

Patient Focus Group Responses to Peer Mentoring in a High Security Hospital

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Abstract

Peer mentoring programs in secure hospitals have attracted limited attention despite reported benefits of similar schemes within other mental health and prison services.

High secure hospital patient perspectives (N=17) on the concept of peer mentoring and the implications for establishing a peer support scheme were investigated via focus groups. Thematic analysis of discussions generated five themes: how to meet the adjustment and support needs of a peer; differences between mentoring and other relationships; mentoring by peers within a secure setting; expectations of a mentor's skills to meet the challenges of mentoring, and ownership of a mentoring scheme. The need to off-set risk management against the potential benefits of peer support for a population excluded on the basis of risk is reviewed throughout.

Keywords: forensic patients; mentoring; peer support; focus groups; thematic analysis; recovery; risk; perceptions; safety; stigma

Introduction

The concept of mentoring emphasizes important relationship qualities, such as warmth (Barondess, 1995), the passing on of knowledge to benefit another (Porteous, 2007) and the emergence of personal growth from a supportive relationship (Renick Thompson & Zand, 2010). Whilst there are a number of definitions of the term, which can be used interchangeably with other descriptions, for example befriender or buddy (Freeman, 2000) the potential benefits of the core attributes commonly described with this role have been considered in forensic and mental health contexts where a person might benefit from such a relationship (e.g. Davidson et al., 1999; Porteous, 2007).

Evidence from prison and hospital settings indicates that peer support can reduce depressive symptoms, feelings of loneliness and shame and increase hope and engagement with larger social networks, which in turn can counteract the effects of stigma and promote an improved quality of life (Borge & Fagermoen, 2008; Bouchard et al., 2010; Davidson et al., 1999; Devilly, Sorbello, Eccleston, & Ward, 2005; Mead, Lester, Chew-Graham, Gask, & Bower, 2010). Benefits have also been reported for the mentor role, including enhanced skills and confidence (Deville et al., 2005; Moran, Russinova, Giddugu, Yim, & Sprague, 2012). These outcomes closely align with the organizing principles of recovery, which support service user empowerment, responsibility, hope and self-determination (Shepherd, Boardman, & Slade, 2008).

The importance of these roles might be understood from an attachment theory perspective to foster the generation of positive internal working models of interpersonal relationships that have the potential to positively affect future relationships (Renick Thompson & Zand, 2010). A mentor might act as a role model and the mentored person might learn by observation from experienced experts (Devilly et al., 2005; Pratt et al., 2010). From this exchange, both parties are provided with a sense of connection, in relation to passing on and acquiring new skills (Moran et al., 2012). Providing and receiving support also has the potential to instill hope and motivate therapeutic engagement (Bouchard, Montreuil, & Gros, 2010; Hossack & Wall, 2005).

However, there are a number of challenges with such a role within secure settings (Clark, 1981), not least because these are traditionally hierarchical, confidential and boundaried systems (Adshead, 2010). Mentors cannot be legally responsible for mentees (Devilly et al., 2005) and both parties are members of the same social system, so concerns about personal safety and confidentiality may arise (Sheldon & Harding, 2010). The history of harmful interpersonal behaviors within these populations contraindicates the suggested attributes for mentors (Bouchard et al., 2010; Sheldon & Harding, 2010), which include robust and sustained social adaptability and there is also the potential, as with all alliances, for romantic attachments to form (Taylor, 1998).

Both the perceived benefits and challenges of mentoring in forensic services and psychiatric services would seemingly apply to forensic mental health settings. These

benefits include a shared identity, self-validation, increasing interpersonal skills and modeling progress in community settings (Crawford et al., 2008). Mentoring is not identified as a formal practice in U.K. high secure settings, where the function is to provide a service to patients who cannot be managed in conditions of lesser security, predominantly forensic patients who have attachment-related and social adjustment treatment needs (Glorney et al., 2010).

Despite the potential difficulties of employing mentoring approaches in high secure forensic mental health settings, it has been argued that a “culture of fear” (Sheldon & Harding, 2010; p. 19) around service user involvement in service development should not overshadow opportunities for service user empowerment and responsibility. A necessary task for services would be to explore the implications for setting up such a system. Therefore, in line with work on the promotion of recovery and service user involvement in all aspects of their care (e.g. Shepherd et al., 2008), this study was designed to provide a service user contribution to the establishment of a peer support program within a high security hospital, one of three national services for forensic mental health in the UK.

