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Staff and Service User Experiences of Forensic Mental Health Services

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This thesis is submitted in partial fulfilment of the requirements for the degree

of

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List of Abbreviations

BPS	British Psychological Society
CASP	Critical Appraisal Skills Programme
CRD	Centre for Reviews and Dissemination
DOH	Department of Health
FMHS	Forensic Mental Health Services
FSU	Forensic Service User
ID	Intellectual Disability
IPA	Interpretative Phenomenological Analysis
MDT	Multi-Disciplinary Team
HSU	High Secure Unit
NHS	National Health Service
PD	Personality Disorder
QAF	Quality Assessment Framework
SMI	Severe Mental Illness

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Declaration

The thesis has been written for submission as a partial fulfilment for the requirements for the Universities of Coventry and Warwick Clinical Psychology Doctorate programme. It has not been submitted for a degree at any other university.

It was carried out under the academic and clinical supervision of Dr Deborah Biggerstaff (Lecturer and Researcher, Warwick Medical School, University of Warwick), Dr Helen Liebling (Senior Lecturer in Clinical Psychology / Research Tutor, Coventry University) and Dr Ruth Fountain (Principal Clinical Psychologist, Birmingham and Solihull Mental Health NHS Foundation Trust) with additional input from Dr Carolyn Gordon (Coventry University) and Dr Tom Patterson (Coventry University). The named supervisors provided suggestions and ideas throughout the research process and read initial drafts of the chapters included. Aside from this the thesis is the candidate's own work.

Chapters one and two are written for submission to the International Journal of Forensic Mental Health. Authorship will be shared with the named supervisors.

Summary

This thesis consists of three chapters. Chapter one is a systematic review of the qualitative literature examining the experiences of clinicians working in mental health services with forensic service users (FSU). Following systematic searches and a process of quality assessment, a total of 14 articles were included and their findings were systematically compared. Staff members experienced both positive and negative emotional responses to their work, there are conflicting aspects to their role and additional challenges within the organisational context. Implications for clinical practice and further research are discussed.

Chapter two uses Interpretative Phenomenological Analysis (IPA) to consider the experiences of FSUs diagnosed with Personality Disorder (PD) in Forensic Services and the meaning given to recovery within their accounts. The findings discuss the disempowered position of FSU participants and suggest that feeling safe within relationships in their environment is important for those with this diagnosis. There was evidence in their accounts of attempts to establish new identities but there also appeared to be multiple barriers to this.

Chapter three offers a reflective account of the researcher's experience of carrying out this study. It demonstrates the reflexive strategies used that allowed the competing subjective roles alongside that of 'researcher', to be examined and their influence on the research process explored.

Total Word Count: 19, 849

Chapter One: Literature Review

Forensic Clinical Practice: A Systematic Review of the Qualitative Literature on Staff Experiences

Chapter word count: 8080 (excluding tables, footnotes and references).

In preparation for submission to the International Journal for Forensic Mental Health (See Appendix A for Instructions for authors).

1.1 Abstract

Staff in Forensic Mental Health Services (FMHS) are considered to be at risk of job related stress and burnout due, in part, to the complex needs of the forensic service users (FSUs) with whom they work. Job related stress has a detrimental effect on individuals, organisations and service users. Further understanding is needed of how staff members in FMHS experience and manage this complex work.

The present review critically evaluates the qualitative empirical research into how staff experience work in mental health services that provide care for FSUs and what helps them to manage the unique demands of this work. Following a systematic search of relevant databases and a process of quality assessment, 14 studies were identified as suitable for inclusion in the review.

The findings indicate that staff in FMHS experience both positive and negative emotional responses to their work, that there are conflicting aspects to their role and additional challenges within the organisational context. Clinical implications of the findings are discussed, limitations of the review are acknowledged and avenues for further research are recommended.

Keywords: Forensic mental health, systematic review, qualitative, staff, experience.

1.2 Introduction

1.2.1 Burnout and Occupational Stress in Mental Health Professionals

Working in mental health services can have a significant emotional impact on employees, with high levels of burnout[1] and diminished wellbeing found in staff teams across a range of settings (Paris & Hodge, 2009). Occupational stress and burnout are associated with a variety of difficulties affecting a person's emotional and physical wellbeing (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). As well as affecting the individual, when prevalent in staff teams these difficulties can have negative consequences for organisations as a whole, contributing to high rates of staff turnover, which has financial implications for employers (Stalker & Harvey, 2002). Furthermore, burnout in staff impacts on the care service users receive; Garman, Corrigan and Morris (2002) found that increased emotional exhaustion in mental health professionals was associated with decreased service user satisfaction. The recent socio-economic climate has meant that despite a drive for "parity of esteem" between mental health and physical health services (Department of Health [DOH], 2011, p.2), there has in fact been a reduction in the funding of mental health services (Doherty & Thornicroft, 2015). In this context, work in these services is thought to have become even more demanding (Norton, 2012).

[1] Burnout in healthcare staff has been described as a syndrome of emotional exhaustion, depersonalisation (a more detached attitude to others in the work environment) and decreased personal accomplishment (Maslach & Jackson, 1986)

1.2.2 The Impact of Working in Forensic Mental Health Services

Job-related factors, including client group characteristics, are associated with burnout and job satisfaction (Happell, Martin, & Pinikahana, 2003). Ewers, Bradshaw, McGovern and Ewers (2002), suggest that professionals working in FMHS are at particular risk of job related stress due to the chronic and complex difficulties experienced by this client group and high levels of service user aggression. The long-term nature of FSUs' difficulties can result in staff experiencing a poor sense of self-efficacy and feelings of frustration (Ewers et al., 2002). Furthermore, the prevalence of trauma and abuse in the early lives of FSUs, along with their offending histories, means those working with them therapeutically could be at risk of vicarious traumatisation (Kurtz, 2005).

In addition to having an impact on staff members, service users and organisations, stress and burnout in staff within FMHS can have a further impact on the effectiveness of the public protection that they provide (Kurtz & Turner, 2007). High profile investigations into care at Ashworth High Security Hospital (Blom-Cooper, Brown, Dolan, & Murphy, 1992; Fallon, Bluglass, & Edwards, 1999) have cited the emotional impact of the work on staff as relevant to the systemic and cultural difficulties that developed in these services.

1.2.3. Impact of Working in Forensic Mental Health Services: Existing Evidence

Despite the highlighted risks, there has been a degree of inconsistency found by quantitative studies considering the constructs of stress and burnout in staff within FMHS. Happell et al. (2003) and Chalder and Nolan (2000) found that

nurses in FMHS experienced lower levels of burnout and job-related stress when compared to mental health nurses in mainstream services. However, elsewhere, significant levels of burnout and stress have been highlighted (Coffey & Coleman, 2001; Kirby & Pollock, 1995).

Two existing literature reviews have considered the experiences of staff working in FMHS, one of which reviews research on stress and burnout in forensic mental health nurses (Dickinson & Wright, 2008). This review identified conflict within staff teams and poor support as factors associated with increased burnout in staff; however, its focus was restricted to one staff group (Dickinson & Wright, 2008). A separate systematic review looked at the impact on staff of working with offenders diagnosed with personality disorder (PD) (Freestone et al., 2015). The review highlighted the risk of burnout for staff, although there were also findings that indicated staff can experience a degree of accomplishment and satisfaction from their work. However, this review was restricted to research with staff working in specialist PD services and did not include studies of staff working with clients across the range of mental health presentations represented in FMHS. This review was limited further by the inclusion of a large number of non-empirical, expert opinion articles.

1.2.4 Rationale and Aims

Compared to the highly developed body of literature regarding staff experience in general mental health services, the evidence base in relation to staff in FMHS is limited, with much of the extant research focussing solely on nurses (Harris,

Happell, & Manias, 2015). There is a wealth of descriptive literature and expert opinion which continues to highlight the extreme demands of the work in FMHS (Moore, 2012; Ruszcynski, 2010), however, there is limited empirical research that is methodologically robust or of large scale (Dickinson & Wright, 2008; Freestone et al., 2015).

More recently, a small body of qualitative research has emerged, which has provided a more nuanced understanding of the complex and even contradictory nature of the impact of this work on staff. In healthcare research generally there is thought to be a lack of "cumulative knowledge" from qualitative studies (Pope, Mays, & Popay, 2007). With growing recognition that healthcare policy needs to be informed by a range of data sources, both qualitative and quantitative (Dixon-Woods, Agarwal, Jones, Young, & Sutton, 2005), there is a need to be able to synthesise findings from qualitative studies, so that this body of research can be used pragmatically to inform healthcare practice (Zimmer, 2006). Up until now, the qualitative research into staff experience of FMHS has not been brought together and examined in this way.

To adequately address the impact of stress and burnout in FMHS on staff, service users and organisations, a more in-depth understanding is required of how the range of disciplines working in FMHS experience their work. Reviewing the qualitative findings from across FMHS will help to bring together the key findings regarding staff experience in this setting and therefore inform more specific, quantitative or qualitative, future lines of enquiry.

Thus, the present review aims to critically evaluate the empirical findings of qualitative research exploring the experiences of staff members who work in mental health services that provide care for FSUs. Specifically the review will address the following questions:

1. How do staff members experience this work?
2. What factors help staff to manage the unique demands of working in these services?

1.3 Method

1.3.1 Search Strategy

A systematic search of the literature exploring staff members' experiences of working in FMHS was carried out in October 2016. The search used the following databases: PsychINFO, Web of Science, Cumulative Index of Nursing and Allied Health Literature (CINAHL), Scopus, Medline and Applied Social Science Index and Abstracts (ASSIA), which cover literature within psychology, medicine and nursing. Additional online searches were conducted for completeness using Google Scholar and Encore, a university library search engine. No specific additional search for unpublished literature was carried out, but relevant unpublished articles were retained when found using the search strategies described. The search terms[2] used are represented in Table 1.1. The initial screening of articles was carried out using the title and abstract with

[2] Boolean operators were used in the search as follows: "forensic mental health" OR "secure unit*" OR "secure hospital*" OR "special hospital*" OR "mentally ill offender*" OR "mentally disordered offender" AND staff OR psychiat* OR psycholog* OR nurse* OR "occupational therap*" OR "social worker*" OR psychotherap* OR clinician* OR professional* AND qualitative OR experience* OR perception* OR narrative* OR view* OR perspective*.

reference to the broad criteria of whether the subject related to staff members working within FMHS and was either of qualitative or mixed methodology. Full text articles of the studies meeting these criteria were examined in more depth with specific reference to the inclusion and exclusion criteria (see Table 1.2). At this point a further manual search was conducted, examining the reference lists of all full text articles reviewed.

Table 1.1

Search Terms

Concept	1. Forensic mental health services	2. Members of staff	3. Qualitative
Search term	"Forensic mental health"	Staff	Qualitative
Additional variations	"Secure unit*" "Secure hospital*" "Special hospital*" "Mentally ill offender*" "Mentally disordered offender*"	Psychiat* Psycholog* Nurse* "Occupational therap*" "Social worker*" Psychotherap* Clinician* Professional*	Experience* Perception* Narrative* View* Perspective*

*Represents truncation to allow for variations in terminology

Research that considered staff members' experiences in relation to particular aspects of clinical work in FMHS were included, where these experiences were thought to be common to the forensic setting, for example managing self-harm or aggression. Similarly, as the aim of the review was to understand the

commonalities of staff experience within FMHS generally, papers that considered staff working in a range of services and studies considering staff from a range of disciplines were included. The review aimed to consider research into the experiences of staff working therapeutically with a population detained in relation to both their mental health needs and their offending. Given the significant differences in culture, role and ethos between FMHS and the prison service (Knight & Stephens, 2009), research within a prison setting was not included.

Table 1.2

Inclusion and exclusion criteria

Inclusion criteria	• Research where at least one of the aims required participants to speak about how they experience their work. • Research with staff members working with FSUs in any mental health service or with any professional group working in FMHS.
Exclusion criteria	• Quantitative studies with no qualitative data. • Research in which data from staff members and FSUs was analysed together rather than separately. • Research in which data from staff working with FSUs and data from staff working with other populations was analysed together rather than separately. • Data that was not gathered *directly* from staff working with FSUs • Studies within prison settings. • Studies not published in English.

1.3.2 Search Results

The systematic selection process is presented in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher, Liberati, Tetzlaff, & Altman, 2009) in figure 1.1. Following this strategy 14 studies were identified as suitable for inclusion in the review.

1.3.3 Quality Review

1.3 3.1 Quality assessment tool.

The assessment of quality in the systematic review of qualitative research is a topic of debate. The application of concepts of reliability and validity used in relation to quantitative research to the review of qualitative papers has been criticised (Pope et al., 2007). However, as qualitative research is increasingly having an influence on policy and practice within health care settings, the quality of this research and the confidence policy makers can have in it, is becoming of greater importance (Dixon-Woods, Shaw, Agarwal, & Smith, 2004). Thus, structured assessment as part of the systematic review process is recommended (Centre for Reviews and Dissemination, [CRD], 2001).

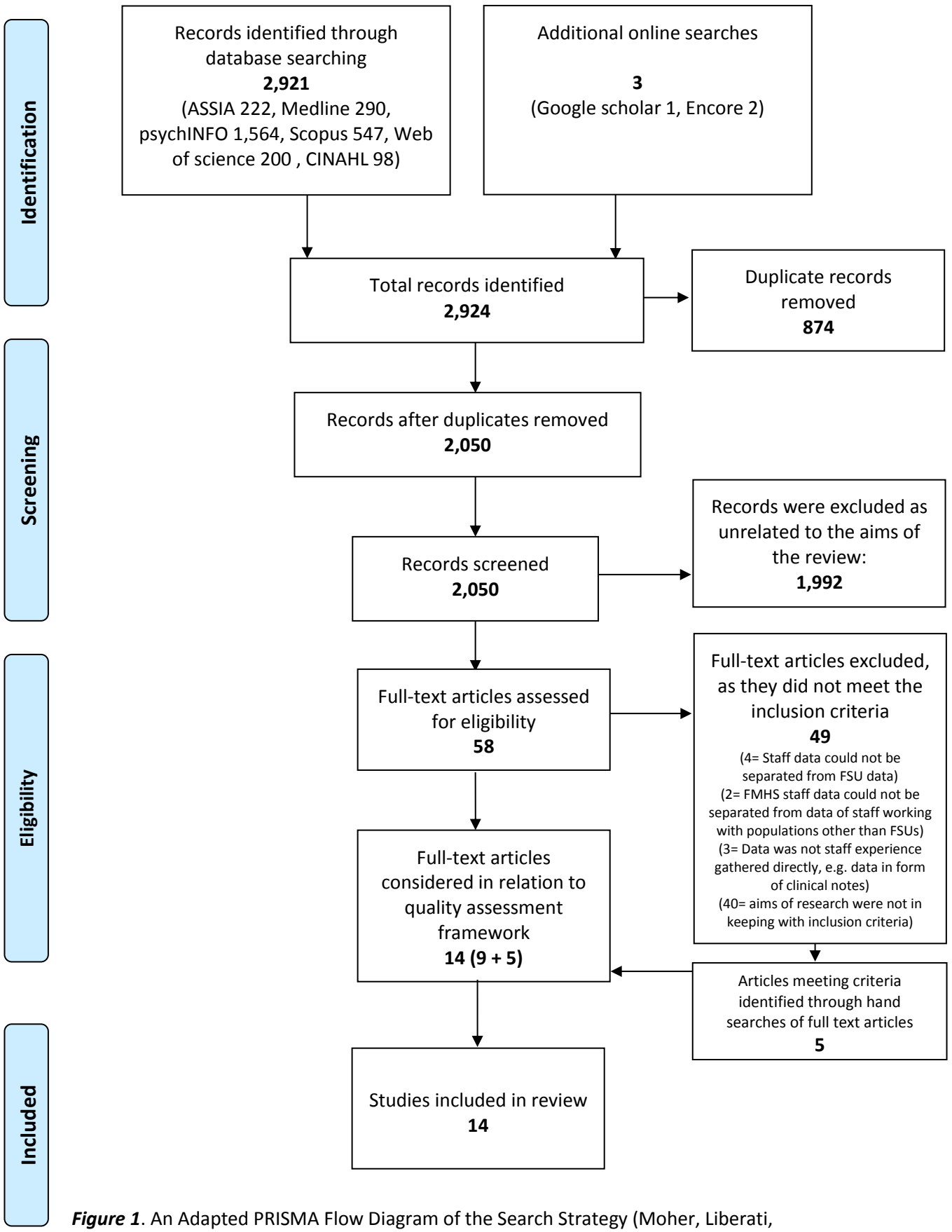

Figure 1. An Adapted PRISMA Flow Diagram of the Search Strategy (Moher, Liberati, Tetzlaff & Altman, 2009

Pope et al. (2007) cite the Critical Appraisal Skills Programme (CASP) checklist for qualitative research studies (CASP, 2006) as one of the most useful frameworks for reviewing the quality of qualitative data (Appendix B). Malpass et al. (2009) found the CASP checklist to be more comprehensive than two alternative qualitative quality assessment frameworks (QAFs) they considered in comparison. This checklist was therefore used in the current review. The CASP has recently been used in qualitative syntheses within the area of forensic mental health (Clark, Lumbard, Sambrook, & Kerr, 2015; Shepherd, Sanders, Doyle, & Shaw, 2015) and therefore offered the advantage of a consistent approach to considering quality with the existing qualitative literature in this field. The CASP framework was scored using the method devised by Duggleby et al. (2010). See Appendix C for further details of the scoring criteria and the criterion scores given for each study.

1.3.3.2 Quality assessment results.

1.3.3.2.1 Overview.

The use of a QAF that generated scores allowed for the reliability of the quality assessment to be enhanced by an inter-rater reliability analysis. Another researcher independently rated a sample of three articles against the same QAF; the results (Kappa = 0.78) suggested there was strong inter-rater reliability.

The CASP scores given to each study are presented in Table 1.3 and are further explained in Appendix C. Overall, the scores suggested that the studies included were of a good standard, with the majority of the papers scoring over 18 out of 24 (75%). Of the three articles that did not, two were mixed methods studies. The presentation of the aims, methods and findings of these studies had to accommodate both quantitative and qualitative data, therefore potentially limiting the depth of discussion possible regarding the latter (Coffey, 2000; Taylor & Trout, 2013).

1.3.3.2.2 Sample and sampling.

In the studies considered, researchers frequently described the practical aspects of their recruitment process but did not identify the type of sampling approach used or justify its appropriateness. There was also limited discussion of how sample size was determined. Research using grounded theory and affiliated methods uses theoretical data saturation in order to determine sample size (Glaser & Strauss, 1967). However, of the three studies using grounded theory or a related methodology (Boyle, Kernohan, & Rush, 2009; Kurtz & Turner, 2007; Barros, Rosa, & Eizink, 2014), only one made reference to this process (Barros et al., 2014). Similarly, the research using phenomenological approaches did not include discussion of how appropriate sample sizes were determined.

The majority of papers provided pertinent demographic details regarding participants and information about the services from which the data was

collected. This 'situated' the sample enabling readers to consider to whom the findings of the research may be relevant (Elliot, Fischer, & Rennie, 1999).

1.3.3.2.3 Methodology and data collection.

The majority of the studies had exploratory research questions and therefore the use of qualitative designs was appropriate, while two studies adopted a mixed methodology as only part of their aims were exploratory (Coffey, 2000; Taylor & Trout, 2013). There was minimal discussion of the epistemological position of the research across the studies reviewed, and generally little justification or rationale given for the methods used with reference to their theoretical roots.

The majority of studies used semi-structured interviews; Taylor and Trout (2013) used focus groups for the qualitative component of their research, Harris et al. (2015) used both focus groups and semi-structured interviews. Two studies used self-report questionnaires (Barros et al., 2014; Coffey, 2000), which appeared to limit the degree of exploration possible when compared to the use of interviews. Tema, Poggenpoel and Myburgh (2011) and Dhondea (1995) used field notes and observations, in addition to data from interviews. However, there was limited explanation regarding the methods of data collection used or how this data was used to inform the analysis. The only study to include a copy of the interview schedule used was Evans, Murray, Jellicoe-Jones and Smith (2012), however a number of papers did describe how interview schedules

were developed (Fortune et al., 2010; Kurtz & Jeffcote, 2011; Kurtz & Turner, 2007).

1.3.3.2.4 The role of the researcher.

A consistent omission throughout the majority of the studies was reflexive consideration of the researcher's role. Kemp (2008) included a more thorough examination of this, an opportunity that may have been afforded by the more generous word count of an unpublished thesis. This might suggest that peer review does not favour this type of reflexive discussion or deem it necessary, which is significant considering it is a widely acknowledged aspect of a qualitative approach (Finlay & Gough, 2003). Where studies did make reference to reflections on the role of the researcher, this was often discussed in relation to just one aspect of the research, rather than considering its impact at different stages of the process (Evans et al., 2012; Kurtz & Turner, 2007).

