Understanding Human Rights in Forensic Psychiatric Services: Staff Perceptions of Human Rights Issues in an Inpatient Forensic Psychiatric Service

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A thesis submitted in partial fulfilment of the requirements of the University of East London for the degree of Professional Doctorate in Clinical Psychology

June 2020

ACKNOWLEDGEMENTS

I would like to sincerely thank my supervisor, Professor Nimisha Patel, for her unending support and kindness throughout my undertaking and writing this thesis. I honestly couldn't have done it without you! I aspire to your passion for, dedication to, and knowledge of this work.

And to my partner, Matt, where do I start? Thank you for your tolerance, your encouragement and your love, and for never giving up. We did it.

ABSTRACT

Human rights apply universally to all human beings, however human rights violations have been well-documented in forensic services. Forensic inpatient psychiatric services (FIPS) in the UK occupy a unique position as a healthcare service with obligations to the criminal justice system. This presents challenges in providing patient-centred and human rights-supportive care due to environmental, ethical and legal constraints. In order to understand these challenges and the position of human rights in FIPS, staff were interviewed to explore their understandings of human rights and human rights issues in FIPS.

A critical realist epistemological stance was taken and a qualitative research design employed. Eleven FIPS staff were individually interviewed and a thematic analysis was conducted, yielding four key themes:

Theme 1: "I Don't Know an Awful Lot About Them": Broad Concepts of Human Rights
Theme 2: "It Always, Always Comes Back to Risk": Human Rights in FIPS
Theme 3: "Do We Know We're Violating? Maybe Not": Human Rights Issues
Theme 4: "I Think I-, I'm…Confused": Tools and Resources in FIPS

In seeking to understand staff's perspectives of human rights in FIPS, this study found that human rights were not widely considered in practice. Practice was predominantly focused around risk and the key legislation considered was the Mental Health Act 1983 (MHA). Both of these factors were seen to justify legally infringing upon human rights, although several practices, lawful under the MHA, were raised as human rights issues, such as restraint and forced medication. Several factors were identified as obstacles to human rights-supportive practice, such as risk management requirements, service culture, and individual practice. However, participants highlighted a need for human rights principles to be integrated into FIPS to improve practice and patient outcomes.

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1. INTRODUCTION

This chapter presents key definitions of human rights and Forensic Inpatient Psychiatric Services (FIPS), outlines the literature search strategy, summarises the UK legislative landscape, and explores relevant psychological and psychiatric literature, that form the context of this research. This chapter discusses how FIPS operate in this legislative context, with specific consideration to human rights obligations and issues. The necessity and rationale for the current study are presented, and the chapter concludes with the study's research questions. A glossary for acronyms can be found in Appendix A.

Each definition, legislative summary and description of literature and context in this study has been written from an individual position. My own experience and context have influenced this thesis throughout, in my interest in the topic of the study, my understanding of the literature, and my approach to the research. Therefore, the first person is used to illustrate this and, in so doing, to acknowledge the plethora of other positions that could have been taken. I hope this transparency allows the reader to consider this thesis with an awareness of my position and invites them to consider their own positioning in relation to the research.

1.1. Reflexivity

Research methodology and conclusions are inextricably linked to a researcher's positioning (Altheide & Johnson, 1998). In exploring this briefly here, the aim is not to caveat this research, but to acknowledge that it is a constructed reality influenced by my context and my ontological and epistemological stances (Pillow, 2003). My positioning on the topic has been influenced by my work and academic experience prior to this doctoral degree. Having completed a Masters degree in Forensic Psychology, I worked in a third sector organisation, within the National Probation Service and in low and medium secure FIPS with individuals with mental health needs and offending histories. I was drawn to work with the individuals who use these services because they are often openly

discriminated against for their past, present and potential actions, yet the drivers of their actions and antecedents to their 'antisocial' behaviour are rarely considered. Overwhelmingly, these service users are victims of inequality, systemic failures, and direct abuse; one could argue that their offending behaviour is a communication of these injustices. Therefore, it not only seems compassionate and ethically right that they receive the support they are legally entitled to, but also logical in order to reduce incidences of reoffending. Whilst I have witnessed excellent practice in my work experience, unfortunately I have also frequently witnessed inadequate support and discriminatory practice. Human rights provide me – and I believe all practitioners in the sector – with a framework to understand why this is unacceptable, legislative weight to explain why it must change, and principles to guide this change.

1.2. Literature Search Strategy

The literature search involved two stages. First, a literature search was undertaken to ascertain key legal documentation, grey literature and associated academic literature which explore human rights in mental healthcare and, more specifically, forensic mental healthcare. Second, relevant academic databases were used to conduct a literature search using the search terms 'forensic', 'mental health' and 'human rights'; this yielded almost 55,000 results. There was a prevalence of psychological studies examining assessment and practice in forensic mental health services, with very little exploring the role and understanding of human rights in mental healthcare in the UK, and less exploring the role and understanding of human rights in forensic mental healthcare. Therefore, I pragmatically decided to broaden the search strategy to include general mental health and forensic mental health literature, as psychologists frequently work in these settings and these issues are relevant to their practice.

1.3. Human Rights

Human rights are a set of universal minimum standards established in international law and adopted in domestic law to respect and protect all human beings (United Nations [UN], 2020b). Human rights apply to every human being

without discrimination, they are inalienable and cannot be removed permanently. Additionally, although established in law, human rights do not depend on the recognition or enactment of States to exist (Mental Welfare Commission for Scotland [MWCS], 2017; Patel, 2019). Human rights were first legally established following the formation of the United Nations (UN), shortly after World War II, with the creation and implementation of the Universal Declaration of Human Rights (UDHR) in 1948. In 1953 the European Convention on Human Rights (ECHR) came into force, largely based upon the UDHR. In 1966 the rights outlined in the UDHR were split into two covenants focusing on civil and political rights and economic and social rights, together forming the International Bill of Rights (Grover & Gaziyev, 2014). International, regional and domestic documents and treaties have been derived from the UDHR and Bill of Rights to make up international human rights law. The Equality and Human Rights Commission (EHRC) was founded in 2007 in order to promote and enforce quality and discrimination laws in England and Wales; relevant UK legislation will be explored later in the chapter. Overall, human rights can be viewed as an international consensus on minimum moral standards and state obligations. (Donald, 2012; Patel, 2019).

In clinical practice, a human rights framework refers to the responsibilities, commitments and principles that are based in international human rights law. The responsibilities lie with the State, as duty-bearer, to protect the human rights of its citizens, rights-bearers. Therefore, individuals that work within State institutions or services, such as the National Health Service (NHS) in the UK, have a dual position as duty-bearers and as rights-bearers (Patel, 2019). Human rights commitments are the pledges States make to adhere to human rights standards. Human rights principles underpin how to adhere to human rights standards. Patel (2019) outlines twelve human rights principles that are most relevant to healthcare practice. Human rights-based approaches (HRBA) to healthcare in the UK tend to draw on the FREDA (fairness, respect, equality, dignity, autonomy) principles (Curtice & Exworthy, 2010) or the PANEL (participation, accountability, non-discrimination, empowerment, legality) principles (Scottish Human Rights Commission [SHRC], 2009).

It is important to also acknowledge, however, that there are a wide range of political, economic, societal and systemic barriers to implementing human rights frameworks into healthcare services locally and internationally. Additionally, human rights have been variously contested theoretically as patriarchal, neocolonialist, politically charged, individualistic and West-centric in rationale, principle and application (An-Na'im, 2016; Donnelly, 2007). Whilst these criticisms question claims of the universality of human rights, it has also been argued that creating a truly universal set of morals would be impossible, perhaps undesirable, and un-reflexive of their context (An-Na'im, 2016; Donnelly, 2007; Patel, 2019). For the purposes of this thesis, the complexity and questions of human rights are acknowledged but the term human rights is used pragmatically to refer to the legal norms adopted in the UK that stipulate minimum standards for the protection of all human beings.

1.4. Forensic Inpatient Psychiatric Services

FIPS exist in various forms across the world; as this research has been conducted in the UK, I have predominantly focused on UK services – also referred to as 'secure services' – in this chapter. FIPS are one of a small range of services at the interface between the law and healthcare. FIPS are commissioned by NHS England and are linked to the Criminal Justice System (CJS) predominantly through their patients, who are admitted to FIPS through the CJS. FIPS are designed for individuals to be assessed or treated for a mental disorder, who pose or have posed a risk of harm to others, often via offending behaviour (Barr et al., 2019; Joint Commissioning Panel for Mental Health [JCPMH], 2013). Patients – as, in my experience, users of FIPS prefer to be called in order to reflect their enforced engagement – are admitted to FIPS under various sections of the Mental Health Act 1983 (MHA) following a deterioration in mental health. Following a criminal charge, patients can be admitted to hospital whilst on remand, and awaiting and throughout trial. Once convicted, patients may receive a hospital order instead of a prison sentence, leading to immediate admission from court; patients can be transferred from prison; or patients can be recalled to hospital from the community for breaching discharge conditions. FIPS can also admit 'informal' patients who do not have an offending history but whose risk is deemed too high to manage either in the

community or in non-forensic inpatient psychiatric services (Edworthy et al., 2016; Forrester & Hopkin, 2019). The Ministry of Justice (MOJ) have oversight over some patients' leave and discharge depending on which Section of the MHA they were admitted to FIPS under; this is explained further in section 1.5.2. FIPS can be high, medium or low secure services, reflected in the level of physical, relational and procedural security measures employed and the gravity of risk individuals are deemed to present (NHS England, 2018). However other factors, such as bureaucracy, often lead to estimated risk and security levels being misaligned over time (Shaw et al., 2001; B. Völlm et al., 2016).

Clinical psychologists are able to make a unique contribution in FIPS via clinical, leadership and research skills. Clinically, their training involves understanding a range of mental health difficulties and diagnoses and suitable interventions to support individuals with these difficulties. Although there is not a focus on understanding offending behaviour and associated interventions, using a systemic lens to understand the whole service user and their context is a key part of clinical psychology practice that is crucial in FIPS. Clinical psychologists can also contribute their leadership skills to FIPS, supporting teams and services in challenging environments and with challenging work through reflection and consultation. Research skills are essential to evaluating and improving services, and in delivering evidence-based clinical and team-related practice.

FIPS operate at the interface between law and healthcare and therefore they, and their staff, have dual aims and obligations in practice: public protection and individual care and treatment (Völlm & Nedopil, 2016). In order to understand human rights in FIPS it is crucial to summarise the legal landscape and its implications for and effect on care.

1.5. Legal Frameworks Relevant to FIPS

FIPS tend to have many more legal obligations, responsibilities and restraints upon them than physical health and non-forensic mental health services, due to their link to the CJS. The key UK parliamentary acts affecting FIPS are the Human Rights Act 1998, the Mental Health Act 1983, the Mental Capacity Act

2005 (MCA) and the Equality Act 2010 (EA), which, along with an outline of the CJS, are summarised below in order to provide the legal context in which FIPS operate.

1.5.1.   Human Rights Act 1998

In the UK, the HRA directly brings rights from the European Convention on Human Rights (ECHR) into national law. The HRA enables people to raise or claim their human rights directly within domestic legal and complaints systems, enables British courts to interpret human rights issues, and is intended to encourage services to actively support human rights fulfilment (Department of Health [DoH], 2007). All domestic laws in the UK, and their interpretation and application, must comply with the HRA. All public bodies, including the NHS and its services, are duty bound to ensure their practice is HRA-compliant.

The UK has ratified almost all international human rights treaties, all of which are translated into various domestic legislation, wholly or in part. Amongst these treaties, the UN Convention on the Rights of Persons with Disabilities 2006 (CRPD) and the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment 1987 (CAT) are particularly relevant to forensic mental healthcare. The UK ratified the CRPD in 2009, thereby agreeing to specifically promote and protect the human rights of disabled people, including those with mental health diagnoses; much of this legislation was translated into the Equality Act 2005 (EA). The CRPD aimed to change attitudes and approaches to persons with disabilities from passive recipients of care and services to active participants who can claim their rights, be active members of society and make decisions about their own lives based on informed consent. The convention clarifies how rights apply to individuals with disabilities, identifies areas where adaptations may need to be made in order that they can effectively exercise their rights, and highlights areas where their rights have been violated and therefore must be supported (EHRC, 2020; UN, 2020). The UK ratified the CAT in 1988, thereby agreeing to criminalise and prevent acts of torture linked to activities that include: arrest, detention and imprisonment; interrogation; the training of staff involved in arrest, detention or questioning; returning someone to another country where they are at serious risk of torture

(EHRC, 2019; Office of the High Commissioner of Human Rights [OHCHR], 2020).

1.5.2. Mental Health Act 1983

The MHA sets out the legal framework for compulsory powers in England and Wales, detailing when someone with a suspected or diagnosed psychiatric condition can be admitted, detained and treated in hospital against their will, even if they have full capacity to make decisions. The MHA also sets out an individual's rights when detained in hospital and being treated in the community. Individuals can be detained if there are significant concerns for their own or others' wellbeing or safety. This is decided by a team of professionals: an approved mental health professional (AMHP); a registered medical practitioner (e.g. individual's GP); and a doctor trained in the MHA, usually a psychiatrist. The MHA gives powers to physically restrain and forcibly treat and medicate individuals, even if treatment is refused (Adshead & Davies, 2016; Mental Health Alliance, 2017).

Individuals are detained, or 'sectioned', under different sections of the MHA. Individuals detained under non-forensic sections are generally sectioned for assessment for up to 28 days under Section 2, and for treatment for up to three months under Section 3; informal patients in FIPS are detained under Section 3. Forensic patients are detained for treatment in FIPS under Section 37, a hospital order issued by the courts pre- or post-conviction; the Crown Court can issue an additional Section 41 restriction order for additional public protection, meaning an individual can only be granted leave (under Section 17) by the MOJ, as opposed to their Responsible Clinician (RC). Patients admitted to hospital from prison are transferred under Section 47. There is no limit to the number of times treatment detentions can be renewed (Edworthy et al., 2016). Patients are discharged from these sections into the community via a Mental Health Tribunal, and health and local authorities are legally required to provide patients with free aftercare under Section 117. However, if a patient has been transferred from prison under section 47 and, when they are ready to be discharged from FIPS, their sentence is still unspent, they will be discharged back to prison (Rethink Mental Illness, 2020).

The application of the MHA in practice has raised much controversy, being deemed archaic and problematic; its coercive nature can lead to abuses of power and traumatising experiences for patients (Mental Health Alliance, 2017). This was acknowledged by the UK Government in their commissioning of an independent review into the use of the MHA, specifically highlighting coercion, fear and lack of dignity in practice (Department of Health and Social Care [DoHSC], 2018). Concerns have been repeatedly raised between the lack of parity in treatment of patients in physical versus mental healthcare (e.g. Adshead & Davies, 2016), suggesting that the MHA is frequently being used in a way that breaches individuals' human rights (DoHSC, 2018). It has been suggested that detaining an individual under the MHA may never be ethical due to an inherent power imbalance and, commonly, patients' lack of autonomy and input into their own care (Chambers et al., 2014; DoHSC, 2018; Kinney, 2009). Indeed, in a study by the Mental Health Alliance (2017), the majority of individuals who had previously been detained under the MHA did not feel that it protected their human rights, in particular, their right to be free from inhuman or degrading treatment. One reason suggested for this is an excessive focus on risk aversion in the use of the MHA, minimising the opportunity for positive risk-taking (DoHSC, 2018b).

1.5.2.1. Mental Capacity Act 2005: Although a separate act, the MCA can be used to facilitate decision-making whilst in detention under the MHA. The MCA sets out an assessment of an individual's capacity to make a decision and, if they are deemed to not have capacity, gives a decision-maker - usually a health professional or carer - the power to make least restrictive, 'best interests' decisions for that individual (The British Institute of Human Rights [BIHR], 2018). In the context of FIPS this is their RC, with the assistance of the multidisciplinary team (MDT) involved in care. Patients detained under the MHA are often assessed as lacking capacity due to their mental ill health (Völlm & Nedopil, 2016). Being deemed non-capacitous whilst also being subject to enforced treatment arguably magnifies the lack of autonomy over, input into, and coercive nature of a patient's care under the MHA in FIPS. The Deprivation of Liberty Safeguards (DoLS) aim to ensure individuals who lack capacity are detained as little as possible. All patients in FIPS are detained in hospital, and

they may be additionally secluded or restrained; all of these deprivations of liberty must be no longer than strictly necessary (BIHR, 2018).

1.5.3. Equality Act 2010

The EA brought all existing discrimination legislation into one statute, harmonising discrimination law and introducing new requirements and recommendations. The act explicitly provides more protection against discrimination of multiple characteristics and of disability, with an emphasis on mental illness (Lockwood et al., 2012). These guidelines echo the intent of human rights law and the practice guidelines for the MHA; they provide a practice framework to ensure that services, including FIPS, avoid unlawful discrimination (Vige et al., 2012). The EA also gives individuals rights to challenge discrimination. Nine characteristics are protected under the act: disability, age, race, religion or belief, sex, sexual orientation, gender reassignment, and pregnancy and maternity. Patients in FIPS will all meet the criteria for disability under the EA, a mental or physical impairment that has a substantial and long-term effect on their ability to carry out normal daily activities (EHRC, 2015). As Black, Asian, and Minority Ethnic (BAME) individuals are disproportionately detained under the MHA (DoHSC, 2018), many FIPS patients will have more than one protected characteristic.

Public bodies, such as the NHS and therefore FIPS, have a duty not only to eliminate unlawful discrimination, harassment and victimisation, but to advance equal opportunity and foster good relations between individuals who share a protected characteristic and who do not. They must ensure that the standard of care that disabled people receive is as equal as possible to that received by non-disabled service users (Vige et al., 2012). However, a report into how public health services met their equality duties found that performance in these areas was poor due to inadequate planning and reporting, lacking leadership, poor adherence to guidance and advice, and failure to operationalise consultation with equality stakeholders (EHRC, 2011).

1.5.4. Criminal Justice System

In England and Wales several agencies work together to form the CJS. Most relevant to FIPS are the police, the Crown Prosecution Service, the courts, and

prison and probation services. The overall aim of the CJS is to reduce reoffending through detecting and preventing crime, punishing and rehabilitating offenders, and supporting victims and witnesses. This work is overseen by the MOJ, Home Office and the Attorney General's Office; the MOJ is the most relevant to FIPS, overseeing the courts, prisons and probation services (McMurran et al., 2012). Each section of the CJS has its own group of parliamentary acts, guidance and case law, which all must comply with human rights as detailed in the HRA. Generally, FIPS patients with convictions will have encountered the CJS when being arrested, tried and sentenced, but are detained under the MHA. Therefore, unless they have a Section 41 restriction order overseen by the MOJ or have been admitted from prison, they are under the health system and are no longer formally in the CJS (Centre for Mental Health, 2011).

1.6. FIPS: Human Rights Obligations

The legal duties for State services (including the NHS and FIPS) which arise from human rights obligations can be addressed by respecting, protecting and fulfilling human rights. Respecting human rights refers to not taking actions that unlawfully restrict human rights or an individual's fulfilment of them. Protecting human rights refers to taking actions that actively prevent or avoid human rights breaches. Fulfilling human rights refers to actions that strengthen access to the full potential of a human right, including ensuring there is a system to prevent or highlight breaches (Méndez, 2014; MWCS, 2017; Valenti & Barrios Flores, 2010). Table 1 details the articles of the HRA most relevant to FIPS and the respectful, preventative and fulfilling actions that should be taken.

Table 1. HRA articles and actions relevant to FIPS.

Article	Respecting	Protecting	Fulfilment
2: Right to life	Actions that do not directly or indirectly threaten or end patients' lives.	Prevent danger and protect patients from harm and self-harm.	Support physical and mental health, ensure treatment removes patients from potentially fatal situations.

