Lived Experiences of Women within Mental Health and Criminal Justice Systems

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List of Abbreviations and Symbols

CASP	Critical Appraisal Skills Programme
CJS	Criminal Justice System
DBT	Dialectical Behaviour Therapy
IPA	Interpretive Phenomenological Analysis
κ	Cohen's Kappa Inter-Rater Reliability Coefficient
NHS	National Health Service
PRISMA	Preferred Reporting Items for Systematic Reviews and Metaanalyses
RCP	Royal College of Psychiatrists
UK	United Kingdom
UN	United Nations
UNODC	United Nations Office on Drugs and Crime
WEMSS	Women Enhanced Secure Services
WISH	Women in Secure Hospitals

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Acknowledgements

Above all, I thank God for blessing me with a second chance at life. I am incredibly thankful to be in this position given the journey it has been for me.

I express my sincere gratitude to all the service users who contributed to my research project. I am truly thankful that you made this research project possible, and I hope I have done you all justice in my interpretations of your experiences. You have all made such progress in your journeys and I hope that through my project, your stories can empower other Black women as they continue their journeys through mental health care.

I would like to thank my supervisors, Dr Anthony Colombo and Dr Helen Liebling, whose patience, expertise, and knowledge have been invaluable in the undertaking of this project. Your compassion and words of encouragement have kept me focussed and motivated at every hurdle and I hope we are able to make a difference for women in secure care by disseminating this work.

The mental health services and staff who supported recruitment for this study, also have my upmost appreciation. I cannot thank you enough for supporting the development of this project despite the added pressures of the pandemic.

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For being such inspirational pillars of support, I thank my parents. Your unconditional love, prayers and belief has given me the courage to pursue this journey. I hope I have made you proud. To my sister and brother, whose support, determination and passion for life has always inspired me, thank you. Finally, to my friends across the globe, thank you for everything. I could not have completed this journey without you.

Declaration

I confirm that this thesis, titled *'Lived Experiences of Women within Mental Health and Criminal Justice Systems'*, is an original piece of my own work. It has been submitted as part of the fulfilment of requirements for the degree of Doctor in Clinical Psychology, to the Universities of Coventry and Warwick. The work included in this thesis has not been submitted for any other qualification or to any other institution, and was completed under the academic supervision of Dr Anthony Colombo and Dr Helen Liebling.

The supervisory process included support in the study designs, analyses, and revision of draft papers. In addition, a colleague also completed quality assessments on all papers included in the systematic review to ensure reliability of the process. With the exception of these collaborations, the content of this thesis is my own.

The systematic review (Chapter One) will be prepared for submission to the Prison Journal, and the empirical paper (Chapter Two) will be prepared for submission to the Journal of International Women's Studies. Journal submission guidelines are provided in Appendices 1A and 1B.

Summary

This thesis is composed of three chapters. Chapter One is a meta-ethnography of sixteen research studies, exploring the lived experiences of imprisoned mothers separated from their children. Three themes emerged: Motherhood, Guilt and Regret; and Children as Incentives. Being separated from children impacted on imprisoned women's dual identity as mothers and offenders, which evoked feelings of guilt and regret around parenting and life choices. However, mothers remained determined to do right by their children where there was hope for reunification. Policy and clinical practice recommendations are made for enhanced psychological and multi-organisational input within custodial settings, to support mothers throughout imprisonment and upon reunification with their children.

Chapter Two is an empirical qualitative study exploring experiences of cultural awareness amongst seven Black women within secure psychiatric care. Interpretative Phenomenological Analysis of semi-structured interviews elicited three superordinate and six subordinate themes: Cultural Disempowerment; Racial and Cultural Assumptions, Pathologised Culture; Beyond Culture; Degrading and Dehumanizing Treatment, Interpersonal Diversity; Cultural Bias within Regimes; Culturally Biased Systems, Navigating the System. The impact of cultural awareness amongst staff combined with risk averse hospital regimes, affected on Black women's experiences and ability to navigate through secure psychiatric care. Recommendations include supporting staff to develop cultural awareness and improve relational security aspects of care, in order to promote culturally competent services.

Chapter Three provides a reflective account of the researcher's experience of undertaking a doctoral level thesis amidst a global pandemic. Reflections also encompass the role of the researcher's identity as a Black woman and researcher-clinician in relation to undertaking research with Black women within secure psychiatric care.

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Chapter I

Imprisoned Mothers Lived Experiences of Separation from their Children in Western Countries: A Meta-ethnographic Review.

1. Abstract

Aim: The present systematic review encompassed qualitative research regarding the lived experiences of imprisoned mothers in Western countries separated from their children.

Methods: Three databases (PsychINFO, Web of Science and Applied Social Science Index and Abstracts [ASSIA]) were systematically searched between January 2021 and March 2021 using terms informed by the aim of the review. Grey literature and reference lists were also screened for relevant articles. The search resulted in 16 studies which were relevant to the review aims based on predefined inclusion and exclusion criteria. Study findings were analysed using Atkins et al.'s (2008) four-step meta-ethnographic process.

Results: Analysis revealed three themes: Motherhood, Guilt and Regret; and Children as Incentives. Maternal identity was characterised by conflicting self-perception as a "good" mother and image of self as a negative role model as a mother. Such experiences resulted in feelings of guilt and regret amongst mothers who accepted that their life choices had compromised their motherly roles. However, opportunities to maintain contact with children and reunify upon release served as an incentive for mothers to rehabilitate.

Conclusions: Imprisoned mothers would benefit from enhanced opportunities to maintain attachment bonds between them and their families, with improved recognition of the dyadic impact of mother-child separation due to imprisonment. Policy recommendations include the implementation of psychologically-informed and compassion-focused approaches to support rehabilitation.

1.1 Introduction

1.1.1 Review Subject and Significance

This systematic review examines evidence regarding the lived experiences of mothers separated from their children due to imprisonment. In this context, imprisonment refers to a period of custodial confinement within the Western Criminal Justice System (Murray et al., 2012), which requires the mother to be separated from her offspring for at least three months (Ministry of Justice, 2016). Lived experiences refer to the imprisoned mothers' first-hand accounts of the emotional, interpersonal and behavioural impact of mother-child separation (Lockwood, 2018). Children of imprisoned mothers refer to biological, not adopted, sons or daughters who were under the age of 24 years at the time of the mother's imprisonment, therefore classed as dependent offspring (United Nations [UN], 1985).

The Prison Reform Trust (2019) estimates that around 12,000 women are imprisoned across the United Kingdom (UK) every year. It is reported that approximately 66% of these imprisoned women are mothers (Epstein, 2014); 55% of which, have at least one child under 16 years of age (United Nations Office on Drugs and Crime [UNODC], 2014). Consequently, an estimated 17,000 children across England and Wales experience separation due to maternal imprisonment (Prison Reform Trust, 2019). However, as information and statistics relating to imprisoned mothers and their children across the UK are not routinely recorded (HM Inspectorate of Prisons, 2005; Jones & Wainaina-Woźna, 2013), the exact numbers for this population remain unknown.

Whilst contact between imprisoned mothers and their children might be maintained through prison visits, letters and telephone contact, imprisonment in itself can severely alter, disrupt or even terminate mothering (Lockwood, 2018). Subsequently, there remains a need for prison environments to promote the maintenance of mother-child bonds throughout the maternal imprisonment experience (UNODC, 2014). Furthermore, a review of the existing literature aims to help the rehabilitation of mothers in prison by ensuring where possible, that

establishments and wider organisations understand how the mother-child bonding processes are affected by current prison regimes.

1.1.2 Evaluation of Previous Reviews

There have been three previous assessments of the literature on subjects related to the current review. Stewart (2020) reviewed 21 mixed method studies conducted between 2000-2019, investigating the psychological impact of maternal imprisonment on children. Research undertaken in America, England, Wales and the Netherlands was included due to these countries sharing broadly similar penal policies. Children were required to be aged under 18 years old at the time of maternal imprisonment to ensure that they were dependent, however no limits were placed on the gender or number of children within a family. Additionally, studies were required to have investigated at least one form of psychological impact or include detailed qualitative accounts of the psychological impact of maternal imprisonment from the child's perspective. A narrative thematic approach was used to synthesise results within which, two main themes including *Chaotic Families* and *Relational Dynamics* emerged. Findings suggest whilst children are relationally and contextually impacted by maternal imprisonment, psychological difficulties are often experienced regardless of mother-child separation. The author recommended for future studies, to explore children's experiences of surviving and thriving throughout maternal imprisonment (Hissell et al., 2011).

Powell et al. (2017) undertook an attachment-focused systematic review of prison policies related to mother-infant separation. This review was one of the first to consider the mother's perspective of maternal imprisonment and was based on United Kingdom, UK, prison documents. The review comprised of 24 academic and 51 grey literature papers and analysed the extent to which these prison documents drew on attachment theory in meeting the needs of imprisoned mothers separated from their children. Policies developed since 1999 and

inspection reports published since the Corston (2007) report up to August 2015 were included. All documents captured the harmful impact separation had on imprisoned mothers, despite linguistic differences across papers. Most documents indirectly referred to attachment, but it was explicitly mentioned in four. However, support for mothers lacked specificity, and staff needs were overlooked. The authors suggested that imprisoned mothers affected by separation from their infants, and supporting staff, could be better supported with implementation of interventions underpinned by attachment theory.

A third systematic review evaluated the effectiveness of parenting programmes for imprisoned mothers (Tremblay & Sutherland, 2017). Based on 16 treatment studies conducted between 1989 and 2014, the review aimed to establish whether parenting programs for imprisoned mothers had a positive effect on different parenting outcomes. Studies were required to have involved a randomized, quasi-experimental, or single-group pre-post design, with quantitative outcomes related to parenting that were collected using standardized measures. Studies with current and formerly imprisoned mothers who had engaged in interventions within correctional or community-based correctional services were included in the review. It was suggested that corrections-based parenting programs could yield short-term positive effects on parenting behaviour, parenting attitudes, and parenting knowledge. However, the authors acknowledged that the reviewed programs did not appear to impact on parenting stress immediately post-treatment.

1.1.3 Rationale and Aim of Current Review

Whilst these previous reviews contribute to the existing knowledge base of mother-child separation due to imprisonment, there are three main limitations in terms of the extent to which they address the experiences and needs of imprisoned mothers. Firstly, previous reviews have tended to focus on the impact of separation due to maternal imprisonment from the child's perspective (Stewart, 2020), thus neglecting the first-hand experiences of

imprisoned mothers' inability to raise or bond with their offspring. Secondly, reviews which have acknowledged the impact of mother-child separation due to maternal imprisonment have focused on policy and document implementation within custodial facilities (Powell et al., 2017). Consequently, there remains a need to understand the findings from those studies that have provided evidence of mothers' first-hand narratives of the impact of mother-child separation. Thirdly, existing reviews include mixed or quantitative evaluations of support offered to imprisoned mothers to improve the mother-child bond (Tremblay & Sutherland, 2017). To the author's knowledge there are no existing systematic reviews of mother-child separation due to maternal imprisonment which solely focus on qualitative accounts from the mothers' perspective.

Table 1 details the main concepts this review used, which were established using the SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research Type) principles (Cooke et al., 2012).

Table 1

Main concepts of Systematic Review

SPIDER Principle	**Main Concepts**
Sample	Mothers in prison to have dependent children at the time of their incarceration
Phenomenon of Interest	Mother-child separation due to imprisonment
Design	Themes (IPA, Thematic Analysis, Discourse Analysis, Grounded Theory)
Evaluation	Experiences, Perceptions
Research method	Qualitative

This review retrieved studies focusing specifically on the first-hand experiences of imprisoned mothers separated from their children. By utilising a meta-ethnographic approach, qualitative research designs have been collated and analysed to provide a deeper understanding of the experiences and needs of this population, and to answer the literature

review question: “What are the lived experiences of imprisoned mothers in Western countries separated from their children?” This review has been ethically approved by Coventry University (see Appendix 2).

1.2 Methods

1.2.1 Systematic Literature Search

A systematic search of relevant literature exploring the lived experiences of imprisoned mothers separated from their children was carried out between January 2021 and March 2021. Electronic databases that gave access to literature within the fields of Psychology, Criminology and the Social Sciences were selected. These included: PsycINFO, Web of Science and Applied Social Science Index and Abstracts (ASSIA). Unpublished doctoral theses were also located within ProQuest Dissertations. Additionally, searches were conducted within Google Scholar and The Prison Reform Trust to retrieve any online literature which was not captured within the electronic databases. The main search terms utilised in this study are presented in Table 2.

Table 2

Key Search Terms

	Main Concepts	Synonyms	Location
Sample	Mother	mother* parent* mum* mom* AND	Title Abstract
	Imprisoned	incarcerat* prison* imprison* inmate* offender* detained custody	Keywords
Phenomenon of Interest	Separated	Detachment from" "isolated from"	Title Abstract
	Children	child* kids offspring son* daughter* dependent* minor*	Keywords
Design	Themes	interview* questionnaire* "focus group*" thematic IPA "Interpretative phenomenological analysis" "grounded theory" "discourse analysis" "template analysis"	Title Abstract Keywords
Evaluation	Experiences	experience* perce* view* coping impact attitude* positive negative	Title Abstract Keywords
Research method	Qualitative		Title Abstract Keywords

The key search terms used were influenced by those employed in previous reviews and included the main concepts of mother, imprisoned, experiences, separated, children and qualitative. Synonyms for each key term were also selected to ensure that all the relevant studies would be identified whilst conducting the searches. To capture all studies relating to mothers, alternative terms for describing mothers were selected. These included alternative spellings as used in the United States of America ("mom") and the United Kingdom ("mum"). The term "parent" was also included to capture non-gender-specific studies detailing imprisoned mothers' experiences. Synonyms selected for the term imprisonment captured language used internationally, such as "incarcerated" which is widely used in the United States. To avoid bias toward negative encounters of mother-child separation, neutral synonyms such as "perception" or "views" were used to capture experiences.

Searches of abstract, titles, and key words were conducted, dependent on the functionality of each database. To broaden the results, synonyms within each main concept were combined with the operator OR. This ensured that retrieved literature could include any of the synonyms. To narrow the results to literature containing each of the main concepts, the operator AND was applied. The wildcard truncation * was utilised to capture variations in wording or spelling. Boolean operators were used to construct the following search algorithm, detailed in Figure 1.

Figure 1

Boolean Terms for Literature Review

(mother* OR parent* OR mum* OR mom*) AND (incarcerat* OR prison* OR imprison* OR inmate* OR offender* OR detained OR custody) AND (“separated from” OR “detachment from” OR “isolated from”) AND (child* OR kids OR offspring OR son* OR daughter*) AND (interview* OR questionnaire* OR “focus group*”) AND (thematic OR IPA OR “Interpretative phenomenological analysis” OR “grounded theory” OR “discourse analysis” OR “template analysis”) AND (experience* OR perce* OR view* OR coping OR impact OR attitudes) AND (positive OR negative) AND qualitative

1.2.2 Inclusion and Exclusion Criteria

Papers included for this review were limited to those written in the English language. Articles and abstracts for studies were initially screened and retained if they: (a) were peer reviewed; (b) empirical studies; (c) explored the experiences of mothers separated from their children due to imprisonment; (d) conducted in 2000 or later; and (e) the full text was available for review. Following the initial screen, full text articles were retrieved and assessed against the inclusion and exclusion criteria detailed in Table 3 to determine eligibility.

Table 3

Literature Inclusion and Exclusion Criteria

	Criteria	Include	Exclude
Type	Country	United Kingdom United States of America Canada Australia New Zealand	Countries outside of the United Kingdom, United States of America, Australia, New Zealand or Canada
	Time	2000-2021	Before 2000
Methodology	Epistemology	Qualitative Mixed	Quantitative
	Research Design	IPA Thematic Analysis Grounded Theory Discourse Analysis Template Analysis	Experiments Longitudinal studies Fixed response surveys
	Method of Data Collection	Interviews Focus Groups Questionnaires Diaries	Numerical data Statistics
	Sample	Any ethnicity but at least 8.9% of participants identify as Black	Any ethnicity with lower than 8.9% of Black participants
Concepts	Mother	Biological	Foster Step-mothers Adoptive Pregnant mothers-to-be
	Mother	18 and over	Under 18
	Imprisonment-length of time	At least three months imprisonment	Less than three months imprisonment
	Imprisonment-separation from child	Mothers in prison	Children in prison with mother (e.g. mother and baby units)
	Separation	Custodial sanction (remand or conviction) – as reason for mother-child separation	Imprisoned mothers who were separated from their child prior to imprisonment Mothers who had experienced child bereavement during their incarceration
	Children	Under 24 at time of separation Classed as ‘dependent’, ‘young’ or ‘minor’	Over 24 at time of separation Children not classed as ‘dependent’, ‘young’ or ‘minor’

Studies included in the review were conducted within the United Kingdom (UK), United States of America (USA), Canada, Australia and New Zealand due to these Western countries sharing broadly similar penal policies and legislations for mothers in prison (House of Commons, 2012). 'Mothering' may also be perceived and approached differently in non-Western cultures (Selin, 2013), adding further weight to exclusion of papers from such countries. Methodologies which did not entail in-depth exploration with participants of their experiences, namely quantitative, experimental and longitudinal studies; or data collection which yielded numerical data or statistics, were excluded. Where relevant, qualitative data was extracted from studies originally conducted with mixed methodology.

Studies from 2000-2021 were included to reflect more contemporary penal policy. In this time, the global rate for women in prison has increased by 53% (Walmsley, 2017). Despite making up 3% of the female population in England and Wales, Black women account for as much as 8.9% of the women's snapshot prison population (Prison Reform Trust, 2017). In 2019, the imprisonment rate for Black women in the USA was over 1.7 times the rate of imprisonment for white women (Carson, 2020). Due to the well-documented over-representation of Black, Caribbean, African or African American women within criminal justice systems across the UK, Canada and USA (e.g. Lammy, 2017; Gurusami, 2019), studies were required to have at least 8.9% participants from within these populations. This ensured that a demographically representative sample of the prison population was included.

Studies which described the experiences of foster mothers were excluded, as experiences of temporary or permanent separation may be experienced differently amongst this population compared to biological, adoptive or stepmothers. Mothers were required to be aged over 18 years at the time of imprisonment. Additionally, to ensure that any themes identified were based on a homogenous sample of participants, studies on the experiences of imprisoned pregnant women who had not yet experienced separation from their children were excluded.

Whilst it is recognised that long-term imprisonment can impact the parent-child relationship (Baldwin, 2020), women in prison tend to be serving short sentences for non-

violent crimes (Prison Reform Trust, 2016). The Ministry of Justice (2016) reports 72% of imprisoned women are serving sentences of six months or less, over 67%, are serving 12 months or less, and 56% three months or less. As Baldwin and Epstein (2017) ascertain that shorter periods of imprisonment can still have a detrimental effect on the mother-child dyad, prison sentences of at least three months were included in this review. There were no limitations on the number of times mothers had been imprisoned.

Studies within establishments which provided opportunities for mothers to remain with their children during incarceration, such as prison mother and baby units, were excluded. Imprisonment was required to be the sole purpose for mother-child separation; therefore, studies where mothers were separated from offspring prior to incarceration, for example through losing custody, were excluded. Additionally, studies describing the experiences of loss and separation for mothers whose children had died during their imprisonment were excluded. This aimed to enable experiences of loss and separation to be solely determined by the mother's imprisonment rather than bereavement. If studies were deemed to not provide a significant contribution to the understanding of the experiences of imprisoned mothers separated from their children, they were also excluded.

Finally, it was important that research was based on mothers of dependent, underage or minor children, as the experience of separation from dependent children might differ to mothers of independent, adult children. Whilst the UN (1985) defines 'children' as persons up to the age of 18, they also describe the transitional age of dependency in a child as ranging between 15-24 across different countries. Studies were therefore excluded if participants did not have at least one child aged under 24 years at the time of imprisonment; however no limits were placed on the gender or number of children each participant had.

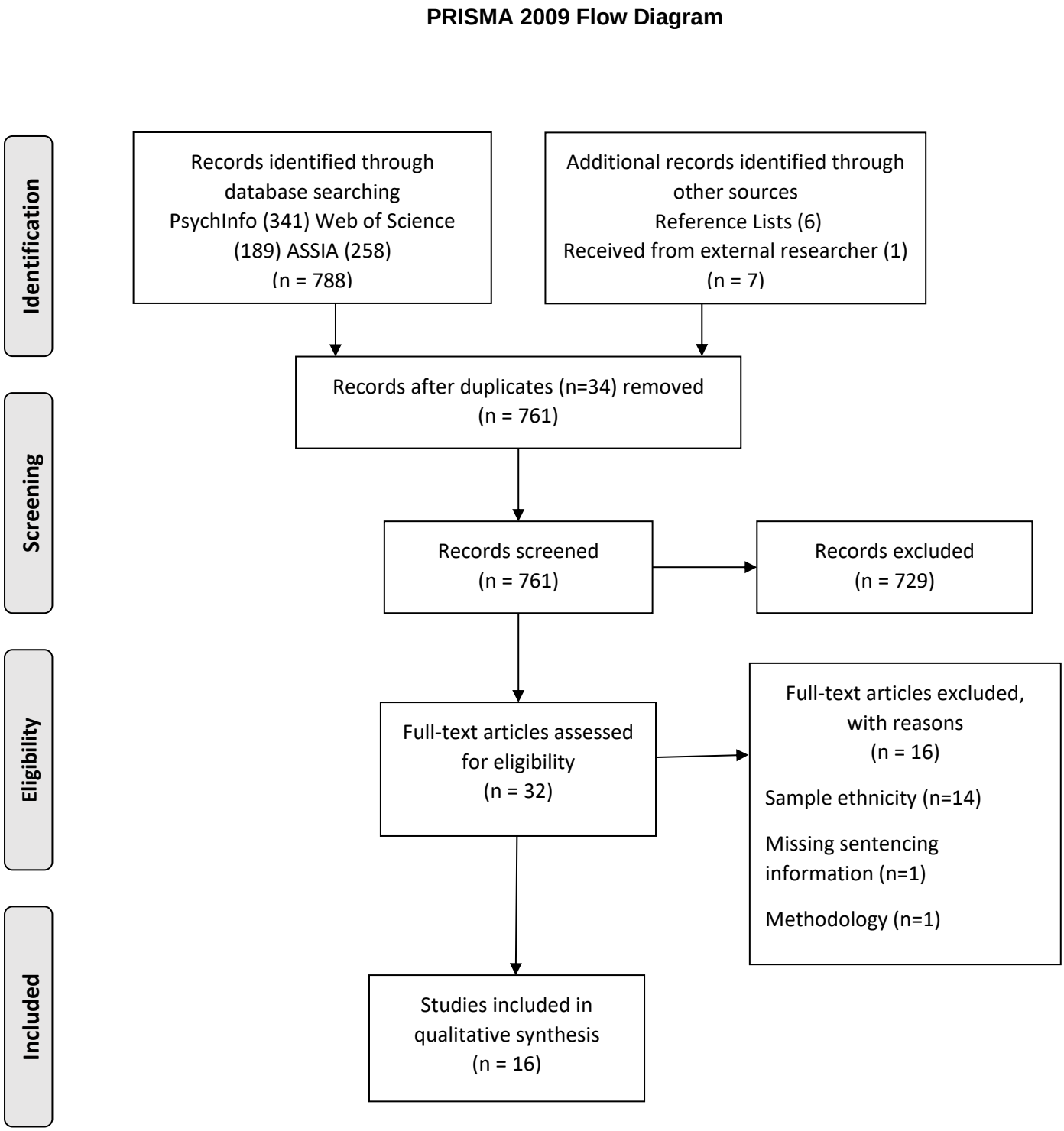
1.2.3 Classification of Studies

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram (Moher et al., 2009) was used to record the studies selected for this review. A

total of 788 studies were identified from conducting the systematic search. After removing duplicates, 761 studies remained. Titles and abstracts of the remaining articles were then reviewed against the predefined inclusion and exclusion criteria (detailed in Table 3), resulting in a further 729 being excluded. Additional reasons for exclusion included articles forming book sections rather than being peer-reviewed empirical studies or demographical information not being provided; at which point the reviewer contacted four researchers to confirm whether missing information was due to the editing style of the selected articles. These articles were also excluded. Reference lists of the remaining articles were then manually searched to identify any potentially appropriate studies, resulting in a further 6 papers. One article was received from the reviewer contacting a researcher requesting further information about a potential paper. The full text of 32 studies were reviewed for eligibility, resulting in the exclusion of a further 16 papers. Research was included if it captured the experiences of participants at the time of imprisonment as well as retrospectively. Reasons for exclusion included the ethnicity of less than 8.9% of participants being recorded as Black, missing sentencing information or the study not applying appropriate methodology. Subsequently, 16 studies were included in the final review.