1.3.3.2.5 Ethical considerations.

Several studies reviewed made no reference to the process of ethical review that the project had been subject to (Coffey, 2000; Kurtz & Jeffcote, 2011) yet did discuss the range of actions taken to ensure the research process was ethical. Other studies made reference to the process of ethical review but did not discuss the ethical considerations particular to the study (Barros et al., 2014; Boyle et al., 2009; Evans et al., 2012). Some studies did not discuss ethical review or the specific ethical considerations of the research (Dhondea, 1995; Kurtz & Turner, 2007; Taylor & Trout, 2013). Research in FMHS poses particular

ethical dilemmas due to the disempowered position of FSUs; explicit discussion of how research is ensured to be ethical in this context is therefore important (Clarke et al., 2015).

1.3.3.2.6 Credibility of findings.

Several papers made use of credibility checks including member checking[3] (Clark, 2013; Fish, 2000; Kurtz & Turner, 2007) and the use of a second qualitative analyst (Evans et al., 2012; Tema et al., 2011; Taylor & Trout, 2013). The credibility checks most frequently included appeared to be those most consistent with quantitative ideas of validity; member checking for example has been criticised for retaining a positivistic search for objective reality when used as "a criterion of transactional validity" (Koelsch, 2013, p. 170).

1.3.3.2.7 Analysis and presentation of results.

The majority of the articles reviewed provided a helpful level of description regarding the process of data analysis and presented coherent themes with appropriate quotations to illustrate them. There were some studies that presented findings as frequencies within categories (Barros et al., 2014; Coffey, 2000) or as themes listed without further discussion or quotations to illustrate them (Taylor & Trout, 2013). Two of these studies used mixed methodologies; again, presenting the findings alongside the quantitative results may have limited the scope for discussion of the qualitative material.

[3] Member checking aims to enhance the validity of qualitative research by seeking feedback from participants on either themes emerging from the data or their transcripts to ensure they feel their views have been adequately captured (Elliot et al., 1999).

1.3.4 Analysis

The present review identified the context, participants and main findings from each study and then systematically compared the findings in order to identify both common themes and areas of divergence across the papers. This method is based on Emslie's (2005) modification of techniques originally used by Britten et al. (2002) and Campbell et al. (2003).

1.4 Results

1.4.1 Characteristics of Studies

The characteristics of the 14 studies reviewed are presented in Table 1.3. Ten studies were with populations within the UK, two were conducted in Australia, one in Brazil and one in South Africa. Two used a mixed methodology (Coffey, 2000; Taylor & Trout, 2013) whilst all others were qualitative. Two papers considered staff teams working with younger people in FMHS (Clark, 2013; Kemp, 2008), two were with staff working in community teams (Boyle et al., 2009; Coffey, 2000), two were with teams working in specialist PD Services (Fortune et al., 2010; Kurtz & Turner, 2007), one was with staff working specifically with FSUs who had committed offences of a sexual nature (Barros et al., 2014), one considered staff working with FSUs diagnosed with intellectual disability (ID) (Fish, 2000) and one was in a high secure service for FSUs diagnosed with both ID and PD (Taylor & Trout, 2013). Four papers examined the experiences of nursing staff (Coffey, 2000; Dhondea, 1995; Tema et al., 2011; Trout & Taylor, 2013), one collected data from unqualified support staff (Evans et al., 2012) and one from forensic psychiatrists (Barros et al., 2014).

The remaining studies gathered data from multi-disciplinary team (MDT) members from a range of disciplines.

In addition to exploring staff members' experiences of their work, other aims explored included how staff manage difficult feelings (Barros et al., 2014; Coffey, 2000), the best means of supporting staff (Dhondea, 1995; Tema et al., 2011), how staff understand their role (Kemp, 2008; Kurtz & Turner, 2007) and barriers and facilitators to building relationships with FSUs (Evans et al., 2012). Discussion of psychodynamic theory was prevalent in a number of the papers reviewed. Some studies used this in an interpretative way in the process of analysis (Barros et al., 2014; Boyle et al., 2009; Kemp, 2008), whereas elsewhere the findings were made sense of in the context of psychodynamic theory subsequent to the analysis (Clark, 2013; Harris et al., 2015; Kurtz & Jeffcote, 2011; Kurtz & Turner, 2007). All of the reviewed articles included some findings that addressed the first aim of the present review; findings relevant to second aim were not discussed in as much depth.

Table 1.3

Characteristics of Studies

Authors, date, publication type.	**Sample (country of origin, setting, size, demographic information).**	**Aims and objectives.**	**Design, data collection method & analysis.**	**Summary of findings relevant to the aims of review.**	**Quality review rating (out of possible score of 24).**
Barros, Rosa, & Eizink (2014) Peer reviewed.	**Brazil** 24 Forensic psychiatrists working in a forensic hospital. Does not specify male or female service users (SUs). 50% male 50% female Age: (mean) 47.1 years. Length of forensic experience: (mean) 24.1 years. 91.6% had personal psychotherapy. 79.1% training in a psychotherapy. Exclusion: Not having assessed or worked with a sex offender.	To explore feelings of countertransference aroused in forensic psychiatrists working with sex offenders. To explore how these feelings are managed.	Qualitative; the method was described as "observational" and used a cross sectional survey. Self-report questionnaires. Analysed using "constant comparison" method until point of saturation.	Most prominent countertransference feelings described: 1. Disgust. 2. Anger. 3. Irritation. Most frequent means of management reported: 1. Maintain focus on task. 2. "Self-analysis" of countertransference. 3. Personal psychotherapy. Written examples of the accounts of 6 psychiatrists are provided.	**18**
Boyle, Kernohan, & Rush (2009) Peer reviewed.	**N. Ireland** 5 CMHT professionals from a "range of professions". Purposive sampling of "experienced and reflective practitioners". No further demographic information provided.	To explore feelings experienced in community forensic practice.	Qualitative; in depth "free associative narrative interview". Analysed using hermeneutic grounded theory.	The following "focussed codes" were found and discussed; emotional responses, binary thinking, deconstructing labels, bureaucratic defence procedures, practice dilemmas, the professional is personal, applying the therapeutic model to the practitioner, trauma, fantasy and imagination.	**18**

Clark (2013) Peer reviewed.	**UK** 13 MDT staff members in secure unit for adolescents. Does not specify male or female FSUs. Sample included nursing staff, psychology, education staff and OT. 5 male. 8 female. Age: 31.15 (mean), 21-44 (range). 100% white British. Time in current role: 2 years 3 months (mean), 8 months-3 years (range).	To examine the difficulties faced and the needs of staff working in a medium secure environment with adolescents.	Qualitative. In depth individual interviews. Interpretative Phenomenological Analysis (IPA).	Findings were presented in relation to the following themes: 1. Risk of isolation. Tension in relationships with outside. 2. Meaningful contact. Desire for therapeutic, meaningful contact. 3. Openness. Ambivalence towards openness 4. Safety. Impact of incidents: emotional safety profoundly challenged. 5. Control & Structure. The need to carefully balance the two aspects of the role. 6. Team dynamics. Relationships with colleagues close knit. 7. Complex task. Stimulation, frustration, satisfaction.	**20**
Coffey (2000) Peer reviewed.	**England & Wales** 80 Forensic mental health nurses attached to National Health Service (NHS) secure units. Does not specify male or female FSUs. 53.8% male 46.2% female Age: 37.8 years (mean) Experience: 15.47 years (mean) Time in current post: 3.68 years (mean).	To investigate stress levels and sources of stress and burnout in this group of nurses.	Mixed methodology; cross sectional survey. Demographic information and qualitative answers. Analysed using thematic content analysis. (Data from the following measures was reported elsewhere; MBI, GHQ & CPNSQ-r).	Most stressful part of job: 1. Caseload issues. 2. Administrative duties. 3. Travel. Most stressful thing that happened to you at work in last month: 1. Managing difficult service users. 2. Conflict with management or other staff. 3. Potential job loss. What helps you cope? 1. Peer support/supportive colleagues. 2. Good supervision.	**16**

				3. Good home life – friends & family.	
Dhondea (1995) Peer reviewed.	**Australia** Sample size not given. Forensic nurses - setting not discussed further than this Does not specify male or female FSUs.	To "gain an understanding of the nurse's working reality" in order to consider what they do and what their training needs are.	Ethnography: interview and direct observation conducted over a year. "Latent content analysis" undertaken on observational, methodological and theoretical notes.	Findings were discussed within the following themes: 1. Nurse's views of their professional identities. 2. Organisational practices. 3. Patterns of interaction. 4. Nurse's concerns and dissatisfaction. Training needs identified: 1. Acquisition of management skills. 2. Knowledge of how to reduce stress and burnout in forensic environments. 3. Importance of considering professional education. 4. Broadening of leaderships skills. 5. Gaining understanding of violence in the setting; educational programme for those managing violent incidents. 6. Broadening understanding of legal issues relating to FMHS.	**15**
Evans et al. (2012) Peer reviewed.	**UK** 10 support staff from 2 medium secure units in North west England (5 from each). Does not specify male or female FSUs. 3 males, 7 females Age: 36 years (mean), 22-60 (range) 100% white British.	To consider how relationships are formed and developed between support staff (unqualified) and patients within secure services. To explore staffs' personal accounts of relationships drawing on experiences, attitudes about	Qualitative. Individual semi-structured interviews. IPA.	The following themes were identified: 1. "Building bridges" The process of forming relationships with service users and what helps this. 2. "You forget what they've done": Seeing the person and managing risk. 3. "Playing our cards close to our chest": maintaining boundaries.	**22**

		relationship formation. Examines factors that enhance this process and factors that are a barrier.			
Fish (2000) Peer reviewed.	**UK** Secure ID services. 9 nursing staff (4 nursing assistants, 3 qualified intellectual disability nurses and 2 clinical team leaders). All had been key workers of service users who self-harm; these were predominantly female service users only 2 had worked with males. No further demographic information provided.	To describe staff experiences of this work. To explore personal and organizational responses to DSH. To consider explanations that staff use to understand the behavior. To make recommendations regarding treatment models and the staff support system.	Qualitative. Individual in depth interviews. "Participatory research framework". Analysed according to Hycner's (1985) guidelines for phenomenological analysis.	Findings discussed in relation to the following themes; 1) Staff- client relationships. 2) Effect of self-harm. 3) Organisational issues. 4) Explanatory reasons. 5) Recommendations for change: - Staff support. - Treatment approach.	**21**
Fortune et al. (2010) Peer reviewed.	**UK** 22 staff from 3 pilot projects of forensic PD services in three different NHS trusts. Adult male FSUs only. 12 males, 10 females. 6 managers (including one consultant psychiatrist and one senior nurse) 1 consultant psychiatrist 3 consultant clinical psychologists	To describe the experiences of staff working in the services. (To describe the experience of FSUs within the services).	Article reports the qualitative component of a "multi-method" research programme evaluating three forensic PD services. This used in depth interviews analysed by thematic analysis (Braun and Clarke, 2006).	Qualitative findings are broadly summarised in relation to findings from staff, findings from SUs, and recommendations for improvements to the services.	**21**

	3 senior nurses 2 nurses 3 health care assistants (HCAs) 2 occupational therapists 2 probation /social workers. Age: 43 years (mean), 29-60 (range). Years in current post 1.5-3 years (range).				
Harris, Happell, & Manias (2015) Peer reviewed.	**Australia** 27 MDT members: 21 inpatient, 6 community Does not specify male or female FSUs. 3 Medics, 9 Allied health professionals, 15 nurses. 12 male, 15 female. No further demographic information provided.	To explore the experiences of working in a forensic mental health setting in Australia. Including: 1. Experiences and attitudes with regard to forensic patients. 2. What are the unique rehabilitation issues during community transition for the FSU as identified by clinicians?	Qualitative 3 focus groups. 6 individual interviews. Analysed using thematic analysis (Braun & Clarke, 2006).	Themes found were: 1. Adjustment to forensic mental health services. 2. Vicarious traumatisation. 3. Therapeutic relationship. 4. Training. 5. Debriefing and supervision.	**20**
Kemp, (2008) Unpublished Thesis.	**UK** 9 MDT staff members in secure forensic units for adolescents. Does not specify male or female FSUs. 6 female, 3 male. Time in post: 3 years (mean). 5 white British 2 white other 1 black African 1 Indian.	What are staff experiences of their work? How do they understand their task?	Qualitative. Individual in depth interviews. IPA.	Superordinate themes found: 1. Powerful internal experiences. 2. Impact of the environment. 3. Negotiating complex staff relationships. 4. Managing complex staff relationships. Superordinate from 'secondary' analysis: 1. Difficulty thinking about and articulating experiences.	**24**

Kurtz & Jeffcote, (2011) Peer reviewed.	**UK** 25 MDT participants: 13 Medium Secure Unit (MSU) ward. Male and female service users. 12 Personality disorder Unit (PDU). Male service users only. 10 male 15 female. 11 nurses 14 MDT. 20 White UK 1 Black African-Caribbean 1 Black African 1 Dual Heritage 2 "Other". <u>MSU</u> Years in profession: 12 (mean), 2-22 (range). Years in current post: 4.25 (mean), 0.5-11 (range). <u>PDU:</u> Years in profession: 14 (mean), 2-27 (range). Years in current post: 2.8 (mean), 0.16-4.5 (range).	To explore the experiences of forensic mental health professionals in two contrasting services.	Qualitative. Data from each unit had initially been analysed using grounded theory. Both sets were subsequently analysed and compared using thematic analysis.	"Everything contradicts in your mind" Experience of the clinical task: 1. Difficulty in achieving task integration. 2. Motivation to build relationships, work through difficulty and bring about change. 3. Minimal sense of risk and anxiety at the centre. Experience of the organisation: 4. A distant and difficult relationship with outside. 5. Preoccupation with staff relationships. 6. Feeling unsafe.	**21** .

Kurtz & Turner (2007) Peer reviewed.	**UK** 13 MDT staff in a personality disorder service within a regional secure unit. Male service users only. 6 male, 7 female. 100% White British 5 inpatient nurses 1 community nurse 1 probation officer 2 psychiatrist 1 psychologist 1 Occupational therapist 1 Social worker 1 teacher. Years in profession: 14 (mean), 2-27 (range). Years in current post: 2.8 (mean) 0.16-4.5 (range).	To Consider: What is the relationship between stress and job satisfaction? Does clinical work with offenders with a PD diagnosis have a negative psychological impact on staff? What are the characteristics of staff's relationships with the external environment? Is their confusions relating to the complexity of the task? How do staff and patients experience control?	Qualitative. Semi-structured interviews. Analysed using grounded theory.	*Core category* "Risk of isolation" *Areas of concern:* 1. Desire for meaningful contact. 2. Contradictory attitude towards openness. 3. Feeling physically safe but emotionally vulnerable. 4. Ambivalence towards structure and control. 5. Emphasis on staff relationships. *Key contextual factors:* 1. Tension in relationship with outside. 2. Complexity of the task.	**21**
Taylor & Trout (2013) Peer reviewed.	**UK** 11 nursing staff in a developing therapeutic community for male service users with an ID and PD. No further demographic information provided.	To present an overview of the experiences of nursing staff working in this service.	Mixed methodology. Qualitative; 2 focus groups data thematically analysed. (Repeated methods administration of the Essen Climate Evaluation Schema questionnaire).	The themes identified were as follows: MDT working 1. Confusion. 2. Clarity. 3. Management support. Nursing Team Practice 1. Team cohesion and stress. 2. Model bedding in. 3. Increased openness and honesty. 4. Understanding risk. Aspirations 1. Reflection/processing time. 2. Clearer pathways.	**15**

				3. Staff training. 4. Communication with senior management.	
Tema, Poggenpoel & Myburgh (2011) Peer reviewed.	**South Africa** 9 nurses who have worked on a forensic ward in Limpopo for over 1 year. Does not specify male or female FSUs. Nurses are dual qualified general and mental health nurses. 2 male 7 female Age: 26-58 years (range) Years in current post: 1-6 years (range).	Explore and describe nursing experiences of hostile behaviour by patients in a forensic ward. Make recommendations about ways of supporting and empowering nurses.	Qualitative research. Data collected data by following means: 1. In depth phenomenolog-ical interviews (Tesch's 2008 open coding method). 2. Participant observations. 3. Field notes.	Findings were discussed within the following themes: 1. Challenges to the therapeutic relationship. 2. Fear related to threats of aggression. 3. Disempowerment/ lack of recognition. 4. Emotional and physical distress. 5. Defences.	**21**

1.4.2 How do Staff Members Experience Work in Mental Health Services that Provide Care for Forensic Service Users?

Findings from the literature reviewed identified the following themes within staff members' experiences of their work.

1.4.2.1 Impact on the individual.

1.4.2.1.1 A positive experience.

Despite co-existing difficult emotional responses, many studies made reference to aspects of the work that were valued or elicited positive emotional responses in staff. Professionals working with FSUs in the community experienced positive feelings towards their work, which were described as "rare, but valued" (Boyle et al., 2006, p. 300). Kemp (2008, p. 68) reported that staff members experienced a "rollercoaster" of emotions including intense positive emotions, such as excitement and delight, as well as more difficult feelings.

Feeling challenged by the complexity of the work but also gratified when there was progress, particularly in relationships with FSUs, was reported in several studies. Kemp (2008, p. 82) described the "massive reward" of building relationships with FSUs and seeing them make progress. Fish (2000) similarly described staff feeling appreciated in the context of relationships with FSUs and experiencing a sense of achievement when things went well for them. As well as reporting that staff found the challenging nature of the work gratifying, Boyle et al. (2009) reported that one staff member expressed a sense of privilege at

being able to connect with FSUs on a human level and understand unique aspects of their experience.

Staff members were described as highly motivated and enthusiastic in several papers. Both Taylor and Trout (2013) and Fortune et al. (2010) commented on the optimism and enthusiasm within the staff teams they studied. Both of these studies, however, consider relatively recently established services, which may have been a factor influencing staff motivation. Kurtz and Turner (2007) described staff feeling a sense of excitement in relation to the work and feeling they were doing something "cutting edge"; possibly reflecting the specialist nature of the PD service they studied.

There was also evidence of compassionate attitudes towards FSUs and an appreciation of the challenges they experienced that may have contributed to their difficulties. Kurtz & Jeffcote (2011) quote a participant reflecting that the same could have happened to them:

> There but for the grace of god [. . .] different upbringing, different social circumstance, different life events, who knows?
>
> (Kurtz & Jeffcote, 2011, p. 251)

1.4.2.1.2 A negative impact.

The majority of the studies reported staff members working in FMHS had experienced difficult and unpleasant emotional responses to their work. Several

articles found that participants experienced fear (Boyle et al., 2009; Fortune et al., 2010; Harris et al., 2015; Tema et al., 2011):

> I felt quite intimidated, I felt he was very hostile towards [me]… I felt scared of him [. . .] to the point I actually felt sick coming into work… really physically sick.
>
> (Fortune et al., 2010, p.190)

In some instances the fear related to a perceived threat of violence; however, staff also felt under attack through other means. There was a description of verbal attacks, a "constant barrage of grievance" (Fortune et al., 2010, p. 190) and female staff in one study reported sexual harassment by male FSUs (Tema et al., 2010).

A number of studies found that staff experienced anxiety in relation to managing the risk-related behaviours of FSUs and felt responsible for ensuring they did not occur (Boyle et al., 2009; Coffey, 2000; Fish, 2000). When they were not able to do so they experienced feelings of incompetence (Fish, 2000; Kemp, 2008). However, dynamics within staff teams discussed below were also relevant to how staff experienced such incidents.

Staff working with FSUs were described as traumatised by aspects of their work (Barros et al., 2011; Boyle et al., 2009) and experiences of flashbacks, insomnia and nightmares were reported (Tema et al., 2011). Vicarious traumatisation was

also discussed in several papers. This was associated with exposure to material relating to FSUs' experiences of trauma and also their offences;

> So (the FSU) starts to describe 'oh there was blood all over the floor'…. And I am building this picture, and I went home and suddenly I've got this damn picture in my head and it is bloody awful.
>
> (Harris et al., 2015, p. 133-134)

The difficult emotions experienced by staff were identified as having further damaging consequences; staff members engaged in potentially harmful coping strategies (Tema et al., 2011) and there was a negative impact on the care they provided. This included a loss of professionalism and objectivity (Barros et al., 2014) and difficulty forming relationships with FSUs (Dhondea, 1995; Harris et al., 2015; Tema et al., 2011).

1.4.2.1.3 A personally transformative experience.

Several papers described staff members feeling altered by their experiences of work with FSUs, in both positive and negative ways. Harris et al. (2015, p. 133) identified that staff experience a stigma similar to that which FSUs do, to a degree that they doubt whether there is "professional life after forensic mental health". These authors also described working with someone who has killed resulting in a realisation for staff that killing someone may not be beyond their own capability; a self-awareness described as "frightening" (Harris et al., p. 134). Boyle et al. (2009) also reported that working with FSUs impacted upon

staff members' world-views, with one participant expressing that they had lost their previous "rose-coloured view of the world" (Boyle et al., 2009, p. 307).