3: Freedom from torture and cruel, inhuman or degrading treatment	Treat patients with dignity, care and respect. Minimum use of non-consensual treatment and seclusion.	Ensuring policy and practice is least-restrictive and prevents and protect patients from ill-treatment; recognise abuse or neglect.	Treatment and systems that promote patients' dignity and respect and protect from torture; promote alternatives to seclusion and restraint.
5: Right to liberty and security	Detaining patients only when strictly necessary and justified in law.	Ensuring detention is for the minimum time possible and practice is least-restrictive. Stringent policies around restrictive practice, including detention.	Supporting patients' liberty in detention and sustained freedom upon discharge; engage in frequent reviews of detention and restriction and own practice.
6: Right to a fair trial	Ensuring trials are accessed, accessible, impartial and non-discriminatory.	Ensuring policy and practice are fair and promote access to fair and adequately frequent trials.	Supporting patients to access trials, the wider legal process and legal resources; giving fair expert testimony.
8: Respect for your private and family life	Ensuring privacy is only breached lawfully for the protection of health and of others' rights. Not arbitrarily restricting relationships.	Ensuring access to information and participation in care decisions; respecting personal relationships, information and spaces.	Support physical, psychological and moral wellbeing through upholding autonomy, choice and dignity, including regarding relationships.
9: Freedom of thought, belief and religion	Respect for all religious and cultural practice	Policy and practice to support all	Support for representation of all religious or

	and requirements; only lawful restrictions on religious practice for protection of the public and others' rights.	religious practice; ensuring there are no policy-related or logistical obstacles to religious practice.	cultural views and values; non-discriminatory consideration of all religious or cultural views and values; support access to religious resources and communities.
14: Protection from discrimination in respect of these rights and freedoms	Patients are not denied treatment, care or resources due to protected characteristics. Treatment, care and resources are appropriate to, and respectful of, protected characteristics.	Ensuring policy and practice is not discriminatory, providing additional support and resources to enable access to treatment, care and legal process.	Supporting access to additional resources where necessary to improve accessibility to treatment, care and legal process; interrogate personal and systemic biases.
Article 25 from the CRPD: Right to health	Good quality physical and mental healthcare available, accessible and acceptable to patients.	Access to evidence-based, up-to-date treatment, accessible information on healthcare and services.	Facilities kept in good condition; person-centred care; proactive needs, medication and treatment reviews; independent visits and monitoring of services.

Note. The table provides examples drawn from several sources, and is not an exhaustive list (e.g. Adshead & Davies, 2016; Ledwith, 2007; Méndez, 2014; MWCS, 2017; Trestman, 2014; Valenti & Barrios Flores, 2010).

1.7. FIPS Practice and Human Rights Considerations

In their role, FIPS practitioners must negotiate the needs and perspectives of several parties, such as the patient, victims, the public, and the state (Livingston et al., 2012). This presents a tension in obligation and the actuality of practice.

1.7.1. Practice Framework

Healthcare obligations necessitate adequate care and treatment for *patients* to improve mental wellbeing and support recovery; criminal justice obligations necessitate detention, risk measures and treatment for *offenders* to curtail offending behaviour and facilitate public protection. Aside from practice goals, and despite growing similarities in population demographics, the CJS and healthcare also have vastly different approaches to issues such as information sharing and confidentiality and psychological interventions (Adshead & Davies, 2016; Livingston et al., 2012; McMurran et al., 2012; Völlm & Nedopil, 2016). In FIPS the medical model dominates, with a focus on diagnosis and medication. Thus, offenders who receive a hospital order do not receive additional formal 'punishment', and their discharge is decided by the clinical team, however they also have no set sentence and therefore length of admission (Edworthy et al., 2016). Treatment can either be aimed at improving mental wellbeing or at reducing offending behaviour, both using assessment, medication and therapies. It has been argued that a clearer distinction is needed between treatment as punishment, which targets offending behaviour, and rehabilitative mental health treatment offered to those who are being punished, and whether all treatment in forensic settings is punishment (Glaser, 2009). Ward and Birgden (2009) suggest that these two frameworks are distinct but overlapping.

These two types of treatment present a dilemma for practitioners in FIPS, and often risk management is prioritised over truly rehabilitative intervention. This is perhaps unsurprising when care is a court instruction and is often overseen by the MOJ, and when considering the serious risk of harm and gravity of illness that patients can present (Green et al., 2011). In balancing competing obligations and perspectives, FIPS practitioners ultimately balance harm: a patient's loss of liberty and autonomy versus potential harm to the public and the patient themself. This is a daunting task in a complex environment, with little guidance; most frequently, risk of harm to the public is prioritised above care

(Barr et al., 2019; Hui, 2016; Livingston et al., 2012; Völlm & Nedopil, 2016). One key issue is the balance of human rights between the offender and the victim, in the case of FIPS this is usually between a patient's rights and those of the direct victim of their crime *and* the public, who represent potential victims. Ultimately, the patient's rights are infringed upon (Birgden & Perlin, 2009).

1.7.2. Human Rights Considerations

In discussing the dual position that FIPS hold, and the resultant approaches to practice, human rights dilemmas are pertinent although rarely discussed. Despite obligations from human rights law, inpatient mental health, criminal detention and FIPS practice worldwide have been described as a global crisis and emergency due to their neglect and violations of human rights (Drew et al., 2011; EHRC, 2020a). Practices that breach human rights principles are well documented across these settings (Perlin & Schriver, 2014). Research specific to FIPS is still lacking – thought to be a long-term consequence of societal othering of offenders (Perlin, 2016) – although practice in non-forensic inpatient psychiatric services is often similar to that in FIPS, and therefore this research can be considered relevant (Perlin, 2013). Examples of where human rights may be breached in FIPS include, but are not limited to, the institutional environments, arbitrary detention, physical and sexual abuse, denial of autonomy, obstacles to accessing healthcare, and discrimination, (e.g. Drew et al., 2011; Gostin, 2008; Hafemeister & Petrila, 1994; Perlin, 2016). Prisoners, and specifically those in forensic mental health settings, have been described as one of the most vulnerable populations in society; they are often acutely unwell and present with complex needs, challenging behaviour and enduring trauma (Barr et al., 2019; Durey et al., 2014; Frueh et al., 2005; Smith et al., 2015). Moreover, these complex needs can be severely misunderstood or negatively misrepresented, and trauma can be replicated in FIPS (Adshead & Davies, 2016).

Across inpatient mental healthcare settings physical violence and aggression are extremely common; in the UK, both patients and staff reported being threatened (31% and 73%, respectively) and physically assaulted (15% and 45%, respectively; The Healthcare Commission, 2008). Importantly, higher rates of aggression in FIPS impact on care and clinicians work more restrictively

(Barr et al., 2019). In addition, patients report unstructured, untherapeutic and inadequate care, and negative staff attitudes; patients have even reported being continually ignored by staff. This can understandably lead to frustration and escalates tension, potentially resulting in aggressive or violent incidents; however, the staff or service contribution to these escalations is rarely acknowledged and patients are heavily disciplined (Fish & Culshaw, 2005; The Healthcare Commission, 2008).

Aggression and violence are frequently managed through coercion, including restraint, seclusion and forced medication (Völlm & Nedopil, 2016). It is generally acknowledged that it would not be possible to completely abolish these measures; indeed it has been argued that forensic inpatient psychiatry is coercive by nature (Albrecht, 2016; Saimeh, 2013; Szaz, 1961; Völlm & Nedopil, 2016). However, coercion must be a last resort, proportionality and caution must be employed, and regulation and monitoring must be implemented, in order to avoid breaching human rights and ethical standards (Nedopil, 2016; Steinert et al., 2010; Valenti & Barrios Flores, 2010). The key human rights principle that coercive measures violate is autonomy, although they may also violate the right to be free from cruel, inhuman or degrading treatment (Adshead & Davies, 2016; Perlin, 2016). Several studies have found that coercive measures are experienced as punitive, isolating and shaming and can incite fear and retraumatise patients (Adshead & Davies, 2016; Kaliski & de Clercq, 2012; Keski-Valkama et al., 2007; Méndez, 2014; Sequeira & Halstead, 2002).

Coercion can also be more subtle or implied, including forceful persuasion and interpersonal pressure (Szmukler & Appelbaum, 2008; Völlm & Nedopil, 2016). The nature of FIPS and enforced treatment means that patients inherently have less access to or influence over their own care, yet their medical and offending information may be carelessly shared with other professionals. The medical model can also mean that patients' choices are overridden on the grounds of 'best interests' decisions and, although made with genuine good intention from professionals (Edworthy et al., 2016; Knabb et al., 2011; Méndez, 2014), this may amount to serious discrimination and certainly goes against the human rights principles of autonomy and respect. Indirect processes can also impact

on autonomy and access to care, such as bureaucratic processes or errors delaying or prolonging treatment (Drew et al., 2011; Trestman, 2014). There is a clear irony in FIPS practice that, despite patients' limited information and involvement regarding their care, their information is shared frequently and widely between several agencies. This presents major ethical issues for healthcare professionals, and infringes upon the right to privacy, yet is mandated by law. Although, again, there is little monitoring that information sharing is necessary and proportionate, and this is frequently not the case (Trestman, 2014).

1.7.3. Practice Debates

Several suggestions have been made as to why and how these problematic practices develop, including paternalism, discrimination, and assumed adherence to human rights law.

Paternalism, as can be manifest through the medical model, in which the patient is positioned as the passive recipient of interventions, is in opposition to guidelines of person-centred care (JCPMH, 2013). However, it has been suggested that striving for patient-centred care is counter-intuitive in FIPS, where patients have reduced culpability for their offences due to their mental ill health and consequential lack of capacity during commission (Pouncey & Lukens, 2010). This argument, though, does not account for improved wellbeing, nor the fact that capacity must be assessed separately for every decision, as opposed to deeming someone universally non-capacitous. Additionally, there is a growing evidence base that collaborative approaches to mental healthcare are effective and valuable (Livingston et al., 2012), and that forward-looking, rehabilitative care based around providing the skills and wellbeing needed to safely re-enter society can support reducing reoffending (Valenti & Barrios Flores, 2010; Ward & Birgden, 2009).

The stigma and discrimination that people with mental illnesses face is widespread and well documented (Fiala-Butora, 2013; Laiho et al., 2016; World Health Organization, 2010). In addition to the shame, alienation and victimisation that FIPS patients can be made to feel regarding their mental health, offenders can also be seen as dangerous and dishonest; forensic

mental health patients are seen as not just 'mad' but 'bad' also (Hirschfield & Piquero, 2010; Marguiles, 1984; Perlin, 2016). This multiple, and often intersectional, stigma may be in response marginalised racial, ethnic and socioeconomic group membership, among others, further impacting the opportunity for patients to develop a positive self-concept and benefit from using national systems and services such as FIPS (Rao et al., 2009; West et al., 2014). Generally these stigmas in society, and the fear behind them, translate into an attitude that forensic mental health patients cannot and should not be allowed to rehabilitate, and must be locked up and preferably not reintegrate into society (Livingston et al., 2012; Perlin, 2016). These attitudes of course contravene human rights principles, but they also act as impediments to implementing these principles in practice, both systemically and personally.

It is suggested that the public and FIPS staff believe that punishment is the main purpose of institutions within, and linked to, the CJS, and therefore coercive measures – and other harsh elements of care and the environment – are not only seen as necessary but as justified (Cullen et al., 2009). A common misconception used to justify coercion is that offenders forfeit their human rights once convicted. However, forfeiture is widely acknowledged as discriminatory – specifically in FIPS regarding disability – and in contrast to human rights tenets of universality (Lippke, 2002). Human rights are universal and cannot be forfeited even in criminal justice settings; however due to their universality, rights can be lawfully limited in order to protect against other human rights breaches and to support human rights fulfilment, both in relation to victims and patients (Patel, 2019; Ward & Birgden, 2007). In FIPS practice, this would only justify restricting freedom. These and other rationales, for example that patients should be grateful that they are getting more support than their victims, who are the truly deserving ones, fundamentally undermine patients' opportunity to engage in, and benefit from, treatment. This is particularly problematic as patients are completely reliant on staff for almost every aspect of their care and lives whilst in FIPS; their relationships have a direct impact on a patient's recovery (Adshead & Davies, 2016; Cullen et al., 2009).

Problematic practice may be seen as acceptable because of the powers given by the MHA. It may also be that human rights adherence is assumed because

the MHA and other dominant legislations legally must adhere to the HRA. Whether seen as an add-on (Donald, 2012) or assumed, human rights may not be seen as a core part of practice requiring attention and consideration. Literature concerning the application of HRBA to FIPS care is also sparse, although does indicate its efficacy (Chan et al., 2012; SHRC, 2009), and research in non-forensic mental healthcare overwhelmingly supports the efficacy of a HRBA (e.g. Donald, 2012; SHRC, 2009). This echoes research in human rights and non-forensic mental health: that violations negatively affect mental health; mental health practice and laws – including coercive treatment – can negatively impact human rights; and promoting human rights promotes better mental health. Therefore, there are not only legal and moral obligations to promote human rights in FIPS, but clinical and economic motivations also (Gostin & Gable, 2009; Mann, 1999; Porsdam Mann et al., 2016; Steel et al., 2014).

1.8. Staff in FIPS

As discussed, staff and their relationships with patients have a huge influence over patient care, outcomes, and fulfilment of human rights.

1.8.1. Ward Environment and Coercion

Staff in FIPS have to balance their legal, professional and moral obligations, and healthcare professionals have expressed distress at ensuring this is a fair as possible (Austin et al., 2008). Frequently, risk and protection are prioritised, which is perhaps unsurprising given that incidents of violence and aggression are common in inpatient mental healthcare and significantly more prevalent in forensic mental healthcare (Dickens et al., 2013). Indeed, safety of both staff and patients – specifically containing and managing dangerous situations – has been cited as the primary task in FIPS; preventing violence and aggression has been cited as the secondary task, and the tertiary task defined as the therapeutic intervention if the two prior tasks are achieved (Nedopil, 2016). Whilst prioritisation of safety is clearly essential, working with these tasks in hierarchy as opposed to equity may facilitate predominantly seeing patients as aggressors rather than therapeutic service users, it would be interesting to understand whether this influences the proportion of each task in patient care.

Staff describe the hospital environment as high pressured due to the risk of aggression and the consequences both in the hospital and in the community. Frequently the technique used to manage violence and aggression is coercion, or threat of coercion. Staff have described this as an expected and routine part of their role, which is necessary to manage incidents and seen as effective in garnering respect, and even thanks, from patients (Hui, 2016; Völlm, 2013). In contrast, patients have suggested that time out of the ward would be more effective in managing their distress and making them feel safer; it would also avoid feelings of humiliation, abandonment and punishment (Völlm, 2013).

1.8.2. Perceptions of Patients

Research suggests that the higher frequency of experiences of and exposure to violence mean that nursing staff in FIPS are at high risk of vicarious trauma, burnout, stress and anxiety, and fear (Barr et al., 2019; Harris et al., 2015; Jacob & Holmes, 2011; Jacob et al., 2009). This impacts on staff attitudes towards patients and aggression, leading to higher rates of restrictive and coercive practice (Dickens et al., 2013; Ward, 2013).

Using coercive measures also may create distance between staff and patients, and perhaps their offences, and in framing these measures as necessary. FIPS staff tend to perceive patients as violent and dangerous (Völlm & Nedopil, 2016) and may experience dissonance between their personal value base and self-preservative instinct and working with offenders. Additionally, causes of aggression were seen to be more reliant on the patient than the environment or situations, reinforcing rationale for keeping distance from patients (Harris et al., 2015; Laiho et al., 2016). Therefore, staff may detach from their personal values around these uncomfortable and arguably unethical practices, in order to fulfil the emotional and institutional demands of the work, creating further distance and perpetuating the use of coercion (Harris et al., 2015; Hui, 2016; Völlm, 2013). The integration or modification of personal values impacts the perception of patients, effectively othering them, and can therefore affect patients' treatment and human rights fulfilment (Johnson et al., 2004).

Thus, several studies have shown that a patient's offence negatively impacts staff's perception of them and therefore affects their therapeutic relationship

(Jacob & Holmes, 2011). One study found that more compliant patients received more respect and flexibility and better care than non-compliant patients. In addition to raising issues of ethical conduct, this was found to intensify existing power dynamics between staff and patients being enacted where patients attempt to counter-intimidate staff who intimidate and threaten them with punishment, rigidity and seclusion (Rose et al., 2011).

1.9. Justification of Current Study

Thus far, no research has investigated human rights understanding and application in forensic mental healthcare in the UK, nor has research been conducted investigating FIPS staff's views and understanding of human rights in their practice. FIPS provide services that have both health and criminal justice demands and obligations, working with patients with multifaceted needs, and working in complex, risk-laden environments. Gaining insight into staff understandings and perceptions of human rights in FIPS is essential in further explaining why and how human rights-supportive practice and breaches can both occur.

1.10. Research Aims and Questions

The aim of this research was to explore FIPS staff's understanding of human rights and human rights issues in the context of FIPS. The key research questions were:

- How do staff understand human rights, specifically in the context of a FIPS?
- What do FIPS staff consider or experience human rights issues to be in FIPS?

The research questions were specifically phrased this way in order to explore definitions, understanding and conceptualisations of human rights and human rights issues, and how these may have formed, in general and in FIPS settings. Importantly, the term 'human rights issues' was used instead of 'human rights violations' in order to avoid the attribution of legal weight to any issues the

participants may discuss. Indeed, the research aims to explore understanding in a reflective way, as opposed to investigating violations that occur in FIPS. The term 'issues' aims to reflect this tentative approach.

2.   METHODOLOGY

This chapter describes the ontological and epistemological stance of the research, followed by details of the study design, recruitment, data collection and data analysis. The position and theory are discussed throughout, along with possible limitations of the methodology.

2.1.   Ontology and Epistemology

Ontologically and epistemologically, this study has been undertaken from a critical realist stance. That is, it takes the position of ontological realism: that phenomena and entities exist whether or not we perceive or experience them, and that theories and data refer to real features of the world (Schwandt, 1997). There is not, however an objective truth that is striven for, and this research acknowledges the possibility that alternative, valid accounts of the same phenomena exist (Maxwell, 2012). And epistemologically, a constructivist stance is taken, which holds that our understanding of the world and its phenomena are inherently constructed from our own perspective and positioning (Bhaskar, 1975). Therefore, although the way we see the world corresponds to reality, in taking a critical realist stance I aimed to acknowledge the social constructions that exist therein, skewing our perception and experience of this reality (Maxwell, 2012). Within this stance human rights are therefore constructed, but the behaviours and actions within are seen as real, whether one attributes them to human rights or not. Qualitative data is also constructed in its interpretation through the researcher's lens throughout the research process, during interview, transcription, analysis and reporting. In this research, my stance assumed that the participants' responses offer an insight into real underlying psychological and social processes but that these were influenced by participants' and my own experiences, beliefs, and wider societal

factors. Thus, in attempting to explore participants' understanding of human rights and associated issues, and how they have come to these understandings, I have intimated that real behaviour and processes underpinned their responses.

In keeping with ontological realism, this stance also acknowledges the intersectionality of the participants, including their personal positioning in terms of personal experience, professional role and discipline; how this may interact with membership of marginalised groups; and the influence, expectations and ethos of the wider service. However, these socially constructed contexts were not rigorously disentangled, in order to ensure the focus of the analysis was on the *content* of the dataset as opposed to *how* it was expressed.