Figure 2

PRISMA Flow Diagram (Moher et al., 2009)



1.2.4 Quality Assessment Checks

It is well recognised that assessing the quality of research is an important, yet difficult task to undertake (Glasziou et al., 2004), particularly with regards to defining the quality of qualitative research (Ring et al., 2011). Firstly, studies exploring similar phenomena may be designed and presented differently to each other. Secondly, it may be difficult to establish common themes across studies where the research aim and methodology are underpinned by different philosophical stances; and thirdly, findings will be subject to the interpretation of the researcher. Therefore, for a reviewer, synthesising data from several different primary studies might prove a challenge depending on the degree and type of interpretation involved (Glasziou et al., 2004). Despite these concerns, the studies selected for this review were assessed for their quality to ensure the review comprised of suitable studies and addressed significant outcomes.

The Critical Appraisal Skills Programme (CASP) Qualitative Studies Checklist (2018) was utilised for this review (Appendix 3). The three-part, ten-question assessment tool was developed for educational purposes and aims to establish the validity and usefulness of qualitative studies. CASP is a screening measure consisting of ten questions which aim to establish whether the criterion was fully met. A limitation to the CASP, is that as the measure was designed as an educational tool, there is no manualised scoring system. The reviewer therefore developed a scoring system where, for each question, studies were given a score of 2 if the criterion were fully met, 1 if partially met/could not tell and 0 not met, with scores between 0 and 20 determining the overall quality of the study. A midpoint score (10) was set as a cut-off point for consideration as to whether a particular study should be included or excluded. Consideration was also given where formatting for publication presented with issues rather than the study itself, for example the editing style required for particular journals.

None of the selected studies fell below the midpoint score. Quality assessment scores ranged from 11 to 20. To improve reliability, all selected studies were reassessed by a second researcher using the same assessment tool, which derived scores ranging between $\kappa = 0.62$

and κ = 1.0. The independent raters discussed significant disagreements in ratings on four questions (see Appendix 4) and reached an agreed score. Statistical inter-rater reliability analysis was performed using Kappa coefficients and are presented in Table 4.

1.2.5 Characteristics of the Literature

The key characteristics of the sixteen studies included in this review are summarised and presented in Table 4. Fourteen studies were conducted in America, with the remaining studies conducted in the UK and Canada. As a prerequisite, all studies employed a qualitative methodology, although the qualitative aspect of a mixed methodology was extracted from two papers and one study utilised a cross-sectional qualitative design. Three studies utilised secondary data from larger or previous research. The studies shared similar aims, to explore experiences of mother-child separation due to maternal imprisonment and its impact on those affected. Participant recruitment processes included randomized, snowball, convenience and purposive sampling. Whilst there were no prerequisites for additional presenting difficulties of imprisoned mothers, one study focused on mothers who also experienced substance misuse difficulties, and another paper explicitly explored experiences in the context of grandmothers becoming carers of the child during the mothers' imprisonment, however also included mothers' experiences. Eight studies were based on experiences of mothers in prison at the time of the research being undertaken, four studies combined current and formerly imprisoned mothers, whereas the remaining four studies were based on retrospective accounts. Semi-structured and open-ended interviews were transcribed and analysed to generate findings presented within grounded theory, thematic analysis or discourse analysis. Two papers did not explicitly state the process of data analysis; although this information is likely to have been omitted due to editorial style. The specific impact of mother-child separation varied between studies, however all studies discovered themes related to maternal identity and the emotional impact of mother-child separation for mothers.

Table 4

Key Characteristics of Studies

Author, Year & Country	Aim	Research Design	Sampling Participants, Size & Sampling Method	Key Findings Related to Experiences of Imprisoned Mothers Separated from Children	Quality Assessment Rating & KAPPA Reliability Coefficient
Baldwin, 2021 UK	To explore the experiences of formerly imprisoned mothers in relation to maternal-identity and the mothering role; and consider the relevance of motherhood and maternal experiences in relation to sentence planning and post-release supervision.	Qualitative design Feminist epistemological framework Purposive and snowball sampling Face-to-face semi-structured interviews (post-prison strand of wider mixed methods project) Thematic analysis	28 formerly imprisoned mothers Aged 19-66 68% (n=19) White 14% (n=4) Black 4% (n=1) Asian 4% (n=1) Romanian 10% (n=3) Mixed-race Sentences ranging 4 months to 4 years, with 57% (n=16) mothers following their first sentence and 43% (n=12) having served multiple sentences All mothers had at least one minor child at the time of imprisonment	Themes: Motherhood Challenged Pre-prison Circumstances Mothers Inside Entering Prison Space Mothering and Grandmothering from a Distance Regimes Rules and Inside Relationships Persistent Pains of Maternal Imprisonment Renegotiating Motherhood, Trust and Surveillance Trauma and Pain	20/20 (κ=1.0)
Kennedy, Mennicke & Allen, 2020 America	To explore the experiences of mothering prior to and during incarceration; and to examine how mothering intersects with incarcerated women's health and health outcomes.	Qualitative design Random selection Secondary data analysis of structured and open-ended interviews, from a larger study on the relationship between childhood abuse and	41 incarcerated mothers Aged 23-63 (M = 38) 68% (n=28) White 25% (n=10) Black 7% (n=3) Native American	Themes: Psychological distress and criminal behaviour prior to incarceration Sacrificing health on behalf of children prior to incarceration Lack of family services during incarceration	18/20 (κ=1.0)

		behavioural health outcomes among incarcerated women Grounded theory	Sentences ranging 90 days to 38 years (M = 7.2 years) Data on the number and ages of each mother's child/ren were not collected in the primary study (children in study described as 'young' and 'minor')	Mother-child connection during incarceration	
McKendy & Ricciardelli, 2020 Canada	To examine the release experiences of formerly incarcerated women in federal Canadian prison.	Qualitative design Secondary data from larger project examining the post-release experiences of federally-sentenced men and women in Canada Content and thematic analysis	43 mothers released from prison 44% (n=19) Black 26% (n=11) White 9% (n=4) Indigenous 20% (n=9) Other Sentenced to a minimum of 2 years in custody Data on the number and ages of each mother's child/ren not available (reference to 'young' and children under custody orders -aged under 18 under Canadian legislation)	Content analysis: Women struggled to enact the mothering identities they had anticipated prior to release, and the inability to freely see their children became a source of considerable pain Themes: Over stimulation, social disorientation and social precarity Missing "hooks" for new identities Parental and custodial struggles Extensive parole obligations Living conditions	18/20 (κ=1.0)
Stanton, 2018 America	To explore the mental health experiences of mothers of minor children after their release from incarceration.	Qualitative design (cross-sectional, exploratory, narrative inquiry qualitative design) Convenience and snowball sampling	25 mothers released from prison Average age of 38 years 44% (n=11) African American 28% (n=7) White	Themes: Overwhelmed Shifting Perspectives On Edge for A While I'm Not Sure I Understand	20/20 (κ=1.0)

		Face-to-face semi-structured interviews Transcripts reviewed for accuracy using Dedoose 7 Narrative and thematic analysis	64% (n=16) were last incarcerated in jail for an average of 9 months Mothers had an average of 4 children, with an average age of 13 at the time of participants' first incarceration	A Tiring Routine Deciding What I Have to Lose Disconnecting Gaining Strength.	
Aiello & McQueeny, 2016 America	To explore how incarcerated mothers construct moral identities as parents in the face of stigma.	Qualitative Design Face-to-face semi-structured interviews; observation of interactions related to motherhood (visitations, groups and classes, counselling, legal meetings, phone calls) Initial coding, collaborative memoing and focused coding Thematic analysis	83 imprisoned mothers Mean age = 32 43% (n=36) White 20% (n=17) Black 36% (n=30) Latina 81 serving ≥ 1 years imprisonment; 2 serving 2 years Average of 3 children each 41 mothers lived with children prior to imprisonment; 15 were not living with their children prior to incarceration but had regular contact; 17 had irregular contact; 12 had no contact	Themes: Jail as a Setting for the Construction of Moral Identities Distancing from "incarcerated mother." Separating mother/addict selves Talking about motherhood as a choice Embracing "Incarcerated Mother" Incarcerated motherhood as hardship and self-sacrifice Incarcerated motherhood as life lesson.	19/20 (κ=0.74)
Few-Demo & Arditti, 2014 America	To explore the influence that formerly incarcerated women's close relationships have on their re-entry experiences with their families.	Qualitative design Secondary analysis of data from previous study including 28 re-entry mothers Convenience sampling	10 mothers: 7 on probation; 3 reincarcerated Aged 25-46 years (M = 36) 70% (n=7) Caucasian	Themes: Ambivalence and Ambiguity Characterize Family and Intimate Relationships Ambivalent Relationships with Parents	16/20 (κ=1.0)

		Face-to-face semi-structured interviews Vulnerability Conceptual Model (VCM) applied to better understand experiences of separation relative to the situational vulnerability that characterizes criminal justice involvement Grounded theory	30% (n=3) African American Average sentence of 11.45 months Mothers had an average of 2 children, with ages ranging 18 months to 27 years (M = 13); younger children resided with four of the mothers prior to incarceration	Ambivalent and Ambiguous Intimate Relationships Ambivalent and Ambiguous Mothering Unresolved Loss and Grief Relational Vulnerabilities and Re-entry Patterns Besieged Mothers Survivor Mothers	
Mignon & Ransford, 2012 America	To explore the lived experiences of female offenders and their families as well as insights about the complicated issues related to maternal incarceration and the challenges of parenting from prison	Qualitative Randomised sampling Interviews Type of analysis not stated	48 sentenced women from state prison (n=35) and minimum security/pre-release facilities (n=13). 69% (n=33) of participants were mothers Aged 19-59 (M = 33.3) 73% (n=35) White 23% (n=11) Black 4% (n=2) Other Mean minimum sentence among the women interviewed was 49.7 months, and the maximum sentence was 38.5 months- no further sentencing information provided Mothers had 1 to 3 children; 52% aged between 10 and 18 years, 26% between 4 and 9 years, and almost 18% 3	Themes: Relationship problems with family members contributed to lack of contact. Stigma associated with being in prison, perpetuated by some family members choosing to keep knowledge of the mother's incarceration from the children. This exacerbates the shame and embarrassment family members can experience. Mothers of the incarcerated women who were most likely to express anger and disappointment.	12/20 (κ=0.84)

			years old and younger. Information not provided for 4% (however reference to 'young' children in study)		
Strozier et al., 2011 America	To examine the unique coparenting relationship of grandmothers and incarcerated mothers.	Qualitative design Constructivist epistemological framework Purposive sampling Face-to-face semi-structured interviews (conducted in either English or Spanish, based on participants preference) Analysed using Atlas TI Thematic analysis	24 incarcerated mothers within mother-grandmother dyads (total participants n=48) Mothers' ages ranged from 20 to 44 (M = 27) 35% (n=17) African American 48% (n=23) Caucasian 10% (n=5) Hispanic/ Latino 2% (n=1) Native American 4% (n=2) did not report their ethnicity No sentencing information available: 'interviews were conducted approximately 3 months into mothers' jail sentence' Children aged between 2 and 6	Themes: Solidarity in the Parenting Relationship Either mother or grandmother is in control and the other endorses the arrangement Parenting is shared without a struggle Compromising, problem-solving together Similar philosophies regarding child rearing Cooperation/teamwork Good communication Affirmation, empathy, and emotional support for parenting Absence of Solidarity in the Parenting Relationship Power struggles over coparenting Conflict over the quality of parenting Unresolved disputes about discipline Undermining or overturning discipline	18/20 (κ=1.0)

				Mother disconnected from parenting Substance abuse issues Despondency, guilt, and fear	
Allen et al., 2010 America	To explore the effects of incarceration for drug-offending incarcerated mothers on their relationships with their children.	Qualitative design Feminist standpoint epistemological framework Face-to-face semi-structured interviews ATLAS-TI qualitative data analysis software (2005) used for analysis Grounded theory	26 imprisoned mothers with history of substance abuse Aged 24-24 (M = 24.5) 57% (n=15) Caucasian 35% (n=9) African American 7% (n=2) Other Sentence duration not available for all participants. Of those noted in the study, duration was documented as 30 years (n=1); and acknowledgement that some had a few prior incarcerations, while others had been incarcerated 20, 30, or even 40 times in the past. Each mother had 1-6 'minor' children; 15 children in kinship care; 8 mothers had parental rights terminated; 2 children in foster care	Themes: Shame of maternal failure Snared in addiction Betrayed by care system Revolving door of homelessness, incarceration and recidivism Untreated mental health issues	17/20 (κ=1.0)
Celinska & Siegel, 2010 America	To explore coping strategies employed by mothers either pre-trial or in incarceration, to deal with potential or actual	Qualitative design Purposive sampling	74 imprisoned mothers, of which 37 were imprisoned (20 pretrial detention; convicted inmates n=17)	Themes: Being a good mother Mothering from prison	17/20 (κ=1.0)

	separation from their children.	Face-to-face semi-structured interviews ATLAS-TI software used for analysis Grounded theory	and 37 awaiting trial at home Aged 23-51 (M = 34) 74% (n=55) Black 26% (n=12) White 10% (n=7) Latino (demographics consistent across imprison and pretrial participants) Sentence durations not available. Convictions for theft, assault and drug selling/possession, as documented in the study, result in sentences over 3 months America Mothers had at least one child aged between 8 and 18 years; 58 mothers lived with at least one of their children prior to incarceration	Role redefinition Dissociation from prisoner identity Self-transformation Planning and preparation Self-blame	
Chambers, 2009 America	To explore the nature and meaning of the mother–infant bonding experience amidst anticipated and forced separation during incarceration.	Qualitative design Constructivist epistemological framework Purposive sampling Semi-structured face-to-face interviews Analysis tool/measure Thematic analysis	12 incarcerated postpartum mothers Aged 19-33 (M = 25) 42% (n=5) Non-Hispanic White 33% (n=4) African American 17% (n=2) Hispanic 8% (n=1) American Indian Sentences ranged from 5-23 months (M = 7.5)	Themes: A love connection Everything was great until I birthed Feeling empty and missing a part of me I don’t try to think too far in advance	18/20 (κ=1.0)

			4 participants describe having children prior to these recent births, no further information on child demographics provided		
Hayes, 2009 America	To develop an understanding of experiences of mothering after prison.	Qualitative design Hermeneutic phenomenological epistemological framework A total of 32 face-to-face semi-structured interviews; number of interviews with each participant varied from two interviews to participation for a year after release from prison Thematic analysis	5 mothers released from prison Aged 27-33 20% (n=1) African American 40% (n=2) Caucasian 40% (n=2) Hispanic 1-4 years sentence 1-3 children aged between 6 months to 18 years	Themes: Doing Mothering Right Family: A Double-Edged Sword The Honeymoon is Over Mothering Beyond the Honeymoon	19/20 (κ=1.0)
Adritti & Few, 2008 America	To advance a core construct to understand mothers' experiences during and after incarceration.	Qualitative design Face-to-face semi-structured interviews Grounded theory	10 mothers; 7 on probation; 3 imprisoned Aged 25-46 (M = 36) 20% (n=2) African American 80% (n=8) Caucasian Average sentence 11.45 months Mothers had an average of two children with a mean age of 13 (range = 1.5–27 years)	Grounded theory analysis yielded a theoretically saturated conceptualization of maternal distress with multiple indicators: (a) psychological distress most obviously manifested by depressive symptomology over a period of 2 years (b) relational distress involving intimate others, unresolved loss, and maternal guilt over substance abuse and incarceration	16/20 (κ=0.75)

				(c) situational features of maternal distress cantering on physical illness and injury and provider concerns	
Moe & Ferraro, 2006 America	To further understand the ways in which motherhood: (1) resonates with incarcerated women's self-perceptions; (2) relates to their motivations for crime, and (3) informs therapeutic programming within the carceral environment	Qualitative design No pre-conceived requirements for participation, other than that the women be willing volunteers Life-history interviews Type of analysis not stated	30 incarcerated women, 90% (n = 27) of which were mothers Aged 21 to 50 (M = 34) 50% (n=15) White 23% (n=7) African American 10% (n=3) Latina 7% (n=2) American Indian 10% (n=3) biracial Limited sentencing information provided, e.g. 25 participants were convicted and sentenced; the majority were being detained on probation violations; 3 were convicted awaiting sentencing and 2 were awaiting trial for murder Mothers had an average of 3 children each; 28 had children under the age of 18; 2 mothers were also pregnant and 1 had given birth just one day prior to her incarceration	Themes: Motherhood and Self-Perception: motherhood viewed from two vantage points: (1) as a valuable social status, that required that women uphold/ try to uphold hegemonic standards of motherhood (2) a pragmatic obligation to provide for their children, which in most instances was made difficult due to poverty, abuse, and drug use Motherhood and Criminality: responsibilities of motherhood provided the motivation for women's economically based offences Need for Social Support as Mothers: limited recognition within the detention facility of motherhood or the powerful role it played in the survival of the inmates	15/20 (κ=0.83)
Poehlmann, 2005 America	To explore the concurrent relations among contact with children, perceived family relationships, early experiences of relationship disconnection and	Qualitative design extracted from mixed methods study Face-to-face semi-structured interviews	98 incarcerated mothers Aged 19-43.5 (M = 28.3) 48% (n=47) African American	Themes: Intense feelings of distress, depression, or guilt Suicidal ideation or actions combined with intense distress	18/20 (κ=1.0)

	trauma, and maternal depressive symptoms amongst incarcerated mothers	Thematic content analysis Grounded theory	34% (n=33) European American 6% (n=6) Hispanic 8% (n=8) Native American Sentence ranged from 3 months to 10 years (M = 48.84 months) Mothers had 1-11 children (M = 3.47), aged 2-7.5 years (M = 4.50)	Maintaining emotional distance from the child Preoccupation with conflict with family or the child's problems Idealization of the child A balanced view of the situation that emphasised personal growth along with recognition of hardships A mixed strategy (i.e., when two or more strategies [aforementioned] equally dominated without recognition of personal growth)	
Forsyth, 2003 America	To examine the discourse of female inmates regarding their attitudes and beliefs about motherhood.	Qualitative design Face-to-face semi-structured interviews; with a 30 minute follow-up interview conducted after participants provided a journal to further recount any feelings arising from the original interview Discourse analysis	28 participants (23 incarcerated, 1 released, 4 staff) Aged 35-44 years old 'The average inmate is Black'- no further demographics provided 'All were long-term inmates'- no further sentencing information provided 'Average of two children'- no further demographics provided ('mother' description refers to children under 18 years of age)	Participants identified separation from their children as the hardest part of being locked up. Participants expressed a great deal of emotional distress because of the obvious disjuncture between the statuses of mother and prisoner.	11/20 (κ=1.0)

1.2.6 Analytic Review Strategy

A meta-ethnographic approach was utilised for this literature review. As one of the most frequently used frequently used methodologies for qualitative evidence synthesis in health and social care research, meta-ethnography is effective in emulating and interpreting the data of the studies being synthesised (Hannes & Macaitis, 2012; Britten et al., 2002). Meta-ethnography goes beyond synthesising findings from individual studies and aims to derive a new interpretation, model or theory from the wealth of information gathered across studies (Noblit & Hare, 1988). The current meta-ethnography followed Atkins et al.'s (2008) four-step process, detailed in Table 5.

Table 5

Summary of meta-ethnographic approach to data synthesis (Atkins et al., 2008)

Stage	Description of process
Reading the studies	Reading and re-reading of relevant studies captured themes from participants (for first order constructs), as well as the studies authors' interpretations of participants' understandings (for second order constructs). Following this, preliminary quotes and themes were extracted from papers.
Exploring how studies are related	Findings across studies were then explored collectively, with themes and quotes considered for how they related to one and other. Generic and infrequently occurring themes were mapped out at this point; and more meaningful and recurring themes were thickened during this synthesis.
Exploring how study themes map onto each other	Papers were reviewed in chronological order, with the first study identified as the index paper. Each paper was assessed for comparison of respective themes and concepts, which were synthesised to create more meaningful, overarching themes (third order themes). Overarching themes then became the point of reference for subsequent papers under review. Throughout this process, the author remained mindful of the context of themes capturing the experiences of both current and formerly imprisoned mothers.
Synthesis of emerging themes through distillation	Analysis moved from descriptive to explanatory analysis for the final stage, from which interpretation became a line of argument synthesis. At this stage, provisional themes were explored with the research supervisory team to consider how to present findings. The outcome of this analysis uncovered a new way of conceptualising participant experiences, with considerations for further exploration in future research.

1.3 Results

A meta-synthesis of sixteen papers led to the development of three themes, each defined in terms of two sub-themes which, helped to better understand the experiences of imprisoned mothers separated from their children (see Table 6). An illustrative representation of the meta-ethnographic approach employed to draw out the key themes is presented in Appendix 5.

Theme 1 drew out evidence relating to how mothers' experience motherhood. Theme 2 revealed the mothers' feelings of Guilt as a result of being in prison; and Theme 3 focused on the role children play during the Rehabilitation process.

Table 6

Themes and Subthemes

Theme	**Subthemes**
Motherhood	Being a "Good" Mother Being a Negative Role Model as a Mother
Guilt and Regret	From Being in Prison From Having Children
Children as Incentives	So Children do not Suffer To Be a Better Mother

The frequency of sub-theme occurrence within each paper reviewed in the current meta-ethnography is illustrated by Table 7.

Table 7

Frequency of each Sub-theme by Original Papers

Main Theme	**Motherhood**		**Guilt and Regret**		**Children as Motivation to Rehabilitate**	
Sub-theme	Being a "Good" Mother	Being a Negative Role Model as a Mother	From Being in Prison	From Having Children	So Children do not Suffer	To Become a Better Mother
Baldwin (2021)	✓	✓	✓	✓	✓	✓
Kennedy et al. (2020)	✓		✓		✓	✓
McKendy & Ricciardelli (2020)		✓	✓		✓	✓
Stanton (2018)		✓	✓		✓	✓
Aiello & McQueeny (2016)	✓	✓	✓		✓	✓
Few-Demo & Arditti (2014)	✓		✓	✓		
Mignon & Ransford (2012)	✓		✓			
Strozier et al. (2011)	✓	✓	✓	✓	✓	
Allen et al. (2010)		✓	✓	✓		✓
Celinska & Siegel (2010)	✓	✓	✓		✓	✓
Chambers (2009)	✓					✓
Hayes (2009)	✓	✓	✓		✓	
Arditti & Few (2008)	✓	✓	✓		✓	✓
Moe & Ferraro (2006)	✓	✓	✓		✓	✓
Phoelmann (2005)			✓	✓	✓	✓
Forsyth (2003)		✓	✓		✓	✓

2.3.1 Theme 1: Motherhood

The theme of *Motherhood* captured mothers' experiences of remaining motherly despite their diminished capacity to actively mother whist in prison. This theme was evident across all sixteen papers, and the status of *Motherhood* was important in terms of how participants attempted to define themselves. However, while being a "*Good" Mother* was often valued, many participants talked about being a *Negative Role Model* for their children.