Elsewhere, work in FMHS was seen to have facilitated a process of personal development for staff. Kurtz & Turner (2007, p.427) suggested that due to the complexity of the therapeutic work with this client group, staff are forced to "face up to" their own difficulties. This was echoed by Clark (2013).

1.4.2.2 Organisational context.

1.4.2.2.1 Staff team relationships.

Many of the studies reviewed explored perceptions of the dynamics within staff teams and describe somewhat contradictory findings. Nurses in Coffey's (2000) study identified conflict with other professionals as a source of job stress, yet support from colleagues was also seen as the most helpful means of coping with the pressures of the work. The qualitative findings of this mixed methodology study were presented as categories with their frequencies listed; therefore limiting the extent to which this study could further clarify these contrasting findings. However, this duality was echoed within several other papers; working within a team could be one of the most enjoyable aspects of the work, yet difficulties in relationships with colleagues could also cause intense distress (Kemp, 2008; Kurtz & Jeffcote, 2011).

Several studies identified tension between nursing staff and other disciplines. Teams were perceived as hierarchical with psychiatry at the top wielding the

most power (Clark, 2013; Dhondea, 1995; Fortune et al., 2010). Nursing staff reported having limited influence on the care of FSUs, despite being the discipline that spent the most time with them (Kemp, 2008).

Dissatisfaction with management was discussed in several studies; they were perceived as having different priorities to clinical staff (Clark, 2013; Kemp, 2008; Kurtz & Jeffcote, 2011). Tema et al. (2011) reported that nursing staff felt management did not care about the quality of life of frontline nursing staff and felt blamed for difficulties managing FSUs, a view echoed elsewhere in the literature (Coffey, 2000; Fish, 2000).

Difficulty establishing open communication within staff teams was identified in a number of studies. One of the barriers to this was the reluctance of staff members to be honest about the emotional impact of the work (Clark, 2013; Fish, 2000; Harris et al., 2015; Kurt & Jeffcote, 2011). Some studies described this impacting on their willingness to make use of the forums of support on offer as they did not wish to "spill their guts" in front of colleagues (Fish, 2000; Harris et al., 2015, p. 135). The desire to avoid conflict with colleagues also affected honest communication. Staff were reluctant to raise concerns or give feedback to each other for fear of being viewed as a "troublemaker" (Clark, 2013, p. 220) or as "attacking" (Kurtz & Turner, 2007, p. 429). Dhondea (1995) described nursing staff going to considerable lengths in order to make recommendations to psychiatrists in a "passive" manner, thus preserving the expected hierarchy.

In contrast to the divisions between disciplines and groups of staff, coexisting close relationships were also described. Participants valued working as a team (Clark, 2013; Fish, 2000; Kurtz & Turner, 2007). Kurtz and Jeffcote (2011, p.253) described staff experiencing a strong sense of being "wanted" and an "overwhelming" sense of welcome within their teams. Whilst these relationships provided essential support (Clark, 2013; Fish, 2000; Coffey, 2000), a risk of them creating division within teams was also highlighted (Clark, 2013, Kemp, 2008).

1.4.2.2.2 Ambivalence towards the outside world.

Present in the findings of studies in *inpatient* FMHS was discussion of the attitudes of staff towards the world outside (Clark, 2013; Evans et al., 2012; Fish, 2000; Kemp, 2008; Kurtz & Jeffcote, 2011; Kurtz & Turner, 2007). There were descriptions of a sense of detachment; "you're in this kind of bubble of a unit" (Clark, 2013, p. 219) with staff feeling unable to talk about their work with others outside the hospital (Clark, 2013; Evans et al., 2012). Kemp (2008) understood this detachment from the outside world as a contributing influence to the intensity of relationships within staff teams.

For some, the distance between the work environment and the outside world was protective, separating staff from the traumatic material they are exposed to in their therapeutic work (Clark, 2013; Evans et al., 2012). Some staff, however, were not able to achieve this sense of distance and their work was

inescapable, encroaching on their thinking outside of work hours (Evans et al., 2012; Fish, 2000; Harris et al., 2015).

Several studies also found that staff teams experienced hostility and difficult relationships with certain external groups, including the media (Kurtz & Turner, 2007), the public (Kurtz & Jeffcote, 2011) and mental health services in the community (Clark, 2013). Staff perceived FMHS were under a persistent degree of scrutiny and the possibility of an inquiry was described as ever present (Kurtz & Jeffcote, 2011).

1.4.2.2.3 Systemic defences.

Drawing on psychodynamic theory, a number of studies identified that staff groups employed both unconscious and conscious defence mechanisms aimed at reducing anxiety in relation to the challenging therapeutic task of their work. Themes describing defences were identified within the findings of several papers (Boyle et al., 2009; Kemp, 2008; Tema et al., 2011). Boyle et al. (2009) described several unconscious defence mechanisms including "bureaucratic" defence processes, whereby staff became focussed on completing paperwork and adhering to policy as a means of managing anxiety regarding risk (Boyle et al., 2009). Dhondea (1995) similarly described nurses' focus on the task-orientated aspects of their roles that appeared to help them avoid the more unpredictable, emotive direct work with FSUs. Kemp (2008) identified a range of defences unconsciously influencing how staff participated in the research, including "vagueness", confusion and contradiction. All were understood as

staff members' attempts to avoid connecting emotionally with the more difficult, anxiety-provoking aspects of their work within the interview.

Harris et al. (2015) described avoidance strategies that were more consciously employed. This included avoiding discussion of index offences due to the fear of "recreating the psychological environment of the crime" (Harris et al., 2015, p. 134). Participants did not feel they had sufficient training in order to address this sensitive topic.

1.4.2.3 Challenges of the task.

1.4.2.3.1 Relationships with service users.

Several papers identified specific themes capturing staff members' experiences of relationships with FSUs (Fish, 2000; Harris et al., 2015; Tema et al., 2011). Fish (2000) described staff feeling manipulated and 'split' in the context of relationships with FSUs who self-harm and the perception of being manipulated was echoed elsewhere (Boyle et al., 2009; Fortune et al., 2010). Clear boundaries and direct communication in relationships with FSUs were perceived as helpful (Evans et al., 2012; Fortune et al., 2010; Harris et al., 2015).

Reflecting the defensive strategies discussed, maintaining a degree of distance from FSUs was identified as a way in which staff managed these relationships; this distance was viewed as protective. The need for protection was understood differently in different studies. Kemp (2008) reported that staff worried about being overwhelmed with sympathy for FSUs, whereas Harris et al. (2015, p. 134)

described staff members' fear of getting to know FSUs at a deeper level and being left with "disturbing" thoughts. The age group of the FSUs appeared relevant to the differing functions of this avoidance, with fear being prominent in the team working with adults (Harris et al., 2015) in contrast to sympathy in those working with young people (Clark, 2013; Kemp, 2008).

Despite these challenges, relationships with FSUs were identified as important to staff (Harris et al., 2015) and it was in the context of these relationships that many of the positive feelings staff members experienced were reported (e.g. Fish, 2000).

1.4.2.3.2 Security versus therapy.

Conflicting aspects of the core task of FMHS in both caring for FSUs in a healthcare context, but also managing risk and addressing offending, were widely reported; this conflict was seen as central to the challenging nature of the work (Boyle et al., 2009; Clark, 2013; Kemp, 2008; Kurtz & Jeffcote, 2011; Kurtz & Turner, 2007). Several areas of conflict were described, including the moral implications of caring for individuals who had committed very serious crimes (Harris et al., 2015, p. 133).

Building positive therapeutic relationships with FSUs whilst also considering their risk was reported to be challenging; staff were described as struggling to hold the latter in mind (Kurtz & Jeffcote, 2011) and "compartmentalising" their offences was a strategy that staff adopted in order to manage this tension

(Evans et al., 2012, p. 109). Kurtz and Turner (2007) found staff did not integrate the therapeutic and custodial aspects of their role and the therapeutic needs of FSUs were prioritised.

Several studies reported that staff appeared ambivalent toward structure and control within the clinical environment, which related to conflicting feelings about the custodial aspect of their role (Kurtz & Turner, 2007; Kemp, 2008; Evans et al., 2012). Boundaries and structure were perceived as necessary to enable staff and FSUs to feel safe (Clark, 2013; Kemp, 2008). However, several papers indicated that staff felt too much control was sometimes used (Taylor & Trout, 2013); they did not wish to "infantilise" service users and obstruct the development of therapeutic relationships (Kurt & Turner, 2007, p. 430).

1.4.3 What Factors Help Staff to Manage the Unique Demands of Working in these Services?

The literature reviewed described what was helpful for staff in their work in relation to organisational features of services and also the individual characteristics of staff.

1.4.3.1 Organisational features.

A majority of studies suggested that increasing staff members' understanding of FSUs and the nature of their difficulties helped them manage the emotional impact of the work; training offered by organisations was therefore suggested

to be important (Boyle et al., 2009; Tema et al., 2011). Boyle et al. (2009) reported that participants who had completed further training in a therapeutic model appeared to apply this knowledge in order to make sense of relationships with FSUs. Staff members in several studies explicitly expressed a desire for more training (Fish, 2000; Dhondea, 1995; Boyle et al., 2009).

Nurses working in a community setting identified that peer support and more formal means of supervision were the greatest source of support within their role (Coffey, 2000). Across the studies reviewed staff felt they needed more forums for support and opportunities to speak about impact of the work (Fish, 2000; Tema et al., 2011) although staff in some studies perceived there to be a stigma attached to making use of such spaces (Clark, 2013; Fish, 2000).

Aspects of the organisational structure within teams were seen as relevant to improving staff experience. Particularly apparent in studies with nursing staff, was evidence of a desire for greater influence within the care of FSUs (Dhondea, 1995; Fish, 2000). Nursing staff also expressed a desire for increased support from their managers (Fish, 2000; Tema et al., 2011) and for wards to be adequately staffed (Evans et al., 2012; Tema et al., 2011).

1.4.3.2. Individual characteristics.

Staff members' personalities were identified as relevant to how they experienced their work:

> But I think more than anything it's got to be the right people. It's not what training they've had or what fancy tools or fancy treatment they can offer; it's who they are as people.
>
> Fortune et al. (2010, p. 191)

Self-awareness was identified as helpful in allowing staff to understand the feelings experienced in relationships with FSUs and helping them to respond appropriately (Barros et al., 2014; Fortune et al., 2010). Staff members who had been in their own personal therapy were thought to have additional resources for this (Barros et al., 2014).

Other advantageous characteristics identified included motivation (Fortune et al., 2010; Dhondea, 1995) and experience (Coffey, 2000). Community forensic nurses also described the importance of having a life outside of work; a family life with hobbies and interests was seen as helpful in relation to job stress (Coffey, 2000). Training by organisations was also suggested as a means of developing staff members' personal capacities to manage stress and maintain their own wellbeing (Dhondea, 1995; Tema et al., 2011).

1.5 Discussion

The current review aimed to critically evaluate the findings of the existing qualitative research into how staff experience working in mental health services with FSUs. The review also aimed to consider the implications of the research

regarding what factors help staff to manage the demands of their work. The findings of the review will now be considered in relation to these aims.

1.5.1 Main Findings

1.5.1.1 How do staff members experience work in mental health services that provide care for forensic service users?

1.5.1.1.1 Impact on the individual.

The findings of the present review demonstrated that staff members working with FSUs experience a range of intense emotional responses to their work. Whilst a variety of difficult, negative emotions were reported, it was apparent in a number of studies that some staff also experienced a sense of pride and satisfaction from their work, in contrast to the way that working in FMHS is often portrayed (e.g. Gordon & Kirtchuk, 2008).

Experiencing stress at work was not found to negate the possibility of job satisfaction (Clark, 2013) and the complexity and challenge of the work was cited as a reason that some staff enjoyed their job (Kemp, 2008; Kurtz & Jeffcote, 2011). This is consistent with research considering occupational stress and burnout in the wider mental health literature, which has demonstrated that jobs can be experienced as both stressful and satisfying (Oynett, 2011). Kurtz (2005) has suggested mental health professionals are motivated and committed to their clinical work, so whilst they may experience stress this does not diminish their satisfaction.

One study, however, in which participants described more extreme responses to the work, with staff feeling attacked, unsafe and unsupported, was the research considering nurses in FMHS in South Africa (Tema et al., 2011). Whilst it is noted this research specifically asked nurses about experiences of hostility, participants described feeling scared and traumatised, with the work having a significant impact on their physical and emotional wellbeing. This may relate more specifically to the context of FMHS in South Africa at this time, yet it also demonstrates the extreme nature of the impact of work in these services, if the appropriate support structures are not in place.

A unique finding that emerged from the present review is that staff were affected by their work to the degree that their views and understanding of the world were permanently altered; their experience was in some way transformative. For some the change was in a distinctly negative way; staff members were left “tainted“ by their experiences (Harris et al., 2015, p.133) and had lost a “rose-coloured” view of the world (Boyle et al., 2009, p.307), whereas others felt they learned about themselves and the world in a positive way.

1.5.1.1.2 Organisational context and challenges of the task.

In addition to the systemic defences identified, when considering their findings in the context of existing literature and theory, several papers made sense of themes discussed within ‘the organisational context’ and ‘the challenges of the

task' as also having a defensive function (Boyle, 2009; Clark, 2013; Kemp, 2008; Kurtz & Jeffcote, 2011; Kurtz & Turner, 2007). The threat from the outside world that staff in inpatient services perceived was seen as a projection of the anxiety experienced in relationships with FSUs (Kurtz & Turner, 2007), as was the hostility evident between different parts of teams (Kemp, 2008; Kurtz & Jeffcote, 2011). Simultaneously an idealisation of some relationships within teams was identified, which protected staff from the risk of vulnerability and isolation (Kemp, 2008; Kurtz & Jeffcote, 2011). Systemic defences were also suggested to influence the balance maintained between the dual roles of carer and custodian (Boyle et al., 2009; Evans et al., 2012; Kurtz & Turner, 2007).

Several studies made sense of these processes in the context of a 'Social Defence System' (Boyle et al., 2009; Kemp, 2008; Kurtz & Jeffcote, 2011; Kurtz & Turner, 2007). This describes the cultures and structures that evolve in a working environment in order to prevent staff members from experiencing anxiety and uncomfortable feelings in relation to their work (Hinshelwood, 1993; Menzies Lyth, 1960). This offers one way of understanding a wide range of the processes and dynamics described elsewhere in the present review.

A reliance on systemic defences within teams has implications for the therapeutic work they undertake. Avoiding emotional connection with FSUs and avoiding their risk and offending, or attempting to restrictively control it, all reduce the opportunity to explore their difficulties. This negates the therapeutic and rehabilitative function of the environment (Gordon & Kirtchuk, 2008). The

research by Taylor and Trout (2013) described an apparently helpful shift in response to the introduction of the therapeutic community model. Staff moved from “managing risk related behaviours” to “facilitating an exploration of risk related behaviours” (Taylor & Trout, 2013, p. 50). This increased both staff and FSUs’ understanding and awareness of their risk.

The defences discussed also appeared to affect communication within teams; the idealised small cliques of staff alluded to in a number of studies were seen as impeding open and direct communication within teams and services. The necessity for open and transparent practice within National Health Service (NHS) settings has been highlighted by the recent Francis report (Francis, 2013), which investigated malpractice within an NHS trust. A central recommendation of this was the need for NHS professionals to adopt a ‘duty of candour’, obliging staff to speak out and raise concerns whenever they become aware of poor practice. The studies considered in this review suggest there may be threats to such open practice within FMHS, which, given the disempowered position of FSUs, is concerning.

1.5.1.2 What factors help staff manage the unique demands of working in these services?

This review has highlighted a range of practical and organisational features and individual qualities that can be considered in relation to support for staff working in FMHS. The aspects of the work environment identified as sources of dissatisfaction included a limited sense of agency and influence within the team

and inadequate support from managers. Again these are known correlates of burnout (Paris & Hodge, 2009).

Individual qualities and capabilities were also implicated in how staff experienced their work including, motivation, experience, self-awareness and quality of life outside of work. These factors present organisations with the alternatives of using this information in the selection of staff, or considering ways of enhancing and maximising such capacities through training.

1.5.2 Limitations

Due to resource limitations this review excluded articles that were not published in English, restricting the scope of articles reviewed. An unpublished thesis was included in the review; whilst this article had not benefitted from the scrutiny of peer review, there is thought to be an advantage to including research from a variety of sources within reviews in order to reduce the potential for publication bias (CRD, 2009). This study also scored highly on the QAF used, further justifying its inclusion.

The present review captured the opinions of participants working in a range of services, with a range of different FSU groups and from a range of professional disciplines. However knowledge of staff experience in relation to working with specific groups or of belonging to different disciplines within FMHS remains limited. Therefore whilst helpful in drawing conclusions about staff experience

more broadly, the review only provides a limited picture of staff experience at the level of specific professional groups and specialisms.

1.5.3 Clinical Implications

Recommendations for training and supervision have been made consistently in the existing literature considering the impact of working in FMHS. Findings from the present review support the view that such interventions are helpful for staff working with FSUs. In particular, the findings appear to indicate that formal supervision should be provided in a regular, mandatory capacity, in order to reduce any stigma attached to making use of it. Though challenging to implement, the provision of consistent supervision could help imbed it within team cultures with an aim of developing more transparent practice (Kurtz, 2005).

Given that whole teams were thought to enact the defensive strategies prevalent in the studies reviewed, there appears to be a rationale for recommending the use of *external* supervision (Clark, 2013; Kurtz & Turner, 2007). Psychoanalytic group supervision is the most widely recommended approach in the literature regarding FMHS (Gordon & Kirtchuk, 2008; Kurtz, 2005; Moore, 2012). This could provide a forum for the emotional impact of the work to be understood in the context of the therapeutic task, helping to mitigate the risk of staff acting out emotional responses in a way that impacts on the care of FSUs.

Present in the majority of the studies reviewed was a view that an increased understanding of the client group and their difficulties was helpful for staff. Moore (2012) suggests that an academic understanding of the behaviours displayed by FSUs in relationships can enhance capacity to tolerate such challenging interpersonal situations. Training in a psychological model that can offer staff members a therapeutic means of understanding FSUs' difficulties therefore appears indicated. Evans et al. (2012) recommend training using attachment theory, which may have the additional benefit of increasing staff members' insight into their own attachment styles and how they may influence their work.

The current review's findings also suggest that training which orients staff to the nature of work in FMHS may be beneficial. Core professional trainings are not thought to adequately prepare staff for the extreme nature of some of the material encountered in this setting (Harris et al., 2015). Given the intense, even transformative impact of the work and the reality of its continually challenging nature, providing an introduction that helps staff manage their expectations and normalises the frustrations they may encounter is recommended.

The present review highlighted a range of individual factors likely to influence how staff members manage work in FMHS. Moore (2012) considers how such knowledge may be used when recruiting staff; with staff members being selected where they have the qualities and attributes identified as protective.

Subsequent to the Francis Report (Francis, 2013), there has been a drive for NHS trusts to use values-based recruitment strategies, meaning there may now be the opportunity for services to consider attitudes in potential employees in a way that has not been possible previously.

The therapeutic community (TC) model appears to offer features consistent with the organisational factors identified as helpful, including a flattened hierarchy in which all community members have a voice and supervision time for staff that is built into the model (Haigh, 1999). The obligation for staff as well as service users to discuss difficulties in group forums could also be helpful in combatting the tightknit staff groups described as having a gagging effect within staff teams (Kemp, 2008; Clark, 2013). Recent research has suggested there can be promising outcomes from adapted therapeutic communities providing a service for male FSUs (Wilson, Freestone, Taylor et al., 2014).

1.5.4 Research Implications

In the first instance more research is needed in order to further understand the needs of staff within specific areas of FMHS and the needs of staff from different disciplines. Findings from the qualitative studies reviewed here point to a need for a range of interventions to support the functioning and wellbeing of staff teams working in FMHS. However, further research empirically evaluating the effectiveness of such interventions is needed. The current review has emphasised the complex and at times contradictory responses staff have to working in these services. Outcome measures used therefore need to examine

both positive and negative responses to the work. Interventions such as training and supervision should be considered over a sufficient timeframe to allow for long-term outcomes such as staff turnover and sickness to be considered. Addressing these factors would be important in demonstrating cost-effectiveness to the managers and commissioners of services. Capturing FSUs' perspectives and evaluating the impact of interventions with staff on a service's wider clinical outcomes is also recommended, to consider whether changes that are beneficial for staff wellbeing also improve therapeutic outcomes and service user experience.

1.5.5 Conclusion

The present review has highlighted the challenging, emotional nature of work in FMHS services and the complex psychological defence mechanisms that appear to be employed by whole teams at times in order to manage the powerful feelings the work can evoke. Despite significant challenges, the review highlights a degree of enthusiasm and dedication within the workforce and a number of avenues that can be considered in order to support staff members in their work. These go beyond the widely recommended interventions of supervision and training and make more specific suggestions regarding their implementation and also the structure and delivery of services.