Method

Design

A qualitative research design using a semi-structured interview with focus groups was applied to investigate patient perspectives on peer mentoring in high security.

Recruitment

The study was approved by the West London Mental Health Trust Clinical Effectiveness and Audit Committee as part of a mentoring service development project that aimed to include patient perspectives. To invite patients at different stages of the high secure hospital pathway and with different levels of experience in terms of length of stay, posters welcoming expressions of interest in participating in a focus group on the topic of mentoring were displayed across all admission, high dependency and assertive rehabilitation wards of one of the UK high secure hospitals. On receipt of interest from prospective participants, clinical care teams were contacted to determine individual suitability on the basis of capacity to consent to take part and risk to self or others. Clinical decision making for capacity and risk was made by clinical care teams who have current experience of each patient's well-being and functioning. If deemed suitable to participate, patients who had raised an interest were individually approached on ward areas and provided with an information sheet and written consent form.

Participants

Twenty men expressed an interest in the study and 17 men took part. Three men chose to opt out of the study at the point of data collection because they felt physically unwell or decided not to participate. The average length of hospital stay for participants was 4.67 years (range: 4 months –over 16 years). Participant ages ranged from 20 to 47 years ($M = 31.11$ years).

Data collection

A focus group approach was selected over individual interviews because questions, feedback and challenges from group members can stimulate a richer exploration of a subject than a one-to-one interaction (Morgan & Krueger, 1993). The social context can furthermore reframe the meaning of a given question and illustrate normative understandings (Massey, 2011). The practical organization and role of focus group facilitators was informed by existing focus group methodology guidance (Gibbs, 1997). Facilitators acted as moderators, asking questions to clarify shared understandings but retaining a neutral position in the discussion between participants. Focus groups 1, 2 and 3 (FG1; FG2; FG3) contained 9, 5 and 3 participants, respectively. The groups were conducted by the hospital-based authors of this article, all of whom have experience of facilitating clinical group work interventions and/or focus groups at the study site. A semi-structured discussion guide was developed and applied across the three focus groups, which began with a general question: “What does mentoring involve?”. This was followed by questions such as “What would you want from a mentor?” or “What

skills and abilities would a mentor have?”. Focus group sessions lasted between 45 and 90 minutes, were audio recorded and transcribed verbatim. Participants were assigned pseudonyms to preserve anonymity and confidentiality.

Data Analysis

Transcripts were analyzed by the first author using Braun and Clarke’s (2006) six steps for Thematic Analysis. The initial analytic step involved repeated listening and reading of recordings and transcripts while taking notes. Next, codes, basic segments of meaningful information, were generated for the entire data set. Coding was inductive to reflect patients’ own perspectives. In the third stage, codes were organized into interpretative themes and relevant data extracts collated under each theme. A theme was defined as “a pattern in the information that at minimum describes and organizes the possible observations and at maximum interprets aspects of the phenomenon” (Boyatzis, 1998, p. 161). Themes were subsequently verified for homogeneity in relation to coded extracts and the entire data set and then mapped out visually. They were then refined by collating emergent themes that appeared to be part of a larger concept and deleting emergent themes with little data to support them. Each theme was also kept in a separate word processing file with supporting evidence and equipped with a clear definition. This entire process was recursive because codes and themes were continually verified against data extracts, which ensures grounding in data (Fereday & Muir-Cochrane, 2006). Meetings with the second and third authors were then held to consolidate themes.

A critical realist perspective was taken during the analysis stage to consider potential subjectivity with which participant perspectives are offered and interpreted (Madill, Jordan, & Shirley, 2000). In contrast to the positivist concepts of reliability and validity, the quality of analysis was reviewed using criteria specifically applicable to qualitative research methods, which included a membership validation process (Yardley, 2000).

Results

Five superordinate themes were identified (see Figure 1). All participants discussed issues of role expectations, validation and boundaries. Together, these themes illustrate what was considered important about mentoring to this group of patients and what they anticipated would present difficulties in forensic mental health settings particularly.