Being a "Good" Mother

Eleven papers captured the theme of *Being a "Good" Mother*, characterised through maintaining the maternal role and sustaining contact with their children from prison. More specifically, mothers prided themselves on not being viewed as bad parents due to being in prison as a mother of two imprisoned on a drugs conviction stated: *"That's a good thing to know, that they look at me as a good mom, not a bad mom, because I'm locked up."* (Celinska & Siegel, 2010, p. 458). Some women had a great deal invested in their self-image as mothers, with the perception of being a good mother reinforced when their children confided in them as an imprisoned mother of one child explained:

> *"But my son will come to me right now and talk to me about his girl . . . he tells me everything, like I'm his best friend in the world. That's being a good mother."*
>
> (Celinska & Siegel, 2010, p.460);

The primary channels for mothering from prison included telephone calls and letters, along with sporadic visits. Mothers utilised such resources to maintain contact with children and provide guidance as Angel, a mother of eleven children stated:

> *"I feel like I'm still teaching him and so I use the letters as an opportunity to put that mothering in there for him and try to keep him on track and keep his spirits lifted and, you know, make sure he's growing."*
>
> (Moe & Ferarro, 2006, p. 7)

For some women, 'good mothering' entailed parenting 'in the background' of their children's lives from prison. For example, Karen described her determination to ring her daughter's school upon discovering her daughter was being bullied, as *'I was still her mum'* (Baldwin, 2021, p. 176). Many mothers 'also wanted information about their child's school situation, including behavioural issues, as well as their children's grades and activities including sports, camps, and church involvement' (Mignon & Ransford, 2012, p. 78).

Some mothers felt it was important to be open with their children about their imprisonment. Thus, these mothers felt that taking responsibility for their circumstances and being honest with their children demonstrated good parenting as Ana, a re-entry mother of two children said:

> *"I want them to know that I'm in jail… I mean I don't want to lie to them. I want them to know that I made a mistake and that it was bad and I had to pay for it."*
>
> (Hayes, 2009, p.232)

Overall, mothers clearly expressed a desire to continue mothering despite imprisonment. However, many re-entry; transition from prison to community, mothers struggled to enact the mothering identities they had anticipated prior to release, with ongoing

multiagency input causing women to fear that their mothering identities were under scrutiny (McKendy & Ricciardelli, 2020, p.11).

Being a Negative Role Model as a Mother

In eleven papers, mothers described a negative view of self, to which they had exposed their children. These experiences were captured under the theme of *Negative Role Model.* The experience of being in prison appeared to deviate from what some mothers perceived as the traditional motherhood ideology, as Rita shared: *"I knew I would forever be looked at as a bad mother… there can't be much worse than a mother who goes to prison can there?"* (Baldwin, 2021, p.164). Several mothers were fearful that their children would eventually emulate their actions as Karen averred:

> *''She wants to be a little me, and I'm like, NOOOO. I'm afraid she knows where I've been. I'm scared that she might grow like I did because I'm in her life. It will vibe off of me and go into the children . . . I feel like I'm not a good role model.''*
>
> (Arditti & Few, 2008, p. 310)

Analysis of the literature recognised the additional responsibility mothers had in ensuring their children did not follow in their footsteps as Natalie explained:

> *"One time my daughter says to me, when I get older, I want to smoke weed and cigarettes go to the club and shake my butt just like my mommy… She's watching me. And I gotta...let her know that you don't wanna be like that. She could end up here."*

(Aiello & McQueeny, 2016, p. 42)

For some mothers, unfortunately this fear became a reality as one mother stated:

> *"It took for the kids to turn and go to a juvenile center or have some kind of crisis…had I been there with my kids this wouldn't have happened."*
>
> (Forsyth, 2003, p.273)

Whilst such events were likely to result in feelings of guilt and regret from the mothers, fundamentally all intentions led back to being a "proper mother". Interestingly, however, some mothers described how their entry into the Criminal Justice System was often guided by their roles as mothers, in that rather than perceiving offending behaviour as irresponsible or neglectful, criminality because of, not despite, their children (Moe & Ferraro, 2006, p. 8). Ironically, although mainstream society might regard mothers who break the law as unfit and deviant, some mothers tended to believe that the essence of motherhood was in fact exemplified by their willingness to sacrifice their own freedom to ensure the well-being of their children and in this way, retained their identity and resilience as imprisoned mothers.

2.3.2 Theme 2: Guilt and Regret

Fifteen papers captured mothers' awareness that their life choices had an adverse impact on their children. Thus, separation appeared to be largely characterised by guilt and regret, which either derived from the choices leading to their imprisonment, or the choice to have children in the first place, having ended up in prison and experiencing separation anxiety due to being away from their children.

From Being in Prison

Many women appeared to feel the full force of the stigma associated with being in prison, which was perpetuated when caregivers chose to keep knowledge of the mother's imprisonment from their children (Mignon & Ransford, 2012, p.80). Some guilt-stricken mothers chose not to disclose that they were actually in prison, as Alexandra shared: *"I don't let my children come to visit; they think I am away at work … I just don't want them to know I did bad things."* (Baldwin, 2021, p. 180). Others mourned over the loss or separation from their children and accepted prison was a result of their own actions. One mother stated:

> *"Deep down you say, well, if I hadn't done what I did. If I hadn't come here things would be different…And you're going to carry it for the rest of your life."*
>
> (Forsyth, 2003, p. 273)

Some regarded maternal imprisonment as a flaw of the judicial system, as one imprisoned mother explained: *"You defeat the purpose here [of] trying to improve the lives of a mother by separating her from her kids"* (Kennedy et al., 2020, p. 8); while others explicitly expressed the guilt they felt about the decisions they had made which resulted in their being in prison and away from their children, as a mother imprisoned for probation violation narrated: *"I feel guilt about ending up here. I feel like as soon as I had a daughter I should have been more responsible."* (Kennedy et al., 2020, p. 6).

Some of the grieving mothers recognised that the feelings of guilt of being separated from their children was not mutually experienced with other imprisoned mothers as one mother said:

> *"Where some people do cry and they hurt...I would say some feel guilty...Some don't care...I would hope all the mothers feel some guilt."*
>
> (Forsyth, 2003, p. 274)

These discourses deviated from the societal expectation that the imprisoned mother was a grieving mother. In these instances, being separated from their children did not appear to impact on mothers' recidivism as Becky explained:

> *"I see a lot of girls that go and come back out and every time they come back they wanna cry about their kids, but...then they're...back two weeks later? They really don't care."*
>
> (Aiello & McQueeney, 2016, p. 40)

There was also recognition that the limited opportunities to mother through letters, telephone calls and visits, could not compensate for the mothers' physical absence nor lost time as Lynn, a mother reincarcerated for probation violation reflected: *''It's very hard to be a mother: Physically I'm not there. Mentally, there's no way to make up the time.''* (Arditti & Few, 2008, p. 309). Guilt was perpetuated by the awareness that as their children grew older, mothers were unable to fully guide them so that they did not make the same life choices as they did, as an imprisoned mother of two explained*:*

> *"I know at this age this is when you get introduced to pot. I've been there. And drinks. So, I wonder about that. And I hope and pray that she don't. That's why I'm mad at myself a lot 'cause I'm not there."*

(Celinska & Siegel, 2010, p. 459).

From Having Children

Five papers described regret experienced by mothers once they had been incarcerated, for having children in the first place (Baldwin, 2021; Few-Demo & Arditti, 2014; Strozier et al., 2011; Allen et al., 2010; Phoelmann, 2005). For some mothers, this appeared to present as ambivalence about their mothering role as Gwin, a re-entry mother expressed:

> *"If I could change one thing about my life, it would probably be not to have any kids because I might as well not because I don't raise them. I love my kids . . . all I did was to give birth to them."*
>
> (Few-Demo & Arditti, 2014, p. 1309)

Other mothers struggled to connect with their mothering identities having not lived up to the role as Lucinda stated: *''sometimes I feel like I don't deserve to be called mother. I feel like a failure, like I've failed them.''* (Allen et al., 2010, p. 166). In such instances, women mournfully reassigned their maternal positions to more deserving caregivers as one mother narrated: *"I see my mother as the primary mother. I hate to say that, I think it makes me feel ashamed and it hurts my head."* (Strozier et al., 2011, p. 7).

One reason why the imprisoned mothers talked about their regret for having children was associated with the psychological distress caused by separation anxiety, with many describing the pain resulting from being away from their children, as one mother elucidated:

> *"I don't feel her every day. I don't have her right here with me… when you don't have them there, it is a separation anxiety that you go through."*
>
> (Chambers, 2009, p. 208)

The emotional distress experienced by Taranpreet, who had convinced herself that her toddler children no longer recognised her as their mother, was evident as she shared: '*I'm totally broken…I'm literally dead inside…the mere fact my own children don't recognise me has torn me apart…I've lost everything'.* (Baldwin, 2021, p.161).

Many mothers openly longed to be with their children and acknowledged the distress arising from losing that sense of connectedness as one mother stated*: "All I'd do was cry. It is horrible being away from your kids, especially when they the only people who care for you."* (Phoelmann, 2005, p. 353). Feelings of guilt and regret also translated into depression as Helen explained:

> *"Prison was very detrimental to me…and (the) most worst part was that I was missing my children. I did not know where they were living. I had made birthday cards for them but did not know where to send them…. Definitely severe depression, loneliness, dissociation, lack of energy."*
>
> (Stanton, 2018, p. 81)

Mothers also voiced regrets that separation also meant not knowing where their children were located, and that their absence consequently required older children to grow up too quickly in having to care for siblings (Mignon & Ransford, 2012, p. 77).

As a sense of self-blame, guilt and regret primarily served as a negative strategy, with some mothers emotionally distancing to cope as one mother stated:

> *"A person can only cry so much, sometimes a person needs to bury it." "I do not have pictures of them up. I do not like to think too much about them or what they're doing…I cannot think of them growing up without me."*
>
> (Phoelmann, 2005, p. 354)

However, self-blame also appeared to be a catalyst in some mothers' self-transformation.

2.3.3 Theme 3: Children as a Motivating Source

Fourteen papers described children as a motivating source in assisting their mothers to engage in rehabilitation. Most mothers expressed a strong desire to reunite with their children upon release from prison. Mothers reflected on the hurt they believed they had inflicted on their children because of imprisonment and perceived this as reason enough to do everything within their control to successfully rehabilitate. Some women also asserted that the experience of mothering from behind bars represented a unique commitment to and appreciation for their children, which spurred them to become better mothers in future.

So Children Do Not Suffer

Mothers often experienced a range of emotions from their children, for example, clinginess and withdrawal, as an imprisoned mother of one child narrated:

> *"[. . .] tells me that I don't love her because if I loved her, I wouldn't be locked up. She tells me that she misses me. Sometimes I can hear in her voice that she's a little depressed. She wants me home."*
>
> (Celinska & Siegel, 2010, p. 459)

In interpreting these contradictory emotions, some mothers felt their children were purposely emotionally absent from them and intent on punishing them for their absence as Lori, a re-entry mother stated:

> *"[My daughter] but she's got this hatred towards me and at first it really hurt. She called my mother and said, "Can you believe my mommy didn't have nothing to do with me?" I said, "Momma, I'm giving her a taste of her own medicine."'*
>
> (Few-Demo & Arditti, 2014, p. 1309)

Guilt also served as a strong impetus for mothers to rehabilitate so children would no longer suffer from being separated, as Ursula stated: *"I suppose the only thing to be done is to make sure that I'm never in that position again and just hope that they'll forgive me at some point."* (Baldwin, 2021, p. 166). Absence served as a motivator for change as Pam discussed: *"[children's distress] for me, stops me from doing something stupid in the future. 'Cause I never wanna be incarcerated again."* (Arditti & Few, 2008, p. 310*)*. Some mothers recognised the rehabilitation process as too distressing for their children to endure, so committed to less disturbing methods of communication to alleviate suffering as Karen explained:

> *"I understand why she didn't come. The visit changed her mood. So the visit upset me, upset my daughter . . . I would write (instead)."*
>
> (Arditti & Few, 2008, p. 310)

However, for some mothers, the awareness that their children were suffering encouraged them to cease communication altogether as Linda narrated, *"We let go of our kids because we feel it is best."* (Allen et al., 2010, p. 165).

For some mothers, there was an awareness that the anguish of imprisonment fell beyond their own plight: *"Not only am I suffering, but my child is suffering, too, because I'm here."* (Phoelmann, 2005, p. 354). Mothers also seemed to recognise that reunification would only be fair if it were sustained: *"I don't want to go back into my son's life and have him get real attached to me and then I screw up again."* (Strozier et al., 2011, p. 8).

To Become a Better Mother

Some women appeared to regard the prison experience as a life lesson that clarified their priorities and empowered them to be better mothers. Indeed, relationship with children was a motivational factor for mothers to rehabilitate, so that the motherly role could be re-established, as one mother stated: *"There were times when I wanted to just give up, but I can't. I must get home to my kids one day."* (Forsyth, 2003, p. 274). Children also served as motivation for mothers to anticipate having a sense of purpose upon reunification:

> *"Sometimes I think I'm still alive because of them, you know, because I want to go home to them. If it hadn't been for them, I don't think I would have cared."*
>
> (Celinska & Siegel, 2010, p. 459)

Whilst mothers expressed dedication, commitment and a desire to reunite with their children, they wanted to be in the best position emotionally before re-establishing their parenting role:

> *"I would love to be a mum now, but I would have to get more clean cut. I'm not ready now. I'm just getting ready."*
>
> (Stanton, 2018, p. 106)

For some women, being separated from their children caused them to re-evaluate their roles as mothers as re-entry mother Ana explained: *"I'm nervous because I want them to have the best mother. I want to be there for them 200%"* (Hayes, 209, p. 231)*;* with some expressing that mothering needed to be their main focus upon release:

> *"I want to do all of the things that I missed and just stop getting out there and worrying about other things that aren't really that important and understand that I have got two children now that I need to grow up and take care of my kids."*
>
> *(*Chambers, 2009, p.209)

However, whilst re-establishing familial roles was often a central goal upon release, the process was often combined with both anticipated and unanticipated challenges. For example, some mothers recognised that reunification was not guaranteed, however this did not appear to compromise their self-regard as mothers, as Nicola shared: *"I might never see them again, but I have sons, I am a mother, and I will always be a mother, no one can take that from me."* (Baldwin, 2021, p. 172). Some women felt robbed of the opportunity to reunify with their

children and become better mothers, having lost custody whilst imprisoned. This left them with little incentive to rehabilitate as Eryka stated:

> *"I had nobody to be a mom to, but I had kids, but I had no one to be a mom to because they took them all from me. That's why I kind of didn't straighten up right away because I had nothing to straighten up for…"*
>
> (Stanton, 2018, p. 104)

Reuniting with children also served as a strong motivation for some mothers to steer away from selling and using drugs, as an imprisoned mother with a long criminal history explained:

> *"I don't want to do drugs, I don't want to sell them... I just want to be a better parent to my kids."*
>
> (Kennedy et al., 2020, p. 8);

with recognition of their inability to be there for their children whilst living with a drug addiction as Veronica said: *"I need to overcome my drug addiction so I can be there for my kids."* (Allen et al., 2010, p.169). Importantly, mothers acknowledged the control they had in ensuring they became better parents to their children, as a mother serving her first criminal charges stated: *"I have a choice to not repeat the cycle. I can choose to mother my kids differently."* (Kennedy et al., 2020, p. 14). Such narratives effectively transformed fighting addiction into good mothering.

1.4 Discussion

This systematic review analysed sixteen studies of the lived experiences of imprisoned mothers separated from their children, according to the meta-ethnography procedure recommended by Aktins et al. (2008). The findings of this review provide a deeper, first-hand understanding of the impact on mothers of being separated from their children through imprisonment.

Firstly, analysis of the literature illustrated that a 'doubly deviant' identity crisis can be experienced by imprisoned women who are mothers. The theme of *Motherhood* captured that in addition to the psychological challenges associated with their status as 'offenders', with a sense of being self-defined as a "good or bad person", participants also experienced a crisis of self-confidence in terms of whether their actions defined them as 'good' or 'bad' mothers. This was illustrated by the sub-theme of *Being a 'Good' Mother* as, despite imprisonment, the women desired to continue acting in ways which they felt represented maternally "appropriate" behaviours. This included maintaining contact with their children and trying to guide them to make better life choices. The sub-theme of *Being a Negative Role Model as a Mother,* further highlighted the ways in which imprisoned mothers recognised the potentially negative sense of self to which they were exposing their children; and how interpretations of Motherhood seemed to be demarcated in terms of what represented appropriate/acceptable and inappropriate/unacceptable mothering behaviour.

Secondly, as illustrated within the theme *Guilt and Regret,* in addition to being denied their liberty as prisoners, participants also felt deprived of their roles as mothers in accordance with what they perceived as 'traditional mothering'. This resulted in considerable guilt and regret for those who felt imprisonment had caused them to fail in their role as mothers, and for many mothers, this caused them to regret the decision to have children in the first place.

Thirdly, the theme *Children as Incentives* captured the motivation of imprisoned mothers to steer away from criminal behaviours and return to playing a more significant mothering role in promoting the well-being of their children. As captured in the sub-theme *To*

Become a Better Mother, the desire to re-establish mothering roles maintained the motivation for mothers to work towards removing themselves from the anxiety-provoking environment of imprisonment.

1.4.1 Integration of Previous Reviews

Insights obtained from the current and previous systematic reviews provide a more holistic understanding of the challenges facing imprisoned mothers in terms of: the dyadic difficulties underlying the mother-child experiences of imprisonment; the attachment problems resulting from separation; and the complexities underlying a successful path to rehabilitation.

Theme One captured how dyadic difficulties meant the needs of neither the imprisoned mother nor the child could be realised whilst they were separated. The mothers in this review sought opportunities to be maternal through prison visits; however, recognised the distress this caused to their children. Similar experiences were also captured within Stewart's (2020) review, with children of imprisoned mothers describing prison visits as 'intimidating' and frightening. Subsequently, as described in *Theme Two,* the mothers in this review opted to rely on alternative, less distressing methods of communication including letters and telephone calls to alleviate distress yet maintain the mother-child bond. Although this limited the opportunities afforded to the women to demonstrate *Being a Good Mother,* the ability to sustain contact with children seemingly reassured imprisoned mothers that their connection could be maintained despite being physically separated*.* Additionally, as illustrated within the sub-theme *Being a Negative Role Model as a Mother,* whilst maternal modelling also helped with bonding, conviction, imprisonment and absence eroded maternal authority for mothers in both moral and practical aspects. Given that Stewart's (2020) review also identified children of imprisoned mothers as being frequently situated within peer groups engaging in high levels of criminal and deviant behaviours, the mothers in this review expressed valid concerns that their children might follow in their footsteps. Nevertheless, attempts to parent by setting

boundaries with children presented with additional conflicts for mothers, including feeling hypocritical for having displayed the same sorts of behaviours themselves in the past.

Whilst previous reviews highlighted the attachment difficulties subsequent to maternal imprisonment (Powell et al., 2017), the current review not only captured *Guilt and Regret* as common emotional difficulties experienced by imprisoned mothers separated from their children, but also participants' motivation to make up for past mistakes, driven by their expressed hopes to become *Better Mothers* as illustrated in *Theme Three*. This review further highlighted the role children play in spurring imprisoned mothers to successfully rehabilitate, illustrated by attempts at mothering from a distance, whilst remaining motivated by the hope of reunification. However, the reunification desires of mothers in this review were often idealised with little consideration of what might be in the child's interest. Correspondingly, within Stewart's (2020) review, a number of children in fact experienced maternal imprisonment as a positive event which offered them respite from emotionally damaging experiences and improved their relationships with their mothers. Subsequently, without fully recognising the complex nature of attachment, or the sense of mother-child disconnect experienced due to their imprisonment (Powell et al., 2017), mothers in this review were not only at risk struggling to re-establish desired bonds, but also at risk of creating erratic attachment behaviours with their children. Additionally, if bonding failed or took longer than expected for mothers, motivation to rehabilitate could falter, as was captured within *Theme Three* where children were described as the sole incentive for some mothers to rehabilitate.

With prisons facilitating improved parenting interventions such as those described in Tremblay and Sutherland's (2017) review, it was understandable that for mothers in this review, motivation to rehabilitate was largely driven by hopes of improving their children's well-being by becoming *Better Mothers*. However, this review also highlighted the paradox in mothers' descriptions of the role having children played in their offending behaviours. Within the sub-theme of *Being a Negative Role Model as a Mother,* participants described how, to

ensure their children's well-being, they were prepared to steal, sell drugs or use violence as a form of protection. Mothers therefore perceived offending behaviours as their willingness to sacrifice their own freedom for the sake of their children. However, as illustrated in this review, mothers then placed a lot of emphasis on reunification with children being their main motivation for not reoffending upon re-entry. Such chaotic lifestyles might further explain why for some children, maternal imprisonment offered respite (Stewart, 2020).

1.4.2 Clinical Implications: Policy and Practice

To improve dyadic difficulties resulting from the challenges of mothering from prison, prison regimes would be enhanced by adopting more child-centred experiences. Tuerk and Loper (2006) shared that only half of imprisoned mothers had visits from their children due to, as was described in this review, the emotional distress experienced by children. Current prison recommendation in England draws upon the value of Prison Play Workers offering opportunities for children maintain their attachment with imprisoned parents through facilitation of therapeutically-informed visits (Wragg, 2016). These have shown to improve dyadic experiences (Woodall & Kinsella, 2017) as well as the emotional well-being of both prisoners and their children (Flynn, 2014; Moran, 2013).

To support imprisoned mothers living with feelings of guilt and regret, inmates could be encouraged to understand the realities of mothering from prison and the psychosocial ways in which the maternal identity and attachments are challenged. Arditti and Few (2008) consider a mother's guilt as one emotion that must be addressed to help women reinvest in their mothering role upon re-entry; and further suggest that imprisoned mothers could benefit from parenting programmes that are connected to their emotional difficulties. Supporting mothers to have a more psychologically-informed understanding of their experiences would require Clinical Psychologists and other therapeutic staff to have a more integral presence within prison regimes. Interventions entailing education on parenting skills within a supportive

environment could improve treatment outcomes for imprisoned mothers (Gilham, 2012), with psychologically-informed groups offering further opportunities to enhance mother–child bonding (Bruns, 2006). There may also be value in providing psychologically-informed training to prison staff, to support their ability to recognise and respond when mothers are struggling with separation from their children.

To support mothers to regard their children as incentives for rehabilitating, collaborative development of psychological formulations could improve their understanding of the factors likely to perpetuate attachment difficulties upon reuniting with children (Wiewel & Mosley, 2006). Psychological support could also entail multiagency working and access to external services prior to reintegration, for example through the development of individualised exit plans to enhance the sustainability of rehabilitation and reunification (Harris, 2017). Whilst the essence of motherhood can empower women upon re-entry following imprisonment, a singular focus on motherhood for rehabilitation is not necessarily advantageous for women. It is therefore argued that mothers should be encouraged to focus on developing their sense of self beyond maternal identity (Baldwin, 2018). This is of particular importance as re-entry mothers reportedly continue to struggle with parenthood (Arditti, 2012), suggesting greater support is still required following reunification with children. Furthermore, as some imprisoned mothers within this review recognised that reunification with their children was not a guarantee (e.g. Baldwin, 2021), it is also important that mothers who are restricted from reuniting with their children upon release are offered appropriate psychosocial support.

Psychological support throughout imprisoned mothers' journeys through the CJS could provide mothers with opportunities for enhancement of self-confidence and self-efficacy to meet the demands of the future (Gilham, 2012). Compassion-Focused Therapy (CFT; Gilbert, 2009), for example, aims to resolve problematic patterns of cognition which often result in emotional distress and maladaptive behaviours. Within CFT, it is further suggested that an inability to self-soothe can impact on an individual's ability to regulate emotions related to

anxiety, anger and self-criticism (Gilbert, 2009). For imprisoned mothers, CFT may improve the emotional difficulties associated with separation whilst affording mothers' motivation for rehabilitation to be driven by more person-centred incentives.

Finally, it is recommended that broader policy initiatives consider the psychological impact of maternal imprisonment whilst preparing mothers for release, with more attention given to opportunities to re-establish bonds with children as this appears to be lacking in current practice. For example, within McKendy and Ricciardelli's (2020) study, women had an average of five parole conditions which conflicted with opportunities to re-establish mother-child bonds, as substantial time was spent attending re-entry supervision meetings. Incorporating international practices which encourage reunification whilst enabling mothers to comply with probation process could reduce recidivism. Illustratively, in response to the growing number of imprisoned mothers in Germany, community-based accommodation was developed for women offenders which enables mothers with young children to live together (Dolan, 2016). All staff in these accommodations have background studies in a relevant caring profession such as Psychology, Social Work and Nursing. As an integrative approach to imprisonment and welfare, the regime requires mothers to access probation-related activities during the day whilst their children attend nursery or school (Prison Reform Trust, 2013), with bonding opportunities afforded outside of these hours. Reportedly, residents within such establishments have a significantly lower rate of reoffending than imprisoned women who are not housed with their children (Farmer, 2019).