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*** Denotes studies included in the present review.**

Chapter Two: Empirical Paper

Exploring Recovery in Forensic Service Users diagnosed with Personality Disorder

Chapter word count: 8,320 (excluding tables, titles, footnotes and references).

In preparation for submission to the *International Journal for Forensic Mental Health* (See Appendix A for Instructions for authors).

2.1 Abstract

The Recovery Model is widely adopted within Forensic Mental Health Services (FMHS), despite tensions between its principles and the secure environment. Personality disorder (PD) is thought to present additional challenges to recovery for forensic service users (FSUs), yet experiences of recovery in this group have not been explored.

Interpretative Phenomenological Analysis (IPA) was used to consider the lived experiences of FSUs diagnosed with PD. Six in depth interviews were conducted with male FSUs exploring their experiences of treatment and the meaning given to recovery within their accounts. Following analysis three superordinate themes were identified; 'disempowered, dehumanised', 'coming back to life' and 'the struggle'.

Participants described feeling disempowered within FMHS and many described experiences of care that were punitive and depriving. However, a number of participants experienced their current care as safe and consistent and had noticed positive changes in this context. Participants appeared to face multiple barriers to developing a sense of identity beyond that of FSU. The implications for clinical practice and further research are considered.

Keywords: Forensic mental health, personality disorder, recovery, Interpretative Phenomenological Analysis, lived experiences.

2.2 Introduction

2.2.1 The Origins of the Recovery Model

The treatment of mental health problems has historically been guided by the medical model, which conceptualises an individual's difficulties as symptoms of an underlying internal, often biological, abnormality (Rapley, Mocreif, & Dillon, 2011). Within this context, recovery is understood as the reduction of symptoms of a diagnosis as observed by clinicians (Slade, 2009). The Recovery Model, which emerged from the service user movement of the 1980s and 1990s, recognised that beyond managing the symptoms of a mental health problem, service users faced multiple challenges, some of which were iatrogenic (Repper & Perkins, 2003). Reflecting this broader understanding of the challenges service users face, recovery has become understood as more complex, with multiple components including functional, social and personal recovery (Lloyd, Waghorn, & Williams, 2008). Functional recovery refers to an individual's capacity to undertake life tasks, such as employment and tasks of daily living (Lloyd et al., 2008). Social recovery includes re-establishing roles in social networks and increasing access to activities important to the individual. Grounded in service user accounts, personal recovery describes the restoration of hope, purpose and meaning in life (Andersen, Oades, & Caputi, 2003).

The Recovery Model has been widely adopted within mental health services (Roberts, 2011) and recent mental health strategy has recommended that services are evaluated in relation to this broader definition of recovery

(Department of Health [DOH], 2011). Services guided by Recovery principles aim to promote service user empowerment; self-management, self-acceptance and a collaborative approach to treatment (Deegan, 1998). The model has more recently been applied in specialist services including FMHS (Simpson & Penny, 2011).

2.2.2 The Recovery Model in Forensic Mental Health Services

In addition to diagnoses of severe mental illness[4] (SMI), FSUs have often also experienced disadvantage in their early lives, with limited opportunity for autonomous living, and social exclusion a common experience (Dorkins & Adshead, 2011). The principles of the recovery approach are therefore cited as of particular value to this group (Dorkins & Adshead, 2011).

A recent qualitative synthesis of the literature exploring the meaning of recovery for FSUs identified themes consistent with the wider Recovery literature, including the importance of connection with others and of hope (Clarke, Lumbard, Sambrook, & Kerr, 2015). A theme specific to FSUs was also identified, describing their need to come to terms with difficult past experiences including their offending behaviour. These authors suggest training staff on Recovery-oriented care and providing opportunities for vocationally focused leave can help facilitate recovery for FSUs.

[4] The definition of severe mental illness used here refers to psychosis, bipolar affective disorder or major mood disorders as determined by the Royal College of Psychiatrists (2015).

However, there are challenges to applying the Recovery Model in secure settings. Many aspects of FMHS appear in direct conflict with Recovery principles (Pouncey & Lukens, 2010) and there is a risk of applying the "rhetoric" of Recovery without it translating meaningfully to the care of FSUs (Mezey, Kavuma, Turton, Demetriou, & Wright, 2010, p. 695). Legally detained FSUs have limited autonomy, and concern for public protection means their wishes cannot always be prioritised; this presents barriers to the collaborative working advocated by the model (Mezey et al., 2010). Furthermore, there are clinical characteristics of FSUs that present further challenges to the process of recovery, including the prevalence of PD (Drennan & Alred, 2012).

2.2.3 Personality Disorder and Recovery

PD remains a contentious diagnosis with criticism of its "overlapping and un-validated categories" (Tyrer, Reed, & Crawford, 2015, p. 712) and stigmatising effect on an already traumatised population (Kingdon, 2007). Its prevalence in service users within FMHS is estimated at 60% (Joint Commissioning Panel for Mental Health [JCPMH], 2013). FSUs with a diagnosis of PD progress through services more slowly and demonstrate higher rates of recidivism on release (JCPMH, 2013). Treatment in FMHS has traditionally focussed on medication for the symptoms of SMI and structured offending behaviour programmes. Drennan and Alred (2012) suggest this does not address the additional needs of FSUs diagnosed with PD.

Recovery is seen as a problematic term for those diagnosed with PD. Turner, Lovell and Brooker (2011) suggest that it fails to reflect the on-going challenges of living with trauma. However, Recovery principles have also been suggested as particularly suited to combating pessimistic attitudes to the treatment of those with the diagnosis (Nehls, 2000). A recent meta-synthesis of qualitative literature with service users diagnosed with PD outside of FMHS identified three themes: 'safety and containment as a prerequisite to recovery', 'social networks and autonomy' and 'identity construction as a process of change' (Shepherd, Sanders, Doyle, & Shaw, 2015). Whilst broadly consistent with descriptions of recovery in the SMI literature, the importance of *safety* in relationships and *ambivalence* toward autonomy described in these findings, show a different emphasis, thought to reflect the contrasting needs of service users diagnosed with PD.

To date, there has been limited research considering recovery in FSUs diagnosed with PD. Jenkinson (2011) used IPA to explore the recovery related experiences of female FSUs with the diagnosis. These findings highlighted the need for services to recognise that recovery journeys for this group are likely to be of some duration. There is no similar research with male FSUs at present.

2.2.4 Rationale and Aims

Recovery journeys are unique to individuals and services cannot hope to "do recovery" to service users (Drennan & Alred, 2012, p. 7). However, research considering the experiences of service users can be used to inform policy and

treatment, so that recovery remains a vision rooted in service user experience, rather than one imposed by professionals (Nehls, 2000; Castillo, Ramon, & Morant, 2013). Further research considering the experiences of FSUs diagnosed with PD appears important given that they are likely to have greater difficulty progressing through treatment (JCPMH, 2013) and that there are nuanced differences in how recovery is articulated by service users with the diagnosis compared to those with other mental health diagnoses (Shepherd et al., 2015).

The current research therefore aimed to use the in-depth accounts of male FSUs diagnosed with PD, to answer the following:

1. What are their experiences of care and treatment in FMHS that are guided by Recovery principles?
2. What, if anything, do their accounts suggest about how they think about recovery?

Traditionally there has been separation in the provision of treatment for FSUs diagnosed with SMI and those with PD (Blackburn, Logan, Donnelly, & Renwick, 2003). The utility of this separation has been questioned due to evidence of considerable co-morbidity within FMHS; co-morbidity is the rule rather than the exception (Blackburn et al., 2003). Participants were therefore not excluded on the basis of any additional mental health diagnoses.

2.3 Method

2.3.1 Design

Consistent with the exploratory aims of the research, a qualitative design was used. IPA is an approach that aims to understand the lived experiences of participants. Its idiographic focus allows for the generation of a nuanced understanding of participants' perspectives (Smith, Flowers, & Larkin, 2009). IPA has been widely used to study experiences of recovery in other populations (e.g. Ferrito, Vertere, Adshead, & Moore, 2012; O'Sullivan, Boulter, & Black, 2013).

2.3.2 Procedure

2.3.2.1 Ethical review.

Ethical approval for the project was obtained from Coventry University (Appendix D), an NHS Research Ethics Committee (Appendix E) and from the relevant NHS Trust's Research and Development department (Appendix F). British Psychological Society (BPS) guidelines and the BPS Code of Conduct informed the identification and management of ethical issues within the research (BPS, 2010; BPS, 2009). Participants provided written informed consent (Appendix G) prior to taking part. Information was stored in accordance with the Data Protection Act (1998) and Coventry University procedures.

2.3.2.2 Recruitment.

Recruitment took place within FMHS described as being Recovery oriented in their approach. The researcher attended several community meetings on a dual diagnosis PD and SMI ward to introduce the research and distribute information sheets (Appendix H) directly to FSUs. Additionally, psychologists working across secure services were asked to distribute information sheets and flyers (Appendix I) to FSUs who met the inclusion criteria.

2.3.2.3 Materials.

An interview schedule was developed in collaboration with professionals working within FMHS (Appendix J). IPA interviews seek to facilitate discussion of the phenomenon of interest in participants' own terms (Smith et al., 2009). Questions therefore allowed participants to speak about the aspects of their experience most important to them. The word 'recovery' was omitted from the interview schedule due to any preconceptions FSUs might have had about this term.

2.3.2.4 Interviews.

Semi-structured interviews were conducted with participants between July 2015 and March 2016. These were conducted in a private room on the ward in which the participant resided and was digitally recorded. Prior to each interview, the participant information sheet (Appendix H) was discussed and participants had the opportunity to ask questions. All interviewees completed a demographic information form (Appendix K) and a signed consent form

(Appendix G) prior to commencing the interview. Interviews lasted between 30 and 109 minutes with a mean length of 66 minutes. Participants had the opportunity to ask questions at the end of the interview and were provided with debriefing information (Appendix L).

Table 2.1

Participant inclusion and exclusion criteria

Inclusion criteria	• Detained under the Mental Health Act (1983) in medium secure services. • Diagnosed with a personality disorder. • Detained for a period of longer than 12 months.
Exclusion criteria	• Diagnosed intellectual disability. • Non-English speaking. • FSUs on Psychiatric Intensive Care Units. • FSUs assessed by clinical team as unsuitable due to instability of mental health or concern regarding capacity to give fully informed consent.

2.3.3 Participants

Participants were purposively sampled male FSUs, over 18 years old. Further inclusion and exclusion criteria are presented in Table 2.1. Research using IPA aims to consider relatively homogenous samples. The current sample was homogenous in terms of participants' experience of FMHS and diagnosis of PD. Given the extensive criticism regarding the arbitrary nature of the diagnostic categories of PD (Tyrer et al., 2015), the current research aimed to capture the

experiences of those with “personality pathology” i.e. any diagnosis of PD rather than one specific type (Bornstein, 2011, p. 362). FSUs detained for a period of at least twelve months were recruited to ensure participants had significant lived experience of FMHS. There were no inclusion criteria relating to where FSUs perceived themselves to be in terms of recovery; the aim was to explore ideas regarding recovery for service users at various stages of treatment.

IPA methodology challenges the assumption that a greater number of participants increases the value of research (Reid, Flowers, & Larkin, 2005). Given the depth and complexity of information captured using IPA, there is a risk larger data sets can result in the loss of subtle meanings within participant accounts (Collins & Nicholson, 2002). Six participants were recruited and this was considered sufficient to allow for an exploration of similarities and differences in accounts within the scope of a professional doctoral thesis (Smith et al., 2009).

Participants were predominantly White British, with African Caribbean ethnicity also represented. The average age was 33.7 years with a range of 23-44 years. All participants had diagnoses of antisocial personality disorder; two had additional diagnoses of borderline personality disorder. Four participants had comorbid SMI diagnoses, including paranoid schizophrenia and bipolar affective disorder. The mean length of time spent in FMHS was approximately five years. Five participants were recruited from the dual diagnosis ward and one from a

generic rehabilitation ward. Individual participant demographic information is presented in Table 2.2[5].

Table 2.2

Participant Demographics

Name	**Mental Health Issue(s)**	**Length of time in FMHS**	**Location prior to admission**
Corey	PD diagnosis Co-morbid SMI diagnosis	Over five years	High secure unit
Carl	PD diagnosis	Under five years	Medium secure unit
Alfie	PD diagnosis	Under five years	Prison
Bob	PD diagnosis with co-morbid SMI diagnosis	Over five years	High secure unit
Steve	PD diagnosis with co-morbid SMI diagnosis	Under five years	Community
Richard-James	PD diagnosis with co-morbid SMI diagnosis	Over five years	Prison

2.3.4 Analysis

2.3.4.1 Method of analysis.

Audio recordings of interviews were transcribed verbatim, excluding any identifying information. Transcribed data was then analysed using the

[5] Pseudonyms are used to preserve anonymity, participants each selected their own.

guidelines for IPA provided by Smith et al. (2009) and summarised in Table 2.3. Consistent with the idiographic focus of IPA, each transcript was analysed individually, prior to considering the next. An excerpt from a transcript showing initial notes and emergent themes is provided in Appendix M, together with an example of the grouping of emergent themes for one participant (Appendix N), examples of superordinate themes and quotations for individual participants (Appendix O) and a snapshot of the process of making connections across cases (Appendix P).

Table 2.3

Stages of Analysis based on guidance from Smith et al. (2009)

Stage of Analysis	**Actions taken**
1. Initial reading and re-reading	Data is read and re-read in detail.
2. Initial noting	Exploratory notes made considering conceptual, descriptive and linguistic aspects of the data.
3. Emergent themes	Initial notes alongside transcripts are reviewed to identify emergent themes; reducing the volume of detail but retaining the complexity.
4. Connecting emergent themes	Superordinate themes are developed by organising emergent themes through processes including abstraction, subsumption and polarisation.
5. Analysing subsequent cases	The processes above are repeated for all further participant transcripts.
6. Finding patterns across cases	Connections are made across transcripts, themes are brought together to make super-ordinate/ sub-ordinate themes for whole corpus.

2.3.4.2 Validity.

Consistent with guidelines for ensuring validity in qualitative research, several measures to enhance 'credibility' were used (Elliot, Fischer, & Rennie, 1999; Yardley, 2008). Findings at each stage of analysis were discussed with research supervisors experienced in IPA research. Sections of two transcripts were analysed by another researcher using IPA and emergent themes compared.

Reflection on the position of the researcher is important to the credibility of qualitative research (Elliot et al., 1999). Prior to data collection a bracketing interview was conducted, enabling the researcher to identify assumptions brought to the research. A research journal was then used to facilitate reflexive consideration of the researcher's position throughout data collection, analysis and interpretation. The researcher was a trainee clinical psychologist, who had previously worked in a forensic PD service, which used psychoanalytic theory in the context of a therapeutic community model. The researcher was mindful of this theoretical influence on how she might understand FSUs.

2.4 Results

Three superordinate themes emerged from analysis of the data and within each a number of subordinate themes were identified, as presented in table 2.4. A narrative discussion of each theme is provided, with illustrative quotations.

Table 2.4

Superordinate and subordinate themes

Superordinate theme	Subordinate themes
Disempowered, dehumanised	The dynamics of power
	"Contained" and deprived
	Echoes of the past
Coming back to life	A safe and humane environment
	Becoming a person again
The Struggle	A "normal" self?
	"Snakes and Ladders"

2.4.1 Disempowered, Dehumanised

This theme describes participants' experiences of a disempowering and punitive environment within FMHS. They described being "contained" without being helped in a meaningful way and there were aspects of the environment that appeared reminiscent of participants' difficult early experiences. Overall the nature of the experiences described suggested there were times participants felt they were not treated as human beings. All participants had experienced FMHS in this way at some point and so all contributed to this theme.

2.4.1.1 The dynamics of power.

Prominent in all participant accounts was discussion of their powerless positions and the limited control they had over their lives within FMHS:

> You're very, very powerless in these environments. You can say what the hell you want but it will never reach or anything happen about it.
>
> (Carl, 521)

Carl's comment here suggests that his voice has no impact. Consistent with this lack of voice, Richard-James described being 'done to' by the clinical team:

> At the end of it they have a meeting and decide what to do with you, whether to admit you or… or whatever they're going to do with you, send you back to prison or whatever.
>
> (Richard-James 423-424)

Participants experienced power enacted over them in a range of ways. Diagnosis was one aspect of this. Richard-James and Bob did not agree with their diagnoses. Carl described confusion regarding his:

> There's loads of different ones. I don't know if they make them up as they go along. Or I don't really revise or look up on them things, but people who go uni, college, training or whatever they know that sort of thing.
>
> (Carl, 498-500)

Several participants who had been in high secure units (HSUs) discussed medical treatment as another way in which power was enacted by clinical

teams, at times imposed without consent and with physically harmful consequences:

> The medication done something to his heart like a bad side effect [. . .] the doctors said to him I know the medication has done damage to you and I know it could kill you but I recommend you stay on it.
>
> (Richard-James, 438-441)

Bob, Carl and Richard-James described punitive treatment from staff. Bob associated this with his previous HSU, in which he described staff as "draconian" (Bob, 282):

> Seclusion is used a lot more frequently, for minor things, which they shouldn't really do, that helped to condition people.
>
> (Bob, 235-236)

Bob and Richard-James described corruption amongst staff teams in their previous HSUs. Bob referred to a staff member bringing in illegal drugs and assaulting a FSU. He suggested that there was a culture within staff teams whereby they protected each other:

> If someone is informing on their group it's taken very personally and that person suffers because of it.
>
> (Bob, 340-341)

Richard-James and Carl suggested that FSUs are morally judged in relation to their offences which is how staff justify treating them badly:

> He feels like he's been victimised because of what he's in for [. . .] People look at your offence more than anything else. And people are not supposed to do that.
>
> (Richard-James 224-227)

In managing their disempowered positions, Carl, Steve and Bob suggested that attempts to "fight the system" (Carl, 175) were futile. Discussion of the need to comply with treatment was evident in most participants' accounts; "Keep ticking the boxes and keep following the rules" (Steve, 57). This included psychological intervention, which despite having engaged with, some participants did not see as necessary or helpful; "I didn't benefit nothing from it, it was a waste of time" (Richard-James, 318-319). Carl identified psychological work as important to Mental Health Review Tribunals (MHRTs) and several participants discussed it as a necessary task to be completed in order to "get out" (Steve, 49). It was seen as the most important part of treatment; "the only thing you need to do is psychology" (Carl, 917).

Bob and Carl appeared to describe a degree of institutionalisation. Carl referred to having spent a month in seclusion and suggested that you can get used to situations however undesirable they are:

> It sounds pretty sick but you get adjusted to it, you know you're not going to be in there forever but what can you do really?
>
> (Carl, 276-277)

Bob reflected on how difficult he found it when he first came to medium secure care after being in a HSU. He found the increased access to facilities daunting and avoided using them initially; he commented, "I felt like a child that had to learn again" (Bob, 223). This builds on Bob's suggestion that FSUs are conditioned and suggests a degree of learned helplessness develops in response to their prolonged experience of disempowerment.

Several participants described strategies they consciously employed to help reduce their sense of disempowerment. Alfie sought to make the most of what was in his control:

> There's not much control that I have [. . .] but there are things that I can grasp control of so, one thing that I'm very controlling over is the food I eat, the smoking.
>
> (Alfie, 149-151)

For Richard-James it was education that protected him from feeling powerless; "Knowledge empowers you" (Richard-James, 84).

2.4.1.2 “Contained” and deprived.

This subtheme describes participants’ experience of feeling merely held, warehoused or “contained” within FMHS, without attempts being made to help them work toward a better future:

> I don’t think nothing is done to really help people to go out there and be assets to society instead of liabilities [. . .] the only thing that these institutions do is to contain people.
>
> (Richard-James, 203-205)

The environments in which FSUs were “contained” were experienced as depriving, as Corey‘s description of his previous HSU indicates:

> They lock you up at night, let you out in the day, they don’t talk to you, they give you your meds and that was it.
>
> (Corey, 211-212)

Several participants described there being a lack of meaningful activity available in hospital; “every day for two years I’ve been bored out my face” (Richard-James, 266). Richard-James was also concerned that the occupational activities available to FSUs did not lead to qualifications that would translate to employment once back in the community. Carl felt he had no reason to get up in the morning:

> What are you getting up for? [. . .] You're up and sitting and staring at four walls or asking for an argument or being provoked.
>
> (Carl, 422-424)

A number of participants described a sense of loss in relation to interests and aspects of their lives that were important to them when in the community:

> The internet was a big part of my life. Being online. When that's taken away from you it seems to be a big loss.
>
> (Steve, 28-29)

There was also reference to the loss of certain liberties. Bob explained how he missed not being able to buy things for himself and described the impact of losing such freedoms:

> You know a lot of people don't realise what it does to you to have all those things taken from you.
>
> (Bob, 482-483)

Being "contained" in such close proximity to other FSUs was also problematic. The majority of participants made reference to being unable to escape the difficulties of peers and one individual's behaviour could have consequences for the whole environment. It appeared within FMHS the degree of individuation between FSUs was limited and they sometimes felt treated as a group, rather

than as individuals. Consistent with the feeling of being warehoused, several participants described being moved around within FMHS, moving between wards, hospitals and at times secluded, with apparently little control over this.