INSERT FIGURE 1 ABOUT HERE

1. The Mentor's Potential to Meet Multiple Adjustment and Support Needs

Areas of need where a mentor might be able to provide support:

Adjustment. Participants described difficulties associated with admission to high security hospital and transitions within it. Participants felt “scared” (William, FG1) and that “it’s a lot of change in experience. It was just like I was having a nightmare” (Christopher, FG3). The suggested role of the mentor was to provide information from a position of

experience. This was thought to reduce distress and integrate the mentee to facilitate a next phase: “it prepares you for your stay” (Christopher, FG3).

Relating. This subtheme refers to a shared understanding between mentor and mentee about the mentee’s concerns: “Basically just nurturing someone and helping them (. . .) in maybe one topic or one area. And helping them progress in it” (Michael, FG2). “Relating” was not exclusively about emotional support because a need to “share things” (Robert, FG1) with someone and achieve personal closeness was also described. The benefits of this relationship were suggested by John (FG1) to enable “sharing” in other relationships.

Advice. Advice was discussed in all groups regarding its value and how it was used.

The first question we’ve got here is what does listening involve and what is it not and one of the things that I thought about what it isn’t is about giving advice. (. . .) You don’t tell them “yeah, go and get another girlfriend” or “go and do this and go and do that” but you draw them out and (. . .) then through doing that, through talking about it, they heal themselves (John, FG1).

The mentor offering guidance through advice was juxtaposed with the idea of the mentor guiding the mentee’s discovery process for themselves. The mentee therefore takes an active role in healing. These two positions were not adopted in FG3, where advice was more simply viewed as beneficial “where needed” (Christopher).

2. *The Care System*

Barriers in the participants' care and their own position that prevent the meeting of their needs by means other than mentoring.

Clinical roles. Mentoring was discussed in terms of how it differs from support systems already in place: "Nurses, psychologists, OT, everybody else we see (. . .) it's like being under a microscope. Everything is enlarged by ten. Everything that you do" (Nicholas, FG1). Staff, by virtue of their clinical roles, were positioned separately from patients with aims of assessment, management and rehabilitation. Some participants expressed this to be a barrier to seeking their support because of the thought that "everything is written down" (Mark, FG1). Being monitored could also have negative consequences such as seclusion, an intervention used by staff to ensure physical safety in response to, for example, disclosure of suicidal feelings. Seclusion was sometimes experienced as a "form of punishment" (Richard, FG3) which meant that measures taken by staff to ensure safety could make confiding in staff feel unsafe.

In FG1, the idea of a mentor and mentee cooperating was equated to an "alliance" which might be perceived by staff as a "threat" (Robert) to the existent role division. This raised the question as to how the system might deal with a patient adopting a supportive role that could resemble a staff role. This idea was contested by Steven (FG1) in his feedback session: "If you don't have boundaries, it's gonna be destructive". Rules

and structure could therefore be negative barriers or positive boundaries depending on the interpretation and the context within which these operate.

Attitudes and fears. Attitudes and fears encompass the more personal barriers to interpersonal relating: “Initially I thought, you know, “ah, it’s a mental place” and in here nobody would care anymore and I would get into trouble (. . .) I was just naturally paranoid” (Thomas, FG2). Patients were seen to regard staff as “the enemy” (Richard, FG3) because of prison or “street” experiences and to mistrust the mental health setting, whereas staff were thought to hold suspicion, fear of assault and condescension against patients in high dependency areas. There was therefore a concept of an in-group of patients and an out-group of staff, which made relating to a fellow patient less threatening, especially in areas of the hospital where patients anticipated negativity or hostility from staff.

Shared experience. Shared experience was constructed as a basis for understanding in FG1 and FG3.

So what you’ve got to remember is that some people are really unstable and then maybe they need a bit more understanding because obviously, you’re the professionals, but we’ve had the experiences where someone might have hallucinated before, someone else might have heard voices before (Christopher, FG3).