1.4.3 Strengths and Limitations

This meta-ethnography is strengthened by including grey literature alongside published and peer-reviewed studies, attempting to counteract the publication bias that often exists in reviews (Aromataris & Pearson, 2014). Papers which used a range of methodologies across a broad sample of current and formerly imprisoned mothers, were synthesised to

present a meaningful consideration of how separation and reunification are experienced by imprisoned mothers in Western countries. Due to the well-documented over-representation of Black women within criminal justice systems across the UK, Canada and USA (e.g. Lammy, 2017; Gurusami, 2019), papers were only included in this review if they were deemed demographically representative of the prison population.

As the definition of maternal imprisonment was limited to Western cultures, this review captured the experiences of mothers across the UK, USA and Canada. Therefore, by not including a broader cultural representation of imprisoned mothers' experiences, synthesizing of findings might inadvertently portray motherhood, attachment and separation anxiety as culturally bound concepts (Friedman, 2016).

Finally, it is acknowledged that non-English language papers were excluded from the current review due to time and cost implications, which introduced an unavoidable language bias (Butler et al., 2016).

1.5 Conclusion

1.5.1 New Knowledge Arising from the Review

This meta-ethnography has highlighted the additional challenges that imprisoned women who are mothers have in maintaining their maternal identities and the subsequent attachment and psychological difficulties that arise as a result. This review further identified the significant role children have in motivating imprisoned mothers to persevere with the rehabilitation process despite the practical and emotional challenges in maintaining meaningful contact.

Given the systemic and psychosocial nature of imprisoned mothers' experiences, holistic, multidisciplinary and multi-agency working is essential for supporting their needs. Current practices could be revised to implement more compassionate, psychologically-

informed approaches to treatment and support for mothers, both in terms of acceptance of separation from children and in preparation for sustainable rehabilitation and reunification.

1.5.2 Unanswered Questions and Future Directions

There remains a need for UK based studies to analyse the lived experiences of imprisoned mothers separated from their children which, demographically include an appropriate proportion of Black mothers. Future research could also investigate the effectiveness of psychologically-informed approaches to supporting imprisoned mothers within individual, group and systemic interventions. Longitudinal studies following the experiences of mothers from the point of entering the CJS, throughout imprisonment and upon re-entry could provide further understanding of the journey's mothers embark on in navigating through prison whilst being separated from their children. Finally, given the significant role children play in motivating mothers towards successful rehabilitation, research could compare the experiences of mothers who are able to reconnect with their children to mothers who are legally prevented from reunification.

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Chapter II

Black Women's Experiences of Cultural Awareness in Secure Psychiatric Settings

2. Abstract

Aim: The aim of this research was to gain a clearer understanding of Black women's experiences as service users within secure psychiatric settings.

Methods: The study employed Interpretive Phenomenological Analysis (IPA) to investigate the experiences of seven women aged between 18 and 44 years old who: identified as being of Black ethnicity, were sectioned to hospital care under the Mental Health Act and had resided in secure psychiatric care for at least six months. One-to-one interviews were employed.

Results: Following a six-stage analysis process following interviews, three superordinate themes emerged: 1) Cultural Disempowerment, characterised by experiences of assumed or pathologised culture; 2) Beyond Culture, highlighted within degrading and dehumanising treatment from staff, contrasting with interpersonal diversity; and 3) Cultural Bias within Regimes, demonstrated by culturally bias practices and the ways in which service users learned to navigate the system.

Conclusions: These findings highlight the need for better cultural awareness amongst clinicians to improve the experiences of Black women receiving mental health care within secure psychiatric settings. Recommendations for staff training, policy development and implementing more effective clinical practice are discussed.

2.1 Introduction

2.1.1 Review Subject and Significance

This research aimed to explore Black women's experiences of cultural awareness in secure psychiatric settings in the United Kingdom (UK). The term 'Black' refers to people of African descent and origin, who may commonly be referred to as African, Afro-Caribbean, African-American, Caribbean or Black British. For the purpose of this study, 'experiences' refer to both positive and negative events that Black women face within secure psychiatric settings in terms of the context, environment, relationships and treatment. This project focused on cultural awareness which, for study purposes refers to the interconnected nature of social categorisations of race, gender and mental health lives in shaping participant's experiences (Lewis & Dyke, 2018).

Over-representation of Black Communities in Mental Health Services

A 2011 Care Quality Commission survey focused on people from specific ethnic backgrounds experiencing mental health problems concluded that people from Ethnic Minorities remain disproportionately represented in inpatient settings, with no indication of improvement (Care Quality Commission, 2011). Hospital admissions were between 19% and 32% above average amongst Black Caribbean, Black African and mixed White/Black groups, which was two times higher than the average for 2010 (Walker, 2020). Supporting these findings, the Mental Health Foundation (2016) identified Black or Black British people as the highest proportion of ethnic minority groups to have received inpatient mental health treatment in the year 2014 to 2015. The over-representation of Black people detained under the Mental Health Act (1983), despite this population also being under-represented in community treatments including counselling or therapy, remains an ongoing issue across the UK (Cabinet Office; Race Disparity Audit, 2017), which suggests that support for Black people in accessing primary care to prevent deterioration in mental health requires further attention.

Across the UK, secure psychiatric services provide specialist treatment for individuals with complex presentations who often pose a significant risk of harm to themselves or others (Bui et al., 2016). A majority of service users within these environments are convicted offenders detained under the Mental Health Act (1983). A 2017 independent review into the treatment and outcomes for Black, Asian and Minority Ethnic individuals in the Criminal Justice System (CJS), reported that despite forming 14% of the general population, Black, Asian and Minority Ethnic men and women formed 25% of the forensic population, costing taxpayers an estimated £309 million per year (Lammy, 2017)**.** Whilst primary care is the main pathway for accessing mental health treatment (Tanskanen et al., 2011), Black people remain more likely to enter mental health services through the criminal justice system and receive treatment in secure settings (Cooper et al., 2013). Despite the knowledge evolving from research, reports, reviews and recommendations, there remains an ongoing disproportionality of representation faced by Black people in mental health and CJS (Walker, 2020).

Existing literature suggests the disproportionate over-representation of Black people in mental health services could be attributed to a range of factors including social disadvantage, racial discrimination and cultural misinterpretation resulting in misplaced diagnosis (Sharpley et al., 2001; Singh et al., 2014; Alarcon, 2009). More recently, however, the Commission on Race and Ethnic Disparities Report (2021) received much criticism from professional bodies such as the Association of Clinical Psychologists due to the reports' failure to acknowledge the extent to which the needs of ethnic monitories, including Black communities, remain neglected within mental health services (Rahim & Jameel, 2021). For example, only three pages out of the 258-page report identified the well-established, significant inequalities experienced amongst ethnic minority populations within mental health services. Within this, however, the report failed to consider whether over-representation of ethnic minority populations within the CJS contributed to experiences of inequality and unfair treatment within this sector; and disregarded consideration of how institutional racism may contribute to or exacerbate inequalities amongst this population. The Commission on Race

and Ethnic Disparities Report (2021) exemplifies the longstanding omission of acknowledgement of unfair treatment experienced by ethnic minority populations in mental healthcare settings across the UK. This further highlights the need for first-hand accounts of mental healthcare treatment experiences within ethnic minority populations to be incorporated into literature in order for these well-established disparities to be sufficiently acknowledged, addressed and improved.

Care Provision Improvements for Women in Secure Psychiatric Settings

The provision of secure mental health care for women in England has undergone significant changes over the last two decades, primarily in response to the growing consensus that women's needs are not being met within secure environments (Department of Health, 2004). In response to the inappropriate number of women being admitted to high secure hospitals despite not fulfilling high secure criterion, Women's Enhanced Medium Secure Services (WEMSS) were developed across England to deliver an alternative model of care for service users with complex mental health needs within a more suitable level of security (Edge, 2005). The WEMSS model aimed to improve service user experiences of therapeutic engagement, quality of life and relational security, whilst opportuning faster movement through treatment pathways (Edge et al., 2017). By 2007, Rampton Hospital was the only national high secure service for women.

More recently, as outlined in the NHS England Long Term Plan Implementation Framework (Thomas, 2019), Women's Secure Blended Services were developed nationally as a model of care aiming to improve relational security for women through trauma-informed care provision, whilst reducing transitions between secure environments by blending medium and low secure services in a single location. Whilst organizational changes to care provision have been implemented to meet the needs of women in secure mental health settings, there remains a need for services to consider the needs of Black women in these environments,

especially given their over-representation within secure settings (Lammy, 2017). In line with this, Women in Secure Hospitals (WISH) have identified a clinical demand for the needs of Black, Asian and Minority Ethnic women to be appropriately met in secure psychiatric settings (WISH, 2019).

2.1.2 Previous Literature

It appears that a majority of research into women in secure psychiatric settings either has a quantitative focus on service user characteristics (Bartlett et al., 2014; Ribeiro et al., 2015); or qualitatively captures the experiences and views of clinicians (Somers & Bartlett, 2014; Bartlett & Somers, 2017; Beryl et al., 2018). Following the development of WEMSS, Walker et al. (2019) conducted the first qualitative study capturing service user experiences of the enhanced secure setting compared to standard Medium Secure care provision for women in the UK. Forming part of a larger evaluative study, the research highlighted service user experiences of relationships with staff, challenges of living with other women and personal involvement in care and treatment; and suggested similar experiences in these areas amongst women in WEMSS and Medium Secure Settings. The main differences between services were in relation to the amount of pre-transfer information women received and levels of staff support. Although service users gave predominantly positive feedback about their current services, as demographic information was not provided within the research, the extent to which findings could be applied to the experiences of Black women remains unknown, and thus still requires further exploration.

Whilst literature has long acknowledged a disproportionate over-representation of Black women within secure psychiatric settings (Boast & Chesterman, 1995; Shubsachs et al., 1995), globally, there does not appear to be any recent literature which, explores the lived experiences of Black women in secure psychiatric settings specifically. Stafford's (1999) report into the experiences of Black women in secure hospitals captured service user's experiences

of feeling threatened in secure provision, particularly within male-dominated Medium Secure Units. Stafford further reported service users' descriptions of ill treatment being classed as "legitimised" assaults against them. This included being exposed to harassment and abuse, feeling violated by staff administering forced treatment, and the underlying causes of their distress being neglected.

In more recent times, studies of race and mental health in secure psychiatric settings tend to be gender-blind (e.g. Coid & Dunn, 2004; Holley at el., 2016); whilst studies based on gender predominantly capture the experiences of Black males or White women (e.g. Pashley et al., 2018). Despite Parkes and Freshwater's (2012) acknowledgement of Black women's over-representation in secure psychiatric hospitals, there were no Black participants (n=11) in their qualitative research into the phenomenon of psychological distress amongst women residing in secure psychiatric hospitals. Therefore, the recommendation for treatment plans combining medication, informal support networks, intensive individual therapy and active engagement in a therapeutic programme requires further exploration to establish applicability to the needs of Black women in secure settings.

1.1.3 Rationale and Research Question

There are two main reasons the current study was undertaken: firstly, despite an awareness that Black women are over-represented in secure psychiatric settings, to date, there had been little research exploring the lived experiences of this population. Secondly, the most recent qualitative research into women in secure psychiatric settings appeared to focus more on staff experiences than those of service users. Therefore, there remains a need for services to become aware of how the structural position of Black women in such settings sustains their fear and anxiety (Stafford, 1999). Thus, the current research attempted to bridge the longstanding gap in literature by addressing the following research question: *"What are Black women's experiences of cultural awareness in secure psychiatric settings in the UK?*

2.2 Methods

2.2.1 Research Design

The research took an interpretivist epistemological position to understanding experiences of cultural awareness amongst Black women in secure psychiatric settings. Interpretative Phenomenological Analysis (IPA) was employed as a phenomenological qualitative approach. This was concerned with exploring the in-depth lived experiences in its own terms to capture how people make sense of their life experiences (Smith et al., 2009). As a double hermeneutic, IPA entails the researcher trying to make sense of the participant trying to make sense of their experiences (Smith et al., 2009; Alase, 2017). It is also considered an idiographic approach, in that experiences obtained from participants aim to contribute to the current level of understanding of phenomena based on individual experiences, rather than findings being generalised (Hefferon & Gil-Rodriguez, 2011). Thus, IPA was consistent with an interpretivist approach.

2.2.2 Sampling Design and Participants

The research used a non-probability, purposive sampling design, offering the researcher greater insight into the experiences of participants (Smith et al., 2009). Within phenomenological research studies, participants are required to identify amongst a homogeneous population, for the researcher to develop an understanding of the research subject-matter (Alase, 2017). Consistent with IPA methodology, this also ensures that participants share characteristics which allow them to be closely defined in a way that maintains the significance of the research question (Smith & Osborn, 2008). Participants were recruited based on a predefined inclusion criterion, detailed in Table 8.

Table 8

Inclusion and Exclusion Criteria for Recruitment of Participants

Criteria	Inclusion Criteria	Exclusion Criteria
Ethnicity	Self-identify as: Black British African Caribbean	Self-identify as any ethnicity other than Black
Gender	Female	Any other gender
Age	18 years and above	Below 18 years
Treatment in a secure psychiatric setting	Experience of residing in a secure psychiatric setting in the UK (current admission or discharged up to 1 year)	No current or prior experience of residing in a secure psychiatric setting in the UK Experience of residing in a secure psychiatric setting for less than a year
Mental state	Assessed as stable in mental state at time of participation	Participation likely to cause emotional distress
Language	Able to understand spoken and written English	Unable to understand spoken and written English

This research focused on the experiences of adult Black women who had resided in a secure psychiatric setting. The focal population for this research was women aged eighteen years and above, who identified themselves as Black. The terminology of ‘identifying as Black’ was important, as it was possible that women of mixed heritage may identify as black; and would have therefore been discriminated against if they were to be excluded for not meeting a biological or standard demographical criterion (e.g. Wilson, 2001).

Additionally, participants were required to have experience of residing in a secure psychiatric setting for at least one year. This was in the hope that the experiences described by women were less informed by the admission process. Former in-patients were also invited to participate if they had been discharged from a secure psychiatric setting up to two years prior to interview, in the hope that they could still recall past experiences as inpatients. Although prisons across the UK contain separate healthcare facilities which provide care to offenders with mental health difficulties, these environments were excluded from the current research.

There were no offence-related criteria for inclusion to this research, as it is acknowledged that secure psychiatric services are not exclusive to individuals with forensic histories; and may provide treatment pathways for individuals whose complex needs and challenging presentations made it difficult for them to be managed adequately within mainstream mental health services. For instance, it is reported that 10% of Black patients in forensic settings have not committed a crime, having been admitted to secure units from general psychiatric wards (Thornicroft, 2006). As the objective of this research focused on race and gender, there were no diagnostic restrictions to this population.

Unfortunately, ethnic minority groups are often excluded from research due to the limitations of accessibility and language barriers. Due to time constraints and restricted facilities for translation, participants were required to be able to speak and understand the English language to an appropriate standard. This was with the aim of reducing the likelihood of misinterpretation of language use and terms described during the interviewing process.

Recruitment occurred across three forensic mental health services in the West Midlands. Initially, a Women's Blended Service within an NHS secure psychiatric hospital was approached to discuss the research and disseminate information sheets for potential participants. However, due to low participant uptake at the initial site, a mixed gender community NHS forensic service and a women's unit within a voluntary sector secure

psychiatric hospital were also approached as potential recruitment sites. Staff on service users' behalf, or service users themselves then contacted the author to participate.

IPA studies usually entail relatively small sample sizes, which still enables researchers to sufficiently engage with the material provided from each participant (Smith et al., 2009). Creswell (2013) further suggests an important point of qualitative research is to describe the meaning of a phenomenon for a small number of individuals who have experienced it. With small sample sizes, researchers are also able to examine similarities and differences between participants (Smith & Osborn, 2008; Smith et al., 2009). Subsequently, seven[1] women were recruited to participate in the study and their demographics are detailed in a pen portrait, provided in Appendix 6.

2.2.3 Measuring Instruments (Materials)

A semi-structured interview schedule guided data collection. Open-ended questions were presented to participants, providing them with the opportunity to use their own voice in narrating their lived experiences (Hefferon & Gil-Rogriguez, 2011). As within the IPA methodology, semi-structured interviews also supported the development of a positive rapport between researcher and participant. Smith et al. (2009) acknowledge that the most important thing at the beginning of the interview is to establish a rapport with the participant; as unless the researcher succeeds in establishing this rapport, they are unlikely to obtain trust from the participant. The questions were designed to prevent the researcher obtaining responses that imposed their understanding of the research topic onto participants (Smith et al., 2009). The interview schedule included, 'Can you tell me of any experiences of feeling valued and respected?' and 'Can you tell me about your experiences of service provision and whether

[1] One service user provided a written response to interview questions due to personal issues. The reflective chapter of this thesis details the participants' contributions with regards to ethical versus feasible recruitment with hard to reach populations (See Chapter 3).

you feel the current service meets your needs'. The full interview schedule is presented in Appendix 7.

2.2.4 Methods of Data Collection (Procedure)

This study employed one-to-one interviewing as the method of data collection. Due to social distancing regulations initiated in light of COVID-19, the interviews were conducted virtually utilising Microsoft Teams, a video linked software actively used within the services. To ensure the safety of the researcher and participants, and in accordance with establishment regulations (Smith & Osborn, 2008), interviews were remotely undertaken in a room with computer access which, afforded participants privacy.in a confidential location dependent on settings in which participants resided.

2.2.5 Ethical Considerations

Ethical considerations required particular attention for conducting research in forensic mental health services (Coffey, 2006). Ethical approval was obtained from the Coventry University Ethics Committee (ethics code P102447) on the 7th May 2020 (Appendix 8A). Ethical approval was also obtained through the Integrated Research Application System (IRAS; project ID 280065) for Health Research Authority (HRA) approval (Appendix 8B) on 21st August 2020. Thereafter, permission was granted from the Research and Innovation services within participating sites. The research was guided by the ethical standards of the British Psychological Society (BPS; 2014).

Informed Consent

Potential participants were provided with information regarding the nature of the research (Appendix 9), so that they could make an informed decision regarding whether they

wished to participate. This was provided during recruitment, through communication with clinicians and recruitment posters (Appendix 10). Women participants also had the opportunity to speak with the Chief Investigator directly and ask questions before consenting to participate in the study. Those who agreed to participate signed a consent form (Appendix 11), with any queries answered before the commencement of the interview. The semi-structured interviews also began with the Chief Investigator obtaining verbal consent, within which the consent form was reviewed as a mutual understanding between the participant and researcher. Consent was treated as an ongoing process, with the voluntary nature of participation emphasised throughout the study. Due to the forensic context and population, the participant information and debriefing information (Appendix 12) also acknowledged that participation would not impact on the treatment pathways for those who chose to participate, those who declined participation, or those who withdrew their consent during the study.

Confidentiality

Interviews were arranged to be conducted within a confidential environment which, could assure participants privacy. Participants were informed that they could stop the interview at any time if they believed their confidentiality had not been upheld. Participants were asked to choose a pseudonym which, would be used to describe them in the interview transcripts; and were informed that any information which could reveal their identity would be erased in the process of transcription. For security and data protection purposes, two participants required staff to remain in the room throughout the duration of interviews. The potential impact of staff presence during interviews is explored further in the reflective chapter of this research (see Chapter 3). There were no other staff or service users present at the time of the research undertaking interviews with the remaining participants, however, it was arranged for staff to be available for participants throughout and beyond the interview process.

Furthermore, consistent with GDPR regulations and data protection, the data collected was stored on Coventry University's secure, password protected drive and was anonymised once transcribed.

Risk

Given the nature of this research area, all participants were provided with information about how to access emotional support should they become distressed (Alase, 2017). There were no instances of participants expressing emotional distress or opting to pause or discontinue with the interview process.

2.2.6 Method(s) of Data Analysis

All interviews were audio-recorded, transcribed verbatim and analysed using IPA. The method of IPA data analysis was conducted as six-stage process (Smith & Osborn, 2008), detailed in Table 9.

Table 9

IPA Procedure (Smith & Osborn, 2008)

Step	Description	Procedure
Step 1	Reading and re-reading	The initial stage involved listening to the audio recording and reading the transcript several times. This enabled the researcher to become immersed in the data and enter the participants' world. At this stage, the researcher also noted reflections about the interview experience including initial interpretative comments.
Step 2	Initial noting	During the second stage, the researcher used their initial notes to formulate a concise phrase which, was grounded in the detail of the participant's account. As a double hermeneutic, this integrated the participant's lived experience with the researcher's interpretation of these experiences.
Step 3	Developing emergent themes	The next stage involved identifying connections between emerging themes; and grouping them together according to conceptual similarities under a descriptive label.
Step 4	Searching for connections across emergent themes	The following stage compiled themes across the whole transcript before looking for connections and clusters.
Step 5	Moving to the next case	Once the emergent themes appeared meaningfully connected, they were presented to be reflected in a more structured manner. This process was repeated for each participant.
Step 6	Identifying patterns across cases	The final stage required the researcher to identify patterns across all participants to derive a series of themes and sub-themes.

The researcher and academic supervisors of this research jointly reviewed coding, interpretation and analyses to ensure validity, consistent with Yardley's (2000) recommendations for validity in IPA research with regards to transparency, rigour and impact. With consideration of the researcher's position as a Black woman interested in the lived experiences of Black women in secure psychiatric settings, bracketing interviews were

undertaken with the research team to ensure the researcher remained mindful of personal and professional experiences during data collection and analysis (Alase, 2017). Evidence of analysis, including transcription coding and thematic mapping is provided in Appendices 13A to 13D. Further, Chapter 3 describes how the researcher managed their subjectivity whilst conducting this research; and ensured that the data collected was co-created with participants (Banister et al., 1994).

2.3 Findings

IPA analyses of interviews with participants elicited three super-ordinate themes (See Table 10). *Theme 1: Cultural Disempowerment* refers to the loss of cultural identity and autonomy experienced by Black women following admission to a secure psychiatric setting. *Theme 2: Beyond Culture* highlights the secure psychiatric hospital practices and women's experiences that fell outside of culture. *Theme 3: Cultural Bias within Regimes* encompasses cultural policy and process bias in secure psychiatric care. Supporting participant quotes are supplemented by excerpts in Appendix 14.

Table 10

Super-ordinate Themes and Sub-ordinate Themes

Super-ordinate Themes	**Sub-ordinate Themes**
Cultural Disempowerment	Racial and Cultural Assumptions
	Pathologised Culture
Beyond Culture	Degrading and Dehumanising Treatment
	Interpersonal Diversity
Cultural Bias within Regimes	Culturally Biased Systems
	Navigating the System

2.3.1 Theme 1: Cultural Disempowerment

Black women entered secure settings feeling a great deal of emotional insecurity as Brenda described:

> *"I was scared. Erm, like I've never known anything about hospital before and, that it's the unknown. I was quite scared and yeah, I didn't know what to expect."*
>
> (Brenda, lines 100-101)

as well as uncertainty: ***"****My doctor didn't tell me when I'm 'gonna leave, she said, 'In the future you might'."* (Hodon, lines 118-119). However, these women also felt a sense of cultural disempowerment, especially through the *Racial and Cultural Assumptions* that were made and the automatic *Pathologising* of socio-cultural difficulties.