2.2. Reflexivity

Reflexivity is essential in qualitative research to promote rigour and avoid intentionally or unintentionally biasing results, thus hopefully improving data reliability (Jootun et al., 2009). Reflexivity extends our understanding of how our positions and interests as researchers affect all stages of research process, as the researcher is part of the social world under study.

When considering the methodology, qualitative research appealed to me personally and seemed particularly suitable to FIPS because, in my experience, the power structures in these services are rigid and segregational, preventing the consideration of individual staff views and experiences. Therefore, in using qualitative methodology the voices of staff members can have a platform.

2.3. Methodology

The methodology of this research was influenced by previous studies undertaken and supervised by my Director of Studies in psychiatric intensive care units and child and adolescent inpatient psychiatric care (Patel, 2016; Sharville, 2019). In Patel's study staff, service users and carers were interviewed; in Sharville's study service users were interviewed. Although interviewing all of the three groups would have been ideal to gain a more

comprehensive and multi-faceted perspective, due to time constraints this was not possible for this study but could guide future research. Of the three groups, staff were chosen due to the potential ethical issues of interviewing service users or carers who feel they have experienced, or continue to experience, human rights violations whilst in FIPS, particularly as the researcher had no capacity to support or engage with any potential litigative action. Additionally, staff may have a greater ability to effect change by reflecting on their understanding of human rights and their relevance to these services, improving their understanding, and adopting an approach more aligned with human rights principles.

Qualitative methodology was chosen as in the previous studies. Qualitative data collection is participant-led in order for meanings and experiences to be heard; this and the absence of rigid hypotheses facilitated exploratory content within which context could be considered (Carter & Little, 2007; Willig, 2013)

2.3.1. Study Site

Participants were recruited from a single NHS medium secure forensic inpatient psychiatric hospital. The site consists of seven wards; an isolation ward for one patient, which is typically used upon admission or if patients are deemed to present a level of risk to themselves or others that is unmanageable on their main ward; two male acute wards with sixteen beds each; one male rehabilitative ward with eighteen beds; one male pre-discharge ward with twelve beds; one female ward with both acute and rehabilitative patients with sixteen beds; and one rehabilitative and pre-discharge ward for women with thirteen beds. The choice of study site was pragmatic due to the limited number of FIPS in the South East of England, due to my professional links with the NHS Trust and FIPS, and the agreement by a service manager to act as a link between myself and the service, to facilitate recruitment of participants.

2.3.2. Recruitment

The FIPS service manager linked to the study assisted in advertising the study internally (to staff only) by a service-wide email, and by placing an advert for the research on the Trust intranet, citing inclusion criteria and briefly outlining the research and interview process (Appendix B). Participants contacted the

researcher via email. Interview slots were arranged via email response. The researcher then liaised with the service manager to book a private room in which to conduct the interview and to arrange a visitor pass and escort for the researcher. Participants' details were not passed on to the service manager and the interview room was in an area of the hospital that staff would usually visit so as to avoid any concerns staff may have had about the implications of taking part in the research.

2.3.3. Inclusion and Exclusion Criteria

I aimed to provide fair and equal access to the study to all members of staff, as far as possible. Since FIPS are structured as MDTs, this study aimed to recruit staff from a range of disciplines. Additionally, this was an attempt to avoid skewing the data towards implicit epistemological biases or expertise that may underlie any one discipline. Therefore, there was no explicit exclusion or inclusion criteria beyond participants being members of hospital staff and having worked in a FIPS setting for a minimum of six months. Language was not an exclusion criteria, although interpreter or translation resources were not required, as all members of staff at the service are English speakers.

2.3.4. Number of Participants

The decision on the number of participants was partly pragmatic, given the time constraints of this research, but also based on a consideration of data saturation. Much debate has been conducted around when data saturation, or a sufficient amount of data, has been reached and conclusions tend to suggest that this will vary between each study depending on the population size (Fusch & Ness, 2015; Guest et al., 2006). Therefore, adequate qualitative data could be better conceptualised as that which is rich in quality, nuance and layers and thick in quantity (Dibley, 2011). Dibley (2011) has suggested that between ten and twenty interviews could provide sufficiently rich and thick data, and other studies have suggested twelve interviews will suffice in a relatively homogeneous sample (e.g. Guest et al., 2006). Therefore, I aimed to interview a minimum of ten participants.

2.3.5. Informed Consent

Informed consent required that information about participation was given fully and accessibly, that consent was given freely, and that participants had capacity to consent in participation of the study (Ogloff & Otto, 1991). In order to facilitate informed consent, participants were provided with a participant information sheet when recruited for the study and again at the start of interview, followed by the consent form.

2.3.5.1. Participant Information Sheet: The participant information sheet (Appendix C) outlined the background and justification for the study, the inclusion criteria for participants, the details of participation, benefits or disadvantages of participation, and the study's focus as understanding staff perspectives and experiences. It also contained information on confidentiality, data use and protection, right to withdraw from the study, dissemination, complaints procedure, and details of organisations supporting the study. Based on the studies by Patel (2016) and Sharville (2019), it was anticipated that during interview participants might feel they were expected to discuss what they saw as past, ongoing, or potential human rights violations, which might deter some staff if this is seen as having ethical, employment and legal consequences for them. Therefore, the information sheet highlighted that the study was not directly investigating human rights violations, but their perspectives.

2.3.5.2. Consent Form: Consent forms were given to participants and completed prior to interview (Appendix D). Participants were asked to confirm their agreement to take part in the study, reminded of confidentiality, and that they were free to withdraw from the study at any point, or to take breaks or reschedule.

2.3.6. Data Collection

In order to gather exploratory data, semi-structured interviews were used, with the loose structure provided by an interview schedule using open-ended questions and prompts (Appendix E). Interview schedules from Patel (2016) and Sharville's (2019) studies were used for reference. The questions at the beginning of the protocol were more general in order to put the participants at ease, and gradually progressed towards more complex and sensitive questions

as greater rapport was built and more thinking and discussion had taken place (Jacob & Furgerson, 2012). This style of interviewing allowed me to adapt the pace of the interview to the interviewee and allow them to co-direct the interview. This was particularly important with participants who felt their human rights knowledge was lacking, as they often felt surprised or even embarrassed at this; the flexibility of the interviews helped to alleviate this and gather richer data.

Each interview lasted between thirty minutes and seventy-five minutes and interviews were recorded using an encrypted dictaphone provided by the University of East London. Data collection was conducted in a private room in the team base (non-clinical area) of the hospital. The hospital location was chosen to conduct the interviews as the hospital itself is in a somewhat isolated location. Logistically, meeting at the participants' place of work meant the participants could find availability to meet during their working day, it was also more practical in terms of arranging several interviews in a day. However, it was important to consider the possible constraints of conducting interviews about participants' work environment, in their work environment. I aimed to mitigate this by keeping recruitment and participation anonymous, by booking private rooms in a discreet, non-clinical area, and by reiterating confidentiality prior to the interview.

2.4.   Analysis

2.4.1. Analytic Framework
Data was analysed using Thematic Analysis (Braun & Clarke, 2006) as it is a form of analysis well suited to a critical realist stance, focusing on experience and how this informs individual meaning-making, and reveals perceptions of objective truth, whilst considering the influence of broader social contexts. Thematic analysis is also compatible with semi-structured interviews as they aim to elicit the participants' perceptions and meaning-making (Braun & Clarke, 2006). Thematic Analysis was used in both Patel's (2016) and Sharville's (2019) research, therefore I decided that using the same analytic framework could potentially enrich further discussion of implications of the studies.

Other analytic frameworks were considered, including Narrative Analysis (Riessman, 2003), Interpretative Phenomenological Analysis (IPA; Smith & Osborn, 2015) and Discourse Analysis (Potter, 2003). Narrative Analysis could have been used to discuss how participants 'story' human rights in their practice and services , but I wanted to focus on themes in individual and collective experience, as opposed to moving to a more structured 'story' that, arguably, may be more heavily infused with the researcher's interpretation. Similarly, although IPA is similar to Thematic Analysis in its focus on 'sense-making' – which does feature in this research in the sense-making of human rights generally and in FIPS – the focus of the research is not necessarily on personal experience but on understanding of concepts and how they may be applied to personal *and* hypothetical experiences (Smith & Osborn, 2015). Further, IPA is not as aligned with a realist ontological approach, in that it does not incorporate pre-existing theoretical preconceptions into the analytic frame, within which, arguably, human rights fall. Discourse analysis explicitly looks at the context of speech, trying to understand underlying ideologies that affect how and why people use language, with a focus on the actions people aim to achieve in social interactions. Whilst the consideration of ideologies and context would have been useful in this research, I was interested in how these ideas had formed and informed practice, as opposed to their influence over *how* participants conveyed this (Potter, 2003).

Apart from the critical realist epistemological stance there are no explicit or emerging theories guiding the analysis, in line with the exploratory nature of the study, to allow for an inductive interpretation of the data, identifying themes across the dataset.

2.4.2. Transcription

Transcription is a theoretical, selective, interpretative and representational process (Davidson, 2009), and choices when transcribing data are inherently linked to theoretical positioning (Jaffe, 2007). I transcribed interviews verbatim with the aim of translating or transforming them into as complete and accurate a dataset as possible, in order to support 'rich interpretations'; this process also promotes familiarity with dataset (Duranti, 2006; ten Have, 2007). However, there remains the influence of the researcher in choosing how the aural data

was heard, understood and then represented in text, as it is not possible to record all features of speech/conversation in text (Davidson, 2009). Therefore, the transcriptions were interpreted as a personal presentation of an event, striving for realism. In general, the speech content was the primary focus, although pauses, hesitations, stutters, sighing and laughter were also conveyed in an attempt to imbue as much context into the transcriptions as possible. This context was important to convey because, in line with a realist ontological stance, it represents a further layer of truth or knowledge that is crucial in order to understand and question the knowledge represented in the semantic content. A key of symbols used in transcription and analysis is provided in Appendix F.

2.4.3. Analytic Process (Braun & Clarke, 2006)

Following transcription, a thematic analysis was conducted on the dataset following Braun and Clarke's (2006) six phases. Phase one consisted of familiarising myself with the dataset through note-taking and re-reading, in addition to transcription. Phase two consisted of generating initial codes for each line or sentence of a transcript, which are considered to represent the most basic meaning of an item of raw data (Boyatzis, 1998) (see an excerpt of a coded transcript in Appendix G). The third phase of data involved collating these codes (see an example of a code in Appendix H) into broader themes through active search and construction. With over two thousand initial codes it was essential to first identify broad similarities to sort these into loose categories or potential themes. Initially, there were eight different categories with several inter-connecting subthemes and these categories were reviewed and critiqued for consistency both internally and with the raw data.

In order to crystallise the codes into inclusive yet discrete categories and themes, I used initial thematic trees and thought maps (Appendix I). There was still considerable overlap between the trees; therefore, the fourth stage of analysis required collapsing, discarding and regenerating some themes, resulting in a more refined tree (Appendix J). Although, this was further developed having re-visited and analysed the raw data, resulting in the tree being further refined.

In the fifth stage of analysis, the final list of themes and sub-themes in the thematic tree were constructed. The final stage of analysis was the write up, which enabled further analysis and refinement of the thematic tree.

2.5.   Ethical Considerations

2.5.1. Ethical approval

As the study involves active members of an NHS MDT, ethical approval was applied for and was granted by the Health Research Authority (HRA) using the Integrated Research Application System (IRAS). Minor changes were requested and submitted via email. A copy of the HRA approval letter can be found in Appendix K.

2.5.2. Potential Risks

Although participants were not explicitly asked to give details of their personal experience of human rights violations in their work, if the concept of human rights violations did feel relevant to them personally, this could have led to participants becoming distressed. Prior to the interview beginning, we discussed that if an individual were to show signs of becoming distressed during the interview, they would be offered the opportunity to take a break, to reschedule the interview for another time or to withdraw from the study without stating a reason. Following this, they would be offered the opportunity to discuss the matter with me further. Alternatively, where appropriate, the participant would be advised to make contact with their staff support service, or line manager. When discussing the participant information sheet I explained that as an external researcher conducting a time-limited study it would not be appropriate or feasible to investigate any potential human rights breaches that were mentioned, and participants were encouraged to discuss this with their line manager or with the Trust whistleblowing representative.

2.5.3. Confidentiality and Anonymity

The Caldicott Principles (NHS England, 2010) regarding confidentiality and anonymity were followed, including: explaining the limits of confidentiality both in person and in the participant information sheet; choice of interview setting; and collection and handling of data. Minimal information on participants was

collected in order to facilitate recruitment and engagement; this information has been kept strictly confidential. Participants were asked generally about their role in terms of profession, any human rights-related training they had received as part of their role, and their length of employment within the service and other forensic psychiatric services.

The content of interviews has been kept confidential. The limits of confidentiality were explained to participants before beginning the interview, including that confidentiality could have been broken if the researcher had serious concerns about someone's safety and the relevant service manager would have been consulted. However, there was no cause for this throughout the research process.

In order to protect anonymity, any identifying features, including the name of the hospital, people's names, and people's country of origin, whether revealed intentionally or inadvertently, have been altered in interview transcripts, and therefore in extracts used in this thesis and any publications. It was made clear that, as the final research may be shared with the NHS Trust involved, it is possible that readers from within the organisation could identify a participant from their interview contributions; quotes have been carefully selected to minimise this.

2.5.4. Data Management

Consent forms and transcripts have been kept in a locked environment; all interviews were transcribed by the researcher; and all digital files were encrypted. Only the researcher, supervisor and examiners have access to transcripts.

In accordance with current ethics protocols, all recordings of interviews will be stored electronically on an encrypted cloud network provided by University of East London until after examination of the research by University of East London (September 2020). Transcripts of all recordings were anonymised. All transcripts are stored electronically on an encrypted cloud network provided by the University of East London until after examination and will be subsequently destroyed. Access to the recordings and to the transcripts is strictly limited to

the study's researcher, supervisor and examiners, under the supervision of the researcher.

3. ANALYSIS

This chapter presents the research findings as a series of themes, using participants' words to illustrate how these themes were derived. To reiterate the critical realist stance, this chapter is one of many possible interpretations of the data and the underlying 'real' experiences of participants in order to construct an argument. In order to reflect the data as faithfully as possible, quotes or phrases from participants were used to rename some of the themes in this final stage.

3.1. Participants

Eleven participants were interviewed. In the interest of anonymity, only brief demographic information is provided here. Of the participants, two were male and nine were female. The sample was made up of two consultant psychiatrists, two clinical psychologists, one trainee forensic psychologist, two nurses, three social workers, and one trainee occupational therapist. Three of the participants identified as People of Colour, the rest of the participants identified as White. All interviews have been included in the dataset; no participants asked for their data to be withdrawn. Most interviews lasted approximately forty-five or fifty minutes, although two were shorter at about thirty minutes and three lasted between one hour and 75 minutes.

3.2. Key Themes

The analysis led to four key themes and several subthemes emerging. These are summarised in Table 2. The analysis of these themes includes extracts from the transcribed interviews; a key for the presentation of these extracts is presented in Appendix L.

Table 2. Overview of themes and subthemes

Theme	Subtheme
"I Don't Know an Awful Lot About Them": Broad Concepts of Human Rights	Uncertainty
	What We Do Know
	Violations
	How We Know
"It Always, Always Comes Back to Risk": Practice in FIPS	Current Practice: Treatment, Care, Protection and Best Practice
	The FIPS Context: Roles, Environment and Staff
	Patients: Vulnerabilities, Discrimination and Disempowerment
"Do We Know We're Violating? Maybe Not": Human Rights Issues in FIPS	Detention
	Private and Family Life
	Restrictive Practice
"I Think I-, I'm…Confused": Tools and Resources in FIPS	Mental Health Act 1983
	Resources

3.3. "I Don't Know an Awful Lot About Them": Broad Concepts of Human Rights

This theme focuses on participants' general understanding of human rights and human rights violations, not necessarily related to FIPS. These extracts are drawn predominantly from the beginning of interviews and set the context of uncertainty around human rights knowledge throughout the data. Although participants were often initially taken aback by the gaps in their knowledge, this also prompted contemplation of human rights outside of legal understandings and definitions. Less formal and more idiosyncratic ideas of human rights emerged, along with thinking around how basic understandings are developed, and of why, in a work environment that presents human rights issues, human rights do not feel present.

3.3.1. Uncertainty

When participants were asked about their general understanding of the term human rights, responses were most frequently a variation of 'I don't know enough'.

> *Erm…yeah, that is difficult because I don't, I don't know it well enough.* (P3)

Participants seemed somewhat surprised at their lack of knowledge, considering the nature of their work and work environment.

> *Yeah. I've got, I would- I've got no idea what is actually included in…in it really. Now I'm saying it out like it's quite surprising really. Cos I work with humans (laughing) it would be good to know what their rights are.* (P5)

There could be several reasons why it was difficult for participants to recall human rights knowledge during interview, such as confidence, not wishing to answer 'incorrectly', or not having the language perceived necessary to articulate their understanding. Many participants offered their own explanations as to why human rights concepts felt difficult to access, namely that in a work context they are not discussed or the subject of any training.

> *No formal training the- there isn't any formal training [around human rights].* (P2)

> *[Human rights] wasn't something I brought up or the supervisor brought up, um, when discussing clients.* (P11)

A lack of training and discussion related to human rights within the NHS Trust, service and hospital could explain why human rights were not at the forefront of practitioners' minds and why knowledge of human rights was not there, as some participants stated, or not confidently expressed. Whilst human rights principles may well be practised in the service, it seemed that they are not recognised as such and thus not linked to human rights frameworks and legislation. Outside of FIPS, there may also exist a lack of explicit consideration of human rights, both personally and societally. Crucially, these discussions and learning had only occurred in passing, if that, during professional training for

nurses, consultant psychiatrists, clinical and forensic psychologists and occupational therapists; even amongst the social workers, who explicitly focus on human rights during training, human rights knowledge varied.

3.3.2. What We Do Know

Despite participants' uncertainty when discussing human rights, several key concepts emerged. Everyone mentioned the idea of universality, and of human rights indicating minimum or basic standards of living or treatment.

> *My understanding would be that they are inalienable rights…inalienable rights that every human being ought to have.'* (P1)

Most participants elaborated on their understandings by discussing specific articles and broad principles, suggesting how human rights may have emerged and been applied in participants' experience and practice. Some participants spoke quite casually about human rights, implying they are an exhaustive, and perhaps exhausting, list that is difficult to keep track of.

> *So it's all about liberty and dignity and your right to choose and your right to be treated fairly and it goes on and on and on, doesn't it? The rest is, sort of, fair trial, punishment without…without trial, your right to be free or cared for and free of torture and…oh all sorts of…* (P3)

Participants recognised the legal notion of human rights, including some brief discussion of the hierarchy and balance between rights.

> *Erm, your right to life is absolute and, and that's the end of it. […] Um, right to family life, so the right to family life…isn't absolute because everyone does have that, but then there are occasions when…that right…other rights have to come above that right.* (P9)

All the social worker participants also spoke explicitly about the protective and preventative aspects of human rights, as well as introducing ideas of collective responsibility.

Erm so I suppose I think of it as um…safeguards and protection. Um…so, unfairness can seep into all different layers of life in society and for organisations, so human rights is setting out a basic standard to stop, I suppose on the grander scale, atrocities from occurring, but also on an individual- individual scale, protecting people, with a particular focus on protecting vulnerable people…(P7)

Apart from a comment about mutual respect, participants from other disciplines did not mention who holds responsibility for upholding human rights. Perhaps the idea of human rights as being law may have meant that they are not seen as an individual's responsibility, but as something held by governments, Trusts and heads of service.

3.3.3. Violations

Similarly to human rights principles and legislation, participants expressed uncertainty when defining human rights violations, generally defining them simply as acts directly breaching a right.

