)	13	14.4
Maximum degree		
None	2	2.2
Incomplete primary	34	37.8
Complete primary	21	23.3
Incomplete secondary	12	13.3
Complete secondary	10	11.1
Incomplete university	4	4.4
Complete university	2	2.2
Others	5	5.6

For the analysis of convergent validity, the Pearson coefficient of correlation was used to compare the total needs according to the user and professional with the GAF of activity and the LSP.

RESULTS

Table 1 shows the sociodemographic characteristics of the participants in the study. As in the penitentiary population, there is a greater percentage of men, single, Spanish nationality and with primary studies. In Table 2, the principal diagnoses on axis I and axis II are shown. Regarding the total sample, 71.6% had the principal diagnoses of Psychotic Disorder followed by Bipolar Disorder with almost 16%. In the case of Axis II, 25% had some type of Personality Disorder, although the majority, that is, 60% did not have this diagnosis on this axis. The pre-

Table 2	Clinical and judicial data	
	n	%
Axis I		
Psychotic disorder	63	71.6
Mood state disorder	7	8.0
Bipolar Disorder	14	15.9
Others	4	4.5
Axis II		
Personality Disorder	19	25.7
Intellectual discapacity	7	9.5
Without diagnosis	45	60.8
Under study	3	4.1
Crime		
Homicide	32	37.6
Sexual offense	6	7.1
Domestic violence	3	3.5
Lesions	5	5.9
Robbery	29	34.1
Against public health	1	1.2
Infringement	2	2.4
Arson	2	2.4
Others	5	5.9
Background		
YES	39	46.4
NO	45	53.6
Judicial Situation		
Convicted prisoner	39	45.3
Security Measure	32	37.2
Preventive	15	17.4
Pending causes		
YES	13	15.5
NO	70	83.3
Unknown	1	1.2

sence of intellectual incapacity in some degree is almost 10%. In 4% of the sample, no diagnosis on axis II has been confirmed since they were in the period of diagnostic study. Some data could not be confirmed in all of the sample, so that in reference to the axis II data, the sample is reduced to 74 subjects.

The same table shows judicial data of the study patients, except for 5 subjects for whom this information could not be obtained. Almost 40% of the sample had been tried for homicide. In this category, homicides as well as murders and severe attempts have been included. Robbery is the second most prevalent criminal offense in the sample, accounting for 34%.

Table 3	Description questionnaire results	
	n	%
CANFOR Scale (n 90)		
Total User Needs	4.1	2.5
Total Staff Needs	5.1	3.1
User Needs Covered	2.3	1.6
Staff Needs Covered	3.0	2.0
User Needs Not Covered	1.8	1.7
Staff Needs Not Covered	2.1	1.8
LSP Scale (n 82)		
Self-care	38.1	2.5
Interpersonal social Behavior	37.9	2.3
Social Contact Communication	20.7	3.3
Non-personal social behavior	23.5	1.2
Autonomous Life	21.3	4.6
GAF (n 79)	56.9	11.6

In relationship to the judicial situation of the patients, 37% are serving time in jail as a security measure. This means that they have been acquitted due to exculpatory circumstances based on mental disease. Half of the sample have been convicted, that is, it has been considered that there is no mental disease to absolve them from the crime or it is understood that they had no disorder when they were tried and 17% of the sample is in preventive situation. In this case it means that the crime has been collected for which they are accused but they have still not been tried. Almost half of the sample have a criminal record and most do not have pending causes.

As can be observed in table 3, the users detected a mean of 4.1 (SD: 2.5) needs while this staff detected a mean of 5.1 (SD: 3.1) needs. The total needs evaluated by the CANFOR is 2.5. Therefore, these results, which must be analyzed more carefully, can be considered as positive.

Uncovered needs detected by the user had a mean of 1.8 (SD: 1.7) while those found by this staff were 2.1 (SD: 1.8) uncovered needs as a mean. These uncovered needs are those that can undergo intervention.

The sample shows general functioning, evaluated by the GAF, of 56 points of the subjects whose functioning was characterized by moderate or severe symptoms and significant difficulties or alterations in the social, work, family areas. The heterogeneity of the population must be consi-

dered since the sample described is distributed between the scores from 30 to 80.

Reliability

The Kappa and weighted Kappa in the comparison of the 2 raters with the responses of each one of the questions of need and of the help received were performed for the evaluation of inter-rater reliability.

All the patients were interviewed in the first visit by an interviewer from the team and 44 of them were scored not only by the interviewer but also by another rater.