2.4.1.3 Echoes of the past.

Participants' experiences in FMHS appeared to resonate with aspects of their lives prior to detention. As evidenced in the other subthemes within 'disempowered, dehumanised' participants' described a degree of deprivation and mistreatment within FMHS and this was consistent with the early experiences they discussed.

The majority of participants, three of whom had been in care, spoke about challenging experiences when they were younger including abuse, neglect or mistreatment from people in positions of trust. Corey did not discuss his early childhood in detail, but did give a sense of being in a hostile environment; "I was brought up in quite a critical environment" (Corey, 533). Steve was the only participant who did not refer to difficulties in relationships or challenging experiences growing up.

How participants experienced and managed the secure environment now as adults appeared influenced by this history. Ambivalence towards relationships was evident in the majority of participant accounts and several participants described an awareness of how their present relationships were influenced by those in their past. Carl spoke extensively about difficulties in his relationships

with staff who he felt could not be trusted. Alfie described an anticipation that others would let him down and also experienced “paranoia”, often worrying whether others were speaking about him behind his back (Alfie, 162). Corey and Bob also reported difficulties trusting others.

In addition to mistrust, several participants described a co-existing desire for close relationships with others, yet the prospect appeared challenging for them. Carl appeared to seek the care of staff and was preoccupied with their availability; “they can’t wait to break their necks and get on bloody annual leave” (Carl, 1026). When staff were not consistent in their support this appeared very challenging for him. Similarly, Alfie appeared to desire close relationships but also found them difficult to cope with. He described a wish for family life, which he felt watching reality television gave him taste of:

> I try and see if I can get a bit of that, even just by watching something. And for that hour or however long a time, I feel I’m there.
>
> (Alfie 114-115)

However in reality he deliberately avoided opportunities for relationships: “I choose to be a loner, if you like” (Alfie, 418).

In contrast Bob described his early experiences leaving him with a strong sense of independence; “I was used to fending for myself” (Bob, 978). Richard-James also spoke about being independent and this appeared to affect the way he

engaged with staff and treatment in FMHS, “there’s nothing they can do for me [. . .] it’s just myself” (Richard-James, 517).

The frequent moves participants had made within FMHS appeared reminiscent of the lack of stability several participants described in their early lives. Alfie described having been “got rid of” (Alfie, 426) and two participants had experienced the breakdown of multiple placements with foster carers and in residential settings. It appeared being moved within FMHS may have echoed early rejections in a family context for some participants.

Bob described being bullied physically when he was young and, encouraged by others around him at the time, ultimately responded to this violently. Subsequently he described using physical strength and aggression habitually in order to protect himself, feeling this was necessary for survival. This was reinforced when he was in Young Offender Institutions:

> You’ve either got to fight him or look like a fool and everyone rides you.
>
> (Bob, 835-836)

Similarly Richard James described himself acting “like an animal” in prison when he was younger and suggested that this had developed in response to repeat provocation from prison officers: “if you poke a dog he’ll bark at you won’t he” (Richard-James, 471).

The sense of threat experienced in relationships with peers and staff in FMHS appeared to reinforce participants' beliefs regarding the necessity of self-defence and the dangers of showing weakness. Carl referred to relationships with peers as follows:

> Pure evil in here like, poison. Like if someone sees you doing well in here [. . .], you've got to look after yourself, self-defence like.
>
> (Carl, 565-566)

Similarly Bob described a confrontation with a peer in which he did not wish to lose face: "I'm not being chased off the day room by him" (Bob, 224).

Further to this Richard-James and Bob both described an ability to detach from their emotions that professionals in FMHS had suggested was related to their history. Richard-James had been told by a psychologist that he was "too controlled" with his emotions (Richard-James, 575); however he felt this helped him to cope in FMHS: "I've seen really emotional people and they don't get nowhere" (Richard-James, 580).

The apparent continuity between participants' histories and aspects of the secure environment appeared to reinforce ways of coping developed in response to the initial challenges they faced.

2.4.2 Coming Back to Life

*'*Coming back to life' described a contrasting experience of FMHS fo*r* participants. This included care that was safe and humane, in the context of which some participants noticed changes in themselves, which Bob described as making him feel more "like a person" (Bob, 414). 'Coming back to life' was particularly prominent in Alfie, Bob and Corey's accounts, although Richard-James' and Steve's experiences were consistent with some aspects of the theme.

2.4.2.1 A safe and humane environment.

Alfie described his current environment within FMHS as safe and acknowledged that staff worked hard in order to provide such care:

> One thing is the care that we get. Nobody sees what goes on behind the scenes, just to keep me here. Keep me safe, keep me fed, keep me warm.
>
> (Alfie, 293-294)

Several participants made reference to the consistency and availability of support from staff. A number reported feeling helped by psychology and psychiatry, but nursing staff in particular were discussed as the most present and available source of support:

> The ward environment as well that's therapeutic at times

> [. . .] Just being on the ward around nurses and you know you've got the support there.
>
> (Corey, 172-174)

In the accounts of Bob, Alfie and Corey there was a sense that staff had been persistent in their efforts to engage and support them, despite this being challenging at times. Bob reported he was accepted to stay on the ward despite having difficulties when he was initially admitted. Alfie described the persistence of staff, even in the face of his verbal abuse:

> All I know is that I wasn't very nice to them verbally, but they still continued to be caring.
>
> (Alfie, 312-313)

Bob described a humane quality to the way staff treated FSUs; "People are being treated like people" (Bob, 508). He felt staff managed incidents of aggression safely, avoiding physical intervention where possible:

> They're not wanting to grapple them, they're not pulling the alarm and then grabbing them.
>
> (Bob, 501)

Bob also perceived that staff used a "human touch" in the way they supported FSUs (Bob, 524) and reported staff of all grades joined in activities on the ward.

He and Alfie described staff and FSUs joining together for celebrations and events. This appeared suggestive of a sense of community and belonging:

> Say someone's leaving and we'll all chuck in a couple of pound together, we cook it and then we have a nice little meal all together, staff and the patients.
>
> (Bob, 526-527)

Relationships with peers also contributed to the safe atmosphere at times. Most participants described either helping peers who they knew were having a difficult time or being helped by others:

> Like there's another patient, I'm quite supportive to him [. . .] I've got a lot of time for him.
>
> (Corey, 67-70)

In contrast to the care described above in 'disempowered, dehumanised', there was a sense of treatment being collaborative, rather than FSUs being "done to". Corey for instance described staff working *with* him:

> But it's the work they've done with me as well, you know the effort they've put in with me since I've been here.
>
> (Corey, 559)

Richard-James did not speak as warmly about the care within his current ward as others did; but acknowledged a difference between hospital and prison; “they are in truth more therapeutic than prison aren’t they”. He also felt he had positive relationships with staff at present; “in hospital I’ve never really had difficult relationships, that’s prison” (Richard-James, 1014). Carl felt he had very difficult relationships with staff: “Staff are a last resort. I don’t really speak to them. Cause I hate them basically”. His experience of the environment and relationships within it remained consistent with that described within the superordinate theme, ‘disempowered, dehumanised’.

2.4.2.2 Becoming a person again.

This subtheme describes participants’ awareness of changes within themselves in the context of the safe environment described. Bob (479) reported feeling “like a person” again; this was consistent with the nature of the changes discussed by others.

Alfie reported he had been able to stop self-harming since coming to hospital and had also come off prescribed medication, which he was pleased with, as he had previously thought he needed this in order to function. He also described being able to manage worries that others were talking about him differently, which he attributed to a psychology group he had undertaken, despite initially doubting its relevance to him. He now had a desire to connect with others:

> I'm learning to accept people for who they are [. . .] and that's helped me to get to a place where I can understand people and am willing to understand, want to understand them.
>
> (Alfie 210-211)

Corey also described a change in relating to others:

> Being able to talk to people and open up and stuff that's definitely progress; I've never done it in the past.
>
> (Corey, 230-231)

He used the example of the research interview as evidence of this change: "I wouldn't have been able to talk to you like this a year ago" (Corey, 21).

Bob talked about his experience of community leave in his current hospital, "it gives you life again" (Bob, 414). Being able to pay for things made him feel "human" and he spoke about the small interactions he had with others whilst on leave; "it just felt nice you know, it was real, there were no cuffs" (Bob, 471-472).

Steve attributed the changes he had noticed since coming to hospital to his medication, which he was pleased with. He described being very unwell prior to admission and explained he did not feel like himself when he was like this:

> Being unwell it changes your personality [. . .] I've got no patience for anything I'm just loud and obnoxious. And not that nice to be honest.
>
> (Steve, 335-338).

2.4.3 The Struggle

This theme was evident in all participants' accounts and describes the challenges of trying to progress through FMHS and trying to develop a sense of identity for their future lives beyond FMHS. There was a suggestion in participant accounts of resilience, motivation and hope but also co-existing constraints, ties and barriers and overall a sense of struggle between the two.

2.4.3.1 A "normal" self?

Several participants referred to the idea of having a "normal" life in future (Carl, 21; Corey, 50; Alfie 401). For most participants this included employment, a place to live and having a family. There was suggestion in several participant accounts of who they wanted to be in this "normal" life. Bob spoke about a desire to make a new name for himself, one not associated with violence and crime; "I'm hoping once I get out there to do something with me life, make a new name" (Bob, 941). He had legally changed his name in order to help this. Richard-James felt he was "transformed" (Richard-James, 10) through education and wished in the future to use his understanding of socio-cultural issues to effect change within society.

However, there appeared to be a range of factors impeding this development of a new sense of identity, with ties to participants' pasts both in the context of FMHS and within themselves. In describing helping others, Bob made several references to the use of physical aggression, which appeared to suggest that it was still an important part of how he saw himself:

> I've seen parents they hold their child by the arm and they're slapping them really hard [. . .] and I'm like how about you feel my fist in your face.
>
> (Bob, 920-921)

Alongside the hopes he expressed regarding a different future, ties to who he had been remained present. Here he describes an intention to remain loyal to friends from his past:

> Making a new life, new friends - keep some of the old ones obviously; I wouldn't ignore all my lads that have been good to me over the years.
>
> (Bob, 1333-1334)

Bob, Richard-James and Corey all spoke about the challenges of someone in their position returning to the community. Corey was very aware that his "history" still influenced how others saw him and this meant staff were "cautious" in allowing him to progress (Corey, 424). Some participants described restrictions dictating where they would be able live due to multi-agency public protection arrangements (MAPPA). Several participants made reference to stigma in society and thought that their identities as ex-offenders and mental health service users would not be acceptable to some. Bob described the limiting impact this had on how he could relate to others when outside of the hospital, as the secure unit was "hated" in the local area (Bob, 777). Richard-James discussed the difficulties seeking employment people in his position face; "there'd be a lot of stigma. If I go to get a job or whatever" (Richard-James, 278). Bob and Carl also made reference to the victims of their offences, consideration of whom was another reality of returning to the community and a very clear reminder of their identities as perpetrators.

In contrast to the other participants, Steve did not express the same desire to change as a person. He explained that previously he had been able to appear "normal" for mental health professionals and this was how he had managed being in the community:

> I have the ability to you know, put on a normal face.
>
> (Steve, 475)

2.4.3.2 “Snakes and ladders”.

Trying to progress in FMHS was challenging and there were ups and downs and obstacles in working toward the “normal life” (Carl, 21; Corey, 50; Alfie, 401) that participants hoped for. Every participant had experienced setbacks within FMHS and these were often in the form of incidents of self-harm or aggression. Steve described trying to make progress as like “snakes and ladders” (Steve, 408), demonstrating that the process was not linear and it often felt like “one step forward and two steps back” (Steve, 404).

The majority of participants reported that experiencing incidents of self-harm or aggression had a significant negative impact emotionally. Alfie seemed to describe a sense of exhaustion at having to pick himself up after repeat setbacks:

> I always end up back at square one [. . .] it was so many times that I was tired of dragging myself up and fighting me way back to where I was and trying again, trying again, trying again.
>
> (Alfie, 403-404)

Such incidents could lead to a loss of hope; Steve, Alfie and Corey all described the temptation to “give up” (Steve, 370). Two participants discussed periods of feeling suicidal and it appeared that this was what giving up represented to them and was the alternative to progress.

All participants however, described factors that helped maintain their motivation, enabling them to "keep going" (Steve, 408), "keep motivated" (Carl, 54) and "keep focussed" (Corey, 500). Family outside of hospital appeared a motivating influence for most participants:

> I always have in the back of my mind like I need to get out to them and like support my little niece and nephew.
>
> (Corey, 500).

Progress itself appeared self-perpetuating; noticing changes increased participants' sense of hope and motivation. For Bob getting his community leave gave him "something to fight for" (Bob, 452). Similarly Alfie described what making progress felt like for him:

> It makes me feel happy. Makes me feel like I've accomplished something. Makes me feel that just maybe my life isn't going to be a f**k up like it has been for the last 30 years. Maybe the next 30 years are going to be the better years.
>
> (Alfie, 357-359)

Several participants made reference to an internal quality that helped them cope with setbacks; "it's some kind of inner strength" (Steve, 428). Richard James felt his previous experiences had given him a degree of resilience; "I can cope with difficulties quite well", (Richard-James, 564). He and Alfie also

appeared to take motivation from a very firm belief that change for them was necessary; “Wanting to change. Needing to change” (Alfie, 201). Of further help to Alfie was an apparent acceptance that the journey would be challenging: “you don’t get to the top of a mountain just by looking at it” (Alfie 411-412).

2.5 Discussion

The current research explored how FSUs diagnosed with PD experienced Recovery oriented treatment in FMHS and how they thought about recovery. The main findings are discussed in the context of existing literature, limitations of the research are acknowledged and implications for clinical practice and further research are considered.

2.5.1 Discussion of Main Findings

2.5.1.1 Power and relationships.

Participants in this research with prior experience of HSUs were unanimously damning in describing them, with reference to abuses of power, draconian treatment and minimal therapeutic input. Whilst participants generally spoke more positively about their current medium secure placement, discussion of the limited control they have over their lives remained present in their accounts. The FSU perspective of treatment has tended to be “delegitimised” and dismissed (Hinsby & Baker, 2004, p.342). However, practices and cultures within FMHS have been found to be unethical in some instances. As reports into malpractice at Ashworth HSU demonstrate, services can be at risk of becoming over-controlling and abusive (Blom-Cooper, Brown, Dolan, & Murphy, 1992) or

corrupt and collusive (Fallon, Bluglass, & Edwards, 1999). The experiences of participants within the current research, particularly within HSUs, are consistent with existing literature suggesting that FMHS are environments susceptible to abuses of power (Davies, 2004).

However, participants' relationships with staff in FMHS did appear to be influenced by their early attachment experiences to some degree. This was something that participants were aware of; they described a deep mistrust of others, particularly those in a care giving or authoritative role. Insecure attachment styles are overly represented in those who commit crime and in individuals diagnosed with PD (Sainsbury, 2011). Those who have experienced developmental trauma and separation may experience connection with potential attachment figures as threatening, anticipating they will be hurt and responding in order to try and make themselves safe (Golding, 2008).

Psychoanalytic theory offers further understanding of why staff teams in FMHS are vulnerable to corruption and posits that staff members can come to act out the projected roles of attachment figures from FSUs' histories. Consistent with the resonance found between participants' early experiences and those within FMHS, such projected roles may be played out on a larger scale, resulting in whole teams enacting the frightening, absent or neglectful care figures likely to have been experienced by this population (Ruszczynski, 2008).

2.5.1.2 The problem of compliance.

Several participants identified compliance with psychological intervention as necessary in order to progress towards discharge and participants felt it was particularly valued by MHRTs. Some participants had engaged in therapeutic groups without believing they were relevant to them, whilst one participant who was initially reluctant to engage, went on to find the groups beneficial. The contrasting experiences of participants reflects the dilemma of how engagement in psychological therapy is ensured to be fully consensual and meaningful in an environment when there is such a strong incentive to participate. It has been suggested that therapeutic outcomes are enhanced when those who have committed offences engage in treatment of their own volition (Parhar, Wormith, Derzen, & Beauregard, 2008). However one participant's experience was consistent with other research suggesting that willingness to engage for FSUs can improve once they have begun an intervention (Day, Tucker, & Howells, 2006).

Considering FSUs' motivations for engaging in treatment remains an ethical dilemma for psychologists working in such settings. Whilst they, as individuals, may not be compelling FSUs to engage in treatment, they need to be aware of the strong incentives for this that exist within services (Day et al., 2006). Furthermore, there appears a risk that MHRTs, and consequently, FSUs place such an emphasis on psychological intervention, the value of other aspects of treatment important to recovery are undermined (Drennan et al., 2014).

2.5.1.3 A corrective emotional experience.

Several accounts suggested that participants can experience an environment as safe and therapeutic, despite their attachment histories and the restrictions of FMHS. A number of participants described an experience of consistent, persistent, and warm care, which provided predictable responses to their needs, safe limits, and tolerance of their emotional distress. This appeared to describe an experience of psychological containment, in contrast to the purely physical containment discussed above, which enabled participants to reconnect with others and begin to make changes in the context of these relationships (Sainsbury, 2011). The environment itself was described as therapeutic, consistent with the idea of the therapeutic milieu or the environment as a whole being the therapeutic agent (Ruszczynski, 2008), analogous to the idea that for those with diagnosed with PD, the therapeutic relationship, or in this case relationships, are not just necessary for therapeutic work, but are a vital part of it (Sainsbury, 2011).

This emphasis on safety in relationships in the present study is consistent with previous research with service users diagnosed with PD outside of FMHS (Shepherd et al., 2015; Gillard, Turner, & Neffgen, 2015) suggesting it relates particularly to this client group.

2.5.1.4 Identities under construction.

Participant accounts described ideas of a future self within the context of the "normal life" they hoped for. Ex-offenders who have 'gone straight' distinguish

between a former self and newly emerged identity (Maruna, 2001). Consistent with previous research with FSUs (Ferrito et al., 2012; Mezey et al., 2010) there was evidence of transition in the identities of participants, yet multiple barriers for them in developing a sense of self beyond that of FSU.

Participants' experiences appear to reflect well-documented difficulties regarding social networks for FSUs post discharge (Drennan & Alred, 2012). For many, the only available networks are former acquaintances with a history of offending, relationships that are thought likely to limit their ability to establish a sense of themselves outside of this context (O'Sullivan et al., 2013). Similarly, meaningful activity and social and occupational roles are repeatedly cited as essential for the recovery process; helping individuals develop their sense of self and feel valued (Drennan et al., 2014). Consistent with previous research however, participants described limited opportunity in this area (Farnworth, Nikitin, & Fossey, 2004; Stewart & Craik, 2007).

The pressure to comply with treatment within FMHS presents a further difficulty for FSUs trying to develop a "recovered" sense of self. O'Sullivan et al. (2013) describe the pressure to conform and present a more socially acceptable self for staff members, meaning a more authentic process of self-discovery may be inhibited. The idea of putting on a "normal face" discussed within the subordinate theme 'a "normal" self?' appeared consistent with this observation.

2.5.2 Limitations

Consistent with the idiographic nature of IPA, the findings relate to a small group of participants within a particular context and are not intended to be generalisable to a wider population. However the presentation of the context and research process has aimed to allow the findings to be transferable to some degree (Shenton, 2004).

Participation in the research was voluntary, meaning there was a risk of bias in the participants who chose to take part. They may have had motivations unknown to the researcher, for example particular satisfaction or dissatisfaction with their treatment. A further source of potential bias was the exclusion of FSUs who were experiencing acute difficulties in their mental state to a degree that clinical teams did not feel they were able to participate. Whilst ethically necessary, it may mean that the views of recovery considered were restricted to those beyond a certain point in their recovery journeys. This research also struggled to recruit participants from generic forensic wards, with ultimately only one participant being recruited from this environment. The sample was therefore predominantly from a specialist dual diagnosis PD and SMI service, limiting the relevance of the findings to FSUs diagnosed with PD elsewhere in FMHS.

2.5.3 Clinical Implications

Discussion of disempowerment and abuses of power were prominent within the accounts of participants. There appears to be a need for continued efforts

to try and establish cultures of transparent practice in FMHS, ensuring the loss of liberty FSUs are subjected to is managed as ethically as possible. This finding also lends support to literature suggesting a need for advocacy in forensic settings, which has been described as essential (Palmer et al., 2012).