Racial and Cultural Assumptions

Communication between staff and service users was often influenced by racial stereotypes and limited cultural awareness. For example, poor communication between women and staff resulted in culturally bound misinterpretations of service users' use of language and its meaning, as Julie described:

> *"A Black member of staff put in my ward round report…She's talking patois in her language, what we can't really understand… and I says 'it wasn't that I was talking patois!'"*
>
> (Julie, lines 138-144)

Additionally, in what echoed historical practice of Black communities receiving different treatment from their non-Black peers, participants experienced implicit segregation on the basis of their colour, as Brenda recalled:

> *"I was playing volleyball and then the staff member picked teams and it ended up being Black people versus White people. That was just a mistake I think and I mentioned it and we had a little giggle and then the next two times, he did the exact same thing, put Black people against White people...The first time it was quite funny cause it was a mistake but after that I thought like that was a bit dodgy."*
>
> (Brenda, lines 536-541)

Similarly, Nina described receiving contrasting treatment from her non-Black peers, which she attributed to her Black identity:

> ***"****At one point, one of the girls, a White girl, she asked for her nail clippers [in storage] and they allowed her to have it... And then when I asked if I could have mine I was told no and I thought is it because of my race… I thought, is that because I'm Black so yeah for me that was one issue.****"***
>
> (Nina, lines 157-161)

Pre-judgements were also based on cultural misperceptions of Black women's body image, as Brenda described:

"I think because the way I am, people expect me to be a six-foot Black woman let's put it that way [laughs] because obviously they read about me before they get to see me, they expect the worst from me. Someone's actually said that to me before, a staff member."

(Brenda, lines 308-322)

Pathologised Culture

Participants' vulnerable positions as Black women with mental health difficulties were often overlooked, resulting in the pathologising of genuine concerns regarding racial prejudice. For example, whilst Hodon acknowledged that she experienced mental health difficulties, she recalled the challenge of staff viewing the social problem of racial hatred or stalking as a symptom of paranoia:

"When you tell them 'I was in the shops and I think somebody was following me,' they don't understand, they think like, erm, like 'you're paranoid somebody's following you in the shop.' They don't understand things like that."

(Hodon, lines 457-459)

Additionally, Black women's cultural expression of emotions were pathologised by staff as being incompatible with secure psychiatric care environments, as Julie expressed:

"I think for us as cultural people, when we go to church, we're happy! We express vibrance, sing, clap, loud, do you know what I mean? And I think that's just the way we express. When my dad used to play dominoes, my dad used to express himself

through dominoes. People would think that they was fighting!... If they played dominoes now, they'd press the alarms!"

(Julie, lines 219-225)

Supporting women without awareness of their history in their cultural context resulted in the development of culturally bias risk assessments and formulations, with treatment aspects such as insight determined by Western sociocultural practices, as Hodon described:

"When you go to a psychology session, and you tell them what you experience, they don't understand… And I don't think there are enough Black psychologists… They didn't understand my childhood, I grew up in a warzone in Somalia. And I used to carry a knife, I used to kill animals, skin the lamb, skin the beef and the cow, stuff like that. They don't understand things that you can do there."

(Hodon, lines 451-469)

Furthermore, whilst therapeutic models including Dialectical Behaviour Therapy (DBT) promoted psychosocial skills development (Linehan, 1993), Julie described how, as a structured and culturally insensitive behavioural intervention, DBT had ill-prepared her for life beyond that particular care setting:

"Coming from a Dialectical Behavioural Therapy Ward, a DBT Ward, which was very structured, where I'd been told be quiet like, my banter was like put down... So I'd have to sit on my hands when I wanted to pipe up, or anything that like was like 'blud, fam,' yeah I wasn't allowed none of that…So when the noise that people was making [in

new hospital setting] I was like [gasps]…So to adjust back to that it was a bit nerve-wracking."

(Julie, lines 211-217)

Throughout the women's accounts, it was evident that attempts at receiving emotional support left participants feeling unheard and uncared for. Brenda, for example, perceived that staff seemed more prepared to provide medication than to interpersonally support women with emotional difficulties:

"Sometimes [staff are] like 'oh you need to take meds' and I'm like I don't need meds I need this kind of support… I just need someone to listen… Like sometimes it's just an easy way out for them. Inject you, put you in seclusion for the night and then deal with you the next day."

(Brenda, lines 272-277)

Participants' accounts exemplified how the interconnectedness of race, gender and mental health placed Black women in more vulnerable positions in secure settings. Cultural disempowerment emerged due to an emphasis of staff pathologising women's behaviour rather than understanding its socio-cultural context.

2.3.2 Theme 2: Beyond Culture

Beyond feeling disempowered as Black women, participants experienced *Dehumanising and Degrading Treatment* from the point of admission to secure settings.

However the *Interpersonal Diversity* amongst staff and peers also enabled participants to experience more positive relational encounters within secure psychiatric care.

Dehumanising and Degrading Treatment

Unpleasant experiences characterised by inhumane treatment from staff were encountered from the point of admission to secure psychiatric care, with secure hospital processes including lengthy seclusion stays precluding compassionate care for service users. For example, Sarah shared:

> *"When I went in [secure hospital] I went straight into seclusion for two months. It felt really degrading, I'm not 'gonna lie…I couldn't have no clothes, I had to wear anti-rip top and anti-rip shorts… When I was showering, I had to use loo roll to dry myself, I couldn't even brush my teeth for two months because they would not give me a toothbrush. Erm, I couldn't wear anything on my feet so, I had to be barefoot and it used to hurt my feet for hours. Er, if there were male staff on in the seclusion, watching me at the time, I had to deal with it, and the male staff were watching me showering me you know, erm, and it really traumatised me at the time."*
>
> (Sarah, lines 192-199)

Brenda further detailed the traumatic impact of gender insensitivity in staff allocation for observations during the admission process:

> *"Well, I was on my monthlies, and I was in seclusion and they didn't give me anything to wear or-, I was literally just bleeding. And I was crying cause there's a male on my*

obs, watching me and stuff, and I'm bleeding and they won't give me nothing and that was so degrading."

(Brenda, lines 348-351)

These accounts illustrated the emotional fear, powerlessness, and dehumanising treatment experienced by many women participants upon their arrival to secure hospital.

Unequal power dynamics with clinical staff left participants feeling belittled and disrespected. Sarah, for example, recalled feeling that her fragile mental state resulted in unfair, undermining treatment from some staff:

"I honestly do feel like they think, because we've got mental illness that they can just treat us like crap. Like they can treat us like children… And that's what I feel like half the time… I dunno, we feel degraded sometimes, not gonna lie."

(Sarah, lines 418-419)

The lack of respect in interpersonal relationships with staff understandably intensified feelings of frustration and psychological distress amongst participants, leaving women fearful of the consequences of challenging staff regarding their mistreatment as Sarah narrated:

"From the very start of being in [secure hospital] to the very end, I just felt that like, if the staff picked up on you feeling crap or low or angry or annoyed, whatever the emotion was as long as it was negative, they kind of fed off it. It's almost like they liked it. And some of the staff would feed on it that much that they would provoke you to be

even more annoyed, angry or whatever, to the point where you blow up so they can just-, I dunno, give you consequence, punish you in some sort of way."

(Sarah, lines 218-223)

Participants also considered whether as Black women, perceived unfairness as service users could also be attributed to sexism and racism, as Brenda expressed, *"Sometimes I do wonder, like did I get treated differently because of being a female and my race?"* (Brenda, lines 169-170).

Interpersonal Diversity

Whilst it is evident that interpersonal relationships with staff encompass a wealth of unpleasant encounters, positive relational encounters also enabled participants to develop a sense of trust and feeling listened to, as Denise described: *"I felt valued and respected at [ward] meetings, where I had my chance to speak and voice my opinions."* (Denise, line 5). Participants sought therapeutic relationships with staff that promoted safety, confidence and emotional stability, although it was acknowledged that it was important to at least try to form positive working relations, as Julie shared:

"I have good working relationships with all my team, yeah…Some staff you're gonna but heads with but it's about turning that around, just to try and have a working relationship with all of them."

(Julie, lines 472-476)

Women felt supported by staff as they progressed through their care pathways, as Brenda recalled:

> ***"****When I have ward rounds and stuff, the staff and the Doctors actually listened to me and actually listened to my opinion and helped me progress and stuff."*
>
> (Brenda, lines 376-377)

The importance of feeling listened to and taken seriously was evident across all the participants' narratives, with the above quotes exemplifying how staff actively attempted to meet women's emotional needs.

2.3.3 Theme 3: Cultural Bias within Regimes

Secure care hospital regimes implement policies and practices that promote a *Culturally Biased System,* within which, Black women are conditioned to develop maladaptive ways of *Navigating the System*.

Culturally Biased Systems

With admission regimes influenced by staffs' initial assumptions that new service users would be violent, participants experienced intimidating first impressions of secure psychiatric care. For example, a heavy staff presence awaited Brenda upon her admission to secure psychiatric care, as she recalled:

"Erm, scary. I think what made it worse was when I arrived at [High Secure Hospital], there was like 16 to 20 members of staff waiting for me."

(Brenda, lines 150-151)

Policy-driven admission processes including using seclusion upon arrival caused further emotional distress to participants who had no prior experiences of being in a secure hospital, re-traumatising those particularly who had experienced earlier life traumas as Nina shared:

"[In seclusion] There was a lot banging noises, like as if people were fighting behind doors and that. It was quite scary. I was getting more negative thoughts there... It was quite scary actually, I didn't feel safe."

(Nina, lines 97-113)

When racially targeted by peers, as experienced by Julie: *"Since I've been here, this is the worst place where I've felt a racist attack since I've been here in [secure hospital]."* (Julie, lines 397-398), hospital policies were not implemented by staff, leaving Black women feeling vulnerable. With respect to this, Julie felt unprotected and let down by staff:

"[Peer] just was left there to continue goading, it was me that had to remove myself… And then staff have just said well, erm, there's nothing we can do, she knows what she's doing is wrong, she's not very well at the moment and that's not a good enough excuse for me."

(Julie, lines 409-420)

A dominant theme which, exemplified the ways in which, racial and cultural identities had been disregarded in hospital regimes, was in catering to participants' personal care needs as Black women. For example, the significance hair has in Black culture and identity was neglected in secure hospital care provision, requiring Black women to rely on staff to access off-site stores for haircare needs, as Sarah shared:

> *"If we haven't got leave, because the shop doesn't provide Black hair care, [staff] would go out for the Black service users and get them some hair care products… And we have asked them to get some in but because of the order site they use, the products are not listed."*
>
> (Sarah, lines 806-820)

In relation to this, Julie recalled witnessing the detrimental effect of not having Afro haircare needs catered to for a fellow service user:

> *"In the private sector, there was a mixed race girl there and she had such beautiful hair, but it was tighter like afro…She said, 'I couldn't even put a comb through it.' It'd been left that long and it had loc'd because they had no products in the secure unit to do her hair that it had got loc'd up."*
>
> (Julie, lines 319-330)

Whilst hospital regimes offered opportunities to celebrate cultural events, little consideration was given to specific Black communities, as Hodon described: *"They used to do Christmas and they used to do Eid as well. They didn't have Black History month, no."*

(Hodon, lines 411-412). Furthermore, Julie recalled the amount of persistence required for the Black Lives Matter movement to be acknowledged:

> *"I was pushing for Black Lives Matter here… With a lot of force, we had a meal, which wasn't cooked properly… and we done a Black Lives Matter poster, that's it really… I think really and truly with what's been going on in the world, we could've done a bit more."*
>
> (Julie, lines 256-268)

Thus, participant accounts of the recognition and effort put into events specific to Black communities within secure hospitals suggested they had been acknowledged and celebrated for tokenistic purposes.

Navigating the System

Approaches to coping and adapting were characterised by strategies which, to participants, demonstrated emotional growth and resilience; yet were in fact unhelpful in preparing service users for life beyond secure care. For example, from feeling disempowered, unsafe, and vulnerable during her hospital treatment, it appeared Sarah had become passive in order to regain a sense of control and protect herself, as she shared: *"Someone could hit me and I could keep calm. That's how calm I am now. There's pros and cons with it really."* (Sarah, line 498). Similarly, Lisa reflected on taking a dignified and insightful approach to racism from a fellow service user and shared:

> ***"…****She was in her sixties. They had a different mentality… And she was ill too, so I didn't take notice much… I didn't take it personally, I just left her, I stopped talking to her, I was doing my thing."*
>
> (Lisa, lines 383-389)

Whilst this was described as an adaptive response to an interpersonal challenge, it also exemplified the perpetuated experiences of disempowerment experienced amongst Black women as service users who had not felt protected by staff following mistreatment.

2.4 Discussion

This study explored experiences of cultural awareness amongst seven Black women who had received secure psychiatric care in the UK. Three superordinate themes were developed: Cultural Disempowerment, Beyond Culture and Cultural Bias within Regimes.

2.4.1 Integration of Results with Previous Literature

It is recognised that forensic services offer unique challenges in service user experiences (Drennan & Alred, 2012), with the implications of sanctions and restrictions making recovery more complex (Turton et al., 2011). Whilst clinical practice improvements have resulted in the development of enhanced care models such as WEMSS to support women with complex mental health needs (Edge, 2005), this study captured that from the point of admission, Black women continue to experience secure psychiatric care as a difficult system to navigate, with security and risk management prioritised over humanistic, culturally-sensitive care.

Upon admission to secure psychiatric care, participants were subjected to uncaring treatment underpinned by risk aversive practices including immediate entry into seclusion and removal of personal clothing in exchange for anti-rip clothing. Consistent with existing literature on women's experiences of secure mental health care (Walker et al., 2019), emotional distress was intensified by the additional challenge of adapting to the secure care environment, and the fear related to uncertainty and loss of freedom as a consequence of involuntary admission (van Daalen-Smith et al., 2020). Further, gender-insensitive clinical practices including male staff observing new admissions in seclusion heightened participants experiences of degrading and dehumanising treatment. This echoed Stafford's (1999) findings within which, male-dominated workforces resulted in Black women feeling vulnerable and threatened in secure care provision, which is likely to be intensified for service users with pre-existing psychological trauma (Walker & Towl, 2016). Consistent with theoretical frameworks of Black Feminist Criminology (Potter, 2006), findings further suggest that existing Criminal Justice Systems inherently dehumanise Black women, and this is enhanced within secure psychiatric care.

It is well recognised that expression of mental health difficulties is often layered in culturally specific nuances (Memon et al., 2016), which can be lost within service user and healthcare provider interactions. Cultural disempowerment experienced amongst participants was exemplified within an assumed understanding of language and the perceived risk of violence becoming enmeshed with Black women's physical image. These experiences correspond with Lammy's (2017) recognition of unconscious, unintended and implicit prejudice as fault lines within the CJS in the UK. Cultural disempowerment was also characterised by lack of understanding of the sociocultural contexts within which Black women's experiences exist, resulting in the development of culturally rigid psychological formulations to inform risk assessment and treatment pathways. Participants felt that clinicians' expertise were given privilege over their personal knowledge about their mental health and interpersonal experiences, which Memon et al.'s (2016) research also highlighted as a challenge for ethnic minority populations accessing mental health treatment. As

suggested by Alarcon (2009), this might further account for the disproportionate over-representation of Black people in secure mental health care.

Exploration of interpersonal relationships with staff and peers highlighted the importance of positive relationships for Black women in secure psychiatric care. Similar to existing literature, women in this study were critical of the medical model within secure psychiatric care, namely the assumption their distress could be managed with medication (van Daalen-Smith et al., 2020). Whilst the importance of relational security in promoting recovery for women's mental health has been captured in both professional guidance and research (Royal College of Psychiatrists [RCP], 2010; Parry-Crooke & Stafford, 2009), this study highlighted that for many Black women in secure care, experiences of disempowerment are exacerbated by poor relational security. This was exemplified by participants feeling unprotected when racially targeted by peers and aligned with Mezey et al.'s (2005) findings that non-physical abuse such as bullying and intimidation may be increased in women-only services. However, despite recalling unpleasant interpersonal encounters, participants were able to draw upon positive relational experiences with staff, characterised by feeling listened to, taken seriously and respected. This corresponded with literature which, describes these as particularly important for secure care service users who spend most of their time with staff and have few opportunities for relationships outside of hospital (Mezey et al., 2010).

Walker et al. (2019) further acknowledge effective management of interpersonal relationships as an important contributor to relational security for women in secure psychiatric care, particularly for individuals who have a history of complex trauma. Participants described how staff did not respond to incidents of racism in a manner which empowered service users, or at least, ensured their safety. Subsequently, participants developed passive strategies to support their navigation through what they experienced as oppressive and culturally biased secure psychiatric care. Literature suggests that throughout the world, Black people have a valid reason to mistrust systems and constructs controlled and defined by non-Black

counterparts, including the CJS (Ramirez, 2014; Sauchelli & Rosenberg, 2015). Nevertheless, as described by Aniefuma et al. (2020), Black women have proven to persevere through Criminal Justice Systems despite experiencing mistreatment, however, tend to suffer silently and bear their trauma. Experiences detailed in this study highlighted how participant's success in navigating through hospital care required them to remain quiet or walk away from interpersonal challenges, which they perceived as a resilient act. These experiences were perpetuated for those residing in therapeutic environments underpinned by structured and culturally insensitive psychological models and frameworks (e.g. Linehan, 1993) which restricted their self-expression. Whilst existing behavioural models have been culturally adapted to meet the needs of ethnic minority populations (e.g. Rathod et al, 2013) there are currently no published studies that consider the cultural responsiveness of DBT to the needs of Black service users (Pierson et al., 2021).

The Commission on Race and Ethnic Disparities report (2021) acknowledge that in current UK practices, "There is certainly a class of actions, behaviours and incidents at organisational level which cause ethnic minorities to lack a sense of belonging." (p.35). Similarly, this study highlighted how secure care provision and regimes do not accommodate for personal care or cultural needs of Black women. Correspondingly, Napier et al.'s (2014) review identified a systematic neglect of the impact of culture on health, with Wilson et al. (2018) regarding this as the largest single barrier to the advancement of health across the world.

2.4.2 Clinical Implications

Secure psychiatric care settings could benefit from the development of psychologically-informed training for staff to promote culturally competent services, with the aim of eradicating cultural bias in clinical practice and decision making. In considering experiences specific to Black women, Jones and Harris (2019) draw upon Black feminist

perspectives for the implementation of theories and practice interventions to support Black women in distinguishing their personal struggles from structural constraints. The Black feminist perspective is regarded as a multifaceted concept made up of beliefs, values, and assumptions based on how the service user, supporting staff and other stakeholders experience and interpret their psychosocial realities. This encompasses challenges, and strengths, thereby moving Black women's experiences from models of pathology to those of wellness (Jones & Harris, 2019).

Culturally responsive adaptations to secure psychiatric care could support the balance of managing risk whilst promoting safety and empowerment for Black women. This could also improve collaboration during assessment, formulation and intervention processes. For example, as a culturally inclusive alternative to understanding psychological distress from a diagnostic perspective, the Power Threat Meaning Framework (Johnstone & Boyle, 2018) could be effective in supporting Black women and supporting staff to understand the bio-psychosocial factors which impact on their experiences as service users. Within this, adopting an intersectional lens to considering how race, gender, culture and mental health interact and enmesh would improve clinician's understanding of Black women's sociocultural experiences and care needs in secure mental health settings (Philips & Webster, 2013), particularly as culture is a determinant of mental health in its own right (Kirmayer & Jarvis, 2019).

Staff would benefit from opportunities to reflect on their current practices and develop confidence in challenging current practices which, prioritise risk over compassionate care. Literature has highlighted that the difficulties experienced by staff supporting women in secure care, is mitigated by personal motivation, counselling and supervision, all of which are important in managing the emotional intensity of working relationally (Beryl et al., 2017). This is of particular importance for staff who recognise the challenge in providing real choices for women who are involuntarily detained (Walker et al., 2017). Within this, whilst the importance of gender-sensitive practice in mental health settings is recognised in existing UK government policies and international reports (World Health Organisation, 2007; Department of Health and

Social Care, 2018), current regimes for admission to secure psychiatric care require revision to ensure women feel safe when being observed in seclusion. This may improve relational security between service users and staff from the point of admission. Further, Parry-Crooke and Stafford (2009) recognise the need for staff interventions that support peer relationships and reduce the risks of women being distressed or re-traumatised by the behaviours of other women on the ward. To assist, services could benefit from reviewing existing policies to ensure appropriate responses are in place for addressing interpersonal challenges such as racial victimisation.

2.5 Conclusion

2.5.1 New Knowledge Arising from the Research

This study makes an important contribution to the understanding of Black women's experiences in secure psychiatric settings in the UK. Experiences have been identified through three key interlinked themes underpinned by cultural awareness, or lack of. A consistent thread across all three themes was the role of staff and wider systems in impacting the service user experience, which has been lacking in previous studies (Staniszewska et al., 2019). Sub-ordinate themes further highlight the active ingredients of current secure psychiatric care provision, as well as the common causes of very poor experiences, and highlight focus areas for improving these.

2.5.2 Strengths and Limitations

Since Stafford's (1999) report, there have been no UK studies based solely on the experiences of Black women in secure psychiatric care, despite their over-representation in such environments (Lammy 2017). This study has started to bridge this gap by capturing Black women's experiences of cultural awareness in secure psychiatric settings. Purposive sampling

including current and former secure psychiatric care service users across three service sites ensured that a wide range of views are represented. With regards to the quality of the findings presented, increased confidence was gained by the first author's prolonged engagement with the data (Lincoln & Guba, 1985). Additionally, three members of the research team analysed the data and subsequent themes, which reduced the likelihood of researcher bias in interpretation of findings.

Due to social restrictions enforced in light of the COVID-19 pandemic, interviews with participants were conducted remotely. This may have compromised the openness and therapeutic engagement experienced between the interviewer and participants. For two service users, openness might have been further impacted from having a staff member present throughout the interview process for security purposes.

Despite small sample sizes being favoured in IPA methodology for phenomenological explorations (Smith & Osborn, 2008; Smith et al., 2009), caution must be exercised in terms of the generalisability of findings; although, the purpose of qualitative research is to transform and apply findings to similar situations in other contexts rather than to generalise them (Hefferon & Gil-Rodriguez, 2011).

2.5.3 Unanswered Questions and Future Directions

Service user experience is an important source of evidence that can drive the provision of high-quality health services (RCP, 2010). Prior to the Department of Health (2008) publishing guidelines for 'Mainstreaming Gender and Women's Mental Health', the importance of empowering women in secure psychiatric settings and giving them a voice had not been captured within clinical practice recommendations. There remains a need for more qualitative research capturing the experiences of Black women in secure psychiatric settings. Extending recruitment across the UK would determine the applicability, quality and strength of the current themes. Additionally, promoting Black women's engagement with service user forums, Patient

Advice and Liaison Service (PALS) and organisations including WISH (2019) might afford additional opportunities for having their voice heard at a more systemic, service-wide level. The identified themes can also be used to provide content for the development of culturally-sensitive service user experience questionnaires or surveys. Finally, including staff and service user views of inpatient mental health care could contribute to a more thorough understanding of facilitators and barriers affecting cultural awareness and secure inpatient care for Black women, leading to more comprehensive recommendations for clinical practice.

2.6 References

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Chapter III

Embracing the Researcher Identity: A Reflective Account

3.1 Introduction

For this chapter, I will be reflecting on the overall experience of conducting my research project, particularly the ways in which this impacted on me personally and in my professional role as a Clinical Psychologist. Whilst this chapter focuses predominantly on the empirical research in Chapter II, Chapter I is referenced where applicable.

Reflective practice is regarded as fundamental to the role of a Clinical Psychologist in transferring experience into learning and professional development through conscious, active, and critical analysis of one's own practice (Taylor, 2014). Furthermore, the British Psychological Society (BPS) recognises reflection as a valuable tool in supporting continued development through self-awareness (BPS, 20017). From a qualitative research perspective, reflective practice supports researchers in remaining mindful of how one's own role, personal biases and assumptions influences the research process (Berger, 2015). This also enables researchers to identify and implement alternative strategies and adaptations for future research and clinical practice.