This provided a prerequisite for relating because an intrinsic value was attached to being heard by someone who can understand “the remorse and guilt that patients feel” (William, FG1). Shared experience referred not only to mental health problems or offending behavior but also the shared position of being detained without liberty to leave. Matthew (FG1) disagreed with the idea that staff are unable to understand; “I believe some people have been in here years (. . .) I think staff can empathize because they’ve got experience and they’re human beings”. His disagreement challenges the idea of differing experience as an obstacle to relating by highlighting shared experience between patients and staff and asserting a shared human identity. This essentially reaffirms the value of experience.

3. Mentor Position

The location of a mentor within the hospital system.

Mentor as separate. A mentor’s value for some participants lay in his position outside the constraints of the care system structure. This was seen to facilitate honesty and provide something novel.

With mentoring, there is no rules. Rules are for staff. (. . .) ‘Cos as soon as you start bringing rules into it or back to that, they won’t be so open and honest with you because they’ll be scared of what the outcome will be (David, FG2).

This aligns with the concept of a mentor as an “ally” who is not bound by “a care plan” (Robert, FG1). However, this was associated with certain risks:

John: If they know that you're gonna go straight back to, you know, "Joe just said that he's gonna hang himself tomorrow", then they're not gonna say that, anyway. The fact that they can't say it won't change the fact that they're thinking about it.

William: But what if Joe says he's gonna hang himself and then he hangs himself tomorrow? You could have done something to prevent him from hanging himself (FG1).

John and William identified the conflict between need for safety and need for confidentiality. Even though a patient might feel safer speaking to someone outside a formal rule-governed dynamic, concern was expressed around ensuring safety. This raised a question as to the extent to which any mentor could operate separately yet within the broader system, which is determined by policy and procedure for good reason in the management of risk and well-being.

Mentor as a bridge. A mentor could act as a link within the system, advising staff on the mentee's needs or advocating on his behalf.

The whole point of having a mentor is (. . .) for a member of staff or for the clinical team to add to the care of the patient by giving them somebody to talk to that has experience (. . .) bridging that gap between patient and staff. So that the care of that patient can be improved (William, FG1).

The proposed benefits were improved care and insight into the mentee's well-being. Mentors would consequently be much more aligned with staff and potentially bound by institutional aims: "I don't suppose you're paying someone to be a mentor or paying for someone to get all his training, when the staff can't get anything out of it" (William, FG1). William describes a need for a practical outcome that would legitimize the mentor role. This position led to disagreement in FG1 because some participants expressed concern about entrusted information being passed on to staff. In his feedback session, Daniel (FG3) also spoke of a "subculture" that would put a patient at risk of harm from others if he "grassed up" another individual. This suggests that it could be unsafe for a mentor to align too closely with staff. The benefits and drawbacks of a "bridge" and a "separate" mentor might therefore differ, but both face issues of safety and validation of the role.

4. Mentor Expectations

Expectations of a mentor and the effects of the mentoring role on the mentor.

Personal attributes. Participants emphasized the qualities and skills that a mentor would need including concentration, attention, respect, patience, a nonjudgmental attitude, listening and communication skills, assertiveness, open-mindedness and the ability to recognize another perspective. These were described in the context of the mentor's interpersonal style, for example: "I'm just good with people" (David, FG2).

Development of these skills through training was acknowledged only by Steven (FG1) and David (FG2), when asked about this in their feedback sessions. Although these

skills were commonly referred to, personal attributes and the pure willingness “to be there” (Daniel, feedback) held stronger emphasis. There was also an acknowledgement that “what fits one person might not fit another” (John, FG1), that mentors could have personal feelings and responses. Therefore, a mentor was not bound by a strict ideal because the quality of the relationship was related to the dynamics between two individuals.

Recovery status. The importance of experience assumes that a mentor has certain experiences, such as sufficient knowledge of the hospital to provide information. However, recovery status was contentious.

William: I think that to get the status of mentor you wouldn't be in the mindset of “this is all shit” anyway because if you're thinking “this is all shit” then you're not gonna get past a certain stage.

Robert: The thing is, I mean, even if you're at the end of treatment, and you've done it all and you come out as well and whole as you feel like a whole new person who's got something useful to contribute, you could still say [the hospital] “is shit” (FG1).