I understand it to be where there's a right which is written down in statute and, and agreed, usually internationally. And some action or decision of mine is (small laugh) *– or of the hospital's - is going to be in collision with that right. So that the person won't have a right to what they should have.* (P1)

In general, participants found it easier to discuss gross violations, such as those reported in the media, perhaps implying that gross violations happen outside of the hospital, thus defending against conceptualising their practice as potentially infringing on human rights. However, most participants discussed "incidental" violations that occur, including barriers to fulfilment of a right.

I don't think it has to be an action with- it doesn't even have to have- that doesn't even have to be the goal of the action. But if that's a by-product that's still a breach of someone's human rights, I think. Um…Yeah, and it's about…anything that can create a barrier that someone can't overcome that

prevents them from achieving the things that they have a right to, is a
breach of their human rights, in some level. (P10)

Interestingly, when discussing violations generally, or violations seen as less severe, participants frequently spoke in the first or second person; most participants also brought in examples related to FIPS or their own practice, unlike when discussing rights, entitlements and gross violations. One reading of this is that less severe violations are seen as more relevant to practice in FIPS, whether in trying to avoid them, or believing that violations that happen.

3.3.4. How We Know

In line with participants' uncertainty, most participants had not developed an understanding of human rights through direct training or education. Participants mostly attributed their understanding to their personal value base, their sense of right and wrong, and life experiences.

Um…I mean I think um…for me it's, it's maybe like a moral……yeah I don't
really know like a kind of mora- more like a moral sense of what I personally
consider to be right or wrong. (P5)

Participants also talked about picking up more direct knowledge vicariously, such as through reading, from observing or talking with colleagues, or through the media.

But I think that is just through chatting and learning and…watching others,
but not necessarily…following others because…they might be doing
something you don't agree with. (P3)

However, participants felt that the media portray human rights negatively, for example by questioning whether specific groups or individuals should be entitled to human rights. This, again, may suggest a wider societal misunderstanding, or lack of understanding, regarding the fundamental principles of human rights. Perhaps this was particularly noticeable for participants as their clients are often those depicted as undeserving of, or forfeiting, their rights. However, through their experiences in FIPS, participants

understand the wider context of the job and of patients' lives, and work with the whole person as opposed to the 'offender'. This tension between societal messages and lived experience may mean that in the absence of training on human rights, and in order to continue practising, participants rely on their own personal values.

> *Um…I think, yeah, in this job though, it's opened your eyes. It just gives another- whole other perspective. Um, yeah, so I think it creeps up everywhere. And you're not always- sometimes it's subconscious as well.* (P9)

This may have been why some participants found it easier to define gross human rights violations, that more easily lead to individual judgements of 'right and wrong', than other human rights issues.

> *I know what that human rights violation is, you know, when you're talking about genocide and war and big things that are covered by the media, is very easy to conceptualise and see it, you know, but if you're talking about within the work environment, it's very…abstract.* (P4)

Some participants had sought training in human rights, although most were social workers. Perhaps human rights knowledge for some participants was seen as unconnected to their healthcare work; or perhaps seen as only relevant in the abstract in FIPS.

3.4.   "It Always, Always Comes Back to Risk": Practice in FIPS

As participants explored their general knowledge of human rights, they used examples from practice to justify their understanding, referring to the work environment and the wider political environment.

3.4.1. Current Practice in FIPS: Treatment, Care, Protection and Best Practice
Three main areas of practice were discussed: treatment, care and protection. There was a sense of constant flux and balance of these practice areas and

principles which influenced practice, but ultimately with risk or protection topping the hierarchy.

Well, I think the right to health is, is given precedence and everything else is subsumed under that…Everything has to be risk assessed. And even on the day it will be risk assessed further. (P1)

3.4.1.1. Treatment: Treatment in FIPS was conceptualised as a pathway, an, ideally linear, progression towards 'wellness' through medical and psychological intervention. Although this concept may be shared across healthcare settings, the goal of wellness in FIPS could be seen as either a by-product of, or the tool with which to achieve, the principal goal of reducing reoffending.

So, so I think for this-… and what makes the difference is because forensic services is really interested in reducing reoffending. That's what we're- from a health aspect, we're reducing reoffending [...] So if you're dealing with the illness, you're dealing- and you take away that bit, you'll be left with a very well um…person who's less likely to offend. (P4)

A patient's progression was described as possible through treatment compliance or engagement, having insight into mental ill health and acceptance of offence(s); further progression equals greater freedoms. All of these markers are set by the clinical team or MOJ, and may not be clearly shared with a patient, particularly if there is an assumed lack of insight or capacity.

There's not a very straightforward, easy way of just letting people see, or to give much input into what's being said, so information - you see people…facing- stuff being written about them while they're in the room and they can't see what's being written. It might even be on a screen on the wall behind them and their back's turned…um to the screen, or they've not got the literacy... (P6)

There is a paradox and unfairness in excluding patients from their own care plan yet expecting adherence; not sharing information yet expecting insight.

Instead of engaging in more collaborative care, most participants spoke about insight and wellness being contingent on medication. Thus, medication is often forced, physically or coercively.

You know, if you didn't enforce that medication, they're gonna remain psychotic, extremely unwell and they're going to be detained in, in hospital for a long time. Which I think is…more of a violation, than, you know… (P9)

Undoubtedly forced treatment can be extremely traumatic, and raises human rights issues, whether this is feeling coerced into taking medication, being restrained and forcibly administered medication, or being left to linger in the system for decades through non-compliance. One participant felt that this level of enforcement was only used in complex cases where clinicians felt stuck and desperate for progression. Although it is unclear whether this progression is for the patient's benefit or to avert risk.

Um…medics might be quite convinced that's the final treatment- or final way that might…work, sort of the end of the line and that if somebody could take [medication] and have enough of a dose that they might then feel better and choose to take it, that's the hope. (P6)

Patients raise this as a human rights issue but are deemed not to have capacity and 'best interests' decisions are used to continue administering medication against their will. The short-term costs of forcing medication were seen as outweighed by the long-term benefits.

You know, and I think patients would have a different view from when they're well to when they're unwell. Um…so sometimes it's working in their best interests. And sometimes our best interest at that moment in time would seem like it is a violation of their human rights. You are…treading on them, gently. But…but not in a way that is malicious or devious or…to cause… purposeful harm. (P9)

However, this raises the question about what is "insight" or "acceptance". Practically, it is the agreement to take medication and that medication is

needed. Conceptually however, it could be an acknowledgement of the system and its inherent power hierarchy, that adhering to an MDT-decided care plan will facilitate progression towards freedom and minimise the likelihood of further iatrogenic trauma.

3.4.1.2. Care: Care in FIPS practice was discussed through the humanity that practitioners injected into their work; the work that is not written in policy or guidance, and that is most in line with human rights principles. In particular, the idea of choice and autonomy were mentioned frequently, and that a more caring approach is to allow patients to make decisions, however unwise, as to do otherwise is potentially punitive.

> *But it's then trying to…balance, isn't it, what is someone's right? What is classed as…the punitive word comes up…quite a lot. And it, it's letting someone be able to make those choices.* (P3)

However, participants spoke of the problem of a caring approach tipping into paternalism and unfair restriction, perhaps due to the tension of roles unique to FIPS: both reducing risk and treating mental health; both monitoring physical health but not treating it.

> *…and I mean I've s- when this has come up quite a bit, I think, in recent years in forensic settings has been around um…er, I mean, you could say trivial stuff, but you know, around kind of like smoking and um…diet…because I think historically…hospitals tended to be quite, kind of, restrictive and just say, well, um…you know…that person's got diabetes, the person's overweight, they were probably doing what, what you could argue might be common sense, and they'd say, well they therefore can't have any more...they can only have diet drinks. And I think increasingly there's a recognition that that's not okay…to do that.* (P4)

Paternalism or being 'too caring' has also led to security breaches, reinforcing the idea that practice must keep treatment, care and protection in balance in order to be safe and effective.

I understand that we've got things wrong in the past, you know, at the time of what's called here, <u>the</u> incident, capital 't' capital 'i' […] I understand that we went <u>way</u>, <u>way</u> down the line of being kind and caring and, therefore, somewhat lax. I know we've tightened up, and the health service executives required us to and I absolutely- now if I look back, I think some of the things we did were completely bizarre (laughing), but it was done with good heart. (P1)

Although in response to both serious and 'more trivial' incidents practitioners have made individual changes, the service has only put in blanket security restrictions. The idea that being 'too caring' can lead to lapses in judgment points to the challenges of working in FIPS and implies a lack of sufficient guidance to do so supportively.

So there's not a prop-…proper governance arrangement. There's no investment in people's righ- I mean if you ask here who's checking people's human rights? Is there such a role, such a post to look after peop-? I mean, there's a security department which is heavily invested in. Four, five staff. (Laughing.) Obviously they are well known. But what's the balance? (P4)

3.4.1.3. Protection: The emphasis on security links to the common thread in the data: the protection against risk as taking priority over all else. This was justified by the significant harm that many patients in medium secure FIPS have caused, and therefore risk was conceptualised as the potential repetition or escalation of this harm. In the context of FIPS, although protection involves managing the risk of harm or of further reoffending to patients, the emphasis was on protecting the rights of victims and the general public, which was seen to take precedence over patients' rights.

So within forensics, there is quite a lot of…er…you know, things to do with risk. There's quite a lot of-…victims, thinking about- there's always a victim in forensic. So the rights of the offender versus the rights of the, of the victim. (P4)

The justification of protecting the rights of the victim may lead, in practice, to viewing the patient's rights as secondary, or the violations of some of their rights as being acceptable.

> *You know, it's risk management and, and public protection. We already know right to life is absolute. We <u>have</u> to be protecting that, I would say over…you know, someone's right to privacy and family life or…you know, to make their own decisions and to choose to live where they want to.…They're not as…they're not…as life changing.* (P9)

The principal way that FIPS manage risk is by detaining their patients, an extremely powerful mechanism controlled, or at least mediated, by clinicians. Teams assess risk in terms of static and dynamic risk factors. However, as only dynamic risk factors can be changed or reduced, perceived overall risk can remain very high, which, coupled with staff views that detention can be justified when there is an identified risk, can mean that patients remain in detention.

> *My experience is, it's not too difficult to argue that they should be detained on the basis of nature. Because you'd be saying- because there's so many things we could always ask the service users to be a bit better at in terms of giving reassurance, of their safety. […] So that's- so anybody, I suppose, at the point of coming into secure services where they've got that sort of risk history, you can- you can extend the stay, I think without too much contention.* (P6)

This reliance on "nature" as an indicator of risk does mean that patients with significant offences but less risky 'nature' can move through the system quickly, but it begs the question of whether other patients are being lawfully detained, i.e. due to their mental ill health.

> *But, we have people in hospital who do really quite terrible things and are out in very short amounts of time and other people that don't- as we said earlier- that don't, don't- you know, their crime isn't particularly damaging to other people. But they're in hospital for a long time. I-i-it's whether or not- do we detain people because of their mental state? We don't…We do- we*

detain people for their behaviour and their behaviour isn't... as far as I'm aware… [covered under] the Mental Health Act. Or, DSM V. (P8)

Overall, all participants perceived risk to be the main focus in FIPS, with one consequence being that treatment or rehabilitation services are relegated or seen as less essential.

I- for me, especially from the…incident, a few years ago, cos we've noticed- so now…because we're on a rehab- so we have our own kitchen…which is meant to be an ADL [activities of daily living] kitchen, which has now been…taken away. So…we still <u>cook</u>, but the patients can't cook. (P3)

Importantly, participants suggested that although risk is focused on, risk is not managed positively or creatively, meaning that patients get 'stuck' in the hospital. Perhaps the irony – or hypocrisy – of practice in FIPS is that patients are expected to accept their offence in order to progress, but their progression often stagnates due to practitioners not being able to accept the offence. However this may be difficult in a system geared towards risk, and when the responsibility for such risk recurring largely lies with clinicians.

So there's this risk, and we can, we can keep on saying there's this risk and they can't do something because of it, or we can say, there is this risk, what can we put in place to minimise it from happening again? And I don't know if we're all as…um…forwards- forwards is probably not the word- as willing or, or…to get involved in doing that. (P8)

3.4.1.4. Best practice: in talking about current practice, several participants spoke about what better practice may look like in FIPS and the kind of practice they would like to see in their service. Several participants highlighted that practice has improved around restraint through more meaningful, and earlier, engagement with patients.

And by virtue of putting in initiatives that are aimed at reducing restrictive practice, which generally involves spending more time around the service users, finding out how they are, helping them resolve their issues earlier,

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and then incident rates, restraints, seclusions all go down. It shows actually that, you know, lots have been unnecessary, really. (P6)

This idea of unnecessarily restrictive practice brings into question other areas of practice that are also not as supportive as they should or could be. For example, participants introduced the idea of using these same powers of the MHA that are used in restraint positively and supportively – to care as well as control.

But, but you have to - whether that's…escorted leave or…we have to do as much as we can to, to, to allow people to live as much of a life as they can, whilst they're in a medium secure or secure setting. And I think that sometimes we forget that…that is part of our job, it's not just to contain and control. It's care and control, it's that dichotomy…(P8)

3.4.2. The FIPS Context: Roles, Environment and Staff

Within FIPS the environment, the structure of the teams and their work, where power is held and how it is used, and individual staff and their human rights all interact to create the service. Each of these elements have qualities and dilemmas unique to FIPS, that highlight not only the relevance of human rights in FIPS, but the challenges and necessity in upholding them.

3.4.2.1.Roles: Participants frequently noted the differences in practice, priorities and attitudes between staff groups, particularly in understanding or application of human rights. although ultimately it was felt these differences were rooted in personal value bases.

Erm…I think [frontline staff's] understanding of human rights, with a small 'h' and a small 'r', is good. I think their understanding of articles and contraventions and so- I don't think that would be quite as clear but…perhaps it's the day to day stuff that matters more, it will all feed into some article or convention anyway […] And I think also for the, for the less enlightened folk, talking about human rights, you must hear the way people, you know, "Oh, human rights," and it's said in this sort of sneery way as if to say, "Well we can dismiss that." I think if you're going to dismiss them, you'll

dismiss them, you either do it and it's embedded in how you do things…or you don't do it at all. (P1)

Overall, a lack of awareness, and consequently understanding, of human rights negates any opportunity for them to be a focus in FIPS and makes explicitly and routinely integrating them into practice extremely difficult.

And…so I think the lack of awareness, throughout the Trust…even I think, probably to some of the higher level- higher ups, are probably unaware of human rights or- and…it's bizarre… (P10)

The surprise at "higher ups" not knowing about human rights reflects both the hierarchy of (legal) responsibility at the hospital, both practical and perceived – because practising lawfully is everyone's responsibility – but also the assumptions made between and about other staff and disciplines. Specifically, in relation to human rights, several reasons for intra-hospital differences were suggested, for example, the varying motivations for working at the hospital.

It's, it's…the people go into the caring…services aren't necessarily caring. I think. And I think…I think you see it every day. I think that it's, it's an easy way to make money, it's a short-staffed industry […] and "I don't need to give a shit about anybody. And as long as I'm not being abusive, and…I'm doing all the things I'm asked to do, I'm not going out of my way. If it's part of my job to understand that this is someone's right and I have to do it…then ge- fine I'm down with that. But why am I going out my way to do it?" (P8)

Inherent in these motivations is a personal value base and views of FIPS patients: what they deserve, what they should be entitled to, how they should be treated. This highlights inter-disciplinary role and power differences, in that the "higher ups" make decisions that are disagreeable to patients, but the ward-based staff have to implement and enforce these decisions and therefore experience the most threat and aggression, in turn reinforcing or creating self-protective attitudes that may negatively affect care.

I think there's variation within the same difference, depending on where- how far away you are from the fire. Because I think if you are in the day to day coalface, and you're not abstract from the day to day, looking after people on the ward, who all need to be managed, all need their section 17…I think your gut feeling becomes um…diluted or polluted, whichever way you want to say. Because you have the harsh practicalities of the day to day. (P4)

Arguably these disciplinary differences are part of the rationale for working in a MDT framework in FIPS and of course difference can also strengthen and improve the quality of care. However, participants described that advocating for patients' rights, including human rights, is not seen as everyone's responsibility, but as a specific task of social workers.

But I think that as a social worker, that's what I feel in all of the team…more than anybody I think it's just my personal view - is that's what my job is to do. Is to kind of champion those people's rights and…kind of promote that…th-that wellbeing and-and kind of rights and justice and the…kind of equal opportunity…and the equity of the service that you give to people. I think that's our job. If there's any role…in an MDT…I think that-that, I personally think that-that that's the role that would try to encompass human rights and people's…maybe wider understanding, it's our job to bring that to an MDT. Like I said I've never heard anyone else, kind of, discuss it. And you kind of get ridiculed as well. (P8)

However, despite this MDT structure the aforementioned disciplinary hierarchies can still lead to less powerful practitioners' voices being overridden. Participants suggested that this varied greatly between ward teams, mainly dependant on how the most legally responsible and professionally powerful clinicians oversee care.

So I think if I was to be working on another ward, I think I'd experience something quite different to, maybe working with this RC or that RC on my ward, compared to…that's my, that's how it feels. (P7)

Perceived as most powerful of all were the security department. They were frequently cited as introducing problematic rules in inappropriate ways because of a risk focus and lack of clinical understanding and experience.

> *Right, so I have become a thorn in the side of our security department. Because…about- oh the other thing is…security practice, edicts come down from on high but they're never shared with clinicians.* (P1)

Perhaps all of these divisions served as a way for practitioners to distance themselves from perceived 'bad practice'. In an environment that most of the participants critiqued as not providing adequate care, focusing on the failings of the security team or "higher ups" may be an attempt to justify or rationalise personal or team practice as 'good enough', given variable guidance and the clinical and environmental restrictions placed on staff when working in FIPS.

3.4.2.2. Environment: The physical and cultural environments in FIPS have a huge impact on treatment, care and risk and, both directly and indirectly, on human rights fulfilment. Participants highlighted the confusion of the environment.

> *And it's, it's the mishmash of rules and the fact that the setting is run…as a business under NHS rules, under the cover of…the Mental Health Act, ignoring the Human rights Act. And all of these rules that are intersecting mean that actually there's no clear guidance.* (P10)

Similarly, normal ethical and practice guidance that is adopted in healthcare settings does not seem to fit well with FIPS.

> *If you look at what, what the, the, the, um…PCFR, what w-w-what we're guided by, tells us all the things that we should do, there are nine domains, and none of them is about giving people medication against their will, or…it's the opposite. So, in, in a way the Mental Health Act is…it's like the total opposite of what…we're taught to do as a profession.* (P8)

This is perhaps unsurprising when the skills learnt in health and social care training are also not specific to FIPS and include little on mental health legislation, leaving practitioners feeling ill-equipped.

> *They're to do with the law and offending and MOJ and…some, some things so some of them are to do with areas where are not our special area of expertise. I am a nurse, you know. Ask me anything about their health and the law related to their health, I'm more confident there. But this is an offender who's mentally unwell…you see. So you've got all those mixed in the same person, you know.* (P4)

In response to this rules are often created by practitioners and non-client facing staff, such as security, that were seen as not rooted in guidance or evidence base and, perhaps unsurprisingly, as unnecessarily and disproportionately restrictive. Participants thought these arbitrary rules were not only misguided and negatively affected rehabilitation, but also were ineffective at reaching their goal of managing risk.