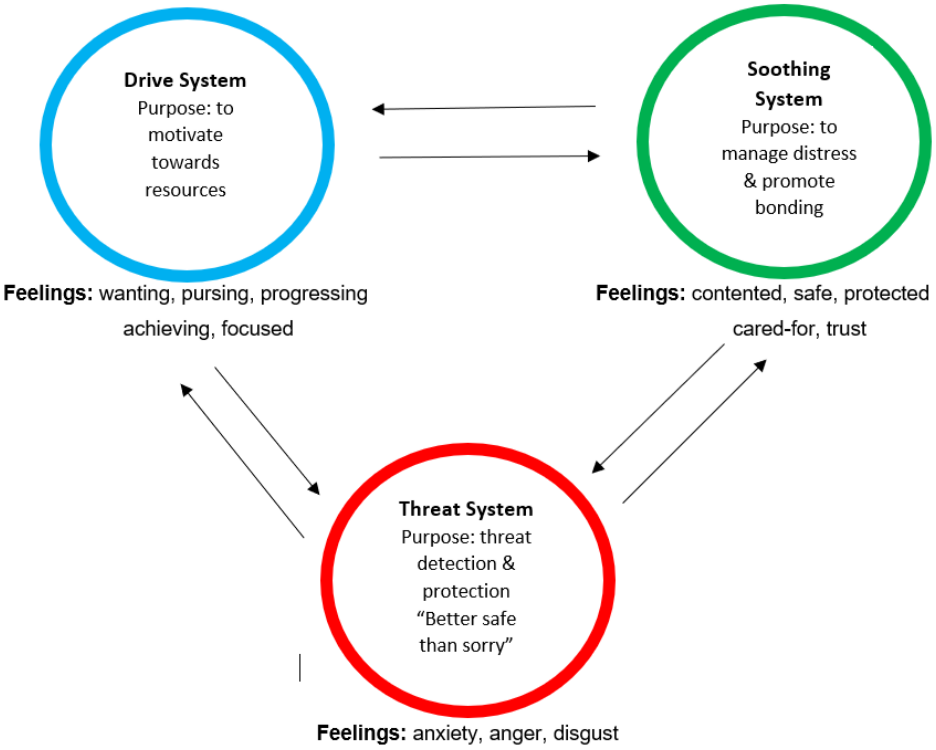
3.1.1 Compassion-Focused Reflections

A range of reflective models have been developed which, aim to ensure optimal learning has been achieved through academic and clinical experiences. Similarly, clinical frameworks are recognised across healthcare contexts for their utility in supporting experiences to be acknowledged and adaptively worked through. To support my reflections, I will be drawing upon a Compassion Focussed clinical framework in describing how I worked through experiences encountered throughout undertaking this research. Compassion Focused Therapy (CFT) by Gilbert (2009) is a model I have regularly drawn upon in reflective spaces throughout clinical training. The CFT model is personally appealing to me as it promotes the idea that experiences of inner warmth, safeness and soothing can transform problematic patterns of thoughts which, often result in emotional distress (Gilbert, 2009). CFT

highlights the importance of biological evolution and suggests that in order to survive, humans function from at least three emotion regulation systems as outlined in Figure 3.

Figure 3

CFT Emotion Regulation Systems (Gilbert, 2009)



Gilbert (2009) suggested that an undeveloped soothing system can impact on one's ability to regulate emotions related to anxiety, anger and self-criticism, making it even more difficult to manage challenges, which was what I personally experienced in varying intensities throughout completing my research project.

3.2 Motivations for Research

The experiences of women in forensic settings have been an interest of mine for several years. Throughout my previous clinical work experiences within women's inpatient services and secure psychiatric settings, I was conscious of how service users felt about being separated from their families, especially given that each clinical environment had different approaches to facilitate service users maintaining contact with loved ones. I also noticed disparities in the demographic make-up of staff compared to service users, which drew me to considering in more depth the experiences of Black women in these settings, especially given their over-representation within the Criminal Justice System (Lammy, 2017).

From conducting the initial literature search for my empirical project, it quicky became apparent that the needs of Black women had long been overlooked in recent forensic mental health literature, which either focused heavily on the experiences of staff, White women or Black men. However, despite feeling driven to bridge this gap, I was also curious about the additional barriers to hearing the narratives of this population. The significance of this became even more pertinent following the death of George Floyd in the United States of America on 25th May 2020. The events surrounding George Floyd's death were widely circulated on various platforms across the world, making it impossible for the longstanding issue of racial discrimination and inequality experienced amongst Black people to be ignored.

3.2.1 Remaining Driven by Curiosity

As a clinician, I have personally experienced how demographically matching service users and staff 'like-for-like' can either be complimentary or detrimental to the therapeutic alliance. For example, I have experienced many therapeutic encounters where demographic similarities have supported the development of a positive alliance, which I attributed to service users feeling understood and anticipating that their experiences might sound relatable and not met with judgement. In such instances, service users appear more likely to meaningfully

engage therapeutically. However, I have also personally experienced Black service users appearing resistant and reluctant to share personal experiences with me. Drawing upon the Social Graces (Burnham, 2012), I wondered whether certain personal characteristics, including being a Black clinician, activated service users' threat systems (Gilbert, 2009) by serving as a reminder of the oppression and judgement experienced by Black people in mental health services.

When formulating my research question, I was careful of not proposing a question I had already assumed the answer to. I was also mindful of Interpretive Phenomenological Analysis being a double hermeneutic which would require me as a researcher to try to make sense of how Black women make sense of their experiences in secure settings (Smith et al., 2009). Within this, I recognised the need to maintain an open-minded and non-judgemental stance in inviting these women to share their experiences with me. Furthermore, in seeking research participants open to sharing their 'experiences of fairness and unfairness in secure psychiatric settings' as my original research question, I was conscious of whether services would support the recruitment process if feedback might portray care provision as oppressive, discriminatory or unreceptive to the needs of Black women.

3.3 Problems Encountered

3.3.1 Sticking with my Passion versus "Better safe than Sorry"

Since early 2019, the COVID-19 pandemic has impacted on functioning in everyday life across the world (Mahase, 2020); with significant consequences to social, physical and mental health care (Ornell et al., 2020). At the time of developing my research protocol, research and ethics boards across the National Health Service (NHS) and wider organisations were prioritising research projects which, could provide some indication of how best to provide healthcare whilst the pandemic persisted. Consequently, studies outside of this area were given low precedence. On reflection, I believe I could have relieved myself of a wealth of

pressure by conducting a study to contribute to the COVID-19 evidence base. However, it was important for me to remain true to my interests and values by persevering with the original project. Thus, whilst feeling driven to continue with my original research project, my threat system was highly activated by the uncertainty this presented. Exploring these uncertainties in peer support groups supported me to reflect without ruminating, whilst ensuring that I continued to self-soothe to maintain a healthy work-life balance.

The decision to pursue my original project elicited a range of reservations. Firstly, I was mindful of how 'behind' I seemed in progressing with the empirical component compared to my trainee peers who had identified COVID-19 related projects or participants in non-NHS settings. Upon sitting the Integrated Research Application System (IRAS) ethics panel, approval of amendments required me to wait an additional month before I could advertise my project, by which time many of my peers had already completed data collection. I then started to consider the appropriateness of undertaking a research project within inpatient settings due to the impact the pandemic likely had on the service user experience overall, particularly amidst staff shortages, remote contact with loved ones and restrictions to activities of daily living. Additionally, I had conflicting feelings regarding the timing of conducting research with a population whose experiences of fairness and unfairness were likely to be exacerbated considering the co-existing pandemic and Black Lives Matter movement. Self-soothing through these potential barriers entailed taking time away from academic work to enjoy time with loved ones and maintain a balanced headspace. I then felt more confident in reminding myself why I had opted to remain with the project and remembering the wider context of navigating through challenging times. Fortunately, after completing my first interview, my passion and motivation felt rejuvenated, and the importance of service users having a platform for their voices and unique stories to be heard was reinforced, which strengthened my drive to remain committed to the project. This was also the first time I recognised the importance of ensuring that despite the conditions the pandemic had imposed on mental health services,

service users were still afforded the opportunity to contribute to service development through research participation.

3.3.2 Time-frames of Research

Due to the uncertainty of how long the pandemic would last, virtual interviews felt most appropriate for ensuring they could be completed within appropriate timeframes. However, I wondered how potential participants felt about interviews being conducted virtually with a stranger, so offered service users the opportunity to meet with me beforehand by virtually attending ward community meetings to introduce myself and advertise the project.

Following advertisement, a significant barrier emerged in proposing timeframes for responses from clinicians which were not honoured. I noticed a power struggle in wanting to assert the importance of the project and the need for gatekeepers to honour their agreement to support with recruitment and facilitation of interviews, however, I felt uncomfortable repeatedly following-up with clinicians when feedback deadlines were not met. This experience activated my threat system as I wanted to stress the importance of timeframes without coming across as entitled. Additionally, I appreciated that an extra challenge was accessing participants from services with limited staffing levels. On several occasions, my anxiety overrode my frustration and I managed by redirecting my focus to other chapters of the research project to ensure I could submit on time. Whilst this may have demonstrated a drive to complete the project, it also intensified my threat system as it meant that by working on other parts of the project rather than chasing gatekeepers, I was potentially delaying the recruitment process. From regular reflections and progress updates with my academic supervisors, I was encouraged to develop a study plan to establish my own timeframes from which to work. This included prioritising completion of the meta-ethnography which entailed analysis of existing literature, and progressively completing this reflective chapter as new

experiences arose. On reflection, as the empirical project lingered with uncertainty, this was a very difficult balance to work with.

The importance of working within timeframes took an unexpected turn when, with three interviews pending, I was struck ill with shingles. Understandably, my threat system was at an all-time high. Despite the frustration I felt in feeling physically unable to work on the project, working did not feel like a viable option. The thought of taking more time off given how much time I had already lost during the ethics and recruitment stages felt like a barrier I would struggle to overcome. However, I recognised that even in trying to persevere, I would not have engaged with participants with the same level of enthusiasm and the quality of my written work would have been poor. My drive system was forced shut and my soothing system felt inaccessible. Consciously taking time off to rest reminded me of the importance of looking after myself through what felt like an overwhelming process. On reflection, I also believe the experience has given me further compassion for clinicians who experience burnout when struggling to maintain a work-life balance, particularly with conflicting demands exacerbated by the pandemic (Jalili et al., 2020).

3.3.3 Ethical versus Feasible Recruitment

An additional stumbling block for conducting my research was working with low response rates whilst not wanting to deviate from the original subject area. During the first four months of advertising the project, I conducted one interview and so felt disappointed as service users did not appear to share my passion for my research area. This made me curious as to whether there were further reasons for the poor representation of Black women within qualitative literature in this area, namely a reluctance to engage rather than not being approached to share their experiences. Low response rates also encouraged me to consider that identifying sites with potential participants does not guarantee that all individuals who meet the inclusion criteria will want to take part, and this is their choice. From exploring and

action planning in supervision, I was reminded that research with hard to reach groups often yields low response rates (Bonevski et al., 2014). I was also encouraged to remain curious about the possible reasons for low responses: Was it due to lack of interest and motivation? Did service users understand how their feedback would be used? Were there concerns around confidentiality?

I also considered the likelihood of stigma attached to service users' stories, which may have raised their concerns about being judged, making them feel less confident to participate in such a process. This was exemplified when I was approached by a service user who would only agree to participate if she could see the interview questions in advance, after which she requested to submit written responses. In drawing upon my clinical experiences, I was curious of what was driving these conditions. From liaising with the service user's Community Psychiatric Nurse, it became apparent that previous engagement with healthcare professionals had influenced her impression of how sharing personal experiences could impact on her care pathway, leaving her feeling more vulnerable and subsequently becoming guarded and ambivalent. This encouraged me to remain mindful of the possible circumstances surrounding lack of participation from Black women service users in recent forensic mental health literature. Following discussions with my research team, we considered the effort the service user was willing to make to share her experiences with me, despite her discomfort in doing so; and agreed for her written responses to be included in the project.

Thirteen weeks before submission, I was able to secure an additional five participants by extending recruitment to include non-NHS secure inpatient settings and community service users who could share retrospective accounts. From the wealth of interest my research received from service users, I realised that my disappointment from the initially low response rate was fuelled by my assumptions around service users' reluctance to engage. Whilst I still believe my recruitment decisions were the most appropriate since they were achieved, the experience highlighted the need to critically reflect, work in accordance with realistic

timeframes and directly address the conflicting issues relating to the decisions we make as researchers. This also reminded me of the importance of context, in that there may be conflicts in priorities with researchers, gatekeepers, participants and clinical teams.

Whilst I was pleased with the increased number of participants, I was mindful of the amount of openness afforded to service users at particular recruitment sites as, for security purposes, participants could not be left unattended with electrical devices. Consequently, this meant that a member of staff sat alongside participants for the duration of our virtual engagement. This roused my curiosity as to whether participants felt they could speak about experiences without being challenged for fear of repercussions; and raised valid concerns when a participant was challenged by an observer for sharing an account of racial prejudice experienced within secure care. I was taken aback by how confrontational the exchange appeared in the moment and felt compelled to remind the member of staff that they were present in an observer capacity. Whilst the observer apologised and the experience did not appear to impact on the participant sharing their experiences with me, it did encourage me to consider what to pre-empt for future interviews requiring staff observation and how to prevent or manage such occurrences. Subsequently, the next interview with staff observing begun with the staff's role being defined and agreed from the offset.

3.4 Grasping Interpretative Phenomenological Analysis

Developing super-ordinate and sub-ordinate themes from interview transcripts proved an interesting aspect of the empirical study, namely in that the interpretative process entailed a thorough and staged process, with invaluable input from my research team in firming up findings. Admittedly, I did not feel confident in proposing themes with supporting quotes, as they initially sounded like ill-conceived assumptions. However, from describing the analytical process from which themes were drawn, the double hermeneutic nature of IPA appeared evident throughout (Smith et al., 2009).

I noticed that my dual role as a clinician-researcher whilst conducting interviews supported my understanding of the interconnectedness of psychological well-being and culture. This was most pertinent when considering the cultural inflexibility of Dialectical Behavioural Therapy (Linehan, 1993) as a therapeutic model and the interpersonal implications this had for service users when readjusting to life beyond hospital environments. From becoming immersed in participants narratives (Smith & Osborn, 2008), the experience of feeling pressured to adapt to societal and contextual norms resonated with my identity as a Black woman, which strengthened the compassion felt for participants as they recalled personal encounters with others which challenged their cultural identities. I also connected with the ways in which my identity as a Black woman had been embraced, challenged or met with curiosity fuelling assumptions in both personal and professional contexts. Further, I considered how in my role as a clinician, I too had missed opportunities for empowering service users by not speaking up when I had recognised cultural ignorance or use of outdated language. Having heard participants' experiences, I am now more conscious of the ways in which my silence as a clinician has perpetuated the interpersonal challenges experienced by vulnerable service users.

3.5 Conclusions: Reigniting My Passion for Research

Undoubtedly, undertaking a Doctoral level thesis presented a wealth of emotionally impactful experiences which often made it difficult for me to maintain sight of my strengths and passion for conducting original research. Contrastingly, however, the experience allowed me to appreciate that undertaking professional training would not equate to emerging as an expert in research, which I have now learned to embrace. From practising self-compassion, I started to appreciate that conducting research with a hard-to-reach population amidst a pandemic would likely entail a range of ups and downs in the form of progress, setbacks, conflict, achievement and disappointment, which in practice, it did. The recruitment stage of the

empirical chapter was extremely stressful and bred a lot of uncertainty regarding whether I was making the best decision in continuing with the project. However, continuing felt right as I was staying true to my passion whilst providing Black service users with the chance to be heard. On reflection, if I were conducting this research as a qualified Clinical Psychologist, the uncertainty of timeframes might have felt more tolerable. Furthermore, I hope that as a qualified clinician, I will have the confidence to assert the importance of honouring agreements and working within agreed timeframes with more senior clinicians.

The challenges that arose over the course of this research helped me to connect with my values as a researcher, clinician, individual and within these, my identity as a Black woman. Reflective spaces within supervision, journaling and peer support groups presented invaluable opportunities for me to tap into my strengths and areas for further development as a researcher. These spaces also empowered me to embrace the experience of approaching the end of my journey as a trainee and gradually coming into my own as a Clinical Psychologist. As I anticipate returning to clinical work, I endeavour to be more mindful of the cultural flexibility of therapeutic models applied to service users from diverse backgrounds. I also hope to use my voice as a clinician to raise awareness of the ways in which cultural identities of Black women have become supressed due to current clinical practices. I anticipate that this experience will also enhance my approach to MDT working, having learned to consider the context of Black service user involvement in therapy and research, or lack of. Additionally, in sharing the findings from my research with participants and the participating secure services, and disseminating to wider audiences through presentations and publication, I hope my research will support secure mental health services in becoming more responsive to the needs of Black women in their care.

Experientially, there is a noticeable shift in how I position myself in the face of conducting research, in that I no longer keep the idea at arm's length. The Doctorate Course ethos, along with support from my research team promoted the reality that even as a qualified

clinician, I would not be expected to know everything, which soothed a lot of my anxieties around coming across as an imposter. Finally, I have considered whether the stress of remaining with my original project impacted on my physical wellbeing and endeavour to maintain a healthy work-life balance should I ever engage in future research or clinical work which, feels emotionally overwhelming.

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Appendix 1A- The Prison Journal submission guidelines

The author intends to adapt Chapter I to fulfil these guidelines post-viva.

Manuscript Submission Guidelines:

***THE PRISON JOURNAL*: An International Forum on Incarceration and Alternative Sanctions** was begun by The Pennsylvania Prison Society, America's oldest prison reform organization, founded in 1787. The editorial team's aim is to establish as a focal point and the forum of choice for studies, ideas, and discussion of adult and juvenile confinement, treatment interventions, and alternative sanctions. Contributions in the form of articles, research notes, review essays, and book reviews should explore broad themes of punishment and correctional intervention. Submissions that advance theory, research, policy, and practice will be considered, as will descriptive and evaluative accounts of innovative programs and policies, state-of-the-art surveys and reviews, and legal and historical analyses.

Manuscript Submissions: *The Prison Journal* uses an online submission and review platform. Manuscripts should be submitted electronically to http://mc.manuscriptcentral.com/prisonjournal. Authors will be required to set up an online account on the SageTrack system powered by ScholarOne. From their account, a new submission can be initiated. Authors will be asked to provide the required information (author names and contact information, abstract, keywords, etc.) and to upload the "title page" and "main document" separately to ensure that the manuscript is ready for a blind review. The site contains links to an online user's guide (Get Help Now) for help navigating the site.

Manuscript and references should follow guidelines of the **Publication Manual of the American Psychological Association (7th edition)**. Submission to *The Prison Journal* implies that the manuscript has not been published elsewhere, nor is it under

consideration by another journal. Authors in doubt about what constitutes prior publication should consult the editor. Submission of a manuscript implies commitment to publish in the journal.

SAGE Choice If you or your funder wishes your article to be freely available online to nonsubscribers immediately upon publication (gold open access), you can opt for it to be included in SAGE Choice, subject to the payment of a publication fee. The manuscript submission and peer review procedure is unchanged. On acceptance of your article, you will be asked to let SAGE know directly if you are choosing SAGE Choice. To check journal eligibility and the publication fee, please visit SAGE Choice. For more information on open access options and compliance at SAGE, including self/author archiving deposits (green open access) visit SAGE Publishing Policies on our Journal Author Gateway.

Authors who want to refine the use of English in their manuscripts might consider utilizing the services of SPi, a non-affiliated company that offers Professional Editing Services to authors of journal articles in the areas of science, technology, medicine or the social sciences. SPi specializes in editing and correcting English-language manuscripts written by authors with a primary language other than English. Visit http://www.prof-editing.com for more information about SPi's Professional Editing Services, pricing, and turn-around times, or to obtain a free quote or submit a manuscript for language polishing.

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Appendix 1B- Journal of International Women's Studies submission guidelines

The author intends to adapt Chapter II to fulfil these guidelines post-viva.

General Submission Guidelines

Submit your article, essay, feminist reflection, fictional and/or creative piece to **JIWS@bridgew.edu**. Reviews typically take 2-3 months with approximately 4-6 months from first submission to publication, depending on how long it takes authors to revise and where we are on the calendar with respect to the next issue. All JIWS submissions go through a blind, peer review process. Please note that we will return articles that need extensive English language editing, do not conform to submission guidelines regarding formatting, and demonstrate a lack of professionalism with respect to quality of presentation—spelling, grammar, punctuation, etc.

Articles are written by scholars, researchers, or professionals who are experts in their fields, publishing the results of research.

Essays are also written by scholars, researchers, or professionals and include more subjective, personal and interpersonal reflective content, often challenging the norms of scholarly article formats across various disciplines. While feminist scholarly articles, rooted in feminist theory can also involve more subjective content essays largely reflect on research, scholarship, academic and professional norms to a greater degree through the lens of feminist ideals.

Feminist reflections are unconventional first-person reflections in a blog or vlog format heightening the personal reflective component found in essays. There is less attention to conventional and scholarly modes of citation.

Fictional/creative works are also encouraged. We seek poetry, short stories, short plays, videos, vlogs or links to vlogs, blogs or links to blogs, photos of artworks, videos of short performance pieces, all with the objective of heightening awareness of patriarchy,

intersectional inequalities, women's subordination and/or seeking to transform these conditions and social structural inequalities.
Only completed work should be submitted. The editors cannot provide feedback on work in progress.

Abstracts and key words should be included in the same file as the article. Abstracts should be 300-350 words in length. Authors should include one key word or phrase about their research methodology.
The maximum length of any contribution should be 7,500 words, inclusive of notes and bibliography.

Contributions should be double-spaced, including all notes and references. Page numbers should be placed in the upper-right corner, paragraphs should be indented, and all illustrations and tables should be labeled and captioned accurately. Use Times New Roman, 12 point font, left/right justified text, and bold-faced headings. Follow APA or MLA citation styles, or a style appropriate to your discipline. Improperly formatted articles will be sent back to the authors and will not be accepted for review.
In the interests of blind peer review, only the title of the paper should appear on the first page. Authors should include their name and affiliation and any acknowledgements on a separate page.

A brief biographical note of not more than 80 words about each author should be supplied on a separate page including your email address if you wish readers to reach out to you.

Contributors should bear in mind the international nature of the journal's audience. Footnote explanations are necessary for all political & geographic references, popular culture references, as well as academic references. Please do not assume that scholars who are famous in one country bear similar prestige elsewhere.

Submission of work to this journal will be taken to imply that it presents work not under consideration for publication elsewhere. On acceptance of work, the authors agree that the exclusive rights to reproduce and distribute the article have been given to ***JIWS***. Permission to extensively quote from or reproduce copyright material must be obtained by the authors before submission and any acknowledgements should be included in the typescript, preferably in the form of an Acknowledgements section at the beginning of the paper. Where photographs or figures are reproduced, acknowledgement of source and copyright should be given in the caption.

Final submissions following revisions should be 12 font, Times New Roman, single spaced; left/right justified; bold topic headings with no space between heading and paragraph including title, abstract, and author's name/s; two spaces between author's name/s and abstract. italicized subheadings (no numbers). Keywords should be italicized with the three (or more) key phrases or words themselves should not be in italics. Follow APA or MLA citation styles, or a style appropriate to your discipline; references/bibliographies, which should be single-spaced. Authors should consult recent editions for guidelines and send inquiries to the editor. Please note: this does not refer to your final draft, but to the final version of your article once it is revised and resubmitted. **Improperly formatted articles will be sent back to the authors and must be received by the publication date to be included in the designated issue. We cannot guarantee which subsequent issue an article will appear in if it is not received on time.**

Appendix 2- Ethical Approval for Systematic Review

Certificate of Ethical Approval

Applicant:	Adele Gordon
Project Title:	Imprisoned Mothers Lived Experiences of Separation from their Children: A Meta-ethnographic Review.

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as Low Risk

Date of approval:	19 Mar 2021
Project Reference Number:	P121022

Appendix 3- Critical Appraisal Skills Programme (CASP) Checklist version 2018

www.casp-uk.net
info@casp-uk.net
Summertown Pavilion, Middle Way Oxford OX2 7LG

CASP Checklist: 10 questions to help you make sense of a **Qualitative** research

How to use this appraisal tool: Three broad issues need to be considered when appraising a qualitative study:

- Are the results of the study valid? (Section A)
- What are the results? (Section B)
- Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

CASP
Critical Appraisal Skills Programme

Paper for appraisal and reference:

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- what was the goal of the research
- why it was thought important
- its relevance

Comments:

2. Is a qualitative methodology appropriate?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal

Comments:

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments:

CASP
Critical Appraisal Skills Programme

4. Was the recruitment strategy appropriate to the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments:

5. Was the data collected in a way that addressed the research issue?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments:

CASP
Critical Appraisal Skills Programme

6. Has the relationship between researcher and participants been adequately considered?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments:

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments:

CASP
Critical Appraisal Skills Programme

8. Was the data analysis sufficiently rigorous?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments:

9. Is there a clear statement of findings?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments:

CASP
Critical Appraisal Skills Programme

Section C: Will the results help locally?