The first issue above is whether a mentor could express negative views to a mentee, which was later agreed to be permissible if done diplomatically. The second idea expressed relates to holding a critical view of the service despite progression through it. William implies an expectation on patients to accept the system to progress in their

recovery. Robert challenges this idea and asserts the legitimacy of criticizing a service while being able to support others within it. “Changes” (Robert, FG1) within individuals over time and “insight” (Christopher, FG3) were seen to play a role in this process.

Benefits. Mentoring was considered in terms of its intrinsic and extrinsic benefits for the mentor: “Somebody said to me that looking after a peer would be a kind of therapy itself, that I’d start to feel better. And I can’t always help myself (. . .) but I feel really good when it helps somebody” (Paul, FG2). In FG3 a wish to help, a desire for positive change and the aim to give something back through everyday behavior were discussed. Extrinsic benefits of the role of a mentor included being seen to achieve something by staff, which “could work for you” (John, FG1). The mentor’s personal development and recognition of the role were therefore important to participants.

Burden and protection. The responsibility mentors might face was acknowledged: “It’s a lot of responsibility towards you. And I didn’t wanna fail them in any way, ‘cos it makes you feel they’re trusting you with that and I didn’t think that I could handle it to begin with” (David, FG2). Drawing on experiences as providers or recipients of support, several participants could recall instances when their informal support of others had been “too much pressure” (Christopher, FG3). This was linked to the mentor’s position in the care system and the resulting decisions he would have to make or information he might hold. For Daniel and Steven (in feedback sessions), this potential burden meant that a mentor should not carry “any real responsibility”. Others stressed the mentor’s

ability to distance himself: “say you have a blank sheet of paper for this person. (. . .) Everything you are you put to one side and you just take the little bits out at a time in a situation you’re in” (David, FG2). This again places the responsibility with the mentor and his skills for managing any strain, although support needs were also acknowledged and a peer support system backed by professionals was suggested.

5. Ownership

This addresses the balance between service and service user centeredness and the negotiation of issues of power and control within mentoring relationships.

Terminology. “Mentor” is used throughout this article to maintain consistency with the initial research question and extant literature. However, in all groups, the term “mentoring” was rejected as unsuitable for the hospital, too alien or likely to generate inaccurate assumptions: “I don’t think it is the right word because I think it’s taking one word and making it into something else into the clinical model” (William, FG1).

Terminology was thought to play an integral part in defining the scheme and relationships between patients. Considerations of power and familiarity of the term were decisive factors in its acceptability. Suggested alternatives to mentor - Peer Supporter, Listener, Buddy, User Support Service - were preferred because the role description sounded more familiar and comfortable and, perhaps, reflected more clearly a sense of the meaning of the role of a mentor, as attributed by participants.

Choices. A suggestion was made that mentees could choose their mentor and the type of support provided. The mentee would therefore be active in shaping his support:

“Because, yeah, you can look and say ‘I think this guy might be really good for him’ but I’m a patient, I know who’s helped me in the past” (James, FG1). This supports peer ownership of the scheme, in line with recovery principles, but challenges freedom of choice. An offered example was that of a newly-admitted patient who might struggle with adjustment to the high secure environment. This patient might not know who to choose as a mentor who, in turn, might have a more or less favorable reputation that would affect the likelihood of them being chosen.

Responsibilities. Ownership could extend to the control of any potential mentor scheme. This included promotion and organization of the scheme and formal ownership of what would happen in the relationship: “Because the minute you get management user group, management mentor group, you’ve lost it. The aims of this and value is in exactly what Robert said, that it’s meant to be user led” (John, FG1). Steven and David (FG1 and FG2; feedback sessions) assigned responsibility to staff, with Steven highlighting the need for psychological services to provide a framework for the mentor/mentee relationship. Safety and role clarity were associated with a more formalized scheme, whereas peer ownership was seen to provide something novel but potentially risky.

The question of ownership relates to both mentor position and the care system but is distinct as a theme by virtue of its individual importance and cohesion across its three areas. It reflects a need to establish how and to what extent peer support could be peer led.