> *But then like you say on a, on a daily basis, as well, you know…um…the patients coming back, you know, that they can't bring a baguette back, you know, in case there's…some drugs in it. Um…Yeah, I just, yeah. I think… sometimes…How far can you go to stop…stop these things from happening? There are gonna be risks…here.* (P9)

These restrictions are also often moralistic or paternalistic in essence; smoking restrictions came up in every interview as an issue that the hospital and staff do not know how to manage. The dilemma here illustrated the balancing act of FIPS: wanting to stop patients smoking to improve their physical health, wanting to offer freedom of choice on leave, but also considering escorting staff's physical health, complying with smoke-free hospital policy, and wanting to minimise the risk of lighters and matches being brought into the hospital. However, the impact of all of these wishes upon patients may not be fairly considered and, along with other arbitrary rules, and they can create unnecessary tension and aggression between staff and patients.

Even the, even the smoking. You can't have a, can't have a- "I've smoked for 30 years. I've come into hospital through no choice of my own and you're telling me I can't even have a cigarette. And now I'm gonna punch you in the face because I can't have a cigarette, now I'm gonna punch someone else in the face, where if I'd just gone outside for five minutes and had a cigarette, and I would've calmed myself down and I would've quite gladly come back in, and then it would all be..." (P3)

A tense and aggressive environment is difficult for both patients and staff, and this can impact on care. Staff have to work with patients even if they feel threatened or upset by patients' behaviour, but how to do so in a therapeutic way requires resilience, compassion and curiosity.

Because people…are abused on a daily basis and they're told to take it, and just to try and…self-check I suppose, be self-aware not to…give it back. And learn you've got to bite your tongue. (P3)

The expectation of coping and carrying on with work creates barriers to accessing and engaging in support. Staff hierarchy, and therefore who is on the frontline of aggression, cannot be ignored, and ward tensions were replicated in team relationships.

And then while we try and create a culture where it's safe and open to talk, actually, a few things get left unsaid, often you'll hear...difficulties in dynamics that don't get brought to reflective practice. (P6)

3.4.2.3. Staff: Although patients are incomparably more restricted than staff, it is important to acknowledge the restrictions and infringements that staff also face working in FIPS. Participants mainly described their human rights being infringed in terms of verbal and physical assault; following these infringements there is an expectation to still do your job, which may also impact on staff's human rights.

I think the biggest problem for staff in these settings, um…and to be honest it's <u>more</u> of a problem, I think for nursing staff, HCA [healthcare assistant] staff, is, is level of exposure to violence […] I think most inpatient forensic

nurses I've worked with have had um…can at least tell you one- you know, one or two occasions or more where they've been assaulted. […] You know, if someone assaults me in the street…um…I'm not expected to ever see them again. In fact, if they get convicted of it I could even have a say in whether they're allowed to live in my street anymore. Whereas if you're a HCA or a nurse…y- there's- you're sort of expected to care for people. (P5)

Some participants argued that working with this client group requires an acceptance that human rights would be infringed; at least they felt that this was an expectation from management. This was explained as a dual expectation of infringements from the patients, for example being at risk of violence, and from the service, for example feeling obliged to engage in practices against your values, such as restraint or seclusion.

Yes there's an expectation that If you, if you work, you work in a forensic field, so what do you expect? So I think yeah…so I think there is, there is an element of actually the staff human rights. If you ask me what are staff human rights, I don't know…This is how bad it is. (P4)

Even if there is a level of acceptance of infringements, participants felt there is not consideration of these service level issues that may infringe upon staff human rights or negatively affect patients who direct frustrations towards staff. One participant talked about staff not being supported or made safe, exacerbated by working conditions that actively put them at risk, such as understaffing and lack of training.

Um, again, with patients, I feel that staff are often put in difficult positions with patients through not enough training or through, um…potentially poor recruitment, that just means that…Yeah, staff aren't protected. Um, and they're not supported to make the right decisions, or they're not educated enough by the Trust to make the right decisions. (P10)

Whether due to role expectations, fear of repercussions or lack of awareness, human rights are rarely raised by staff.

I've never had a staff quote their human rights in a complaint or in an investigation. I mean, I've done quite a lot of investigations here…we have never had a staff saying, "Oh, you're breaching my human rights". It's interesting. (P4)

3.4.3. Patients: Vulnerabilities, Discrimination and Disempowerment

Patients' human rights may be easier to infringe upon not only due to their detention, but due to their vulnerabilities, the way they are viewed by professionals and the inherent power imbalance between staff and patients.

3.4.3.1. Vulnerabilities: Several participants described patients predominantly through the severity of "illness", often using quite extreme language to illustrate their potential for violence. Both of these descriptors, even when used in the context of unmet basic needs, emphasise that patients are understood through risk factors.

You know, we see people coming in here on six man unlock from the prison. They're covered in their own excrement, by their own… probably not capacitous choice…but by their own actions. They're often malnourished because they're so psychotic they won't eat…They may even be dehydrated. I mean, they are primitively unwell. (P1)

All participants recognised the individual and systemic abuse patients are likely to have suffered, which will have impacted on their mental illness and offending behaviour and their journey to hospital. This abuse was seen as sometimes mirrored in and replicated by FIPS:

I mean, my general sense and sort of impression of forensic service users is they come from lives where they felt…um…I suppose they felt the realities of disadvantages, um…abuse of trust, abuse of power, and then end up in a system where there's further, <u>legalised</u> usually, or at least to some extent legalised sort of forms of coercion, and then power being used and occasionally misused. (P6)

Legally, some participants suggested that the MHA may provide support for patients, and that MHA rights may be focused on instead of human rights. This raises questions around whether FIPS do not examine their practice in terms of the HRA because it adheres to the MHA.

> *There is support again, in terms of Mental Health Act for the patients, but there's not enough support in terms of human rights.* (P2)

3.4.3.2. Discrimination: There was acknowledgement that care is not just acting in line with legislation, but that personal attitudes, particularly towards patients, will impact care and may even infringe on patients' human rights.

> *And I suppose I'm not sure that you're necessarily-…you may not be breaching someone's human rights just with your words. But I suppose with words…the way you speak, and the attitudes you hold <u>will</u> affect…the way you…conduct yourself.* (P5)

One participant explained that they separated patients into "two people" that had different needs and perhaps different behaviour, in order to manage potentially harmful attitudes.

> *And, and they are still people- so you find that you have two individuals in one person. So you have, you have the real person, right. And then you have um…this other illness that is the offending aspect of their illness. So the human rights still protects the…the actions to the human being…in the, in the-, who still is entitled…to the human rights. So you- I always view people as two people that's how I've found it very easy to, to deal with what people do.* (P4)

This idea of the non-offending half of a person as "real" hints at a difficulty to reconcile the patient one works with, with their very serious, possibly even 'unreal', offence. Crucially, only the "real" person is seen as deserving of human rights. In practice, moralism such as this, mainly based on offences, could lead to patients being seen as unequal or undeserving of treatment, and to that treatment possibly being made practically inaccessible.

I've seen some lovely practice but equally…at times…I have seen <u>this</u>, you know, pointing the finger. Why should we help you? You're taking drugs […] There is definitely an undercurrent at times of moralising, of moral judgement….Um…And when the moral judgement is made…I think the person…ceases to be an equal in the staff member's eyes. (P1)

This notion of being undeserving can also contribute to ideas of human rights forfeiture. Patients may be actively excluded from care, which has the long-term consequence of hindering their recovery and prolonging their detention.

Well it's like, you know, "What would you mean their human rights? They- he killed his mum. He-he-he raped is kid", or- you know, but…Yeah, but he, but he's still got, he's still got…rights to do- yeah. Yeah. And if we don't treat him as such, then…we, we then- surely we're not making the situation better. (P8)

Participants felt that moralistic attitudes can escalate to explicit abuse. These attitudes and associated practice therefore constitute discrimination. Investigating this more, participants revealed that there are different levels of discrimination, for example based on diagnosis. Patients with psychotic diagnoses were seen as less culpable for their offences and behaviour, and therefore more likeable and preferable to work with, than those with personality disorder diagnoses.

If somebody is not psychotic - I do have a sort of a two-tier system in mind... So if somebody is capacitous and is being vile to someone, I think that it's a criminal offence, they actually should be charged with it. Erm…but if they're psychotic, you know, th-they <u>really</u> don't have the capacity to decide that this might hurt the other person or…you know, would be a criminal offence because it's racist or whatever. (P1)

Another attitude that was presented by participants is the idea of "revolving door" patients, whose risk is lowered enough for detention to be excessive, but they are still in need of treatment. There is an acknowledgement that their

difficulties are not managed in the long term and perhaps that they haven't received the support to enable them to recover; perhaps the support they needed was non-risk focused.

> *It's more…that it's a revolving door and we expect them to come back, and ultimately we haven't fixed everything, so we'll send them out, discharge them, because they're safe at the moment, but we'll see them again in a couple of years.* (P10)

3.4.3.3.   Disempowerment: The environment, MDT variance and staff human rights issues all point to power disparities in FIPS. The starkest of these is between staff and patients, or indeed the patients and the public, and participants noticed the impact of this on human rights.

> *But the balance is always unclear and it's always…the power always tips to-towards us, towards the staff team.* (P8)

There are obvious, physical reasons why staff have greater power than patients in a FIPS setting, namely that it is a locked environment and patients do not have the permission or keys to move around freely, nor the freedom to leave. One less overt explanation for disempowerment is the subjectivity of care and detention. The very core of patients' detainment is determined by a small group of professionals, who inevitably are influenced by their own biases, and who are making decisions dynamically. Therefore, every action or inaction is weighed and measured, contributing to the evidence for or against patients' wellness, and hence their freedom. This dynamic system provides patients with little clear, consistent guidance for recovery. This, and the involvement of MOJ, mean that all care is underpinned by coercion at best, and enforcement at worst.

> *The coercion fundamentally is…the detention in the unit. And that everything is at…you know, subject to the grace and favour of the multidisciplinary team. You know, if we say yes, this man's fine, but we <u>can</u> say no.* (P1)

This power differential was described as becoming universal across care and interactions. Sometimes this was seen as a caring approach but was also seen as paternalism, evident in the restrictions or instructions implemented by the MDT on seemingly minor aspects; the cumulative impact of these is often not considered.

> *Telling them what they can watch on TV, what they're not allowed to watch on TV, what they can watch on computers… what they can watch if they're allowed phones or if they're not allowed phones… if… um… so… you know what they can eat… what they shouldn't eat…um…so I think it's a lot in terms of, th- the main one that I think is about the freedom… um…the wa- the access to free movement.* (P2)

Consequently, participants felt that staff can become desensitised to the inequality of power within FIPS. The imbalance was accepted as a justified enactment of law but it was also explained as descending into othering of patients.

> *I think it's, it's from working in forensics, there's a…there's a massive um…there's a massive feeling of us and them, that sort of...it's just naturally born of the environment. And it's something that I'm quite aware of all the time. Um…But you see that a lot of people who have been in the system for a long time aren't that aware of anymore, and whether or not that something that's like dropped off of their radar or something that they just never…for staff, staff and patients.* (P10)

Othering can mean that the caring aspect of treatment is lost or de-prioritised. Clinical practice may develop in order to maintain control rather than through guidance or evidence. It may also lead to treatment that is overly restrictive, punitive, cruel or inhumane. This was described as having a grave impact on patient wellbeing and rehabilitation; therefore, their disempowerment is furthered through oppressive experiences and through longer physical detainment.

There's a point where, if we continue with the <u>othering</u> of our patients, we're going to increase risk. […] But you know, this is wrong. We are othering people. You know, I appreciate that you're trying to keep us all safe. But there's a point to which if we other people so much, they cease to invest in civilisation, and think well I'm not like them. How could I ever have thought I could be like them? I'm not going to be like them. (P1)

In such a disempowered position, where human rights have been systematically neglected if not breached, risk may unfortunately be realised by patients who feel their only access to power and autonomy is through the use of violence towards themselves or others.

They don't have many rights, and I think that when we, we…when people have- get to that point where their rights are…taken away from them, or certainly they feel they are, the only things that they can do is to harm themselves or to harm other people. So the only control- that, that element of control… Yeah, hurt the environment, hurt other people, hurt themselves. Because what else can you…? Y-you can't control. (P8)

3.5. "Do We Know We're Violating? Maybe Not": Human Rights Issues

Participants acknowledged that human rights issues, breaches and violations occur in FIPS, and identified a range of issues. However, they acknowledged their lack of explicit thinking around issues as associated to human rights.

But the little violations…that are not severe and serious, do they happen? Yes. Do we know we're violating? Maybe not. Are we aware? No. Do we know what is human ri-? No. (P4)

"Subtle" or "small" breaches were often mentioned, but it begs the question of whom are they "small" or "subtle" to (particularly as legally there is not a hierarchy of breaches); arguably these types of breaches would be much more apparent to the patients, whom they impact. However, the harmful cumulative effect of these "small" breaches was acknowledged.

But then it's like the small things that one person does. If each person is doing them on a daily basis, it adds up to quite a big thing. (P11)

A range of views were expressed regarding the severity of human rights issues. Some participants felt that gross violations do occur often in FIPS. However, most participants framed human rights issues in terms of lawful infringements under the MHA as opposed to violations. This may indicate that the idea of being involved in human rights violations could be too threatening.

I think…I think rights can be put on hold, if it's justified. But I think that ultimately putting rights on hold…is something that's taken too lightly. (P10)

3.5.1. Detention

Detention was more frequently described as an infringement on human rights as opposed to a breach. Indeed, detention is lawful as long as it is proportionate and finite. However, it was also acknowledged that detention does not simply affect the right to liberty but many other rights as well.

Well… first of all is th- the freedom…you know we- we lock them up, we- we lock them up and we don't throw away the key <u>quite</u> but not far from it. Um, we take away their liberties and we take away…um… everything from them um in a hope that we can support them and rehabilitate and treat and basically prevent further risk and prevent…um…(P2)

Some participants viewed detention as the easiest and cheapest option to manage mental health. Working in a more human rights-supportive way was seen as expensive and hence not as possible in FIPS with its implied underfunding.

So it's if you take somebody's liberty away, or…you restrict somebody's liberty. If you're a mental health person, it solves your problem […] The solution is to monitor him where he goes. Tag him, monitor him or give him one to one support that is expensive. So human rights are quite expensive to observe. So people do the cheapest thing, which is to breach somebody

else's human rights so that it's cheaper for them. And that's the reality of
forensic. (P4)

Using detention as a cheap solution to mental health management was seen as
problematic for many reasons, but particularly because, unlike prison, patients
do not have a determinate sentence in hospital. In fact, many patients are
detained for significantly longer than if they had served a prison sentence.
Therefore, if FIPS are not able to provide the best service, or a follow on
service, due to funding, patients may be detained for longer, and FIPS may be
systemically breaching patients' human rights and MHA rights.

And that can lead to months and months of somebody being detained.
When actually they're mentally stable, there's a risk management plan in
place, but we can't put- we can't <u>enact</u> the plan because there's a stalling
around the financial side. (P6)

Importantly, once in hospital, ongoing detention is largely decided by the
clinicians and this extends to day-to-day interactions and leave restrictions.
Issues around staffing and around paternalistic or punitive attitudes meant that
participants saw unfair leave restrictions as commonplace, despite being
completely against policy and legislation.

And so…What you're doing by giving someone leave is saying you're well
enough to have leave, or we are going to, to try and, and try you out on a,
on a leave, in order for you to gain back some of your independence, and
then some normality, and then when they smoke on the grounds or when
they smoke with a…escort…your leave's then stopped. So…under what
grounds is their leave stopped? What grounds are you locking them in
hospital for…24 hours? Is that- are they detained under the Mental Health
Act? Because…I'm pretty sure the Mental Health Act doesn't say anything
about smoking in it. (P10)

Participants acknowledged that these arbitrary or punitive rules had emerged
out of genuine reasons, around welfare and risk, for leave to be stopped; but
were usually indicative of coercion and punishment.

I know there is times when that is necessary and you have to…relate leave to…taking medication or attending in your…psychology groups. But I have, I have seen it used as people…"If you don't do what I say, you're, I- you're gonna get your leave stopped." (P3)

3.5.2. Private and Family Life

The very nature of detention infringes upon private and family life due to the inherent separation from family and loved ones, and security and monitoring. Risk management can amplify these issues.

Well, you know, the right to family life is the thing that's affected by any- for anybody when they go into prison or come in here. It happens even in general hospital to a little extent, but certainly <u>hugely</u> so here. (P1)

Paternalism was frequently seen an issue regarding private and family life, as it is imbued with personal values, morals and experience. These biases were thought to lead to discrimination and a default assumption of safeguarding issues.

And I think sometimes there can be a bit of a trade-off there between, like you say, duty of care, and actually, is that overly restrictive then? And actually is that then impacting on their ability to form relationships? Erm, and what could we do differently to make…t-to provide the safeguard without breaching? (P7)

Considering safeguarding was undoubtedly also seen as good practice, as long as it was individualised and situation specific. However, it may be reflective of the blanket, security-based approach to monitoring and therefore infringing upon privacy in the name of protection; participants felt that once your privacy is infringed upon in FIPS, this is universal.

And…um… yeah, so there's no privacy at all…across mental health, across anywhere you're detained realistically. The second you…have someone

um…who's…detaining you for any reason…apparently, it just gives
everyone the right to all of your information. (P10)

The area that participants most frequently mentioned was excessive or unnecessary information sharing, representative of a sense that all members of staff are entitled to access to all patient information.

So it's everybody's human right to disclose or not disclose certain bits of
information or what…who knows what, when and why. And with people who
are offenders that's very…Yeah, it doesn't happen. They almost lose that.
Lose the right to that. And I think sometimes as professionals, we just do it
casually without thinking "Is it necessary?" you know. You know, you breach
somebody's human right. And sometimes we overshare over…you know.
And is it necessary that I mentioned that he murdered two people? (P4)

3.5.3. Restrictive Practice

Restrictive clinical practice exists in many forms but was most often described by participants as non-physical coercion, physical restraint – including forced medication – and seclusion. These practices represent an extra layer of detention, power and infringement of patients and their human rights.

It shows actually that, you know, lots [of restraints] have been
unnecessary, really. And then leads to these issues where there's
tension in that moment where, already, once you're already detained,
and then your human rights are further being infringed. (P6)

Participants felt that overly restrictive practice often developed through local rules on wards in order to manage patients and workload. However this suggests these rules are not grounded in policy or evidence, but rather based on staff attitudes and experience. Even when these rules are developed with good intent, they were described as dehumanising. Additionally, conditional rulemaking was seen to escalate into implicit or explicit threat-based coercion, which could easily constitute inhuman and cruel treatment.

And it's often used as a threat, um…implicitly. So, service users who refuse to take oral medication, sort of the words "depot" will be mentioned and they're given, what I'd put in speech marks as a "choice" between taking, you know- they're given some- it's a sense of you've gotta have the medication anyway. So, either you can take it and we'll observe you take it orally, or we're going put-, you know you'll be given the depot and that might be through a restraint. (P6)

This type of coercive medication compliance was justified by participants, and apparently by patients, as helping patients gain "insight" into their mental health and offending behaviour. However, arguably this support is for the effect of medication as opposed to the methods to achieve this; there may be a lack of curiosity or hopelessness as to how this could be achieved in a more humane way.

I think with people when they're unwell, sometimes they don't have the insight. So what they feel, they feel that it's a violation of their human rights, and I don't want to be given this medication, I'm not choosing to but you're forcing me to. […] But that medication has enabled them to reach the point where we can discharge them. So, at that point in time, it seemed like a violation to their human rights, but actually, the intention has been good. And it's enabled that person, to reach a point where they say, I need to take my medication every day keep myself well, because if I don't, this happens, and that happens. (P9)

Participants reported that coercive practice can easily tip over into abuse both stemming from and reinforcing the inherent power inequity in FIPS. Again, this was seen as a way to manage workload and challenging behaviour in the face of lacking guidance, resources and support for staff. Additionally, the gradual nature of coercive practices being implemented and then widely adopted means that they may be more difficult to notice, monitor and address.