10. How valuable is the research?	HINT: Consider • If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature • If they identify new areas where research is necessary • If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments:	

Appendix 4- Kappa Calculations for Quality Appraisal

SPSS output for Kappa statistic calculations. Outputs are presented for papers where there was a divergence in scoring (i.e. where Kappa scores were less than 1.0).

Aiello & McQueeny (2016)

Symmetric Measures

		Value	Asymptotic Standard Error[a]	Approximate T[b]	Approximate Significance
Measure of Agreement	Kappa	.737	.241	2.415	.016
N of Valid Cases		10			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Mignon & Ransford (2012)

Symmetric Measures

		Value	Asymptotic Standard Error[a]	Approximate T[b]	Approximate Significance
Measure of Agreement	Kappa	.844	.148	3.730	.000
N of Valid Cases		10			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Arditti & Few (2008)

Symmetric Measures

		Value	Asymptotic Standard Error[a]	Approximate T[b]	Approximate Significance
Measure of Agreement	Kappa	.750	.222	2.942	.003
N of Valid Cases		10			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Moe & Ferraro (2006)

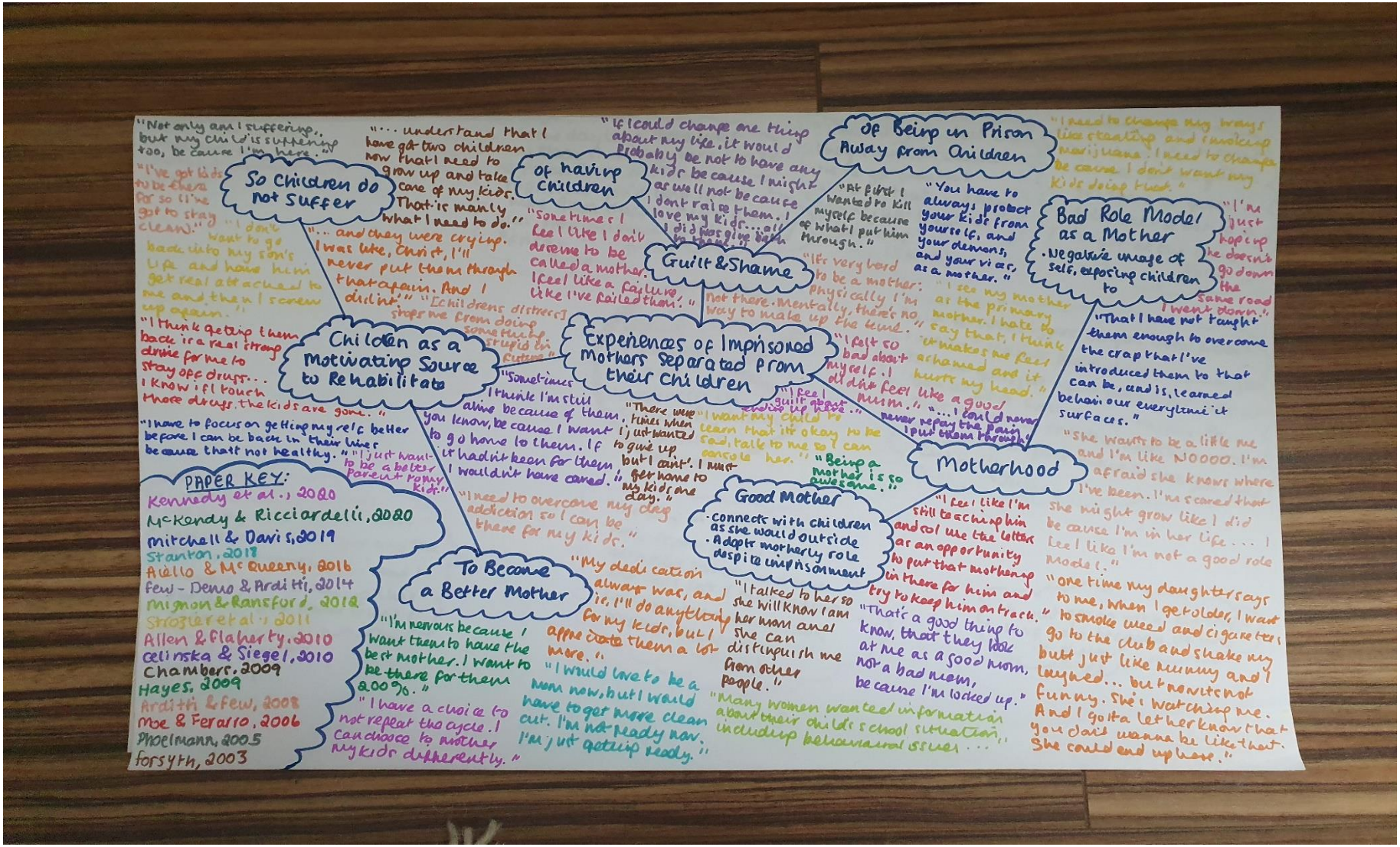
Symmetric Measures

		Value	Asymptotic Standard Error[a]	Approximate T[b]	Approximate Significance
Measure of Agreement	Kappa	.825	.167	3.333	.001
N of Valid Cases		10			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Appendix 5- Systematic Review: Thematic map



Appendix 6- Pen Portraits of Participants

Participant Pseudonym	Pen Portrait
'Julie'	Julie is a current secure psychiatric hospital service user. She is of mixed Black ethnicity and is aged 35-44 years. Julie is single and has children. This is Julie's first admission to a secure psychiatric hospital and she has resided as a service user for over five years. Julie previously received support for emotional difficulties in a prison setting.
'Sarah'	Sarah is a former secure psychiatric hospital service user and previously resided in secure mental health care for 3-5 years. She is of mixed Black ethnicity and is aged 18-24 years. Sarah is single and has children. This was Sarah's first admission to a secure psychiatric hospital.
'Brenda'	Brenda is a former secure psychiatric hospital service user and previously resided in secure mental health care for over 5 years. She is of Black ethnicity and is aged 25-34 years. Brenda is single and does not have children. Brenda has had more than three admissions to secure mental health care settings.
'Hodon'	Hodon is a former secure psychiatric hospital service user and previously resided in secure mental health care for over five years. She is of African ethnicity and is aged 35-44 years. Hodon is single and does not have children. This was Hodon's first admission to a secure psychiatric hospital and she has previously received support for emotional difficulties in a prison setting.
'Lisa'	Lisa is a former secure psychiatric hospital service user and previously resided in secure mental health care for 1-3 years. She is of Black ethnicity and is aged 35-44 years. Lisa is single and has children. This was Lisa's first admission to a secure psychiatric hospital.
'Nina'	Nina is a current secure psychiatric hospital service user. She is of Black British ethnicity and is aged 35-44 years. Julie is single and does not have children. Nina has had more than three admissions to a secure psychiatric hospital, and she has resided as a service user for 3-5 years.
'Denise''	Denise is a current secure psychiatric hospital service user of Black British ethnicity. No further information provided.

Appendix 7- Interview Schedule

Interview Schedule

"What are Black Women's Experiences of Fairness and Unfairness in Secure Psychiatric Settings?"

The purpose of this interview is to explore your experiences since being admitted to a secure psychiatric hospital. I am particularly interested to hear how **you** describe your experience as a Black woman being treated in a secure psychiatric setting. I would encourage you to be as open as you can during the interview. I will be asking you some questions; however, I hope to be led by you and your experiences. I may ask you, at times, to explain what you mean in more detail or ask to clarify something, this is to ensure that I am able to try to understand your experiences in as much detail as you are comfortable to share. Generally, the questions will focus on your experiences since being admitted to the psychiatric hospital which you are currently in.

General prompts for interview schedule:

- Can you tell me what you mean?
- Why do you think that is?
- Do you believe that:
  - Being a woman
  - Being Black
  - Experiencing mental health difficulties?
  - Having a forensic history (if applicable)

  has anything to do with it?
- What did that mean to you?
- How did that leave you feeling?

1. **Can you describe the experiences that led to your current admission to a secure psychiatric hospital?**

2. **Can you tell me about your experiences since admission to this secure psychiatric hospital?**

3. **Can you tell me about your experiences of service provision and whether you feel the current service meets your needs?**

4. **Can you tell me of any experiences of feeling valued and respected?**

5. **Can you tell me your experience of therapeutic relationships with staff?**

6. **Can you tell me your experience of therapeutic relationships with other service users?**

7. **Is there anything else you would like to tell me about your experiences within a secure psychiatric setting?**

Thank you for taking part in this interview

Appendix 8A- Coventry University Ethical Approval for Empirical Study

Certificate of Ethical Approval

Applicant:

Adele Gordon

Project Title:

Black women's experiences of fairness and unfairness in secure psychiatric settings

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as High Risk

Date of approval:

07 May 2020

Project Reference Number:

P102447

Appendix 8B- Integrated Research Application System (IRAS) Ethical Approval for Empirical Study

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Ms Adele Gordon
Research Director
Coventry & Warwickshire Partnership Trust
Coventry University, Faculty of Health and Life Sciences
Priory Street
Coventry
CV1 5FB

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

21 August 2020

Dear Ms Gordon

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Black women's experiences of fairness and unfairness in secure psychiatric settings**
IRAS project ID:	**280065**
Protocol number:	**P102447**
REC reference:	**20/WM/0168**
Sponsor	**Coventry University**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Appendix 9- Participant Information Sheet

PARTICIPANT INFORMATION SHEET

"Black Women's Experiences of Fairness and Unfairness within Secure Psychiatric Settings"

You are being invited to take part in research on the service user experience. Adele Gordon is a student at Coventry University, and is leading this research as part of her training as a Trainee Clinical Psychologist. Before you decide to take part, it is important you understand why the research is being conducted and what it will involve. Please take time to read the following information carefully.

What is the purpose of the study?
This study aims to capture how Black women describe their lived experiences of being admitted to a secure psychiatric setting. The study will explore experiences which may impact on the emotional wellbeing of Black Women in secure psychiatric settings, including service provision and relationships with staff and peers. It is hoped that the responses gathered will help to identify how best to support the experiences of current and future service users who identify as Black women, who are thought to require support in a secure psychiatric setting.

Why have I been chosen to take part?
We are inviting Black women who have been in their current setting for at least 1 year, to take part in this study.

What are the benefits of taking part?
By sharing your experiences with us, you will be helping to raise awareness of the lived experiences of Black women in secure psychiatric settings. This may provide us with a better understanding of what works well, challenges faced by Black women, and the treatment or support areas in need of improvement.

Are there any risks associated with taking part?
This study has been reviewed and approved through Coventry University's formal research ethics procedure. This study has also been reviewed by the Coventry and Warwickshire Research Ethics Committee (REC). There are no significant risks likely to arise from participating. Should you choose to participate, it is important to share that for safeguarding purposes there will be limits to how confidentiality is treated. Any disclosure of harm or potential harm to yourself or others may have to be reported. This will be explored with you before any further steps are taken.

What if something goes wrong?
Discussing personal experiences can cause emotional distress. If this happens during interview, the interview will be paused and you can choose if you would like to continue, reschedule the interview for another time or withdraw from the study. It will also be arranged for a member of your clinical care team to be available for you to access at any point during your participation in the interview. If you feel in need of emotional support, please contact a member of your clinical care team whom you feel comfortable talking to. You can also be supported by clinical staff to arrange a meeting with Gillian Samuel-Connell, who is an Independent Mental Health Advocate (IMHA) in the service. Gillian is available Monday to Thursday, between 9am and 5pm. If you would like to speak with someone outside of the hospital setting, Samaritans are available on a 24-hour basis by contacting 116 123.

Do I have to take part?
No – it is entirely up to you. Adele Gordon, the lead researcher will be happy to arrange speaking with you about the study before you decide whether to participate. If you do decide to take part, please keep this Information Sheet as well as your signed copy of the Informed Consent Form to show that you understand the purpose of this research, as well as your rights to participate and to withdraw.

You are free to withdraw your information from the project data up to 31.03.2021. You should note that your data may be used in the production of formal research outputs (e.g. journal articles, conference papers, theses and reports) prior to this date and so you are advised to contact the university at the earliest opportunity should you wish to withdraw from the study. To withdraw, please ask your clinical team to contact the lead researcher (contact details are provided below). In the event of the lead researcher's absence, your clinical team will also be able to contact the Research Support Office (ethics.hls@coventry.ac.uk; telephone +44(0)247 765 8461, so that your request can be dealt with promptly. You do not need to give a reason. A decision to withdraw, or not to take part, will not affect you in any way.

What will happen if I decide to take part?
You will be asked a number of questions regarding your experiences since admission to your current inpatient setting, which is a secure psychiatric hospital. This study is particularly interested in your experiences as a Black woman receiving care in a secure psychiatric setting. Due to social distancing regulations initiated in light of COVID-19, interviews will be conducted via Skype and will be arranged to take place on the hospital site, in a safe environment at a time that is convenient to you. Ideally, we would like to record your responses (and will require your consent for this), so the location should be in a reasonably quiet area, where you would hopefully feel safe and contained enough to share your experiences. The interview should take around 60-90 minutes to complete.

Data Protection and Confidentiality
All research using patient data must follow UK laws and rules. Your data will be processed in accordance with the General Data Protection Regulation 2018 (GDPR) and the Data Protection Act 2018. All information collected about you will be kept strictly confidential. Unless you are fully anonymised in our records, someone will remove your name from the research data and replace it with a code number. This is called coded data, and can be matched up with any other data relating to you by the code number, such as your consent form. If you consent to the interview being recorded, all recordings will be destroyed once the interview has been transcribed. Your data will only be viewed by the researcher/research team. All electronic data will be stored on a password-protected computer file on the lead researcher's computer, and paper records will be stored in a locked filing cabinet at Coventry University premises. Coventry University will take responsibility for data destruction in line with its policies and procedures.

Data Protection Rights
Coventry University is a Data Controller for the information you provide. You have the right to access information held about you. Your right of access can be exercised in accordance with the GDPR and the Data Protection Act 2018. More details of your rights, including the right to lodge a complaint with the Information Commissioner's Office, is available at www.ico.org.uk. With your consent, questions, comments and requests about your personal data can also be sent to the University Data Protection Officer by a member of your care team - enquiry.ipu@coventry.ac.uk.

What will happen with the results of this study?
The results of this study may be summarised in published articles, reports and presentations.

Making a Complaint
If you are unhappy with any aspect of this research, please first request for contact to be made with the lead researcher, Adele Gordon on gordona8@uni.coventry.ac.uk. This can be requested through Dr Ruth Fountain, who works within your service. Alternatively, you can contact Adele's supervisory team:

Dr Helen Liebling
Clinical Director/Senior Lecturer
Clinical Psychology Doctorate Course
Coventry University
Charles Ward Building
CV1 5FB
Tel: +44(0)24 7765 8714
E: Helen.Liebling@coventry.ac.uk

Dr Ruth Fountain
Principal Clinical Psychologist
Ardenleigh Women's Blended Secure Service
385 Kingsbury Road
Birmingham
B24 9SA
Tel: +44(0)121 301 4535
E: Ruth.Fountain@nhs.net

Dr Anthony Colombo
Research Director
Clinical Psychology Doctorate Course
Coventry University
Charles Ward Building
CV1 5FB
Tel: +44(0)24 7768 5835
E: Anthony.Colombo@coventry.ac.uk

If you still have concerns and wish to make a formal complaint, please write to:
Prof. Nigel Berkeley
Associate Dean of Research
Coventry University
Coventry CV1 5FB
Email: Nigel.Barkeley@covnetry.ac.uk

In your letter please provide information about the research project, specify the name of the researcher and detail the nature of your complaint.

Appendix 10- Recruitment Poster

Research Participants Needed

For study exploring Black women's experiences of fairness and unfairness as inpatients within secure psychiatric settings

My name is Adele Gordon and I am a Trainee Clinical Psychologist at Coventry University. I am carrying out research to capture the fair and unfair experiences of Black women within secure psychiatric settings. I would like to hear from you, if you would be interested in sharing your experiences and meet all of the following criteria:

- **A woman who self-identifies as Black**
- **Aged over 18 years old**
- **Have experience of residing in a secure psychiatric setting for at least 1 year**
- **Able to understand spoken and written English**

Due to social distancing regulations initiated in light of COVID-19, interviews will be conducted remotely. If you are interested, please speak with your named Nurse.

Further questions
If you or those involved in your care have any questions about any aspect of this research, please contact the lead researcher Adele Gordon, who can be contacted via email at gordona8@uni.coventry.ac.uk.

This study has been approved by Coventry University Research Ethics Committee and the Integrated Research Application System (IRAS)

Appendix 11- Informed Consent Form

Participant No.

INFORMED CONSENT FORM:

"Black Women's Experiences of Fairness and Unfairness within Secure Psychiatric Settings"

You are invited to take part in this research study for the purpose of collecting information on Black women's perceptions of fair and unfair experiences in secure psychiatric settings, to support current and future care of Black service users within secure psychiatric settings.

Before you decide to take part, you must **read the accompanying Participant Information Sheet.**

Please do not hesitate to ask questions if anything is unclear or if you would like more information about any aspect of this research. It is important that you feel able to take the necessary time to decide whether or not you wish to take part.

If you are happy to participate, please confirm your consent by placing your initials against each of the below statements and then signing and dating the form as participant.

1	**I confirm that I have read and understood the Participant Information Sheet for the above study and have had the opportunity to ask questions**	**Participant Initials**
2	**I understand my participation is voluntary and that I am free to withdraw my data, without giving a reason, by contacting the lead researcher and the Research Support Office at any time until the date specified in the Participant Information Sheet**	
3	**I understand that all the information I provide will be held securely and treated confidentially**	
4	**I understand that there are limits to confidentiality within this study. For safeguarding purposes, any disclosure of harm or potential harm to myself or to others may have to be reported**	
5	**I am happy for the information I provide to be used (anonymously) in academic papers and other formal research outputs**	
6	**I am happy for the interview to be conducted virtually; and for the information I share to be recorded and destroyed once the interview has been transcribed**	
7	**I agree to take part in the above study**	

Thank you for your participation in this study. Your help is very much appreciated.

Participant's Name	Date	Signature
Researcher	**Date**	**Signature**

Appendix 12- Participant Debrief

Participant debriefing sheet

"Black Women's Experiences of Fairness and Unfairness within Secure Psychiatric Settings"

Thank you for participating in this interview. You may find the following information useful.

What is the purpose of the study? The purpose of the study was to accurately capture and interpret the lived experience of Black women who are currently admitted to a secure psychiatric hospital. The study explored the circumstances preceding the admission, and the emotional and interpersonal impacts since admission to the current setting. Ultimately, the desired outcome is to identify how support current and future care provision of Black women who are admitted to secure psychiatric hospitals.

Who has organised/funded the study? The research is being carried out by Adele Gordon, a Trainee Clinical Psychologist at Coventry University. The research project has been approved for undertaking by the Coventry University Ethics Committee (project ref. P102447), and the Integrated Research Application System (IRAS) (project ref. 280065).

What if I have a question? Please inform Dr Ruth Fountain, Clinical Psychologist and clinical supervisor of the project if you would like some more information about this study. Dr Fountain will be able to make direct contact with the lead researcher (Adele Gordon), who will then make contact to provide any further information required.

What if I want to withdraw from the study? You are free to withdraw your information from the project data set up to 31.03.2021. You should note that your data may be used in the production of formal research outputs (e.g. journal articles, conference papers, theses and reports) prior to this date and so you are advised to contact the university at the earliest opportunity should you wish to withdraw from the study. You do not need to give a reason. In this instance you can have the interview tape recording, the transcription of the interview and your demographic details removed from the study and destroyed. A decision to withdraw, or not to take part, will not affect you in any way.

To withdraw, please inform Dr Ruth Fountain and provide your participant number which is listed on the consent form. Dr Fountain will then contact the researcher (Adele Gordon) directly with this information for your responses to be removed. In the event of the lead researcher's absence, Dr Fountain will also have access to the Research Support Office (ethics.hls@coventry.ac.uk; telephone +44 (0)247 765 8461), so that your request can be dealt with promptly.

Data Protection and Confidentiality: Your data will be processed in accordance with the General Data Protection Regulation 2016 (GDPR) and the Data Protection Act 2018. All information which is collected about you during the course of the research will be kept strictly confidential, and information about you which leaves the hospital will not have your personal details on so that you cannot be recognised. Some parts of this data may be looked at by authorised persons from the University to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant. The information you give as part of the research process will be analysed and used only as part of this study. Codes and false names will used instead of your own names in order to protect your anonymity. Confidentiality may only be broken if the researcher is concerned regarding you or someone else coming to harm; this is rarely necessary, and we would always endeavour to speak to you about these concerns before breaking confidentiality. When the study is completed data generated by the study will be stored in a confidential place at Coventry University for five years and then destroyed. Coventry University will take responsibility for data destruction in line with its policies and procedures.

What will happen to the results of the study? It is intended for the results of the study to be published following its completion in July 2021. You will not be identified in any report, presentation or publication. After participating in the study, a summary of the findings will be sent to you.

What if I wish to make a complaint? If you are unhappy with any aspect of this research, please first request for contact to be made with the lead researcher, Adele Gordon on gordona8@uni.coventry.ac.uk. This can be requested through Dr Ruth Fountain, who works within your service. Alternatively, you can contact Adele's supervisory team:

Dr Helen Liebling
Clinical Director/Senior Lecturer
Clinical Psychology Doctorate Course
Coventry University
Charles Ward Building
CV1 5FB
Tel: +44(0)24 7765 8714
E: Helen.Liebling@coventry.ac.uk

Dr Ruth Fountain
Principal Clinical Psychologist
Ardenleigh Women's Blended Secure Service
385 Kingsbury Road
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B24 9SA
Tel: +44(0)121 301 4535
E: Ruth.Fountain@nhs.net

Dr Anthony Colombo
Research Director
Clinical Psychology Doctorate Course
Coventry University
Charles Ward Building
CV1 5FB
Tel: +44(0)24 7768 5835
E: Anthony.Colombo@coventry.ac.uk

NHS Birmingham and Solihull Mental Health NHS Foundation Trust

Coventry University

If you still have concerns and wish to make a formal complaint, please write to:

Prof. Nigel Berkeley
Associate Dean of Research
Coventry University
Coventry CV1 5FB
Email: Nigel.Barkeley@covnetry.ac.uk

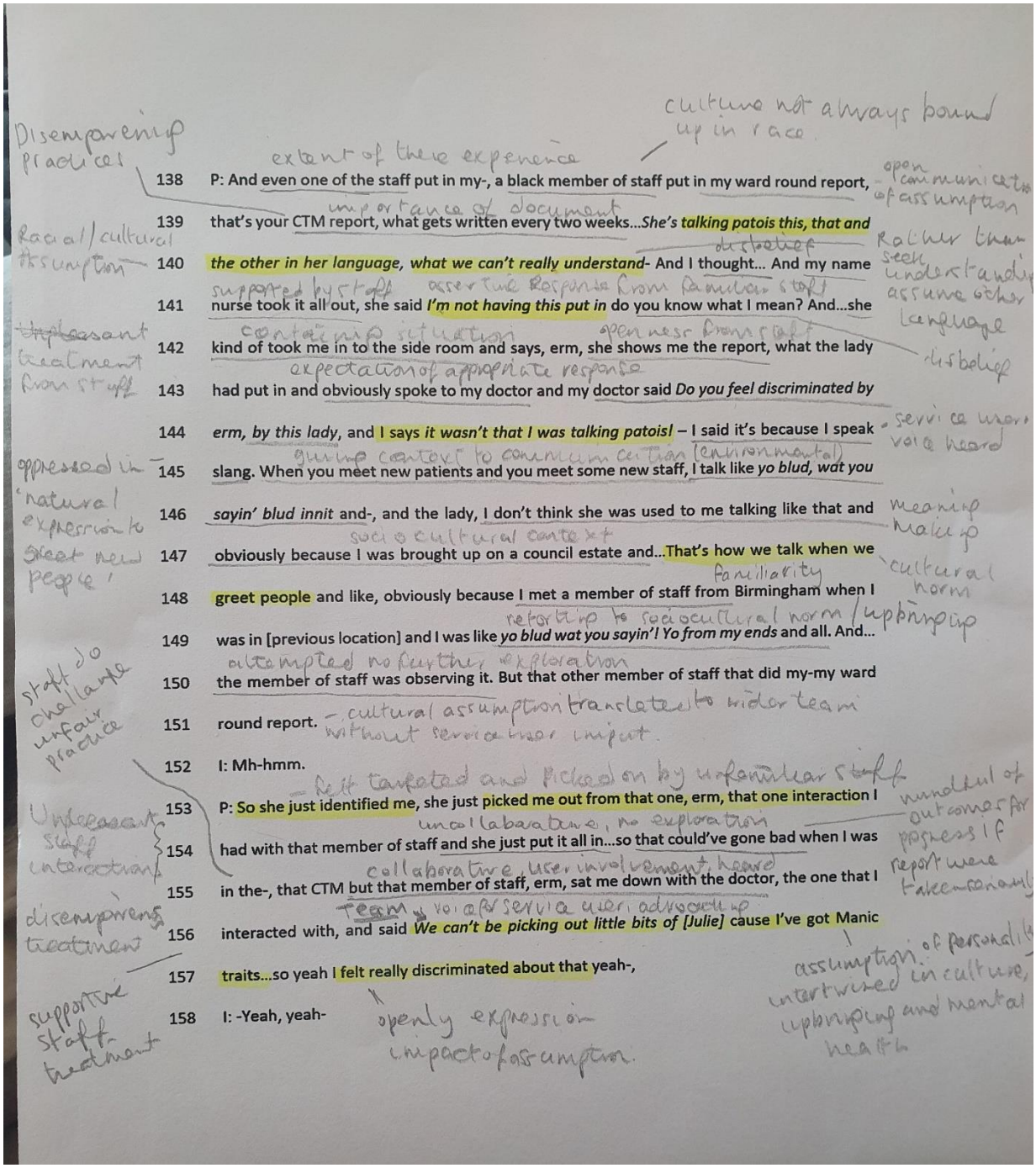
Given the secure context of your care provision, Dr Ruth Fountain will be able to make such requests on your behalf. In your letter please provide information about the research project, specify the name of the researcher and detail the nature of your complaint.