Discussion

The identified themes of this article are reflected in previous research studies, which lend some support to their trustworthiness (Yardley, 2000). Studies of peer support in mental health and custodial settings have likewise identified emotional support, provision of information, advice, the sharing of experience and being understood as important attributes of a mentor role (Bouchard et al., 2010; Coatsworth-Puspoky, Forchuk, & Ward-Griffin, 2006; Crawford et al., 2008; Devilly et al., 2005). Such benefits indicate the value of establishing mentoring activity in forensic settings such as high security hospitals.

Mentoring relationships exist along two continua, intimacy and formality (Haggard, Dougherty, Turban, & Wilbanks, 2011). In this article, the two were experienced by some participants as mutually exclusive because the formality of the care system could make relating unsafe, yet concern was equally expressed about establishing a safe mentor role independently of these structures. Feeling secure and establishing positive relationships have been identified as important aspects in recovery (Brunt & Rask, 2007; Mezey, Kavuma, Turton, Demetriou, & Wright, 2010). Additional research on how

interpersonal boundaries are maintained could provide a clarification of how this issue is negotiated in existent relationships, in a setting where patients might face difficulties specific to attachment. Considerations of power, equality and ownership are part of this negotiation. These power issues have been discussed more in the literature on occupational mentoring (e.g. Beech & Brockbank, 1999), but findings presented in this article indicate that they also arise in a forensic mental health setting. Core to these issues are the common presenting difficulties of forensic patients in terms of challenging interpersonal behaviors and insecure attachment styles. The concept of risk is central to patients in high security and risks of exploitation, collusion, increased stress and jealousy as complex issues from living in secure care (Adshead & McGauley, 2010) need to be carefully balanced against the possible benefits of providing a mentoring service.

Implications

Historically, forensic inpatients have had limited choices and control (Bressington, Stewart, Beer, & MacInnes, 2011) and have experienced stigma and disempowerment (Adshead, 2010). In this study, their inclusion resulted in multiple suggestions for a mentor role and promoted inclusion, ownership and empowerment in line with recovery principles and previous research studies of the benefits of engaging in the role of a mentor (Moran et al., 2012). Relational components and personal experience were important in the added value of a mentor role. Training and a support network could additionally help mentors to develop the personal skills required to meet these needs.

If formality can be a barrier to forming close relationships and service user ownership is desired, should there be formal mentoring schemes at all? Although there was disagreement on the extent of the role, no participant stated that there should not be a peer support scheme. Commonalities existed in the perceived importance of receiving support from someone in the same position. In the UK prison service, the Listeners scheme – run by Samaritan-trained (Befriender Worldwide) prisoners to provide confidential emotional support - advocates a collaborative approach to developing an action plan, involving a team of staff and service users (Samaritans, 2011). The development of a mentoring scheme in a high security hospital would benefit from involvement of patients in the development process and operationalization.

Establishing a clear mentor role was difficult. A mentor in close cooperation with staff was seen to compromise the distinct quality of the relationship and potentially affect how the mentor is perceived by other patients. A separate mentor position would carry a great responsibility; too great for some whilst also in-patients and subject to many of the same context-related pressures as their peers. Clarifying the peer mentor role to distinguish it from existing services (such as advocacy and mediation) to provide information for patients could reduce the risk of disappointment with the scheme. Deterioration in peer support relationships might be detrimental to a service user's well-being (Coatsworth-Puspoky et al., 2006). One way of managing the risk of subsequent disengagement would be through prevention, by having a restricted mentor role with known obligations such as a duty to disclose risk issues. However, participants

were divided about the necessity of this. A rule free space could also be difficult to navigate but developing a scheme at this point and imposing rules externally, while justifying it with patients' concerns, could be experienced as a form of tokenism (Sheldon & Harding, 2010), particularly because it would counteract ownership. The timing of the process of becoming a mentor should be considered. Participants indicated that a mentor should have progressed far enough in his recovery to be able to provide support and navigate the system. The suitability of a peer to act in a mentor role negotiated with the system and to facilitate a good quality supportive relationship is a consideration that applies to all forensic mental health services.