The collaborative emphasis of Recovery principles appears to offer a means of empowering FSUs, as much as they safely can be, within their own treatment. However, the approach needs to be applied in a meaningful way, going beyond merely the "rhetoric" of recovery (Mezey et al., 2010, p. 695). Moore and Drennan (2013) recommend the use of individualised recovery formulations, developed in collaboration with FSUs. Such a shared formulation may mean that FSUs feel less 'done to', and instead a narrative that is "plausible to all parties" can be developed, building their treatment around their individual recovery goals (Moore and Drennan, 2013, p. 235).

The establishment of safe and consistent relationships appears an important aspect of treatment for FSUs diagnosed with PD. In order to develop such relational environments, training and supervision for staff members appears indicated. This would aim to increase staff understanding of the functions and origins of FSUs' interpersonal difficulties and enhance their capacity to tolerate them. This could be achieved through the provision of attachment based training or supervision from a psychoanalytic perspective (Boyle et al., 2009; Evans et al., 2012). Ensuring that staff are adequately supported may enable

them to support FSUs with the consistent, humane approach that was so valued by several participants in this research.

A number of participants in the research described an experience of FMHS in which their time lacked purpose and meaning. Occupational input is known to be important for the quality of life and emotional wellbeing of FSUs (Craik et al., 2010). Furthermore, participants' accounts of trying to develop a "normal" self, and the potential barriers to this also indicates the need for such vocational and leisure activities; they are seen as essential in supporting FSUs to develop a 'recovered' identity (Drennan et al., 2014). The experiences shared by participants in this research suggest that such activity is valued more if it is able to facilitate transition back to community, lending support to recommendations for community leave for FSUs to be used with a more explicit vocational focus (Clarke et al., 2015).

Considering participants' contrasting attitudes to psychological therapy, interventions to enhance motivation may be of benefit. Using motivational interviewing (MI) with FSUs prior to formal therapeutic work has been shown to increase treatment retention and engagement, and improve clinical outcomes (McMurren, 2009). However, it would be important to ensure that these interventions are consistent with the ethos of Recovery; Skinner, Heasley, Stennett and Braham (2014) provide one example of how MI can be used in a Recovery oriented way in FMHS with positive outcomes.

2.5.4 Recommendations for Future Research

Further research with similar aims considering the experiences of FSUs who have a PD diagnosis but who differ in some way to the current sample would help to build upon the present findings. Considering the experiences of those with this diagnosis on generic forensic wards as opposed to within specialist PD services would enable the research to speak more broadly to the population of FSUs diagnosed with PD. Research carried out with groups of greater ethnic diversity, with FSUs who do not have comorbid mental health diagnoses and former FSUs living in the community would all help to further understand and articulate the recovery journey for those with this diagnosis.

There is extensive research into means of assessing and enhancing motivation to change in FSUs and factors associated with their engagement and responsiveness to treatment (McMurren & Ward, 2010; Blackburn, 2004). A further avenue of quantitative exploration could be to investigate the individual and contextual factors associated with treatment completion and positive treatment outcomes for FSUs who were initially poorly motivated to engage. This could be achieved through gathering retrospective self-report data, together with pre and post assessment of motivation to change.

2.5.5 Conclusion

Establishing truly collaborative treatment remains a challenge in FMHS and FSUs diagnosed with PD face multiple obstacles to their recovery. However, in the context of care that was experienced as safe and consistent, several

participants felt they had made positive changes and appeared to have started their recovery journeys. FSUs need support to develop identities beyond their diagnosis and offending; as put by one participant, “a lot of us have got great potential, it’s just not developed” (Richard-James, 102-103). It is the task of FMHS to recognise this potential and facilitate its development, in a direction that is constructive and positive for each individual.

2.6. References

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Chapter Three: Reflective Paper

A Reflective Account of the Research Journey

Chapter word counts: 3449 (excluding all references, footnotes, tables and figures)

3.1 Introduction

In this chapter I present my reflections on the process of conducting this research, including factors that influenced the selection of the topic, methodology and research questions. I also examine and reflect on the subjective positions I became aware of as I got to grips with the role of researcher and evidence the reflexive processes that have supported me in doing so throughout the discussion.

The material used in this chapter is based on the topics explored and documented in my research journal. Even if only capturing a phrase or a few sentences, this enabled me to consistently record particular issues I was contemplating, or points of reflection on any salient emotional response to aspects of the process.

3.2 Starting Out

3.2.1 Returning to Forensic Mental Health and Personality Disorder

Prior to clinical training I worked for a long period as part of a nursing team, in a Personality Disorder (PD) service within forensic mental health services (FMHS). The finding that emerged from the literature review (chapter one) regarding staff members identifying this work as personally transformative resonated with me in relation to my own experience in this setting. There were aspects of myself I understood better after working in FMHS. I also gained an understanding of extreme aspects of human experience that I might never have

appreciated without having worked there, as described by a member of staff in Boyle, Kernoham and Rush (2009):

> Other members of society don't get to see that aspect of humanity that we do. So yes, I don't know what that does for me, really (laughter), but I've had the privilege of seeing that, I suppose.
>
> (Boyle et al. 2009, p. 309)

I also related to the idea discussed with in the literature review of this work being experienced as a rollercoaster, with highs and lows and a wide range of other emotions along the way. Whilst challenging in many ways, it was this environment and client group that I felt drawn to revisit when given the opportunity to do a piece of research; perhaps in order to further understand the clinical work I contributed to and the intense emotional experience that went with it.

3.2.2 "The Impossibility of [. . .] Learning how Psychotherapy Works" (Yalom, 2015, p. 80)

As might be expected from a trainee clinical psychologist, the process of making changes in therapy is fascinating to me. In my first year of training, stimulated by teaching relating to different therapeutic models and clinical work on placement, I was thinking more deeply about change. I was interested in how it is achieved and how it is experienced, not just by service users but also for me and more broadly as a human process. In my research diary at the earliest stage

of conceiving ideas for the project, I had noted down questions regarding the nature of change in the context of therapy. I was interested in ambivalence toward change, and the role of motivation and readiness; can we as therapists enhance this or can we only help when the client is ready? Why have I been unable to make even the small changes that I have wished to previously? When does acceptance become the aim rather than change?

I was struck by an anecdote described by Yalom (2015), in which he discovers the remarkable transformation a former client had experienced was the result of him having recommended a cleaner to him. The change was not, as he had assumed, directly attributable to their therapy. It was reassuring to read that even Yalom remains unsure about the process of therapy and 'what works'; "My mind swirled with thoughts of the impossibility of ever learning how psychotherapy works" (Yalom, 2015, p.80).

When considering the challenges of making changes in therapy, I thought about this in relation to my previous clinical experience in FMHS. For these men, as Alfie went on to describe in his research interview, change is a necessity. For them to have any hopes of a future outside of hospital and the opportunities, relationships and freedoms this affords, they have to demonstrate having made substantial changes; behaviourally, interpersonally and ultimately to their personalities. This left me wondering how trying to change feels when so much is dependent on it.

After consulting the literature regarding treatment in FMHS I was struck by the volume of discussion regarding the Recovery Model. This was not an approach, nor even a term that I had heard used frequently within forensic PD services. In coming to understand how aspects of recovery beyond the clinical component had been articulated in the literature more broadly within mental health, it seemed that they were highly relevant considering the challenges faced by forensic service users (FSUs) diagnosed with PD. Personal recovery appeared particularly pertinent given the especially stigmatising nature of the PD diagnosis (Kingdon, 2007). It appeared the principles of the Recovery approach offered a means of combatting the pessimism that clinicians can experience in these services. Reflecting on previous clinical experience, I wondered whether just using the word itself and language regarding recovery in practice could influence the attitudes of staff and service users. What recovery meant to FSUs with this diagnosis and their experiences of treatment aimed to support this, then became my focus.

3.2.3 Epistemological Position

Chalmers' (1990) asserts that there is not one correct method of scientific investigation only approaches that better suit particular questions, which I agree with and also would argue, approaches that suit particular researchers. The questions regarding change and recovery that were meaningful to me, and the research questions I went on to pose, would have been difficult to answer in the same depth and detail using a quantitative method.

When considering qualitative methods further, a phenomenological approach appeared a natural fit with carrying out research into experiences of treatment and the experience of trying to recover. The focus of study in phenomenology is people's perceptions and experiences; the aim is to seek understanding and the existence of multiple valid perspectives is acknowledged (Barker, Pistrang, & Elliott, 2015). The depth provided by the idiographic nature of Interpretative Phenomenological Analysis (IPA) and the hermeneutic element that allows for researchers to consider the participant's life world in the context of experience, theory and knowledge made this an approach suited to the research questions asked (Larkin, Watts, & Clifton, 2006). These aspects of the methodology also felt familiar and consistent with the task of a clinical psychologist in therapeutic work.

This approach also represented a middle ground between a realist, positivist approach and a more pure relativist position, neither of which entirely fitted with me personally. Larkin et al. (2006, p. 107) describe the idea of "minimal hermeneutic realism" which offers a view of reality in which things can and do independently exist but are only ever made real when encountered and brought to life by us. Therefore in research what we discover is a function of the relationship between the researcher and the subject. Recognising the researcher as part of the world they attempt to understand (Larkin et al., 2006) again felt consistent with how I would approach therapeutic work. The researcher is not objective and uses reflexive approaches to understand their

assumptions just as the therapist is not neutral and has to reflect on their position.

Once the research was underway however, the tension between the position of IPA researcher and trainee clinical psychologist was not always easy to manage.

3.3 Stepping Out of Role: Reflections In and On Research Interviews

3.3.1 I'm not the Therapist!

This was something that I found I needed to remind myself of during most of the research interviews and reflect on subsequently in supervision and in my research journal. Within the interviews, holding the position of the researcher and stepping back from the position of therapist was a challenging task. Some therapy skills were helpful in the interview process, facilitating the establishment of rapport and allowing me to actively listen to interviewees' stories. However, there were occasions in all of the interviews when I instinctively wanted to respond in a certain way, make a reflection or connection, and had to stop myself from doing so. I was also aware of a great deal of curiosity regarding some aspects of participants' narratives, which interested me as a therapist. I had to ensure I reflected on why this was and endeavour to attend to their whole account with equal enthusiasm. I commented to my supervisor afterwards that hearing some of the reflections participants made had felt like hitting "therapeutic gold", but not being able to do anything with it.

These are common dilemmas for the novice qualitative researcher from a psychological or therapeutic background (Biggerstaff & Thompson, 2008). It represented a potential ethical dilemma and it was imperative to hold in mind what exactly the participant had consented to. I was required to question and reflect on where the line was between a therapeutic intervention and an invitation for the participant to explain something in more depth, in order to better illustrate the phenomenon being studied. I discussed this dilemma at an IPA researchers' forum and was left wondering if I had been overly cautious, not 'probing' as much as a researcher from a non-therapy background would have, therefore not gathering data as rich. Ultimately, ensuring I was ethical in my approach to the interviews was the greatest priority, but this experience and reflection on it has helped me to clarify the subtle distinctions between the tasks of the researcher and therapist.

3.3.2 Policing the Interviews

In certain interviews I became aware of an impulse to challenge particular views that participants expressed. I recognised this as a voice coming from my former role as a staff member working in FMHS, which given the secure setting was both custodial as well as caring in nature. For example, when Richard-James suggested that staff members should treat service users like family, my impulse was to ask him if he thought this might present any problems and gently challenge this view. Similarly, when Carl described staff members "breaking their necks" to use their annual leave I felt a pang of sympathy for the staff and an urge to justify their entitlement to time off.

The ‘policing’ role was easier to step out of in the moment. The context of participants’ comments made their positions understandable. Carl had been let down by others in the past and anticipated this happening again; he was waiting for, expecting, others to reject him. It was also a relief to step away from this role. Whilst there were, of course, the usual limits to confidentiality relating to risk, it was nice being able to fully listen to and engage with participant’s narratives without the obligation to question their beliefs and accounts. I reflected afterward how automatically this impulse came to me and wondered whether this is ‘the norm’ for FSUs, to have their perspectives challenged continually and what this might feel like cumulatively over time.

It was a helpful view to have recognised in myself during the interviews, as it prepared me to reflect on how it may have affected my interpretation of the data during analysis.

3.4 The “Interpretative World of the Researcher” (Smith, Flowers & Larkin, 2009)

3.4.1 Combining Participant Accounts

When transcribing and analysing the research interviews, I found myself feeling once again emotionally engaged in participants’ experiences. The idiographic approach of IPA meant immersing myself in each participant’s narrative and making sense of them individually first of all. This was a process I enjoyed; what felt more challenging was the process of pulling themes together across the participants. It felt strange and unfamiliar to the therapist part of me, as though

I was trying to combine six individual formulations. I felt resentful and guilty for having to lose aspects of participants' stories.

Subsequently however, I wondered if the discomfort of this process was actually helpful in ensuring that I attended fully to how each person's story informed the whole narrative emerging. It was also reassuring that as the wider narrative of themes from all participants was being produced, this furthered my understanding of some of the meaning in the accounts of individuals. This was the case with Steve's comment regarding putting on a "normal face", which I had initially considered in the context of compliance with treatment. However, in the context of the themes emerging from other individual accounts, it also suggested fragmentation in participant's identity as they attempted to recover. I became more familiar with this process of hermeneutic cycling as the analysis went on, moving between the 'whole' and the 'part' and seeing how they informed each other, within paragraphs, transcripts and across the dataset as a whole (Smith et al., 2009).

3.4.2 Moral Judgement

Reflecting further on my impulse to somehow 'police' the research interviews, I connected it with Richard-James' idea of being morally judged by staff. The instinct to 'police' what participants expressed revealed an assumption that I was in a position of moral superiority enabling me to judge and question participants. How this could impact on my interpretation and representation of the data was important to consider. There was a risk of "de-legitimising"

participant's voices, as has been the culture in the treatment of this group historically (Hinsby & Baker, 2004, p. 342).

The accounts of participants suggested they had experienced or witnessed abuses of power within forensic institutions and received inadequate care in some circumstances. Representing this was important both in honouring the experiences of the individuals, but also in the context of what is now known regarding historical abuse within public services, including secure hospitals. Common to all situations have been individuals in disempowered positions who were not listened to or believed (Torjesen, 2014). Yet given the hermeneutic process of IPA these experiences needed to be considered in the wider context of the whole set of data gathered and represent my sense-making as the researcher within my "interpretative world" (Smith, Flowers & Larkin, 2009, p. 36). One potential conflict therefore, was the desire to consider how the early experiences of participants may have influenced how they experienced FMHS, without suggesting their perspectives were distorted and therefore not valid.

IPA methodology enabled me to hold onto both of these possibilities. Sitting between the 'hermeneutics of suspicion' and the 'hermeneutics of empathy', IPA is thought to combine the latter with the "hermeneutics of questioning" (Smith, Flowers & Larkin, 2009 p. 36) with an ultimate aim of developing understanding. With its acceptance of multiple realities, the IPA analysis allowed my themes to represent both the influence of early experience but also

the reality of corrupt cultures in FMHS. The existence of one did not negate the truth of the other.

3.4.3 A Personal Recovery

On two occasions during clinical psychology training and the process of conducting this research, I have experienced setbacks that significantly impacted upon my sense of self and were emotional blows that I felt I needed to recover from. Firstly, was a period of being physically unwell, which as well as forcing on me an awareness of my own fallibility, gave me the identity of 'ill'. At the time I worried there were additional labels associated with this such as "weak" or "lazy". More recently in relation to the completion of this project, I did not achieve the outcome I would have hoped for, and again felt this impact on how I saw myself.

These periods were challenging practically, physically and emotionally. Reflecting on this and the journey up to and through clinical training, I could identify with Alfie's idea of climbing a mountain and also with Steve's idea of snakes and ladders. I could also identify with an idea of a "normal life" waiting somewhere ahead but without too clear an idea of what this would look like. However, thinking about the setbacks on my journey in relation to the recoveries of participants was uncomfortable. I began the research process considering aspects of the experience of change that are ubiquitous and as described there were aspects of participant's narratives that I recognised. Yet I had many things in my favour to help me 'recover' and start out up the

mountain again. I had social, emotional and practical support and a personal history that provided me with at least some evidence contrary to the biggest fears I had about myself.

In a recent BPS conference talk discussing clinical psychology and psychiatry's relationship with social context, Boyle (British Psychological Society [BPS], 2015) described how the burden for making the most change in society is placed on those who are least well equipped to do so. Reflecting on my own 'recovery' and how painful this was, emphasised to me the enormity of the task FSUs are undertaking and appeared to illustrate Boyle's assertion (BPS, 2015). The most challenging aspect of my experience was feeling a loss of control over how others viewed me and feeling trapped within the assumptions others could make based on only one aspect of who I am. The multitude of labels that participants had been required to adjust to and the pejorative nature of them, identifying their very selves as disordered, must have a profound impact on a person's sense of self.

3.4.4 "Making the World Go Away" (Boyle, 2011, p. 17)

My response to certain research interviews, particularly those in which participants' narratives described abandonment, abuse and neglect, was to feel angry and frustrated with the reliance on diagnostic labels within mental health services and particularly the use of the term 'personality disorder'. We understand that behaviours and ways of relating that are problematic for those with this diagnosis were adaptive in the context of their early environment. It

feels important to represent that within these men who had perpetrated serious crimes, were also the vulnerable children often let down by family, services and the systems around them. The PD diagnosis appears an example of what Boyle (2011, p.17) describes as “making the world go away”; the wider context of how these difficulties came to be are forgotten and the dysfunction is located entirely in the individual.

Boyle (2011) attributes this aversion to thinking about the social context of mental health difficulties to a remnant of the positivist approach that remains predominant within psychology and clinical psychology. This was certainly the only frame of reference I was given at undergraduate level. However the scientific search for an objective truth within a positivist perspective cannot be assumed to be value free or neutral; political structures have influenced the theories and practice of understanding the world in this way and powerful sections of society remain protected by adhering to such conventions (Boyle, 2011). Clinical psychologists therefore, do not conduct research in a social and political vacuum; whether we intend it or not, our role is politicised.

I have found it difficult to separate my research from my own values and social conscience. I have found it impossible to think about the experiences of the men interviewed in the context of dysfunction or disturbance inherent within them, rather than thinking of the social circumstances and context of their early experiences. I have felt cautious because of the political ramifications of this view and felt bound to speak in terms of diagnosis and mental health; not

wanting to risk flouting scientific convention or being seen as biased. However it also felt important that in discussing the findings I represented the social factors implicated and did not "make the world go away". Boyle (2011) recommends that clinical psychologists should be explicit in articulating the intelligibility and meaningfulness of distress and problem behaviours, as well as paying close attention to the language used to talk about them in order to counter the dominant medical discourse. In discussing the research I attempted to critique the diagnosis of PD and use the subtly different phrase of "diagnosed with PD" rather than "has PD". I also hope the discussion of the findings renders the origins and functions of the difficulties of the men interviewed wholly understandable.

3.5 Conclusion

Conducting this research has helped me to reflect on how the researcher self relates to personal values and beliefs. I have developed an awareness that these are present in the 'whole' of my experience and the broader context in which I have made sense of my data. I have concluded that along with other aspects of the researcher's position in qualitative research, recognising, exploring and representing values and ideologies held is preferable to ignoring their existence. A transparent examination of the multiple subjective positions of the researcher allows readers to understand how knowledge has been constructed and the lens through which the findings have been seen and understood.

Revealing the “pure” experience of participants is beyond the capability of phenomenologists yet I hope that in examining the influence of each of the subjective positions discussed, I have been able to perform a “sensitive and responsive” job in making sense of participants’ experiences and doing justice to their narratives (Larkin, Watts & Clifton, 2008, p.108). I hope that this research can make a meaningful contribution to understanding the experiences of this heavily stigmatised group, who often face such pessimism from the very people they rely upon to support them in their recoveries.

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Appendix A: International Journal for Forensic Mental Health Instructions for authors

AUTHORSERVICES
Supporting Taylor & Francis authors

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All parts of the manuscript should be typewritten, double spaced, with margins of at least one inch on all sides. Number manuscript pages consecutively throughout the paper. Authors should also suppy a shortened version of the title suitable for the running head, not exceeding 50 character spaces. Each article should be summarized in an abstract of not more than 100 words. Avoid abbreviations, diagrams, and reference to the text in the abstract. Each author should be listed with his or her primary departmental affiliation and institution name, and city/state/country (where applicable).

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References. References, citations, and general style of manuscripts should be prepared in accordance with the APA Publication Manual, 6th ed. Cite in the text by author and date (Smith, 1983) and include an alphabetical list at the end of the article. *Examples: Journal:* Tsai, M., & Wagner, N.N. (1978). Therapy groups for women sexually molested as children. *Archives of Sexual Behaviour*, 7(6), 417-427. doi: 10.1037/0096-3445.134.2.258
Book: Millman, M. (1980). *Such a pretty face.* New York: W.W. Norton.
Contribution to a Book: Hartley, J.T., & Walsh, D.A. (1980). Contemporary issues in adult development of learning. In I.W. Poon (ed.). *Ageing jin the 1980s* (pp. 239-252). Washington, DC: American Psychological Association.