Yeah, I think it's a, it's a tricky grey area that, if not checked, can lead to a culture of abuse of people's human rights. And you need to check the culture. And the relation to make sure it's not being done esp-, especially in

seclusion, I hate seclusion. Because it ends up being an easy option. It ends up being a first option. Take somebody's liberties away. Just lock them up, you know […] You know, why do you have 15 unwell people in one environment and only four staff? So the seclusion becomes an extra four staff. (P4)

Often at the point of restraint or seclusion participants felt there may be very few, if any, other options available to staff, making restraints justifiable. However, they felt that the antecedents, including staff contribution to escalation and related human rights infringements, can go unnoticed and unchecked. Thus, the cycle of unnecessary restrictive practice can continue.

Then I'm thinking - and I think this is some of the difficulty in terms of thinking about human rights or what happens - because when you've got to that reactive point, actually some of the actions will be quite reasonable. But has what's happened in the hours, days, weeks, months leading to that incident transpiring, has always been focused, um, with sort of a human rights mentality, with people's dignity being thought about, with good communication…? And I think <u>there</u>, although I don't think we'd <u>eliminate</u> incidents, I think, probably there've been lots of times when, actually, the interactions between service users and staff haven't been of good enough quality. (P6)

As mentioned, there are two main techniques employed in restrictive practice: physical restraint and seclusion. Both are used to contain violence or aggression, including self-harm; and restraint is also used to forcefully administer medication. Again, the rationale underpinning forced medication was the medical model view that medical treatment is more supportive of human rights over time than temporary restraints.

There's also, um…think of, of other women who may r- refuse medication, for example, and would need to receive the depot under restraint… what's, what's, what's likely to occur if this person doesn't receive…medication in terms of their, erm…risk to themselves or others? Erm…versus their choice to receive that treatment. (P7)

Although all participants felt that restraint was a necessary technique in FIPS due to the levels of violence and aggression on the wards, there was recognition that this aggression could be understandable as distress. However, this brings into question the idea of using restraint, a distressing technique, to manage distress. In light of this one participant felt that restraint powers should not be granted under the MHA as this type of treatment contravenes professional ethics, and that it should only be justified to prevent or manage criminal behaviour.

> *I don't think restraint is ever necessary under the Mental Health Act. I think restraint should only ever be necessary under the criminal law act, and therefore, to protect life or limb in the sense that whether or not it's the life of another patient, the life of a nurse, the life of that individual. That's the only time it will be necessary. I've seen restraint used to give medication. Um…I don't think that's necessary […] Using it properly…using force against another person for any reason…is still a human rights issue. It's not that it's not a human rights issue anymore. But it is a human rights issue…It's a human rights violation that had…to be done.* (P10)

The majority of participants expressed concern that restraint in itself is traumatic, being overpowered and held down by several people, and possibly having something forcibly inserted into your body. They noted that restraint can replicate trauma, making it degrading and cruel. Although, some staff had seen forced medication as so ingrained in practice that they had not considered the impact on patients.

> *And this patient had just been restrained, yes they'd been violent. They'd been restrained. He was a male patient, he'd been restrained. And as part of that restraint, his trousers had been pulled down - because the staff will be holding you down - and then he had this bum injected, by a male. He w- by then, he was <u>sobbing</u>. And he said it felt like he'd been raped. And it really struck me that, like what? He's like, "Yeah, I feel like I've been raped with other people looking, holding me down, and not doing anything about it."* (P4)

Similarly, to coercive practice, restraint was seen as a routine, everyday part of a FIPS role and staff can become desensitised to its effects, which may account for some lack of acknowledgement of trauma. However, through experience and monitoring, other de-escalation and aggression-management techniques have been developed.

> *The acute wards can be so frequently…responding to these situations, that it might be second nature to just go straight down that, bull in a china shop route and, will restrain. But equally, they've got so much…experience with it, that they've also picked up all these helpful other ways of dealing with it.* (P9)

However, it was felt by some participants that although these new techniques have been developed to prevent restraint, there is still a lack of training or skill in teams and less confidence in using them, therefore they are not used as frequently as possible, despite the stress they cause everyone involved.

> *Massively, I hate restraining, there's nothing I hate more, um, about the job. Um…but which- that's why I'm always the first one there. Not because I love restraining but because I hate restraining, it's because I want to ensure that it happens…as little as possible. And so yeah, I think, again, it's the training, in the sense that…if…staff felt they had the tools to…de-escalate a situation or…talk to a, a patient about medication in a way that would make them want to take it…then I don't see how anyone could choose to restrain over…just talking, do you know what I mean? It's, it's a lot less physical. It's a lot less stressful for everyone.* (P10)

This highlights a common ambivalence amongst participants: that restrictive practice felt like a necessary and expected part of their role, but it was distressing and misaligned with their personal values. Similarly, seclusion was seen as justifiable and necessary in FIPS in the short term, although concerns were raised around seclusion as a long-term intervention. This use of seclusion adds weight to the argument that restrictive practice is used as another staff

member because there are not sufficient resources to manage the level of risk the patient presents with on a ward.

> *Um…I think <u>if</u> you are removing someone away from situation to stop them from hurting themselves or other people…and it's- as a temporary measure. Erm…I think that I'm probably alright with it, I've never really thought about it. Erm, I <u>don't</u> like the idea of somebody being in…seclusion for…you know as- on an ongoing treatment basis. We had someone erm…in for kind of 11 or 12 weeks.* (P8)

There were also concerns raised about *how* seclusion is managed and practiced. Due to the constant monitoring, isolation – both physical and social – and lack of stimulation, seclusion can be a degrading or cruel experience. The experience may be lacking in dignity and respect, particularly depending on staff attitudes around aggressive behaviour and punishment. However, clinicians did mention positive and supportive practice around seclusion also.

> *Because you know, if you're in seclusion in a medium secure unit, it's it's a pretty…<u>sparse</u> experience, and it could be degrading. But all the time, I hear nurses all the time - particularly the senior ones that I would have a lot of respect for - they bring more dignity into a lot of what they do.* (P1)

Participants sometimes justified seclusion by explaining that some patients request seclusion. Interestingly within this point seclusion was described as a way to make patients feel safe both from causing and suffering harm. However, this can also be viewed as a concern: it may illustrate that the ward environment is so distressing, unmanageable and managed, that the extreme environment of seclusion is seen by patients as preferable and perhaps more supportive of human rights.

> *However, we do have patients who say, "Put me in seclusion", we do have patients who <u>ask</u> to be secluded, and in high secure hospital we have patients who <u>ask</u> to be secluded. So there is something around people knowing that they just need to be made safe.* (P1)

Again, with the acknowledgement of these issues the challenge of working in FIPS was reiterated. For the participants and staff that feel this way it may present the question of why they continue to work in FIPS. Although, arguably, it is better that staff are aware of issues and try to work to prevent human rights issues.

And that's another thing, you know, we medicate and we do all these things- I've got- but that sits really difficult- that's why I think it's an oppressive act. It- it sits really difficult…ly. Difficult. It's difficult…as a social worker, we medicate people against their will. We…detain people against their will. (P8)

A lack of awareness or knowledge of human rights has, and continues to, lead to "incidental" or unintentional rights infringements and breaches. They may be things that staff perceive as small but can have huge impact on patients.

But human rights, I think…the thing with human rights is that it can be so easily overstepped. Without staff realising. You know, sending a letter to a wrong address, sending an email, you know, they're the smaller things, on a smaller scale. (P9)

One example of this was administrative errors, practice errors and delays in processes, particularly between agencies such as FIPS and the MOJ. This was attributed to recent staffing crises, mainly in the MOJ, such that leave and discharge applications were extremely delayed in processing. This had resulted in excessive and unlawful detention, often managed by not sharing this information with the patient to avoid legal repercussions.

There's an…don't know and then I think sometimes people muck up with um…the Mental Health Act stuff as well. I can think of times when- not that often, but you know- I can think of a time when um…a patient was- once or twice I've known it where a patient has been um…you know it's like…basically illegally detained for a day or two because somebody hasn't renewed their section, which I know isn't necessarily…fairly, well it's like an administrative process, but…it's an important process because without that process you are being…illegally detained. (P5)

FIPS were also seen to be affected by inadequate funding. In fact, poor funding was directly linked to increased human rights issues in services and as a barrier to implementing a HRBA. Although the expense of HRBAs is somewhat of a misconception, it may be that this participant view was representative of a service-wide view of HRBAs.

> *Yeah, I think service structures and funding are breaching human rights. And maybe that's why we don't talk about them, you know. So observing human rights is expensive…Do you know, do you know what I mean? It's, it's it is expensive. And the right does not come with money. […] So poorly funded services will abuse human rights more because they have to be able to curtail- I'm talking about, if you're talking about forensic mental health - poorly funded services, they will abuse people human rights.* (P4)

3.6.   "I Think I-, I'm…Confused": Tools and Resources in FIPS

Participants discussed resources that FIPS staff draw on. Mainly they highlighted the MHA, but also informal tools such as personal and work experience and personal value bases, and more formal tools, such as training, policy and academic resources, and team discussion.

3.6.1. Mental Health Act 1983

Participants stressed a lack of clarity or training regarding how to navigate a range of legislations, professional guidelines and ethical obligations, and service specific policy and guidance.

> *I think I-, I'm…confused by different sorts of legislations. Wh- I don't- in the end I don't know what's what anymore. Because…Say for example, if you work in forensics erm…you've worked [with] more than the average type of…conditions or…acts and whatever…who knows… to live to. Partly some are health, majority are not. Yeah? They're to do with the law and offending and MOJ and…some, some things so some of them are to do with areas where are not our special area of expertise.* (P4)

Participants implied that FIPS staff didn't need to know about other legislation than the MHA because it seems that services are only required to know and adhere to the MHA. Participants also suggested that because individuals have rights under the MHA, human rights are seen to be fulfilled.

> *I do wonder if it's…um…sort of understood that it's covered a lot by the Mental Health Act, um, to a degree because we do…um there's a lot of what we do guided by the Mental Health Act. And I think because of that, and because you know the, the staff read the rights when a section is renewed, and I feel like it's- rights. You've got these rights. But they are rights under the Mental Health Act rather than the human rights as such.* (P2)

Even when the HRA and potential breaches are raised by patients, staff can incorrectly counter that the MHA trumps the HRA or seen as less relevant; another indication of the disparity between MHA legislation and practicing under the MHA.

> *I can think of times when service users have said, "You can't do this because of my human rights." And the response has been, "Well actually the Mental Health Act…um, enables us to do this," and then, "Here, have this leaflet that will explain it", or… on the Mental Health Act. Um…which generally states that there's been consideration of, of the Human Rights Act.* (P6)

3.6.2. Resources

Throughout the data staff expressed that, due to a lack of legislative knowledge or clarity, they drew on more informal resources such as work experience and personal values to inform their views of human rights and of humane practice. Perhaps reflective of the necessity for personal value bases and experience to supplement practice was the fact that human rights training was lacking in the service. In fact, the last training that participants recalled was in 2007 around the launch of the Equality and Human Rights Commission (a monitoring body in England and Wales).

Erm…and so how many people have come to work here since I've had that [human rights] training? Dozens. Perhaps more than a hundred. So, you know, they haven't had the training, I think. (P1)

In the absence of formal training in the service, participants thought about whether there were resources in the workplace on human rights, but these seemed to be lacking as well.

It's also the fact that like, I mean…when we look in our office, we have information such as, like - in terms of what pre-qualified psychologists have access to - we have books on how to work with personality disorder, we have mental health practice books, um…and that information's available also on our intranet. But there's not really something that I can go into the office and pick up regarding human rights. So it's interesting that it doesn't seem as accessible either, which gives me the impression that the Mental Health Act is held more highly. (P11)

Participants explained that the explicit absence of human rights resources and training led to there also being very little discussion around human rights in the service. Consequently, participants and other staff have had less opportunity to learn about human rights through experience and from colleagues.

Um…can't think where people really have- I can't think in my mind, which shows the absence, really, of those kinds of conversations where people have talked about, about human rights. (P6)

Some participants suggested that this may be – whether intentionally or not – a protective strategy for the staff and services.

Some people might be scared that they might do it wrong, and then they are breach- some people might be scared that actually if we do discuss this, it's going to show that we are breaching and in itself…that that opens up possibly a can of worms, especially when we start exploring how long we've been breaching for. (P10)

In response to this absence and silence, participants discussed how human rights could be incorporated into practice. Everyone agreed that human rights training would be helpful. Although they felt that it would have to be specific and tailored to FIPS services, due to the unique position they occupy. However, everyone also agreed that just implementing training would not necessarily create a culture shift, and that this would be essential to genuinely working towards human rights fulfilment.

I wouldn't say training, more I would say raising awareness. In a more longitudinal way. And then integrating it into the processes. And that way it has a more chance of a longitudinal survival and that being sustained. And it's not another thing that people do. It's just part of…what they do. (P4)

4. DISCUSSION

In this chapter the analyses are discussed in relation to the study's two main research questions.

- *How do FIPS staff understand human rights, specifically in the context of a FIPS?*
- *What do FIPS staff consider or experience human rights issues to be in FIPS?*

The implications for clinical practice and research are considered, and the limitations and implications of the research are discussed.

4.1. Staff's Understandings and Experiences of Human Rights in FIPS

A number of themes emerged through analysis that are relevant to how staff understood and experienced human rights in FIPS. The main points are inter-connected and to relevant across themes and have been discussed together.

4.1.1. Awareness and Understanding of Human Rights

An overarching feature of the research was a sense of uncertainty regarding human rights in general and as relevant to FIPS. Participants were somewhat surprised by this. There was, however, an awareness of human rights and an understanding that they are relevant and applicable to FIPS. Therefore, this may be more reflective of a lack of complex or specific language seen as necessary to adequately express these ideas. Indeed, participants also cited a lack of professional and service training related to human rights, which could have provided them with this language and technical understanding. This aligns with Barr and colleagues' (2019) research that FIPS staff are not required to have, and often not provided with, any specialist training to work in the forensic field.

Despite this perceived lack of knowledge, all the participants' understandings, although often quite simplistic, echoed healthcare and human rights principles – for example the FREDA principles (e.g. Curtice & Exworthy, 2010) – as opposed to legislation. Participants felt that these principles should be somewhat instinctual in caring professionals and were strengthened – not instilled by – professional training. Several participants described human rights as a legal set of fundamental standards, applicable to all humans. Some participants cited specific human rights legislation and rights relevant to FIPS, such as the rights to liberty and fair trial. Participants also explained their understanding of human rights through reference to some of the key principles, for example dignity and respect. These principles are included in healthcare practice guidelines (e.g. JCPMH, 2013), which is perhaps why they were more familiar than other human rights principles (e.g. Patel, 2019). Interestingly, only one participant highlighted their role as a duty-bearer to uphold and fulfil human rights (Greenhill et al., 2010; Patel, 2019), suggesting that staff in FIPS are unaware of this legal obligation as integral to their role requirements in the NHS.

4.1.2. Practice in FIPS

FIPS are characterised by their dual position in both the healthcare and criminal justice systems, with dual obligations and aims (Livingston et al., 2012; Völlm & Nedopil, 2016).

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4.1.2.1.The dominance of risk: Overall, participants identified risk as the main focus and driving force in FIPS practice and they drew on the MHA to frame their understanding, and confusion, of human rights. It is unclear whether this risk focus was originally influenced by the MHA, or whether it has influenced the application of the MHA in practice, but much has been written about the problematic and archaic use of the MHA, including describing it as being overly risk-focused (DoHSC, 2018; Mental Health Alliance, 2017). Detention and additional restrictions upon liberty were seen as a key tool to manage risk in FIPS, endorsed by the MHA. Thus creating an ethos in which practices in FIPS, including ones that may present human rights issues, can be justified by this overarching task of detention, seen as endorsed by the MHA – reducing risk. Overall, there was a sense that human rights were not considered, discussed or actively protected in FIPS because practice was seen as only needing to adhere to the MHA. Consequently, a system in which human rights are seen as secondary to detention, the MHA and perhaps the CJS, is reinforced and maintained. Indeed, patients had been directed to MHA legislation when raising human rights issues. Whilst technically this assumption is correct given that the MHA must adhere to the HRA, this does not account for poor practice in the application of the MHA. Participants queried the level of power the MHA grants, and confusion was expressed over whether the MHA rights were sufficient in supporting human rights overall. Participants highlighted that risk- and detention-focused practice inherently disempowers patients and can lead to care decisions based on paternalism, moralism and punishment, as opposed to clinical need, (Völlm & Nedopil, 2016), contravening the principles of autonomy and least-restriction. It was also recognised as in contravention with the person-centred guidance for FIPS (JCPMH, 2013).

4.1.2.2.Risk-based care: The largest challenge presented by this position is the tension between treatment and punishment (Glaser, 2009; Ward & Birgden, 2009). Whilst participants initially characterised treatment as a progression towards wellness, they saw the main goal of treating patients was to reduce reoffending and risk. The progression to wellness was partially defined by compliance with forced medication and acceptance of one's conviction. Although in opposition to healthcare ethics and human rights principles, participants justified forced treatment as essential to improve mental wellbeing

and reduce risk, and as minimally harmful in the long term, despite claims of short-term distress. This view of treatment as essential, such that it may need to be forced, was similar to previous research (Bush et al., 2006; Glaser, 2009; Ward & Salmon, 2009). A requirement for staff to balance rights was voiced by most participants, for example, suggesting that they must prioritise the long-term human right of health and wellbeing – using mandated or forced medication – over the short-term right to autonomy and possibly dignity. However, whilst lawfully infringing upon some rights is a key human rights principle (Patel, 2019), the healthcare role is more explicitly about balancing interests, as opposed to rights, made possible via the powers granted by the MHA (Adshead & Davies, 2016; Mental Health Alliance, 2017). The judgement of when an action based on the balancing of rights is legally justified is one which can only be made by the courts.

An alternative interpretation of how participants understood the balance of short- and long-term wellbeing was as the tension between patients' rights and the rights of the public, with patients' rights more frequently being infringed upon (Birgden & Perlin, 2009). Participants shared the understanding that risk management ultimately aims to uphold the right to life, mainly of potential victims (Nedopil, 2016). However, participants also suggested that meaningful therapeutic engagement was hindered by this focus on risk, both due to, and leading to, excessive restriction or detention (Barr et al., 2019). For participants it didn't always seem clear how to distinguish between lawful balance and infringement of rights and excessive restriction. Once deemed risky, the balance was not seen to lean in a patient's favour and some, if not all, of their rights were curtailed.

4.1.2.3. Detention and human rights issues: Human rights issues dominated staff's overall understanding of human rights: instead of seeing them in terms of rights to be upheld, they were thought of in terms of areas for potential or actual breaches that had to be managed. This is consistent with the generally reactive approach to risk management in FIPS (Ward, 2008). "More serious" violations, such as physical abuse, were most easily identified, and it was felt that only extreme and very clear, unlawful human rights breaches, which would also breach MHA legislation, were discussed in the service and in wider society.

Although these "serious" violations were understood as only happening very infrequently in FIPS, despite research to the contrary (e.g. Drew et al., 2011; Gostin, 2008; Hafemeister & Petrila, 1994; Perlin, 2016). Instead, practices which may breach human rights in FIPS were conceptualised as infringements legalised by the MHA and rights forfeited by patients. Due to the legality of some infringements, participants found it difficult to clarify which practices are lawful and which may 'subtly' or 'slightly' breach human rights. This may reflect a lack of engagement with one's practice as potentially harmful, in order to continue practising in such a challenging environment (Harris et al., 2015; Jacob & Holmes, 2011; Jacob et al., 2009).