The inter-rater reliability was calculated for each item of the CANFOR, in the user and staff responses.

Table 4 shows the percentage of agreement and the Kappa coefficient for the evaluation of the presence of need both for the scores of the patient as well as by the professionals. There was not enough information for items 4, user, 12, staff and user and 19, staff and user. Therefore, it was not possible to calculate the inter-rater Kappa agreement. The scores of the 45 patients are the same, thus the calculation cannot be made since the score distribution is null. In the case of the evaluation of the staff in item 12, the Kappa coefficient is 0. This fact is also explained by the distribution of the responses. In this case, all the responses are equal except for one. This fact is statistically explained by a Kappa value of 0, however, the inter-rater grade of agreement is 97.7%.

Item 12, Alcohol, has a score of 0 for all the patients. This score means that there is no problem in this area. In the penitentiary centers, it is not possible to obtain alcohol. Therefore, when referring to alcohol consumption in the last months, in our sample we find that all the patients had been hospitalized during this time period. On the other hand, in the case of items 13 that refers to the same situation but in regards to drugs, it is possible that some patient may have been able to obtain this in a jail leave, for example some toxic substance and that it would have been detected in the toxicological analysis on returning to the unit. This is not true with alcohol that is only measured through expired air and this measurement only makes it possible to know the consumption in the recent hours.

In the case of item 19, telephone, the subject is asked if they can use the telephone and in every case, they responded that there was no problem in this area.

This statistical effect does not prevent the evaluation of the percentage of agreement existing between the rater. As all the patients and users scored in the same direction, a high grade of agreement was obtained.

ITEM	Staff (n=44)		User (n=44)	
	% agreement	Kappa Coefficient	% agreement	Kappa Coefficient
Accommodation	100.00	1.0000	100.00	1.0000
Food	100.00	1.0000	100.00	1.0000
Setting	100.00	1.0000	100.00	1.0000
Self-Care	97.73	0.8798	not evaluable *	
Daily activities	95.35	0.9289	95.45	0.9272
Physical health	97.73	0.9296	97.73	0.9409
Psychotic Symptoms	97.73	0.9494	95.45	0.8952
Information treatment	97.73	0.9654	97.73	0.9625
Anxiety	93.02	0.8080	97.67	0.9436
Safety to self	97.73	0.8908	97.73	0.8908
Safety to others	100.00	1.0000	100.00	1.0000
Alcohol	97.73	0.0000	not evaluable *	
Drugs	97.73	0.7915	100.00	1.0000
Company	100.00	1.0000	100.00	1.0000
Intimate relationships	100.00	1.0000	100.00	1.0000
Sexual expression	100.00	1.0000	100.00	1.0000
Child care	95.45	0.9095	95.45	0.9083
Basic education	97.67	0.8900	100.00	1.0000
Telephone	not evaluable *		not evaluable *	
Transport	97.73	0.8795	97.73	0.6589
Money management	97.67	0.9310	97.73	0.8795
Social benefits	95.45	0.7805	97.73	0.9125
Treatment	97.73	0.9412	97.73	0.9375
Sexual Offenses	93.18	0.7442	93.18	0.7376
Arson	84.09	0.4420	84.09	0.4420

* kappa not evaluable because there is not enough differential information to calculate it

Table 5 shows the percentage of agreement and the Kappa coefficient for the evaluation of the presence of need both for the scores of the patients and for those of the professionals of the test-retest reliability.

As has been observed in the inter-rater reliability analysis, no statistical calculation could be used in items 12 and 19, both the responses of the staff as well as of the user because of the null distribution of the responses. The percentage of agreement is high for all the items for the evaluations with an interval of one week.

As can be observed, the Kappa coefficient is adequate for all the items both in the responses of the user and of the

staff, and in the percentage of agreement. The Kappa score did not fall below 0.60 in any of the cases.

Validity

Table 6 relates the total and uncovered needs of the professional and user, with general functioning and psychosocial functioning.

The scores on the GAF scales correlate negatively with the scores on the CANFOR scale for both the user and professional evaluation ($p < 0.01-0.05$).