What if I would like some emotional support? I hope that you have found it interesting and have not been upset by any of the topics discussed. However, if you have found any part of this experience to be distressing and you wish to speak to someone, please arrange a space to talk with someone whom you feel comfortable talking to. Please contact your named Nurse in the first instance.

For further support, please contact your Advocacy service. Your named Nurse will be able to support with arranging this. Additionally, **Samaritans** is available for anyone struggling to cope and provide a safe place to talk 24 hours a day. It is your right to contact Samaritans at any time you feel in need of emotional support. Telephone: 116 123.

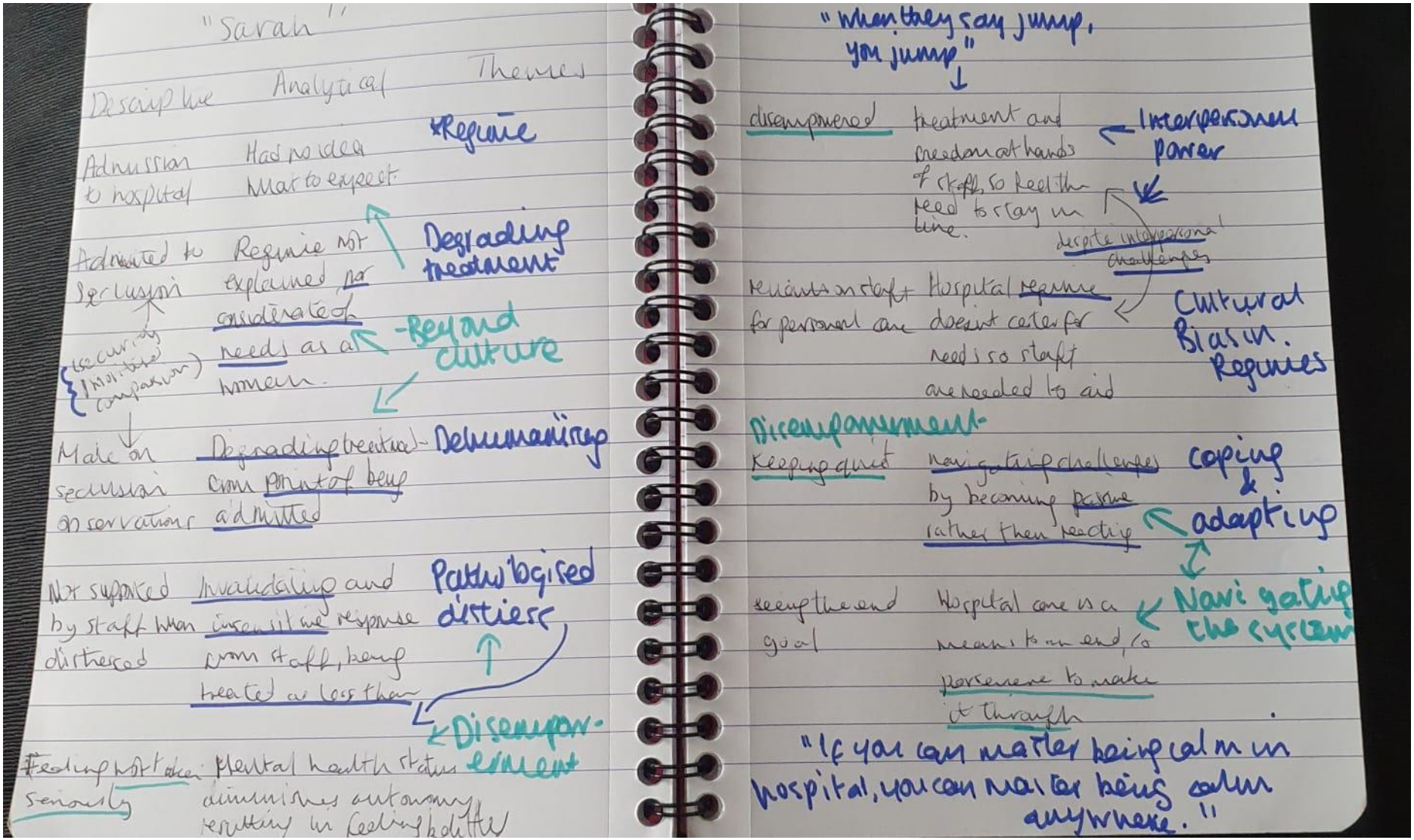
Thank you again for your participation

Appendix 13A- Coded Transcript Excerpt

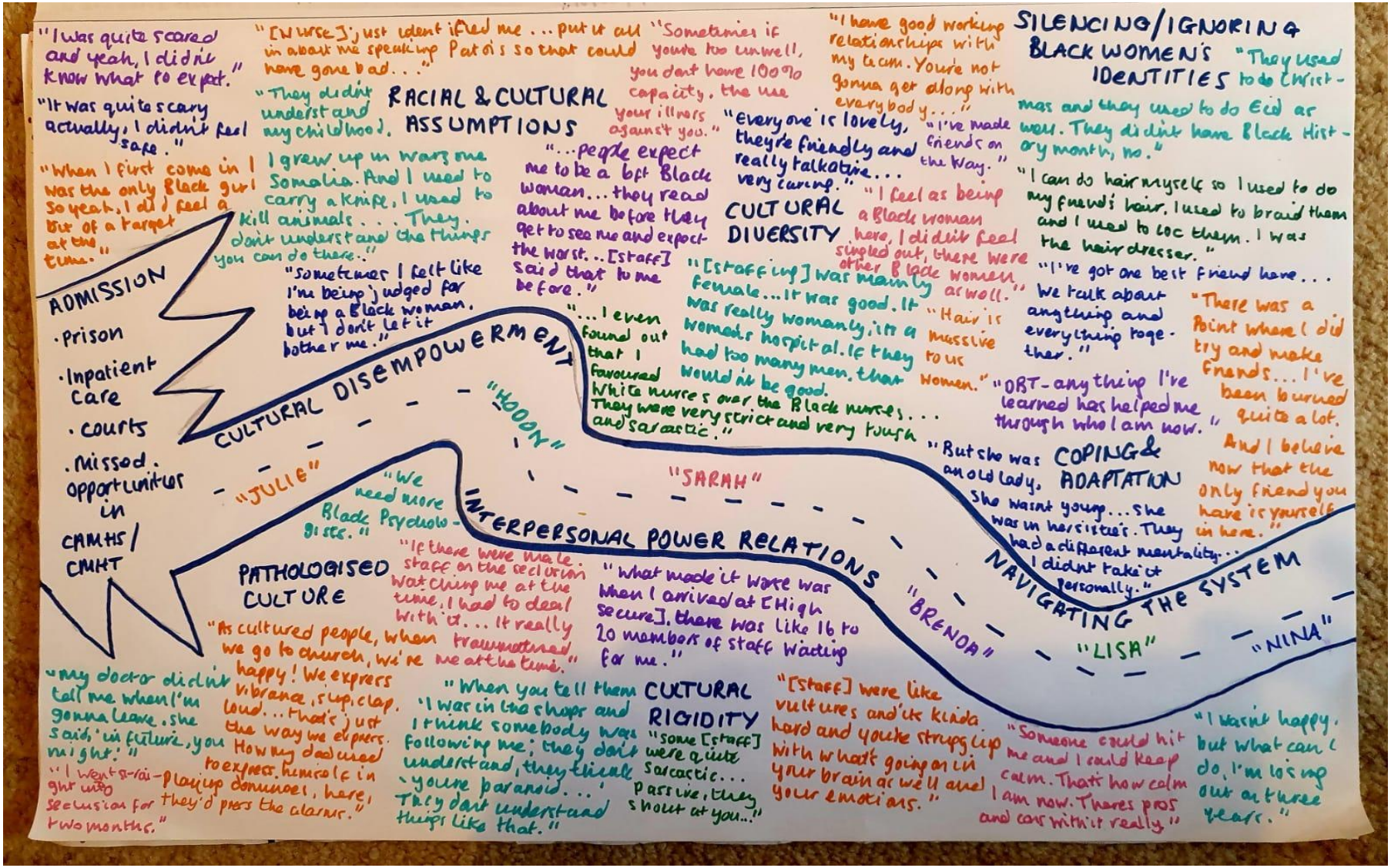


138 P: And even one of the staff put in my-, a black member of staff put in my ward round report,
139 that's your CTM report, what gets written every two weeks...*She's talking patois this, that and*
140 *the other in her language, what we can't really understand*- And I thought... And my name
141 nurse took it all out, she said *I'm not having this put in* do you know what I mean? And...she
142 kind of took me in to the side room and says, erm, she shows me the report, what the lady
143 had put in and obviously spoke to my doctor and my doctor said *Do you feel discriminated by*
144 *erm, by this lady*, and I says *it wasn't that I was talking patois!* – I said it's because I speak
145 slang. When you meet new patients and you meet some new staff, I talk like *yo blud, wat you*
146 *sayin' blud innit* and-, and the lady, I don't think she was used to me talking like that and
147 obviously because I was brought up on a council estate and...That's how we talk when we
148 greet people and like, obviously because I met a member of staff from Birmingham when I
149 was in [previous location] and I was like *yo blud wat you sayin'! Yo from my ends* and all. And...
150 the member of staff was observing it. But that other member of staff that did my-my ward
151 round report.
152 I: Mh-hmm.
153 P: So she just identified me, she just picked me out from that one, erm, that one interaction I
154 had with that member of staff and she just put it all in...so that could've gone bad when I was
155 in the-, that CTM but that member of staff, erm, sat me down with the doctor, the one that I
156 interacted with, and said *We can't be picking out little bits of [Julie]* cause I've got Manic
157 traits...so yeah I felt really discriminated about that yeah-,
158 I: -Yeah, yeah-

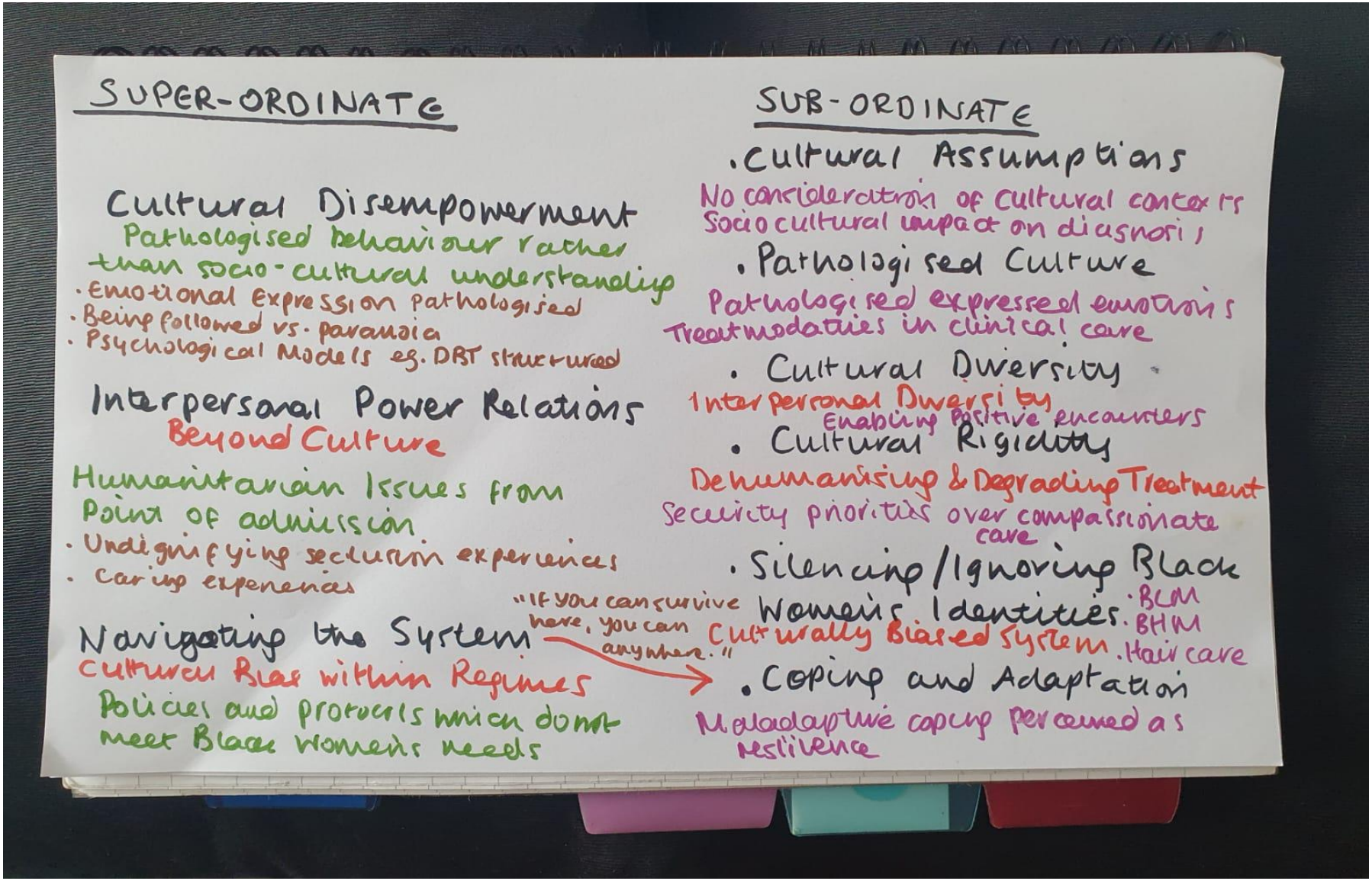
Appendix 13B- Example of Coding Analysis



Appendix 13C- Illustrative IPA Process



Appendix 13D- Revision of IPA Themes



Appendix 14- Additional Excerpts from Transcripts to Evidence Themes

Admission Experiences

"It was outrageous 'cause I'd never seen anything like that before I mean…they offered me a blue nightie and I'd never - *[laughs]* – I'd never seen anything like a blue nightie." (Julie, lines 85-87)

"They wanted to take my shoelaces off me and I was-, I didn't even understand why they wanted to take my shoelaces off me." (Julie, lines 89-90)

"There was a lot banging noises, like as if people were fighting behind doors and that. It was quite scary. I was getting more negative thoughts there... It was quite scary actually, I didn't feel safe." (Nina, lines 97-113)

Theme 1: Cultural Disempowerment

Racial and Cultural Assumptions

"A lot of stereotypes…and I think it's because obviously, I think people don't wanna get to know you, just read your notes, look at you at face value and think *oh she's gonna be trouble she is* and then as soon as you open your mouth they're like *eugh.*" (Julie, lines 186-189)

Pathologised Culture

*"*So *[nurse]* just identified me, she just picked me out from that one interaction I had with that member of staff and she just put it all in about speaking Patois… …so yeah I felt really discriminated about that yeah-." (Julie, lines 153-157)

Theme 2: Beyond Culture

Degrading and Dehumanising Treatment

“There was a lot banging noises, like as if people were fighting behind doors and that. It was quite scary. I was getting more negative thoughts there... It was quite scary actually, I didn’t feel safe.” (Nina, lines 97-113)

“I wish I had a bit more support and stuff.” (Brenda, line 112)

“At one point I was upset, I don’t know what about, I was crying and this staff member started mimicking me like went *[crying noises]* like that because I was upset and crying and, yeah that really got to me.” (Brenda, lines 470-479)

“If something really bad happens like…for example like if a staff is abusive, I don’t mean abusive like beat someone up but like speaks rudely to us or says something they shouldn’t do and it needs to be reported, we fill out one of those complaint forms and we pass it to the staff to pass on to whoever, and it never gets anywhere! I used to think these staff are just shredding these complaint forms, because they don’t wanna get in trouble.” (Sarah, lines 402-408)

“Some [staff] were quite erm, sarcastic? And, erm, passive. Sometimes they’d shout at you. They’d just raise their voice, you’d talk to them and if they weren’t happy they’d raise their voice.” (Lisa, lines 72-82)

“I was kind of thrown in at the deep end and it was left for the girls to explain kinda certain things, my peer on the ward” (Julie, lines 97-98)

“They’re [staff] like vultures and it’s kinda hard and you’re struggling with what’s going on in your brain as well and your emotions.” (Julie, lines 110-111)

Interpersonal Diversity

“It was difficult but [staff] were kind to me… Yeah, some of them, they were kind and some of them, they were bossy.” (Lisa, lines 62-64)

“[Staff] just talk nicely to me, help me, treat me good.” (Lisa, line 67)

“[Staff] listened to you, they gave you good advice…It was good to talk to them” (Lisa, line 164-166)

“It was just one incident, but I done a complaint about it… [Staff] shouted at me… And I wasn’t happy, so I done a complaint. You know we talked, and we made up and it didn’t happen again… Yeah we had the chance to sit together and we made up and talked. We made up at the end…And she never shouted at me again, never again. She learned her lesson!” (Lisa, lines 182-205)

“There was one patient and she was ill. And when she’s ill she calls the Black staff and the Black patients *fucking Black* and being racist… Wasn’t nice to hear that… One of the nurses told the lady *I’m happy to be Black, go away*.” (Lisa, lines 368-377)

“I’m not saying that all staff are bad, the normal regular staff, but… you know you did have some good staff, do you know what I mean?” (Sarah, lines 625-626)

“If I wanna change medication my doctor’s always been open to changing my medication as long as it’s not gonna be detrimental to my mental health.” (Sarah, lines 341-343)

“When like I have ward rounds and stuff, the staff and the doctors actually listened to me and actually listened to my opinion and like helped me progress and stuff.” (Brenda, lines 375-377)

“I think I got good support, especially when I went to [medium secure hospital], things were changing and like if I needed the staff, they all wanted to be there for me.” (Brenda, lines 449-450)

“Yeah, yeah I felt that I was listened to, yeah, definitely.” (Hodon, line 193)

Theme 3: Cultural Bias within Regimes

Culturally Biased Systems

"I mean some of the food that we have and some of the way that we cook… our cooking takes time. The way that we're taught to cook in here…we have to be cleaned, cooked, out of the kitchen in an hour. That's not the way we cook!" (Julie, lines 229-231)

"I get stuck a bit here because I want to be who I am here! They say they do a lot for Black women here but I don't think they do" (Julie, lines 253-254)

Culturally insensitive psychological models

"DBT, Dialectical Behavioural Therapy Ward, they expect you to talk with this sort or charisma and this sort of mannerisms… And…I ain't got the mannerisms, textbook mannerisms." (Julie, lines 165-168)

Cultural events celebrated in the Black community

"We had one meal in Black History Month, one meal…. they do a lot for Eid, they do a lot for Diwali, they do a lot for this, they do a lot for that but come on guys…I just think they let the side down really." (Julie, lines 262-273)

"I don't think [Black History Month] was really recognised. Like there was sometimes they'd do stuff for like Eid or something. But they didn't really do anything for Black History Month." (Brenda, lines 646-649)

Haircare

“As a woman, and I’ve got mine [pride], is my hair. We need to do certain stuff, I mean I’ve even got psoriasis in my hair because I don’t use the right products and it stresses me out. And when you don’t use the right stuff on your scalp, you feel your scalp gets stressed. They don’t buy the right products for me for my scalp. My skin gets dry. So obviously when you mix two different cultures, we’ve got different skin types, we’ve got African women here. And their needs are a lot different.” (Julie, lines 278-286)

“It’s OK for some of these young, no offence, some of these young English girls because the staff can help them in the shower… And help them by putting the shampoo and conditioner and combing through their hair. I’ve never seen a member of staff help these Jamaican or African or mixed race and help them and comb through their hair because they haven’t got the right products.” (Julie, lines 354-359)

“I don’t know If I should say this, but you know when people’s hands are dry and crusty? I see some people walking round with that, because obviously their mental health, they don’t get to do stuff, their family ain’t there so…in a way, yeah, they get neglected.” (Brenda, lines 417-423)

“My dad gets [hair products] for me. As much as getting some hair oil and some relaxer. He got me two each, two hair oils and two relaxers. That’s going to last me for a year now.” (Nina, lines 362-363)

“[Black hairdresser] used to come in the hospital. But after a while she stopped coming to the hospital, so when you have leave, you can go to the high street and do you hair there.” (Lisa, lines 429-430)

“They used to let the Black nurses do our hair, but they weren’t allowed to anymore… because one of the girls wasn’t happy with her hair, with how they’d done it. So to not get into trouble they stopped doing our hair.” (Lisa, lines 434-438)

“Haircare, for example, I wasn’t allowed to go outside…And the shop that is inside the hospital didn’t sell Black hair stuff. So one of the staff offered to walk to the shop for me and buy me hair stuff.” (Hodon, lines 216-219)

Navigating the System

“I have to adjust to a lot of other people’s behaviours and other people’s *ways.* And I respect it but I’m expected to adhere to certain things and it’s not- and I do! But to shun my own beliefs as well, and my own opinions, and I shouldn’t have to do that.” (Julie, lines 240-243)

“I mean obviously not everyone is gonna like certain things, and if you’ve been, you’ve been brought up in-, shoved in your face by your mum and your dad and taught not to like black people I mean, obviously it’s gonna be passed down to you…And the first thing you’re gonna shout when you don’t like somebody Is *you black bitch* and it happened to me quite a lot.” (Julie, lines 402-402)

“I’ve been called a *P*** *a darkie a Black b**** all my life so at the end of the day…you have to take it with a pinch of salt and just get on with it, ‘cause you can’t let it spoil your life can you?” (Julie, 441-443)

“Usually I feel like I’m more quiet so, no they listened to me.” (Hodon, line 195)

“Some women are overdramatic in their personality. I’m more like calm and relaxed and most staff used to like me cause I never used to bother them unless I need to.” (Hodon, lines 237-239)