Restrictive practice was noted as an area of practice in which human rights breaches were more easily identifiable, perhaps because it often involves violence and is experienced as traumatic by participants and their patients (Adshead & Davies, 2016; Kaliski & de Clercq, 2012; Keski-Valkama et al., 2007; Méndez, 2014; Sequeira & Halstead, 2002). The tension between different human rights interests featured heavily in participants' understanding of restrictive practice. In all of its forms (coercion, physical restraint and forced medication, and seclusion) it was seen as a required part of FIPS practice that, however human-rights supportive practice became, could not be eliminated due to the level of risk that patients were perceived to present. This is widely corroborated in prior research, and the balance of long-term wellbeing versus short-term human rights infringement was again used by participants in relation to forced medication (e.g. Völlm & Nedopil, 2016).

Participants also identified restrictive practice as the area of their work most in contravention to human rights and healthcare principles (Barr et al., 2019). These restrictive practices were mostly seen as tipping into abuse when they were allowed to go unmonitored (Valenti & Barrios Flores, 2010), and were perpetuated when and the long- and short- term antecedents were not examined. As one participant said, when the antecedents are rarely examined, earlier opportunities to intervene and prevent violence may not be seen; thus the violent incident is seen as the only point to intervene, and physical restriction is seen as an appropriate, justifiable technique (Hui, 2016; Völlm, 2013). Participants did also feel that even when justifiable, restraint and

seclusion, particularly for the administration of forced medication, were traumatising and degrading experiences for patients (Kaliski & de Clercq, 2012; Keski-Valkama et al., 2007; Sequeira & Halstead, 2002); and participants relayed experiences that had influenced their understanding of this. Although some good practice was highlighted, overwhelmingly participants felt concerned by the regularity with which restraint and seclusion are used as opposed to other de-escalation techniques, and, for seclusion, the excessive length of time the technique is used for. Again, it was felt that these techniques were fuelled by moralism, othering and punitive attitudes (Johnson et al., 2004). Therefore participants appeared to have an uncertain relationship to coercion, threat and conditional rulemaking as, despite most participants citing them as potentially excessively restrictive, abusive and possibly dehumanising, they were also seen as necessary when used correctly.

Participants felt that, more commonly, breaches happened lawfully or "unintentionally", and detention itself was highlighted as presenting issues such as the consequential, yet unconsidered, curtailment of other rights (Trestman, 2014). For example, participants discussed that immediate questions of safeguarding around family and personal relationships amongst patients were frequent, related to assumptions of lacking capacity that were derived from personal judgements of desirable or undesirable relationships. This, apart from being seen as disrespectful, was seen as becoming an excessive expression of power that unlawfully curtailed patients' rights and autonomy. Assumption of lack of capacity may also contravene EA legislation and the tenets of the CRPD (Adshead & Davies, 2016). In addition, an overarching lack of privacy in FIPS, seen in constant monitoring both electronically and by staff, was seen as an excessive infringement on rights. Information sharing was also seen as problematic, which was felt to be unnecessarily detailed, sensationalist and wide reaching. Although participants noted these infringements, there was a sense that the service position, informally, was that admission into FIPS meant any and all of your information was accessible for staff. Again, this can be linked back to risk as justification, and the position of FIPS as between two public authorities who have greatly different policies on information sharing (Adshead & Davies, 2016; McMurran et al., 2012).

Further "unintentional" human rights issues stemmed from human rights being overlooked in both service ethos and everyday practice (Donald, 2012). This included "incidental" breaches: actions outside of patient-staff interactions, such as administrative errors, staffing issues and poor funding (Drew et al., 2011; Porsdam Mann et al., 2016). Administrative errors were raised most frequently, particularly to explain unlawful detention. Funding was directly linked to human rights issues in this study: the more poorly funded the service, the higher the frequency of unnecessary or excessive detention, and the greater the human rights issues. In fact, working in a human rights supportive way was seen as unattainable due to the expense it would require; however previous studies have suggested the economic benefits of a HRBA (Porsdam Mann et al., 2016). Importantly, the impact of these human rights issues was considered, particularly the cumulative effect of "subtle" issues, however this understanding seemed to have had an impact on individual practice and patients only, as opposed to having influenced thinking and practice service wide.

4.1.2.4.Risk and power: Participants highlighted that the service environment, due to prescribed and learned practice, was not supportive of human rights, nor of developing an understanding of human rights for staff or patients. The perceived lack of human rights consideration in the service correlated with often-held discriminatory views of patients (Hirschfield & Piquero, 2010; Jacob & Holmes, 2011), despite also holding in mind their vulnerability, and therefore additional need for human rights support. This discrimination in itself is disempowering and spoke to the greatest perceived power imbalance in FIPS, that between staff and patients (Rose et al., 2011). Staff mentioned becoming desensitised to the power imbalance, perpetuating discriminatory attitudes and directly and indirectly impacting care and treatment negatively (Rao et al., 2009; West et al., 2014). This can be seen in 'best interests' decisions in regard to forced treatment, where treatment is administered despite patients explicitly raising this as a human rights issue; staff's understanding of human rights (as secondary to the MHA) is prioritised. This contributed further to a sense of human rights as inaccessible through the uncertainty of whether patients are entitled to rights in FIPS and when the infringements upon their rights may end. Staff also queried their own entitlement to human rights at work and felt there was a lack of consideration of their rights in FIPS. Participants outlined a

service culture and expectation that in taking a job in FIPS staff were aware of the aggressive environment and associated risks, and therefore that staff paused their rights whilst at work. Staff cited verbal and physical aggression (Dickens et al., 2013), discrimination, and service-imposed restrictions on personal freedoms. Therefore, this compounded staff's understanding of human rights as 'on hold', not relevant or not considered, and risk management as paramount task in FIPS for both patients and staff.

4.1.2.5.Variance in practice: There was some variation amongst how participants understood human rights and how they were applied, and a large perceived variation amongst the wider service. Generally, the understanding and application of human rights across the service was conceptualised in relation to patient contact, with ward-based staff at one end, such as nurses and HCAs, and non-patient facing staff at the other, such as security staff. It was felt that both groups at the extremes were less likely to consider patients' human rights and the implications of their practice on these rights and were more likely to focus on risk management. Participants felt that ward-based staff had little space to consider human rights due to the frequently aggressive environment of the wards and resultant, almost automatic, restrictive practice in response (Barr et al., 2019; Hui, 2016; Nedopil, 2016) in order to manage immediate risk; the aggression and restrictive practice were seen as interdependent and cyclical. This was seen to be compounded by a lack of training on human rights principles and obligations, meaning personal biases regarding offences and behaviour dominated decision-making and ward-based staff's understanding of human rights. For non-client facing staff, such as security, their lack of clinical experience, healthcare training, and service-level risk focus were seen as impeding their understanding of human rights. It was implied that their lack of contact with patients led to them holding discriminatory and moralistic views similar to general societal views that offenders are not entitled to rehabilitative care and thus human rights (Livingston et al., 2012; Perlin, 2016). Clinicians in the middle of the spectrum, as many of the participants were, were seen as having enough patient contact to hold patients in mind when decision-making, but enough distance to consider contextual factors such as antecedents to aggression, making them less risk-focused and more able to consider human rights principles in practice. Overall, although all participants acknowledged that

patients are entitled to human rights, in practice 'human rights' was seen as a position and responsibility held by social workers and responsible clinicians, rather than as applicable, and maybe accessible, to all staff in their practice.

In response to this confusion participants relied on personal and work experience, personal value bases and team discussion, where available, as training and formal human rights resources were noted as absent in their service. As discussed throughout, personal attitudes to patients, treatment and punishment negatively influenced understandings of human rights and subsequent practice. This supports research that found staff detached from or modified their personal values and othered patients in order to manage the requirements of their roles (for example restraint) in FIPS (Johnson et al., 2004). This idea of modification also matches participants' views that all staff members had a baseline of wanting to care for patients, but this was tainted by the realities of the role and service environment. All participants expressed a desire to learn more about human rights and emphasised the need for specific guidance for FIPS practice and practitioners. They felt that this would help provide staff with skills and give them the confidence to work within a HRBA. This echoes research that found that forensic mental health nurses felt ill-equipped, deskilled and lacking guidance in their FIPS work (Barr et al., 2019). Participants felt that with a better understanding of human rights and a tailored skillset, human rights could be better supported, and human rights issues would decrease. In addition, a HRBA could improve staff stress and burnout, excessive risk focus and staff-patient engagement (SHRC, 2009).

4.2.   Limitations of the Research

As with all research, there are methodological limitations of this study and ethical considerations. Some of these have already been discussed in Chapter 2, although through data collection, analysis and further reflection more concerns and considerations have appeared.

4.2.1. Sample Limitations
The participants were self-selected. This resulted in a range of disciplines and qualification levels amongst participants. Overall, social workers were

(marginally) over-represented and there were no participants from the wider range of staff represented in FIPS, including administrative staff, security staff and healthcare assistants. The sample size was also fairly small, limiting the scope of the study. The inclusion of more interviews with participants from more disciplines would have provided a broader dataset. In particular, staff positioning regarding distance from ward-based work featured heavily in the dataset, with the suggestion that the roles at the two extremes of this spectrum – full time ward-based working and no ward-based working at all – were the least likely to consider the impact of their practice on patients and thus their human rights. However, these roles were underrepresented in the dataset and therefore their understandings of human rights cannot be fairly speculated upon. Additionally, as participants elected to be interviewed, the data may represent the views of staff who were already thinking about human rights and their relevance in FIPS, and not necessarily representative of staff in the service. The self-elected nature of participants was largely a result of pragmatic decisions made about recruitment, which was challenging due to the high-pressure environment of FIPS. Taking a critical realist stance, I acknowledge that this data can only ever be considered within an individual-, service- and research-specific context. Therefore, this study is seen as a contribution towards a better understanding of how staff in FIPS view and experience human rights at work.

4.2.2. Interview Schedule and Process

Overall the interview process felt participant-led and collaborative; however, I did have some concerns about the language used in the interview schedule and the spoken modifications I made to mitigate this. It may have helped to prepare participants better by discussing the exploratory nature of the research more. This highlighted an issue with drafting all the questions: ensuring that relevant topics were covered without leading participants. For example, when explicitly asking about detention via the MHA and CJS, I felt concerned about leading the participants towards expressing a certain viewpoint. In order to attempt to mitigate this, I did frequently mention that whether or not human rights were affected, or whether or not they had experience of human rights issues in FIPS, all answers were valid and welcomed. Ultimately, as mentioned when discussing the critical realist stance of this research, this study cannot be free

from my own personal context and, although I did not mention my work experience in FIPS before the interviews, the simple choice of research topic will have conveyed something of my stance on the topic. In turn, this may have influenced participants, who themselves will have had some interest or curiosity in the topic to take part. In hindsight, I could have mitigated some of these concerns by completing a pilot run of the interview schedule and adapting it accordingly, and would do so in future research. Another contextual factor that should be considered is the interview location; namely that participants were interviewed at work whilst discussing possibly contentious practice from their workplace. Although the conversations overall felt very open, curious and non-blaming, this may have made some participants reluctant to openly discuss their understanding of human rights.

4.3.   Quality of the Research (Yardley, 2008)

Unlike quantitative research, there are no established, universal standards for qualitative research, although suggestions have been made regarding coherence, transparency, rigour and impact (Yardley, 2008).

Coherence refers to sensitivity of both the micro- and macro-level themes in the text. This was achieved by considering the allusions that participants made in the data. Through supervision and checking codes during the analytic process I was able to consider what other understandings might be within the data without straying from what participants had explicitly expressed. Transparency and rigour ensure that research is contextualised. In this research I have taken a critical realist stance which embodies this transparency, and I have attempted to fulfil this through reflections upon my positioning towards the topic and the research. The rigour of this research is mainly demonstrated through my in-depth engagement with the topic which has allowed me to interpret the dataset with some understanding of the service and legal context. The impact of this research could be seen as starting with the interviews. Analysing each transcription highlighted the shift in confidence in talking about human rights and in each participants' own understanding. Therefore, the interviews may have formed the start of a reflective process for participants. As requested,

some basic information on human rights and literature relevant to the study was sent to participants following the interviews, hopefully supporting this process.

4.4.   Implications for Clinical Practice

The implications of this study are numerous and multi-level. The key implications are summarised below, with a particular focus on clinical practice including training, professional and service-level implications.

4.4.1. Training

The lack of training and education regarding human rights was highlighted by all participants. Indeed, to ensure that individuals and services are fulfilling their human rights responsibilities as duty-bearers and understand and apply human rights principles (e.g. Patel, 2019), individuals and services must have clearer guidance as to these responsibilities. Crucially, this must be tailored specifically to FIPS, possibly even at each service level, to ensure all the legislation and policy are considered and the interactions clarified and understood. As in previous successful HRBA trainings, staff and patient collaboration would be important in the design and dissemination stages and to encourage a non-blaming, participatory and inclusive training content and approach (SHRC, 2009).

4.4.2. Psychology and FIPS Professionals

The implications for professionals are wide-ranging, as each professional is a duty-bearer in the service. Through service training FIPS professionals would be provided with the skills to work in a more human rights-supportive manner, but implementing this into practice can only be done by the professionals themselves. This would also result in practice that is aligned with professional values, reducing distress in deciding how to balance rights and avoid rights breaches. Clearly HRBAs are applicable outside of FIPS also, and it would be beneficial for human rights to be included in all healthcare training, as it is in professional social care training. Specifically, human rights should be a focus for psychologists in training and in practice. Many participants assumed that psychologists were knowledgeable and considerate of human rights in their practice; yet it is not mandatory in clinical psychology training. Considering the

distress, trauma and negative effects on emotional wellbeing human rights breaches have, psychologists have an ethical duty to understand human rights and practise with a human rights-based approach, with particular emphasis on the operations of power (Patel, 2020). As senior members of services they also have a responsibility to champion this approach and disseminate an understanding of human rights and human rights issues, with attention to both patient and staff human rights. This is particularly crucial in detention settings which present particularly barriers to the fulfilment of human rights and mental wellbeing. The skills that psychologists possess and the requirement of their roles offer many opportunities for this, for example facilitating rights-focused reflective spaces for staff, teams and patients, and using their positions and knowledge to influence service culture and policy.

4.4.3. Services and Policy

In light of evidence supporting the implementation of a HRBA to forensic mental healthcare (SHFC, 2009), a HRBA has been shown to be beneficial not just at a staff and patient level, but also at a culture and service level ref. This study has highlighted multiple and frequent human rights issues which arise in FIPS, and many of these issues may be relevant to other mental health services and require attention to improve practice. As suggested by many participants, human rights training and training around other legislation relevant to FIPS should be mandatory and regularly updated, and related resources should be readily available in all services. In order to effect an organisational cultural change, human rights principles should be integrated into policy and guidance and some form of monitoring should be implemented.

4.4.4. Future Research

This study has contributed to a body of work initiated by Patel (2016) but differs in that this study has only investigated one group's – staff's – understandings of human rights. Therefore in order to develop a broader perspective, patients and carers could be interviewed also. In order to investigate the issues in more depth, further research could investigate specific areas raised in this study. For example, further investigation into how staff balance human rights, with particular attention to the use of the MHA in this, could help clarify the dilemmas and uncertainties that staff face and the implications, practically and

emotionally, for their practice. More practically, an extension of the SHRC's study of implementing a HRBA in a FIPS could look at results longitudinally. This would be essential in understanding the practical challenges of establishing and maintaining a HRBA in FIPS and the implications of this on culture over time.

4.5. Reflexivity

The opportunity to undertake research encompassing the topics of offending, mental health and human rights felt like a culmination of the three mains part of my psychological work experience thus far; my past present and, hopefully, future. They are all topics that I feel very passionately about and my excitement at this research was also tinged with worry and the desire to do the research and its participants justice. By that, I mean fairly representing FIPS staff as doing extremely challenging work to the best of their ability with the resources available, whilst also highlighting any barriers to them achieving this, and therefore achieving the best outcomes for patients. Through highlighting this I wanted to contribute to a change in these challenged services and in the lives of the people they treat. I also wanted to do 'right' by my supervisor, by contributing a strong piece of research worthy of sitting alongside a body of work that I admire. This desire to stoke progress in FIPS in particular is likely rooted in guilt at my own relative ignorance working in these services as an assistant psychologist; when I felt that things weren't right but also feeling that I did not have the knowledge, experience or authority to challenge this. Learning about human rights in clinical psychology, I felt hopeful that things can change.

One of my main concerns was avoiding bias in this research. As mentioned, and is probably clear, my experience in FIPS has been the most significant influence on this study. That experience involved directly and indirectly witnessing a lot of pain, most often enacted through gross power imbalances past and present. Learning of patients' stories and then seeing the same disempowerment being re-enacted in hospital was confusing, infuriating and frustrating – and made me constantly question how disheartening and frightening it must be for patients. Due to this I also wanted to ensure that patients' voices were held in mind, since they were not interviewed. So,

maintaining an impartial stance during interviews was difficult, particularly as participants often recalled thoughts and experiences similar to my own, and I had to resist the urge to build rapport through shared experience.

I considered my position during interviews as a pre-qualified psychologist: my power in and between each interview varied greatly. Between interviews I had greater and fewer qualifications, was older or younger, was paid more or less, and was more or less knowledgeable about FIPS or about human rights, and so on. Within interviews I was more often than not in the expert position, sometimes seen as testing knowledge, sometimes as collaboratively thinking with participants, sometimes inexperienced, perhaps sometimes seen as full of expectation. Occupying these different positions highlighted the dominance of hierarchy in FIPS, and perhaps in wider services and society, and has made me confront how I want to occupy space. As a clinical psychologist, but also personally, I am drawn to wanting to be more consistent in this, and perhaps in myself. I am then, maybe illustratively, drawn to counter and question this notion. My sense is that for me this is born of clinical training in the critical, curious, flexible approach I have felt I needed to take, and the actual pace of change.

I hope that a sense of curiosity and openness was felt by participants, and I hope this has imbued the whole research process, although I was mindful once more of how my bias may creep into analysis and this discussion. In adopting a critical realist stance, which is also in keeping with my own values and world view, I have tried to interrogate my position throughout the research process and in writing to provide a sense of my own context. I hope to achieve this because without validity this research cannot contribute to greater change.

4.6.   Conclusions

This research was devised following a notion, and subsequent findings, that human rights issues are entrenched in inpatient psychiatric services, and in particular FIPS; and in the desire to start understanding why and how. In seeking staff's views of human rights in FIPS, a paradox of practice was revealed that was considered harmful, degrading, discriminatory and punitive,

and yet the majority of this was lawful. Whilst this was mostly attributed to confusion over legislation and excessive use of powers of the MHA, it highlighted a wider culture of overlooking and not-knowing human rights. Inevitably, through investigating the perspectives of staff, this study can only give a partial picture, and patients' and carers' views would be invaluable to build a richer understanding of the issue. However, this study has highlighted the complexity of care in FIPS and the desperate need for services that protect, support and fulfil the human rights of both its patients and staff.

Service changes require more than the enthusiasm of the few and in order for these changes to follow, a multi-level approach must be taken. Organisational training, resources, policy and practice must be altered; staff's understanding and awareness of human rights, specifically in relation to FIPS and the MHA, must be improved; and human rights advocacy and information must also be effectively offered to patients and carers. Thus, this study aims to contribute to the improved, tailored understanding and awareness of human rights, applicable to everyone involved in FIPS; and consequently the improvement of forensic mental health services.