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Limitations

Focus group designs have been criticized for favoring dominant voices, which become represented as a group theme, and encouraging "normative discourses" (Smithson, 2000, p. 112), where one view is assumed by group members to be the standard. Opinions expressed in groups are sensitive to previous relationships and power dynamics between members (Farnsworth & Boon, 2010). In his feedback session, Steven (FG1) stated that a group of nine was too large, that a few individuals had been dominant and that he had felt unable to disagree. Polarization of opinions and challenges were indeed most common in FG1 because of group size and composition. Three participants barely spoke at all. Having smaller, evenly sized groups might

therefore have promoted a wider range of perspectives. Nevertheless, this analysis attempted to reflect dissenting voices and “shared experiences” (Bradbury-Jones, Sambrook, & Irvine, 2008, p. 667) can validate and add to the sum of the individuals’ experiences. The feedback sessions provided an additional level of validation of the analysis.

A selection bias is noted because participants deemed to be at immediate risk of harm to themselves or others were not included. Most participants, when asked, did not express a wish for a mentor but considered acting in this role. This excludes views of individuals currently desiring peer support, or suggests that something prevents them from expressing this in a group setting where patients might not wish to appear vulnerable (Jennings & Sawyer, 2003). Some participants might have been aware – either through engagement in treatment or previous research – of the increasing importance placed on recovery as an orientation to service delivery in forensic mental health settings (Mezey et al., 2010). Therefore, expressing an opinion supportive of peer support and empowerment might be the hot topic or socially desirable. This should not be regarded as a pure reflection of personal experience in isolation of this discourse.

Conclusion

In this article we sought to establish what patients in a forensic mental health setting understand by the concept of mentoring and what the implications for setting up a formal mentoring system in high security might be. Informal peer mentoring processes

occur in inpatient settings; patients with more experience of the system take the mentor role and support others informally. This can have valuable and detrimental effects to the mentee and these were acknowledged by the focus group participants. The findings indicate that the role of a mentor in a high security hospital could be valuable, providing a guide to help adjustment, practical and material support and, above all, the opportunity to relate to a fellow patient through shared understanding. This was thought to be hindered by the rule-bound nature of the care system, personal attitudes and differences in experience. A mentor's position within this system was thought to have implications for the expectations and limits of the role and could raise difficulties such as confidentiality. Expectations of the mentor's personal skills, the benefits and strain of the role were high. Support needs were acknowledged. Patient ownership was negotiated in the domains of terminology, choices and responsibilities. Any service development must therefore address role clarity, training, supervision and support and the question of how a mentoring scheme might provide an element within recovery-oriented services that differs from support systems already in place, including informal peer mentoring.

This study highlights some of the features of the process of mentoring and raises awareness about how the concept might be translated in practice into a setting where the adjustment process requires settling in, typically involuntarily, to a new role as service recipient in a forensic mental health setting. The role of mentor (Buddy/Peer Supporter/User Supporter/Listener) has the potential to fulfil a dual role within this

system. It is potentially complicated to deliver and sustain but nonetheless could be experienced as a meaningful, genuine connection and a unique opportunity for those at paradoxically the greatest risk of disenfranchisement and disconnection from the very system that is in place to help them.

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Table 1. Practical Implications for the Development of a Mentoring Scheme

Aim to.....	Do not.....
<p>....assess whether a formal peer support program is wanted or needed by consulting with service users.</p>	<p>....implement a peer support program without assessing potential risks and considering the responsibilities and boundaries of the supporter’s role.</p>
<p>....acknowledge that the experience of someone who has “been through it” holds a unique value.</p>	<p>....assume that someone who has “been through it” will necessarily advocate service engagement. His or her experience with services might be negative.</p>
<p>....involve service users in choosing a suitable name for the initiative</p>	<p>....use “jargon”.</p>
<p>....consider the different options that might work in an institution (for example, emotional versus limited informational support).</p>	<p>....disregard the impact providing support will have on the provider (for example, strain versus life skills development and the experience of making a contribution).</p>
<p>....provide training and ongoing support for mentors. Their personal skills are considered important and they</p>	<p>....turn a mentor into an “ally” or “informant” of staff. This might actually endanger him or her and could be</p>

may be faced with difficult situations.	experienced as a betrayal of the mentee's trust.
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Figure 1. Thematic Map. This illustrates both superordinate themes (in the middle of each cluster) and subordinate components of each theme (clustered around).