ITEM	Staff (n=45)		User (n=45)	
	% agreement	Kappa Coefficient	% agreement	Kappa Coefficient
Accommodation	100.00	1.0000	91.11	0.8560
Food	93.33	0.8787	97.73	0.9367
Setting	88.89	0.7627	93.18	0.8125
Self-Care	95.56	0.8256	100.00	1.0000
Daily activities	95.56	0.9226	91.11	0.8628
Physical health	91.11	0.7561	86.67	0.6853
Psychotic Symptoms	86.67	0.7199	86.67	0.7345
Information treatment	75.56	0.6256	77.78	0.6445
Anxiety	84.09	0.6419	81.82	0.6235
Safety to self	93.33	0.7000	93.33	0.7000
Safety to others	100.00	1.0000	100.00	1.0000
Alcohol	not evaluable *		not evaluable *	
Drugs	100.00	1.0000	100.00	1.0000
Company	88.89	0.6888	95.56	0.8384
Intimate relationships	93.33	0.6987	91.11	0.6538
Sexual expression	93.33	0.8000	93.33	0.8000
Child care	91.11	0.8476	88.89	0.8108
Basic education	91.11	0.6525	91.11	0.6000
Telephone	not evaluable *		not evaluable *	
Transport	95.56	0.8279	97.78	0.6591
Money management	95.45	0.8755	95.56	0.7783
Social benefits	97.78	0.9102	97.78	0.9275
Treatment	93.33	0.8166	88.89	0.6715
Sexual Offenses	100.00	1.0000	100.00	1.0000
Arson	97.62	0.8444	97.62	0.8444

* kappa not evaluable because there is not enough differential information to calculate it

	GAF	LSP				
		Self care	Interpersonal social behavior	Communication and social contact	Non-interpersonal social behavior	Autonomous Life
Total staff needs						
Coefficiente Correlación Pearson	-0.296	-0.304	-0.229	-0.477	-0.332	-0.552
Significación P	0.006	0.006	0.038	<0.001	0.002	<0.001
Total user needs						
Pearson Coefficient Correlation	-0.229	-0.156	-0.201	-0.396	-0.285	-0.396
P significance	0.034	0.163	0.070	<0.001	0.009	<0.001

Correlations with the CANFOR scale in its evaluation of the professional correlate negatively with all the subscales of the LSP ($p < 0.001 - 0.05$), so that the better the score on the LSP, the less the needs on the CANFOR scale. Regar-

ding the CANFOR scale in its evaluation of the user and the subscales of the LSP, we have found that there is a negative correlation with the subscales: LSP communication and social contact, LSP non-interpersonal social behavior and LSP

autonomous life ($p < 0.001 - 0.01$). These data indicate that higher levels of needs correlate with words general functioning and worse social functioning.

CONCLUSIONS

The Spanish version of the CANFOR scale maintains the psychometric properties described in the original version. It has been verified that it is a valid and reliable scale, so that it is considered to be an adequate instrument to evaluate the needs of the person's suffering mental disorder and who are within the forensic settings.

After having analyzed the scale, we will propose to the author some clarifications that we consider necessary to avoid confusion when scoring the items. In the final item that corresponds to arson, Kappa coefficient is significantly lower than the others. The investigator team has analyzed this fact and considers that this result responds to the difficulty when scoring the item. This item, as with that of sexual offense, has the following interpretation "Evaluate only when it is indicated/with previous history." The evaluation options for Section 1 are: 0 No problem, 1 Moderate problem because of the help given, 2 Severe problem, 8 Not applicable and 9 Unknown. On reviewing the CRF, we have verified that there is some confusion regarding the score that should be given for certain subjects. When there is no previous history, a score of 8 (not applicable) should be given, but some subjects were given a score of 0 (no problem). This fact would explain the low Kappa score, although it should be mentioned that the percentage of agreement continues to be high for all the items. In order to solve this problem, a proposal is made to give more detailed information in the administration manual of the CANFOR on the response options of these items and the way to score them.

The CANFOR scale is an instrument with a wide scope of application, since it can be used in hospitalization units, nursing units, in psychiatric care consultations of the modules and in the residential modules per se by the treatment teams.

Another application setting would be the security measures that are complied with in the community psychiatric network to evaluate the areas that suppose a greater risk of control in settings of limited security, as is this one.

The CANFOR Scale can be used, as variable, to consider if the patient is in the most adequate facility or whether the patient should be referred to another type of facility more in agreement with his/her needs, both psychiatric care as well as security.

Our experience allows us to consider that the CANFOR scale is easy to administer, after minimum training and can be administered by different profiles of the raters. The

approximate administration time is 20 minutes. This makes it possible for it to be a useful instrument in the daily clinical and judicial routine.

Another characteristic that makes the CANFOR scale an instrument of choice in the different settings described is that it provides the view of the user and the staff.

The clinical view of the CANFOR scale makes it possible to plan the interventions and their subsequent evaluation.