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Appendix B: Critical Appraisal Skills Programme Qualitative Assessment Framework

10 questions to help you make sense of qualitative research

How to use this appraisal tool

Three broad issues need to be considered when appraising the report of a qualitative research:

- **Are the results of the review valid?**
- **What are the results?**
- **Will the results help locally?**

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.

These checklists were designed to be used as educational tools as part of a workshop setting

There will not be time in the small groups to answer them all in detail!

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Screening Questions

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

---

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?

Is it worth continuing?

Detailed questions

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)?

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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)

5. Was the data collected in a way that addressed the research issue? ❒ Yes ❒ Can't tell ❒ No

HINT: Consider

- If the setting for 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 were 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

---

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

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

---

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

9. Is there a clear statement of findings?

❒ Yes ❒ Can't tell ❒ No

HINT: Consider

- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researchers 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

---

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

Appendix C: Quality assessment using CASP checklist

CASP Criteria	Studies assessed in relation to the quality assessment framework													
	Barros et al. (2001)	Boyle et al. (2009)	Clark (2013)	Coffey (2000)	Dhondea (1995)	Evans et al. (2012)	Fish (2000)	Fortune et al. (2010)	Harris et al. (2015)	Kemp (2008)	Kurtz & Jeffcote (2011)	Kurtz & Turner (2007)	Taylor & Trout (2013)	Tema et al, (2011)
1. Clear statement of research aims (Screening question)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2. Qualitative method appropriate (Screening question)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3. Suitable research design	3	3	2	2	3	3	3	3	3	3	3	2	2	3
4. Suitability of recruitment strategy	3	3	2	3	1	3	2	2	3	3	3	3	1	3
5. Suitability of data collection	2	3	3	2	2	3	3	3	2	3	3	3	3	2
6. Consideration of relationship between researcher and participant	1	1	2	2	1	2	2	2	1	3	2	2	1	1
7. Consideration of ethical issues	2	2	3	2	1	2	3	3	3	3	2	2	1	3

8. Rigorous analysis of data	3	2	3	1	2	3	3	2	3	3	3	3	2	3
9. Clear statement of findings	2	2	2	2	3	3	3	3	2	3	3	3	2	3
10. Value of research	2	2	3	2	2	3	2	3	3	3	2	3	3	2
Total CASP Score	18	18	20	16	15	22	21	21	20	24	21	21	15	21

Scoring Criteria:

The CASP features two initial screening questions to identify the appropriateness of inclusion and then eight subsequent questions relating to the quality of qualitative research. As used by Duggleby, Holstander, Kymla et al. (2010), studies were excluded if they did not meet the requirements of the initial screening questions which required 'yes' or 'no' answers (no studies were excluded at this point). The remaining eight items of the CASP were then used to generate a score using a three point scoring system. A score of 'one' was given where there was little or no discussion in relation to the CASP criteria, 'two' was given when there was some reference to an area of quality but with only limited discussion and a score of 'three' was given where there was full and explicit discussion in relation to the CASP criteria. This allowed a total out of 24 to be calculated for each study with a higher score indicating the presence of more quality indicators. Consistent with Duggleby et al. (2010), if papers were not excluded by the screening questions of the CASP, they were retained in the review and the CASP scores and criterion were used in order to consider strengths and weakness of the studies.

Appendix D: Coventry University Ethical Approval

TO WHOM IT MAY CONCERN QRS/Ethics/Sponsorlet

Friday, 04 April 2014

Dear Sir/Madam

Researcher's name: **Stephanie Baker**
Project Reference: **P20265**
Project Title: **Exploring Recovery in Forensic Service Users diagnosed with Personality Disorder**

The above named student has successfully completed the Coventry University Ethical Approval process for her project to proceed.

I should like to confirm that Coventry University is happy to act as the sole sponsor for this student and attach details of our Public Liability Insurance documentation.

With kind regards

Yours faithfully

Professor Ian Marshall
Deputy Vice-Chancellor, Academic

Enc

Certificate of Ethical Approval

Applicant:

Stephanie Baker

Project Title:

Exploring Recovery in Forensic Service Users diagnosed with Personality Disorder

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:

09 March 2016

Project Reference Number:

P20265

Appendix E: National Research Ethics Service Approval

NHS
Health Research Authority

NRES Committee West Midlands - Solihull
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Telephone: 0115 8839368

06 June 2014

Miss Stephanie Baker
Department of Clinical Psychology
Coventry University
James Starley Building, Priory Street
CV1 5FB

Dear Miss Baker

Study title:	**Exploring Recovery for Forensic Service Users diagnosed with Personality Disorder.**
REC reference:	**14/WM/0153**
IRAS project ID:	**148934**

Thank you for your email of 03 June 2014. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 28 May 2014.

Documents received

The documents received were as follows:

Document	*Version*	*Date*
Other [Demographic Information Sheet]	2	02 June 2014
Participant consent form	2	02 June 2014

Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)	Allianz	
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)	AON - Liability	01 July 2013
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)	AON - Professional Indemnity	01 July 2013
Interview schedules or topic guides for participants	1	17 April 2014
Letter from sponsor		04 April 2014

Other [Participant Debrief Sheet]	1	17 April 2014
Other [CV - Dr Deborah Biggerstaff]		
Other [CV - Dr Helen Liebling]		05 February 2014
Other [Demographic Information Sheet]	2	02 June 2014
Participant consent form	2	02 June 2014
Participant information sheet (PIS)	1	17 April 2014
REC Application Form	148934/598188/1/116	17 April 2014
Research protocol or project proposal	1	17 April 2014
Summary CV for Chief Investigator (CI)	Stephanie Baker	07 April 2014

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

14/WM/0153	**Please quote this number on all correspondence**

Yours sincerely

W Rees

Wendy Rees
REC Manager

E-mail: nrescommittee.westmidlands-solihull@nhs.net

Copy to: *Dr Paul MacDonald , Birmingham and Solihull Mental Health Foundation NHS trust*

NHS
Health Research Authority

NRES Committee West Midlands - Solihull
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Tel: 0115 8839311

08 June 2015

Miss Stephanie Baker
Department of Clinical Psychology
Coventry University
James Starley Building, Priory Street
CV1 5FB

Dear Miss Baker

Study title:	**Exploring Recovery for Forensic Service Users diagnosed with Personality Disorder.**
REC reference:	**14/WM/0153**
Amendment number:	**Minor amendment 12.5.15**
Amendment date:	**12 May 2015**
IRAS project ID:	**148934**

Thank you for your letter of 12 May 2015, notifying the Committee of the above amendment.

The Committee does not consider this to be a "substantial amendment" as defined in the Standard Operating Procedures for Research Ethics Committees. The amendment does not therefore require an ethical opinion from the Committee and may be implemented immediately, provided that it does not affect the approval for the research given by the R&D office for the relevant NHS care organisation.

Documents received

The documents received were as follows:

Document	*Version*	*Date*
Interview schedules or topic guides for participants	version 2 (clean and tracked)	01 June 2015
Notice of Minor Amendment [Minor amendment 12.5.15]	Minor amendment 12.5.15	12 May 2015
Participant information sheet (PIS) [Participant debriefing sheet]	2	01 May 2015

Participant information sheet (PIS)	2 (clean and tracked)	01 June 2015

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

14/WM/0153: Please quote this number on all correspondence

Yours sincerely

Andrea Graham
REC Manager

Email: nrescommittee.westmidlands-solihull@nhs.net

Copy to: *Dr Paul MacDonald , Birmingham and Solihull Mental Health Foundation NHS trust*
Miss Stephanie Baker

Appendix F: Trust Research and Development Team Approval

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

Research & Innovation
Suite O
Radclyffe House
66/68 Hagley Road
Edgbaston
Birmingham
B16 8PF

Tel: 0121 301 4327
Fax: 0121 301 4340

Miss Stephanie Baker
Department of Clinical Psychology
Coventry University
James Starley Building
Priory Street
CV1 5FB

Dear Stephanie

Exploring Recovery for Forensic Service Users diagnosed with Personality Disorder

Letter of access for research – NRR1302

As an existing NHS employee you do not require an additional honorary research contract with this NHS organisation. We are satisfied that the research activities that you will undertake in this NHS organisation are commensurate with the activities you undertake for your employer. Your employer is fully responsible for ensuring such checks as are necessary have been carried out. Your employer has confirmed in writing to this NHS organisation that the necessary pre-engagement check are in place in accordance with the role you plan to carry out in this organisation. This letter confirms your right of access to conduct research through **Birmingham & Solihull Mental Health Foundation Trust** for the purpose and on the terms and conditions set out below. This right of access commences on **3 July 2014** and ends on **30 June 2016** unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

You are considered to be a legal visitor to **Birmingham & Solihull Mental Health Foundation Trust** premises. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through **Birmingham & Solihull Mental Health Foundation Trust**, you will remain accountable to **your employer**, but you are required to follow the reasonable instructions of your nominated manager **Dr Paul McDonald, Research & Innovation Manager** in this NHS organisation or those given on her/his behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with **Birmingham & Solihull Mental Health Foundation Trust** policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with **Birmingham & Solihull Mental Health Foundation Trust** in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on **Birmingham & Solihull Mental Health Foundation Trust** premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

Birmingham & Solihull Mental Health Foundation Trust will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. Where applicable, your substantive employer will initiate your Independent Safeguarding Authority (ISA) registration in-line with the phasing strategy adopted within the NHS and the applicable legislation. Once you are ISA-registered, your employer will continue to monitor your ISA registration status via the on-line ISA service. Should you cease to be ISA-registered, this letter of access is immediately terminated. Your substantive employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or ISA registration, or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the NHS organisation that employs you through its normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely

Dr Paul McDonald
Research & Innovation Manager

Appendix G: Informed Consent Forms

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

CONSENT FORM
Version Number 2

Title of Study: **Exploring Recovery in Forensic Service Users diagnosed with Personality Disorder.**

Name of Researcher: Stephanie Baker

Patient Identification number:

Please initial box

1. I confirm that I have read and understand the Patient Information Sheet version number 2 for the above study. I have had the opportunity to consider the information and ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw up until the point of data being analysed, without giving any reason, and without my medical or legal rights being affected. ☐

3. I understand that relevant sections of data collected in the study may be looked at by individuals from Coventry University and the University of Warwick, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in the research. I give permission for these individuals to have access to my study records ☐

4. I understand that interviews will be recorded and that any ***anonymous*** direct quotes from the interview may be used in the study report and may be used in subsequent publications. ☐

5. I agree to the use of audio recording ☐

P.T.O

6. I understand that if I disclose information suggesting that I or anybody else may be at risk of physical harm, information relating to a hospital security breach or crimes that I have not been convicted of then this information will be passed on to my clinical team. ☐

7. I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

Appendix H: Participant Information Sheet

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

Participant Information Sheet

Title of Study: Exploring Recovery in Forensic Service Users diagnosed with Personality Disorder

Name of Researcher: Stephanie Baker

Participant Information Sheet
You are being invited to take part in a research study. Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish.

What is the purpose of this study?
This research is being conducted as part of a Clinical Psychology Doctorate training course. The purpose is to explore the experiences of service users; in particular their opinions about trying to progress whilst in hospital.

Do I have to take part?
You are under no obligation to participate in this research.

What does the study involve?
You will have the opportunity to meet with the researcher and discuss your participation further. Should you choose to participate in this research then you will be invited to meet with the researcher on your ward and discuss your experiences whilst in hospital, your thoughts about the future and your journey up to this point. The length of the meeting will be determined by how much you have to say but it is thought likely to last between 60 minutes and 90 minutes although it can be shorter if you wish. The discussion would be digitally recorded in order to make sure the researcher gathers all the information discussed. You would be asked to sign a consent form before participating and provide information regarding your age, diagnoses, index offence and the length of time you have been in hospital.

What are the possible disadvantages and risks of taking part?
As described above, participating in this research will take up some of your time. Although the discussion will be guided by what you feel happy to share some participants may feel the topic is sensitive and find it difficult to talk about.

What are the possible benefits of taking part?
It is hoped the research will provide an in depth understanding of how people diagnosed with personality disorder experience care and treatment in hospital and how they feel about trying to progress within secure services. This will contribute to a growing body of literature representing service user views which aims to inform and enhance treatment and care across forensic services within the NHS.

What will happen if I don't want to carry on with the study?
You are under no obligation to participate in this research and are able to withdraw at any time up until March 31st 2016 at which point the research will be analysed; it would not be possible to remove your data part way through this process.

Will my taking part in this study be kept confidential?
All your information will be kept confidential within the research team. When the research is presented pseudonyms will be used to protect your identity.

There may be a need to give feedback to your clinical team should we discuss information that suggests you may be at risk of harming yourself or any another person may be at risk of harm. Similarly, information regarding hospital security breaches or information relating to offences you have not been convicted would also be passed on.

If the researcher was concerned that the interview had caused you significant distress then your clinical team would be made aware of this. Should this be the case you would be told within the interview. You have the right to end the research interview at any time.

What if there is a problem?
If you have any concerns you can contact the researcher using the details provided below.

You may also wish to discuss your concerns further with the Birmingham and Solihull Mental Health NHS Foundation Trust's PALS service who can be contacted on 0800 953 0045.

What will happen to the results of the study?
A summary of findings will be made available to participants and staff teams when the research has been completed. The research will be submitted for publication through scientific peer reviewed journals. If published the researcher can assist you in obtaining a copy should you wish.

Who is organising and funding the research?
This research is part of my Clinical Psychology Doctorate through the Universities of Coventry and Warwick. Funding is through Coventry University and Coventry and Warwickshire Partnership Trust.

The research team includes:

Principal Researcher
Stephanie Baker
Trainee Clinical Psychologist
Universities of Coventry and Warwick
Room JSG24,
James Starley Building
Coventry
CV1 5FB
Tel. 024 7688 7806

Academic Supervisor
Dr Helen Liebling
Senior Lecturer in Clinical Psychology /Research Tutor
Clinical Psychology Doctorate
Universities of Coventry and Warwick
Room JSG24, James Starley Building
Coventry
CV1 5FB
Tel. 024 7688 7806

Local Collaborator
Dr Ruth Fountain
Principal Clinical Psychologist
The Tamarind Centre
165 Yardley Green Road
Bordesley Green
Birmingham
B9 5PU

Academic Supervisor
Dr Deborah Biggerstaff
Lecturer and Researcher
Warwick Medical School
University of Warwick
Gibbet Hill Road
Coventry
CV4 7AL

Who has reviewed the study?
The study has been reviewed by academic tutors and the Ethics Committee at Coventry University. It has also been approved by the National Research Ethics Service and the Birmingham and Solihull Mental Health Foundation Trust's Research and Development team.

Thank you for taking the time to read this.
If you would like to discuss participation in this research further, or if you have any other questions then please contact the principal researcher.

Appendix I: Promotional Flyer

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

Exploring Recovery in Forensic Services

Have you got a diagnosis of Personality Disorder and experience of being in a secure hospital?

Would you like to take part in a research project exploring service users' experiences of treatment in hospital?

This is research based on your views and it hopes to contribute to informing and improving care across forensic services within the NHS.

What would I need to do?

- Meet with Steph the researcher and discuss your experiences whilst in hospital and your thoughts about the future
- The length of the meeting will depend on how much you have to say!

How can I take part?

- Let the psychologist in your team know you are interested and they can contact Dr Gemma Lees-Warley at Reaside or Dr Ruth Fountain at the Tamarind Centre.

"Hi, I'm Steph, I'm based at the universities of Coventry and Warwick - this research is part of my Clinical Psychology training"

This research has been approved by the ethics committee of Coventry University, the National Research Ethics Committee and the Birmingham and Solihull Mental Health Foundation trust's Research and Development department.

Version1 **07/02/2016**

Appendix J: Interview Schedule

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

Interview Schedule

Title of Study: **Exploring Recovery in Forensic Service Users diagnosed with Personality Disorder.**

Name of Researcher: Stephanie Baker

Interview Schedule

Thank you for agreeing to take part in this research. As you know, I am exploring service users' experiences of treatment and being in a medium secure hospital. I am particularly interested in your opinions about trying to progress and make changes whilst you're in hospital. I'd like to ask you some questions about this. These questions are only a guide – feel free to tell me what you feel is important to you. You may see me referring to this sheet from time to time. If I do this, it is only to make sure that we cover the topics while we have our conversation. You can have a copy of these questions for you reference. Only say as much as you feel comfortable to.

1. How would you describe yourself as a person?

Possible prompts: What do you enjoy doing?
What is important to you?
How do you think other people see you?

2. Can you tell me a bit about your experiences of being here in hospital?

Possible prompts: What are different aspects of the care you receive here?

3. Has there been a time since coming here that you became aware of feeling you had made progress?

Possible prompts: Would you mind telling me a little bit more about this?
What happened?
How did this make you feel

4. Has there been a time since coming here you experienced a set back?

Possible prompts: Would you mind telling me a little bit more about this?
What happened?
How did this make you feel?

5. Can you tell me a little about why you're here in hospital?

Possible prompts: What difficulties have you experienced in the past?

6. Is there anything that helps you move forward?

Possible prompt: Is there anything that helps you make positive changes in your life?

7. Is there anything that makes moving forward difficult?

Possible prompt: Is there anything that means making positive changes in your life is difficult?

8. How do you see yourself in the future?

   Possible prompts:

   Do you have plans for your future?

   Do you have any particular hopes for the future?

Thank you for helping me with this research project!

Do you have any questions or concerns following the conversation we had?

Please refer to the debriefing sheet for more information.

Appendix K: Demographic Information Sheet

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

Demographic Information Sheet

Title of Study: Exploring Recovery in Forensic Service Users diagnosed with Personality Disorder.
Name of Researcher: Stephanie Baker

Please complete the following with your named nurse or another member of your clinical team.

Participant ID number …….

1. Please can you provide your current age.

   .....

2. How would you describe your ethnic group of origin?

   .....

3. Do you have a diagnosis? If so please say what you think this is.

   ……

   ……

4. Where were you before you came to the Tamarind Centre? For example, in prison, in a different secure hospital or in the community.

   .....

   .....

P.T.O

Version 2 02.06.2014

5. Do you know what section of the Mental Health Act you are currently detained under?

.....

6. What was the index offence that brought you to hospital?.....

.....

7. How long have you been detained in hospital? If you were in a different secure hospital before coming to the Tamarind Centre please include this.

.....

Appendix L: Participant Debriefing Sheet

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

Participant Debriefing Sheet

Title of Study: Exploring Recovery in Forensic Service Users diagnosed with Personality Disorder.

Name of Researcher: Stephanie Baker

What will happen now?

The recording of this interview will be written up by the lead researcher; however your name and any identifiable information will be removed from this document in order to preserve anonymity. The research team will then read the document and make notes about important themes that have come up in our discussion.

What will happen to the results?

This research will be written up and submitted by the lead researcher Stephanie Baker as part of the requirements of the Doctorate of Clinical Psychology . A summary of findings will be made available to participants and staff teams when the research has been completed. The research will be submitted for publication through scientific peer reviewed journals. If published the researcher can assist you in obtaining a copy should you wish.

What if I have any questions about the study?

If you have any concerns you can contact the researcher Stephanie Baker or any member of the research team on the contact details provided below.

You may also wish to discuss your concerns further with the Birmingham and Solihull Mental Health NHS Foundation Trust's PALS service who can be contacted on 0800 953 0045.

What if I feel distressed from taking part in the study?

The interview was not intended to cause you any discomfort and it is hoped this will not be the case. However if you are experiencing any distress or worry after taking part

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

in the research it is recommended you speak with a member of your nursing team and inform them of how you are feeling.

Thank you for your participation!