The needs of our population are currently being evaluated in relationship to partial aspects of their condition. However, not all of the needs that should be covered under the conditions in which the subject are found are considered. In this sense, this would provide an instrument that makes it possible to examine the needs of this population.

The CANFOR scales should be introduced as a routine instrument in the psychiatric forensic units. This would make it possible to collect the necessary information to develop interventions and subsequently evaluate the changes. In this sense, the investigator team is currently working on the application of the scale and the study of the sensitivity to change to be able to confirm its utility in the evaluation of our interventions.

Future studies of the needs of the persons who suffer mental disorders in the penitentiary/forensic setting with the CANFOR scale may help us to orient the providing of adequate services for the care of this population.

ACKNOWLEDGMENTS

Este estudio ha sido financiado por el Instituto de Salud Carlos III en la convocatoria de Evaluación de Tecnologías Sanitarias (PI06/90234).

REFERENCES

1. Stevens A, Raftery J. Health care needs assessment the epidemiologically based needs assessment reviews. Oxford: Radcliffe Medical Press, 1994.
2. Phelan M, Slade M, Thornicroft G et al. The Camberwell Assessment of Need (CAN): the validity and reliability of an instrument to assess the needs of people with severe mental illness. *British Journal of Psychiatry* 1995;167: 589-95.
3. Rosales C, Torres F, Luna J et al. Fiabilidad del instrumento de evaluación de necesidades Camberwell (CAN). *Actas Esp de Psiquiatr* 2002;30: 99-104.
4. Hansson L, Bjorkman T, Svensson B. The assessment of needs in psychiatric patients. Interrater reliability of the Swedish version of the Camberwell Assessment of Needs instrument and results from a cross sectional study. *Acta Psychiatrica Scandinavica* 1995;92: 285-93.

5. Ruggeri M, Lasalvia A, Nicolaou S et al. The Italian version of the Camberwell Assessment of Need (CAN), an interview for the identification of needs of care. *Epidemiologia e Psichiatria Sociale* 1999;8: 135-67.
6. Knudsen HC, Vázquez-Barquero JL, Welcher B et al. Translation and cross-cultural adaptation of outcome measurement for schizophrenia. *British Journal of Psychiatry* 2000;177 (suppl 39, s8-s14).
7. Mc Crone P, Leese M, Thornicroft G et al. Reliability of the Camberwell Assessment of Need- European version. *British Journal of Psychiatry* 2000;177: s34-40.
8. Fazel S. Serious mental disorder in 23 000 prisoners: systematic review. *Lancet* 2002;359:545-50.
9. Philip M.J. Brinded, Alexander I.F. Simpson, Tannis M. Laidlaw, Nigel Fairley, Fiona Malcolm. Prevalence of psychiatric disorders in New Zealand prisons: a national study. *Australian and New Zealand Journal of Psychiatry* 2001;35:166-73
10. Código Penal. Editorial Tecnos, 2007.
11. Shaw J, Davies J, Morey H. An assessment of the security, dependency and treatment needs of all patients in secure services in a UK health region *The Journal of Forensic Psychiatry* 2001;12: 610-37
12. Nieuwenhuizen CH, Schene AH, Koeter MWJ. Quality of life in forensic psychiatry: an unreclaimed territory?. *International Review of Psychiatry* 2002;14: 198-202
13. Thomas S, Dolan M, Thornicroft G Re-visiting the need for High Security Psychiatric Hospitals in England. *The Journal of Forensic Psychiatry & Psychology* 2004;15: 197-207
14. Thomas S, Harty MA, Parrott J, McCrone P, Slade M, Thornicroft G. CANFOR: Camberwell Assessment of Need-Forensic Version. The Royal College of Psychiatrists 2003. Gaskell. London
15. Thomas S, Slade M, McCrone P, Harty M-A, Parrott J, Thornicroft G et al. The reliability and validity of the forensic Camberwell Assessment of Need (CANFOR): a needs assessment for forensic mental health service users. *Int J Methods Psychiatr Res.* 2008;17:111-20.
16. Endicott J, Spitzer RL, Fleiss JL, Cohen J. The Global Assessment Scale: A procedure for measuring overall severity of psychiatric disturbance. *Arch Gen Psychiatry* 1976; 33: 766-771.
17. Bulbena, A., Fernández, P. and Domínguez, A. I. Adaptación castellana de la escala LSP (Life Skills Profile scale, Spanish adaptation). *Actas Luso Española de Neurología, Psiquiátría y Ciencias afines* 1992;20: 51-60
18. Landis J, and Koch G. The measurement of observers agreement for categorical data. *Biometrics* 1977;33:159-74.