Research Team:

Principal Researcher
Stephanie Baker
Trainee Clinical Psychologist
Universities of Coventry and Warwick
Room JSG24,
James Starley Building
Coventry
CV1 5FB
Tel. 024 7688 7806

Academic Supervisor
Dr Helen Liebling
Senior Lecturer in Clinical Psychology/
/Research Tutor
Clinical Psychology Doctorate
Universities of Coventry and Warwick
Room JSG24, James Starley Building
Coventry
CV1 5FB
Tel. 024 7688 7806

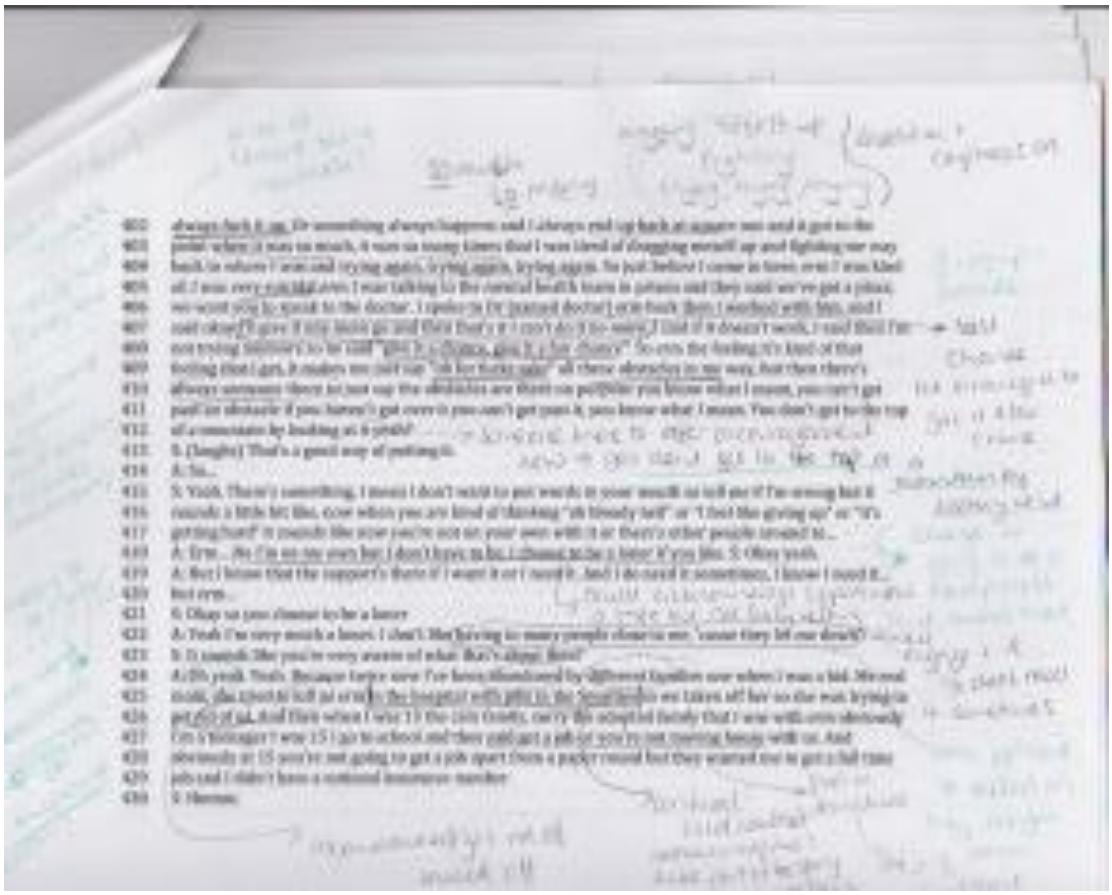
Local Collaborator
Dr Ruth Fountain
Clinical Psychologist

The Tamarind Centre
165 Yardley Green Road
Bordesley Green
Birmingham
B9 5PU

Academic Supervisor
Dr Deborah Biggerstaff
Lecturer and Researcher

Warwick Medical School
University of Warwick
Gibbet Hill Road
Coventry
CV4 7AL

Appendix M: Worked Excerpt of Transcript



always back it up. Or something always happens and I always end up back at square one and it got to the point where it was so much, it was so many times that I was tired of struggling myself up and fighting me way back to where I was and trying again, trying again, trying again. So just before I came to here, erm I was kind of, I was very suicidal erm, I was talking to the mental health team in private and they said we've got a place we want you to speak to the doctor'. I spoke to the [name] doctor[1] or two back then I worked with him, and I said okay I'll give it one more go and then that's it I can't do it no more. I said if it doesn't work, I said then I'm not trying anymore to be cruel "give it a chance, give it a fair chance". So erm, the feeling it's kind of that feeling that I get, it makes me just say "oh for fucks sake" all these obstacles in my way, but then there's always someone there to just say the obstacles are there on purpose you know what I mean, you can't get paid [or obstacle if you haven't got cows in you can't get cows it, you know what I mean. You don't get to the top of a mountain by looking at it yeah?

S: [laughs] That's a good way of putting it.

A: So...

S: Yeah. There's something, I mean I don't want to put words in your mouth so tell me if I'm wrong but it sounds a little bit like, cos when you are kind of thinking "oh bloody hell" or "I feel like giving up" or "it's getting hard" it sounds like now you're not on your own with it or there's other people around to...

A: Erm ... No I'm on my own but I don't have to be, I choose to be a loner if you like. S: Okay yeah.

A: But I know that the support's there if I want it or I need it. And I do need it sometimes, I know I need it... but erm...

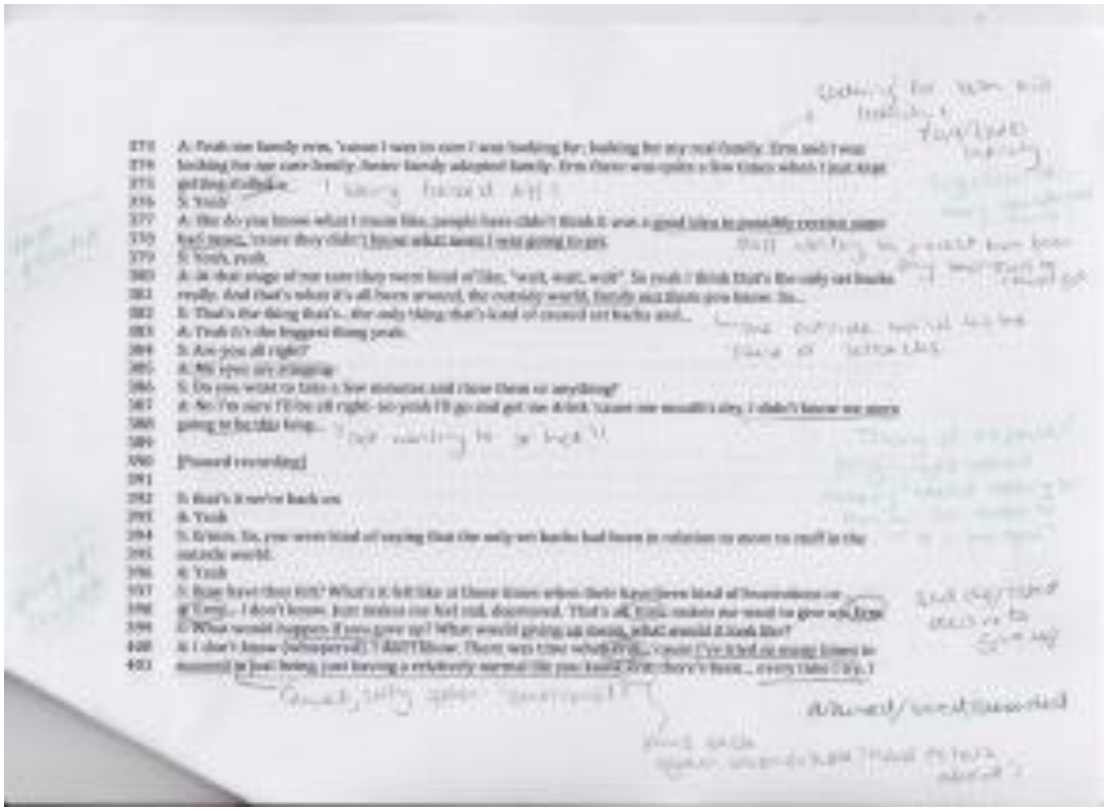
S: Okay so you choose to be a loner

A: Yeah I'm very much a loner. I don't like having so many people close to me 'cause they let me down!

S: It sounds like you're very aware of what that's about there!

A: Oh yeah. Yeah. Because before now I've been [illegible] by different families now when I was a kid. My real mum, she tried to kill us when she [illegible] with pills in the [illegible] we taken off her so she was trying to get rid of us. And then when I was 13 the [illegible], we're the adopted family that I was with now obviously I'm a teenager I was 15 I go to school and they said get a job or you're not moving house with us. And obviously at 15 you're not going to get a job apart from a paper round but they wanted me to get a full time job and I didn't have a national insurance number

S: Hmmm.



A: Yeah our family now, 'cause I was in care I was looking for, looking for my real family. Erm and I was looking for our care family, foster family adopted family. Erm there was quite a few times when I just kept getting [illegible]...

S: Yeah

A: But do you know what I mean like, people have didn't think it was a good idea to possibly contact some[illegible] mean, 'cause they didn't know what [illegible] going to get.

S: Yeah, yeah.

A: At that stage of our care they were kind of like, "wait, wait, wait". So yeah I think that's the only set backs really. And that's what it's all been around, the curiosity world, family and them you know. So...

S: That's the thing that's.. the only thing that's kind of caused set backs and...

A: Yeah it's the biggest thing yeah.

S: Are you all right?

A: Me, yes, sorry [coughs]

S: Do you want us take a few minutes and [illegible] or anything?

A: No I'm sure I'll be all right - so yeah I'll go and get me drink 'cause me mouth's dry, I didn't know we were going to be this long...

[Paused recording]

S: And it's we're back on

A: Yeah

S: It's me. So, you were kind of saying that the only set backs had been in relation to more to stuff in the outside world.

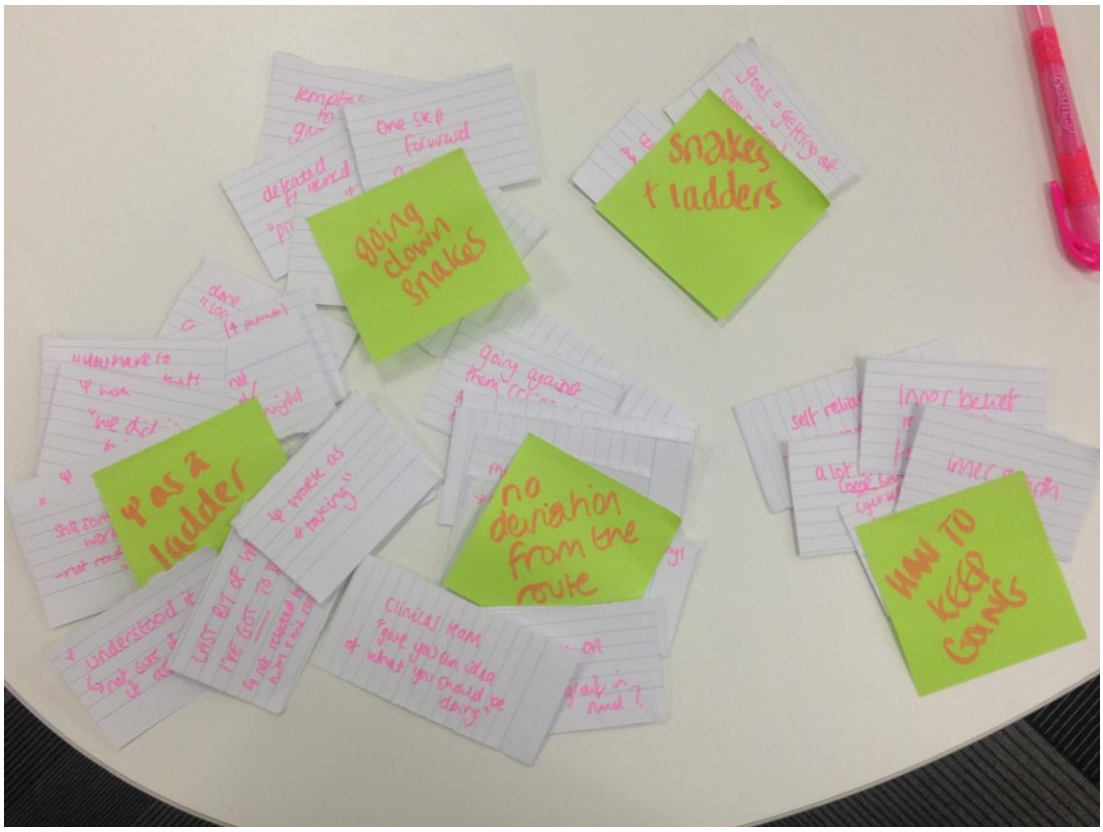
A: Yeah

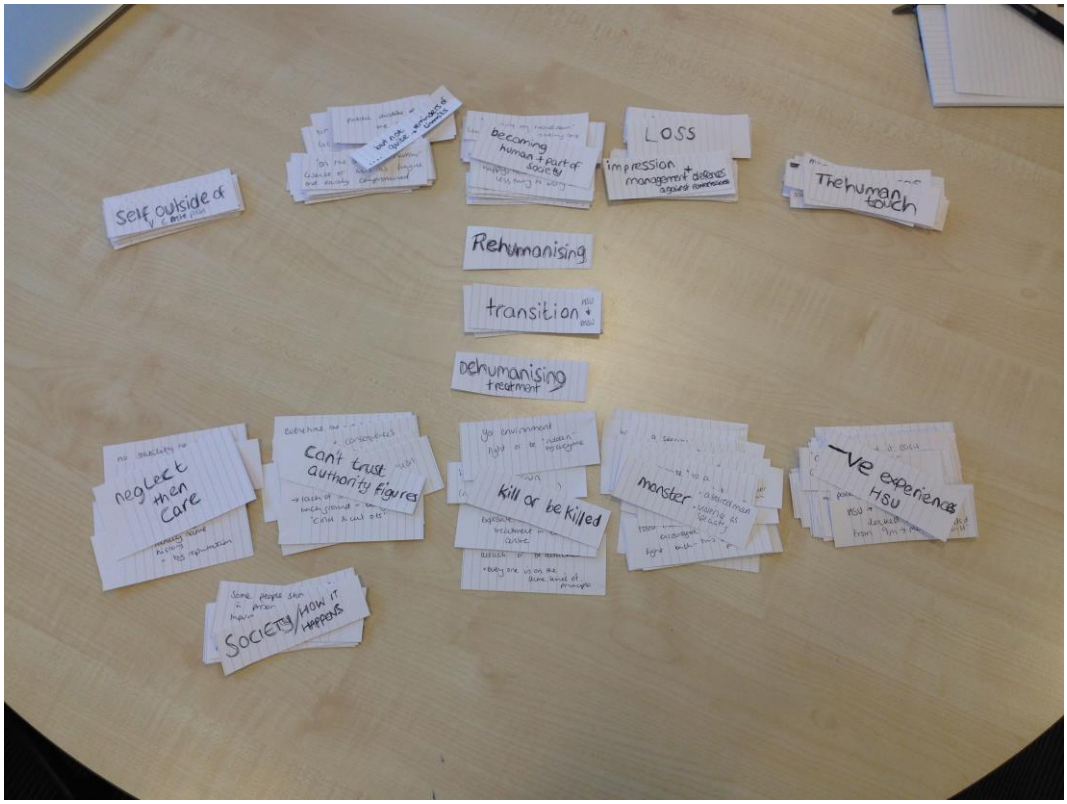
S: How have they felt? What's it felt like at those times when their [illegible] kind of frustrations or [illegible]... I don't know, just makes me feel sad, disappointed. That's all. It's, makes me want to give up, I'm

S: What would happen if you gave up? What would giving up mean, what would it look like?

A: I don't know [whispered]. I don't know. There was time when it's... cause I've tried so many times to succeed in just being just having a relatively normal life you know, it's there's been... every time I try, I

Appendix N: Example of Grouped Emergent themes



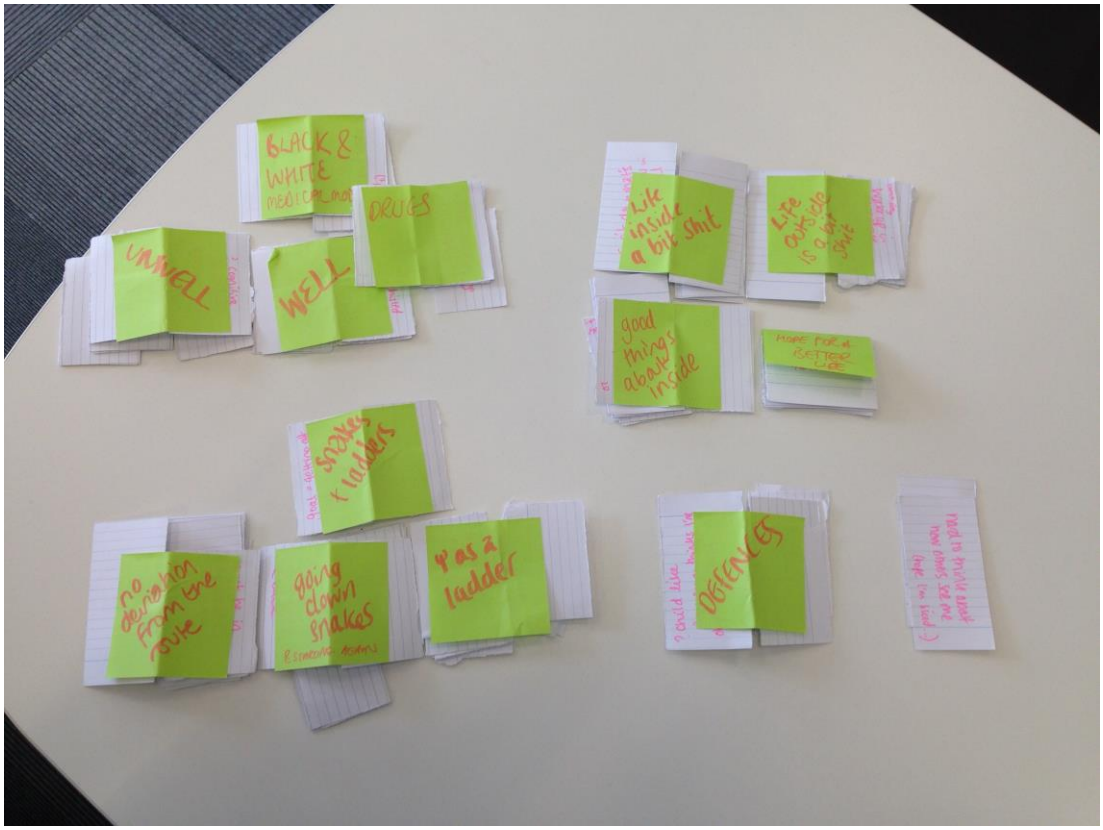


Appendix O: Example of Superordinate Themes and Quotations for Individual Participant

Bob

Superordinate themes Themes	**Key words and quotes**
Dehumanising experiences	
Me against the world	"I was used to fending for myself" p. 25, "trusting people in any form of authority was very, very difficult, I'd take it with a pinch of salt and then ignore it" p.1.
Attack or be attacked	"And that means you've either got to fight him or like, look like a fool and everyone rides you" p. 18
"The enjoyment of violence"	"But erm from that point on something awoke inside of me…A violent side of me. Yeah fear didn't seem to come in anymore" p. 17
"Corrupt" and "Draconian" care	"Seclusion is used a lot more frequently, for minor things which they shouldn't really do that helped to condition people" p. 5
Coping inside	
Loss	"And suddenly like ouch! I've just done all them years has it really been that long? And then you speak to someone you care about in some way or another and it really hits home" p. 15
Impression management and defences against powerlessness	"You know I'm someone that may not have all the answers but someone they can at least talk to or share a problem with because you know, it helps" p. 26
	"I mean you want to turn around and help someone like that" p. 16
A period of transition	"I felt like a child. That had to learn again" p. 5
Coming back to life	
"The human touch"	"They add the human touch to it" p.11 "People are being treated like people" p. 11
Becoming a person and part of society…	"It gives you life again it makes you feel like a person" p. 10
…but not quite.	"You could compromise your own interests. That person may take a dislike to you, could cause you trouble, you don't know. People around here do not like this centre. They really hate it" p. 17

Steve

Superordinate Themes Themes	**Key words/ Quotes**
Snakes and Ladders	
Going down snakes	"It's devastating really 'cause it's like, it's like one step forward and two steps back all the time" p. 9
Psychology as a ladder	"I understood what it was all about. Erm whether or not you know I needed to do what we did I don't know" p. 6
There's no other way – abiding by rules	"keep ticking the boxes and keep following the rules. Don't break any rules and get through this system and get out of here" p. 2
A medical model of illness	"I wasn't chilled until I had these drugs. And now I'm chilled all the time" p. 7
Well	"I don't feel worried about anything; I just feel nice and relaxed" p. 7
Unwell	"Being unwell it changes your personality" p.7 "I'm just loud and erm obnoxious. And not really that nice" p. 7
Black and white thinking	"I think everything's sorted now just waiting to get out" p. 6
Substance use	"He gave me some cocaine and I swallowed it, I didn't snort it I swallowed it and I went off my head" p. 9
Life inside, life outside	
Quality of life inside	"They're very small the rooms are so you feel a bit a cramped when you come in" p. 2
Quality of life outside	"I wake up in the same place, no one to talk to, bored" p. 13
Hope for a better outside	"Hopefully getting my licence back and erm getting a job, full time job" p. 13
Defences	
Avoidance as acknowledged strategy	"Just put it to bed a bit. Try not to think about it too much" p. 12
Avoidance and minimisation in language	"I had an incident with another patient" p. 8, "settled" p. 5
Fantasy	"Winning the lottery" p. 13

Appendix P: Making Connections across Cases