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6. APPENDICES

6.1. Appendix A – Glossary of Acronyms

CJS	**Criminal Justice System**
CRPD	**Convention on the Rights of Disabled Persons**
EA	**Equality Act 2010**
ECHR	**European Convention on Human Rights [NB not European Court of Human Rights]**
EHRC	**Equality and Human Rights Commission**
FIPS	**Forensic Inpatient Psychiatric Services**
FREDA	**Fairness, Respect, Equality, Dignity, Autonomy [principles underlying a HRBA]**
HRA	**Human Rights Act 1998**
HRBA	**Human Rights-Based Approach(es)**
MCA	**Mental Capacity Act 2005**
MDT	**Multidisciplinary Team**
MHA	**Mental Health Act 1983**
MOJ	**Ministry of Justice**
NHS	**National Health Service**
PANEL	**Participation, Accountability, Non-discrimination, Empowerment, Legality [principles underlying a HRBA]**
UDHR	**Universal Declaration on Human Rights**
UN	**United Nations**

6.2. Appendix B – Recruitment Advert

UEL University of East London   [Trust Logo]

UNDERSTANDING HUMAN RIGHTS IN FORENSIC INPATIENT PSYCHIATRIC SERVICES

How do staff working in a medium secure psychiatric hospital understand Human Rights in their service?

Forensic psychiatric services provide care for some of the most vulnerable and distressed people in acute stages of mental health difficulties, whilst also aiming to keep service users, staff and the public safe. However, the locked environment and forensic nature of these services can also risk breaching the Human Rights of service users, carers and staff.

We want to understand more about Human Rights in forensic psychiatric services from the people who work there.

This study aims to understand staff's perspectives on Human Rights in forensic psychiatric services. What do you understand as Human Rights? Do you think there are Human Rights issues in these services? Which issues affect staff? How could issues be improved?

Who can take part?
We would like to hear from all members of staff at all levels who have worked in forensic services for at least 6 months: Nurses, Psychologists, Psychiatrists, Health Care Assistants, Occupational Therapists, Social Workers, Physiotherapists, Drug and Alcohol Workers, Doctors, Pharmacists, Psychotherapists, Sports and Fitness Practitioners

What will taking part involve?
Participants will be asked to take part in a one to one interview lasting 45-60 minutes, in a private room on [The Hospital] site.

Contact
If you would like more information and/or would like to take part in the study, please contact Lucy on u1725742@uel.ac.uk

6.3. Appendix C – Participant Information Sheet

Participant Information Sheet
Understanding Human Rights in Forensic Psychiatric Services:
Staff perceptions of human rights issues in an inpatient forensic psychiatric service.

Invitation
We'd like to invite you to take part in our research study; joining the study is entirely up to you. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through this information sheet with you, to help you decide whether or not you would like to take part and answer any questions you may have. We'd suggest this should take about 10 minutes. Please feel free to talk to others about the study if you wish.

The first part of the Participant Information Sheet tells you the purpose of the study and what will happen to you if you take part.

Then we give you more detailed information about the conduct of the study.

Do ask if anything is unclear

Summary
The Universal Declaration of Human Rights states that human rights are held by every human being. They safeguard individuals and communities to enable them to live a life free from discrimination and torture in order that they may pursue their goals freely (UN General Assembly, 1948). NHS trusts, in line with their obligation as a public body to respect human rights, have strategies in place to promote human rights-based practice.

Forensic inpatient psychiatric services provide care for some of the most vulnerable and distressed people in acute stages of mental health problems, who often present with very challenging behaviour. However, these services, by virtue of the secure or locked environment required for the provision of safe, therapeutic management and treatment, and the nature of patients' health and vulnerability, can be understood as giving rise to risks to breaches of particular rights of the patient, carers and staff. For example, rights at particular risk of breaches in such services include: the right to liberty; the right to be free from cruel, inhumane or degrading treatment or punishment where treatment and care may also amount to torture in some situations; the right to privacy; and the right to family life.

In order to move towards a human rights-based approach in forensic psychiatric services, greater insight into human rights understanding and why violations of both staff and service users' rights occur is essential. The proposed research will use individual interviews to explore how multidisciplinary staff from a forensic psychiatric service understand human rights, which issues they think are most relevant to their work, and what they may have experienced as human rights issues at work.

Any member of staff who has worked at the forensic psychiatric inpatient service for 6 months or more may take part in the study.

Participants will be asked to take part in one individual, anonymous interview lasting approximately one hour. All interviews will be conducted in a private room on-site at the participating service. After this interview staff will not be contacted again, unless they have requested to receive the results of the study. The study aims to interview between 12 participants over the course of approximately two months.

Study background
This study aims to work towards a human rights-based approach to mental healthcare provision by investigating how staff in forensic inpatient psychiatric services understand human rights, which rights they see as most relevant to these services, and what they have experienced as human rights issues in these services.

This study forms part of a larger portfolio of work led by Professor Nimisha Patel. Thus far, Patel (2016) has conducted research into developing a human rights-based approach in psychiatric intensive care units (PICUs). Initially interviews to explore staff, service users and carer understandings and experiences of human rights issues were conducted, followed by the development of a monitoring tool and provision of a learning programme. Prior to this, little research has explored the experience of human rights issues of those involved with mental healthcare. The proposed research would be an extension of this work in a new setting, limited to the first phase of the research and with one group of participants, due to time constraints.

Although some research has been conducted into human rights violations in forensic services, including forensic psychiatric services, little research has explored a human rights-based approach to working with offenders (Ward, 2008). No research has focused on the experiences and understandings of human rights issues in forensic psychiatric services, nor with a focus on staff experience and understanding in this context. Gaining this insight is essential in developing a human rights-based approach towards care provision in forensic psychiatric services and would contribute to understanding overarching themes in implementing this approach across mental healthcare settings.

Therefore, as a staff member in a forensic inpatient psychiatric service, your participation in this study would help to further our overall understanding of human rights and associated issues in mental healthcare, and particularly how this affects staff in forensic mental healthcare.

Taking part
Participation in this research is open to all members of staff who have worked in forensic inpatient psychiatric services for approximately 6 months or more. We would like to recruit between 10 and 15 participants over approximately 2 months.

Participation would involve taking part in one individual interview with the Chief Investigator. You will also need to meet with the Chief Investigator to go through the Participant Information Sheet and Consent Form. The interview will be held in a private room at the service and will last for approximately one hour; the Chief Investigator will

ask for your consent to take part in the study prior to the interview. The interview will be recorded so that themes from the interviews can be analysed, however no personal data will be collected and any identifying features in the data will be completely anonymised before use in the research. Although the report will be shared with the service once completed, no data will be passed back to the service, including negative feedback from participants that may have emerged during the interview, and any identifying features will not be included in the report. If you no longer wish to take part in the study your data would be removed and destroyed immediately.

Possible benefits or disadvantages of taking part
Participants may benefit from taking part in the research by reflecting on or expanding their understanding of human rights and how they are relevant to their day-to-day and long-term practice. Participants may also indirectly benefit as this research aims to contribute to services (including their own) working towards a human rights-based approach to service provision, including ensuring that the rights of staff are upheld.

Participants will not be paid or otherwise compensated for taking part in this study.

Participants are unlikely to experience disadvantages or risks to taking part in this research. It is possible that, after reflecting on the relevance of human rights in their service, participants may be more aware of rights violations that may occur, which may cause distress. However, this positions participants to highlight these violations and help their service, team and individual practice work towards a human rights-based approach. As aforementioned, data collected during the research will be completely confidential and in no way passed back to individual colleagues or the service itself.

Further supporting information and FAQs

My personal data
We will need to use information from you for this research project. This information will include your name and contact details. This information will only be used to arrange and meet for your participation in the research. People who do not need to know who you are will not be able to see your name or contact details. We will keep all information about you safe and secure.

Once your interview/participation is complete this information will be deleted, and your interview data will have a code number instead, should you wish to withdraw your data at a later date. People will use this information to do the research or to check your records to make sure that the research is being done properly.

What if something goes wrong?
If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions (u1725742@uel.ac.uk). If you remain unhappy and wish to complain formally, you can do this by contacting University of East London's Research Integrity and Ethics Manager, Catherine Hitchens (c.hitchens@uel.ac.uk) and/or Dr Carlos De Luna, Head of the Graduate School (c.deluna@uel.ac.uk).

What will happen if I don't want to carry on with the study?

Your decision to take part in the study is completely voluntary and you can change your mind about participating in the study at any time. You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.

If you choose to withdraw from the study there will be no adverse consequences.

How will my information be kept confidential?
You will not be named or identified in the data, but the data will still be anonymised by removing any identifying features. For example, if you were to provide an example of an experience at work, any names mentioned inadvertently (of staff, clients or carers) or identifying features (e.g. a specific language spoken or a specific diagnosis) would be removed or anonymised at the point of transcription. We will write our report in a way that no one can work out that you took part in the study.

During the study the audio files will be transcribed and anonymised by the Chief Investigator. All audio files and transcriptions will be stored electronically in an encrypted cloud service provided by University of East London. Once we have finished the study, we will keep some of the data so we can check the results. After the study is completed, audio recordings will be immediately deleted; anonymised transcriptions will be deleted after three years.

What will happen to the results of this study?
The results of this study will be used in a doctoral thesis, which will be submitted to an assessment panel at the University of East London. It is possible that the findings of the study will be presented to participants and wider staff teams at your service.

Who is organising and funding this study?
The Chief Investigator is organising this study as part of their thesis for the doctoral research at the University of East London; the study is not being funded.

How have patients and the public been involved in this study?
This study is part of a portfolio of research into the understanding of human rights in different mental health settings, and feedback has been taken from staff, service users and carers in a range of mental health settings.

Who has reviewed this study?
All research in the NHS is looked at by an independent group of people to protect your interests. This study has been assessed by the Health Regulatory Authority.

Further information and contact details
General information about research
Further information about research at the University of East London can be found at https://www.uel.ac.uk/research and https://www.uel.ac.uk/about/about-uel/governance/policies-regulations-corporate-documents/research-policies.

Further information about research in the NHS, including data transparency, can be found at https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research/ or by contacting the Chief Investigator.

Specific information about this research study

For further information about this research study, please contact Lucy Rands, Chief Investigator, on u1725742@uel.ac.uk.

What to expect during the consent process

You will meet with the Chief Investigator prior to your interview to go through the participant information sheet, which is also an opportunity for you to discuss any queries or concerns with the Chief Investigator. You will then be asked to sign a consent form if you wish to proceed with the study.

6.4. Appendix D – Consent Form

Consent Form
Understanding Human Rights in Forensic Psychiatric Services:
Staff perceptions of human rights issues in an inpatient forensic psychiatric service.

Please tick as appropriate:

	YES	NO
I confirm that I have read the information sheet dated 16th September 2019 (Version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.		
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. I understand that my data can be withdrawn up to the point of data analysis and that after this point it may not be possible.		
I understand that my involvement in this study, and particular data from this research, will remain strictly confidential as far as possible. Only the researchers involved in the study will have access to the data.		
I give permission for the information collected about me to be used to support other research in the future and may be shared anonymously with other researchers.		
I understand that anonymized quotes may be used in publications.		
It has been explained to me what will happen once the programme has been completed.		
I have independently consented to participate in this study and I do not require a witness due to visual impairment, difficulty in reading or writing, or any other difficulty which might inhibit my ability to consent independently.		
Site Copy ☐ Participant Copy ☐		

Signed by (participant):_____

Signed by (Chief Investigator):_____

Date:

Research conducted by:
Lucy Rands (u1725742@uel.ac.uk)
University of East London

6.5. Appendix E – Interview Schedule

Staff Understandings of Human Rights in Forensic Inpatient Psychiatric Services

The interviews will be semi-structured, therefore the below provides a guide as to areas that could be discussed during interview. The participants' responses will determine how the interview unfolds.

Introductions and Engagement
Discuss consent, confidentiality (including risk), and the right to withdraw from the study at any time; discuss the approximate length and format of the interview. Ask if participant has any questions before starting.

Questions
1. What profession did you train in (are you training in), if any?
2. Approximately how long have you worked in this service?
3. Have you previously worked in forensic, mental health, or forensic mental health services? If so, for approximately how long?
4. Today we are talking about human rights, have you had any training, workshops or meetings at/through work about human rights? (Fine if not.)
5. Starting off broadly, can you tell me what your understanding of human rights is?
6. Can you tell me about how you came to that understanding?
7. What is you understanding of human rights violations?
8. Which human rights do you think are most relevant to forensic psychiatric services and why?
9. Do you think an individual's human rights are affected when they are detained either through the Mental Health Act 1983 or the Criminal Justice System?
10. If yes, how?
11. Do you think that human rights violations occur forensic psychiatric services?
12. If so, what kinds of violations might these be?
13. Do you think your understanding of human rights and, in particular, how they relate to forensic psychiatric services, is similar to that of your service?
14. Have you had experiences at work that you feel are human rights issues?
15. Whether yes or no, how do you feel this has affected your practice?
16. If necessary, what could improve human rights understanding? Training?
17. Is there anything else you would like to share?

6.6. Appendix F – Transcription Key

Symbol	Meaning
…	Participant paused, approximately 5 seconds
.,	Short pauses in speech
Example-	Participant cutting off speech and starting a different sentence or idea
Example – example interjection –	Participant interjecting in their own speech, then returning to their original point
( )	Laughing or non-verbal activity
<u>Underlined</u>	Participant emphasis on a word
[*italicised*]	Word removed or replaced for confidentiality, e.g. name of hospital
[non-italicised]	Interviewer speaking during participant's speech; participant speaking during interviewer's speech
""	Denotes the participant referring to the speech or thought of another person or themselves
P1, P2 etc.	Participant identification number
CI	Chief investigator/interviewer

6.7. Appendix G – Coded Transcript Excerpt

431	CI: Yeah. I see what you mean.		
432		HRs based practice is expensive	
433	P: So the solution to observing people's human rights is an	Services do not give money to HRs	
434	expensive one. And there's never an investment in human	Expensive especially in forensic	Because harder to do? Have to fight punitive/moralistic care? Too many changes to make?
435	rights in, in <u>monetary</u> terms. It's, it's, it's you should respect		
436	human rights but respecting people's human rights is		
437	expensive in the forensic world, you know. I have i- In my		
438	previous job, I was working with people with learning	Solution to offending is restriction/removal of liberty.	
439	disabilities and autism. And what they do is if they offend,		
440	they're given a boundary, yeah? They're told, "You can't go		
441	here. You can't go there." And I had one guy who was	Sometimes restriction so extreme and not thought about at all.	
442	literally left with two streets. You know, surrounding his		
443	house. [Yeah, yeah.] So they're restricting his freedom, right?	Monitoring instead of restriction.	Just a lesser form of restriction?
444	The solution is to monitor him where he goes. Tag him,		
445	monitor him or give him one to one support that is	1:1 monitoring expensive/resource-heavy	
446	expensive. So human rights are quite expensive to observe.		
447	So people do the cheapest thing, which is to breach	Breaching HRs is cheaper	Because no (successful) litigation in forensics?
448	somebody else's human rights so that it's cheaper for them.		
449	And that's the reality of forensic. We use er…what, section	Breaches committed due to staff/service resources.	
450	17 leave, what is it an hour? [Yeah.] it's an hour because…[of		
451	staffing.] Yeah.		
452			
453	CI: So do you think that actually the service structures, not-		
454	thinking I suppose just about forensic services, but possibly		
455	the wider NHS - do you think that the service structures and		
456	funding, I suppose, are breaching human rights?		
457		Service structures breach HRS.	
458	P: Yeah. Yeah, I think they are. And maybe that's why we		
459	don't talk about them, you know. So observing human rights	HRs not funded, so breached, so not spoken about.	
460	is expensive…[Yeah.] Do you know, do you know what I		
461	mean? It's, it's it <u>is</u> expensive. And the right does not come		
462	with money. [That's true. Yeah.] *laughing*.		
463			
464	CI: So, so there's a balance.		
465		Another balance of budget/resources and HRs.	
466	P: So there's a balance or, you know…so it's people who		
467	balance the right with their budgetary income, and those	Less funding = more HRs abuses.	
468	that are so- you um – I don't know whether I'm right or not.		
469	I'm saying poorly funded services will abuse human rights		
470	more.		
471			
472	CI: Okay. Yeah, I'm not sure it's, it's an interesting…theory		
473	isn't it?		
474		If forensic MH service has less funding, still have same goals, so restrict to meet those targets.	
475	P: Yeah. So poorly funded services will abuse human rights		
476	more because they have to be able to curtail- I'm talking		
477	about, if you're talking about forensic mental health - poorly	Less funding = more HRs abuses	
478	funded services, they will abuse people human rights. People		
479	will have less choice…about what they do, they can't choose,		
480	everything will be restricted. So there is a cost element if	Cost may be more influential than risk re: HRs breaches.	
481	you're talking about, you know, why human rights are abus-		
482	there is a cost more than a risk – yes I did talk about risk, it's		
483	about managing risk. But I think as well, there is a cost	Money directly affects HRBA	
484	element to why we don't observe people's human rights.		

[CONTINUED ON NEXT PAGE]

485	CI: And just thinking, again, about balance, I suppose, and		
486	thinking about the Mental Health Act. I mean, we talked		
487	again at the beginning a little bit about balancing these		
488	different legislations. So, we've got the Mental Health Act		
489	and the criminal justice system predominantly, and then		
490	human rights. I mean, how do you think human rights are		
491	affected by being detained under the mental health act		
492	and/or by the criminal justice system?		
493			
494	P: Well, I think it is taking someone's liberties away, isn't it?	MHA/CJS take away HRs through detention.	
495	And…so you are taking someone's human rights. Yes I agree	Detention can be	
496	it's necessary all the time. But are we robust in the checking	necessary initially.	
497	systems of making sure that…at the earliest opportunity and	Once under MHA, practice is not checked, and	
498	the least restrictive Mental Health Act- action is put? I don't	restriction not monitored.	
499	think so. So I think the intention is correct. But is the	Initial intention good but	
500	investment enough in the checks and balances of…clearly	checks not in place to	
501	I've kept people on section three just to be sure. [Okay.	ensure maximum freedom.	
502	Yeah.] Let's just renew it so that we show he's stable. That's	Clinical opinion allows for leeway	
503	not what the mental health act's for, now we're breaching.	Clinicians have to be sure,	
504	So if you ask professionals, realistically… "do you take people	which may be overly	
505	off their section at the earliest opportunity when they don't	restrictive.	
506	need it?" The answer is no. It's kept on for other		
507	administrative reasons. Is there a bed available? No. So let's	People also restricted due to admin – beds, tribunal	
508	keep them on section three. When's the tribunal? It's been	dates.	
509	postponed, so let's renew it until the tribunal. So the checks		
510	and balances…In terms of the MOJ aspect I'd certainly say	Good that people can be	
511	<u>that's</u> helpful, in that…rather than going through the criminal	sent to hospital after offence to receive	
512	justice system, somebody is given the treatment that they	treatment.	
513	need. Er…But sometimes what you find is um…I've had cases		
514	where somebody did a crime…And the offence probably	Going to hospital can mean you serve longer	
515	would have got them a two-year sentence, had they gone to	than your prison sentence.	
516	prison. But because they've gone through the health system,		Is that fair? Is perceived
517	they're still in the medium secure eight years later. Still with	Restriction in hospital can last longer than prison	risk enough to indeterminately detain
518	their freedoms…restricted. [Yeah.] Do you see? [Absolutely.		someone?
519	Yeah.] So there's not a prop-…proper governance	No investment in these	Because patients don't
520	arrangement. There's no investment in people's righ- I mean	checks.	have a voice? Once committed crimes no
521	if you ask here who's checking people's human rights? Is		one cares about their
522	there such a role, such a post to look after peop-? I mean,	No allocation of	HRs?
523	there's a security department which is heavily invested in.	monitoring role. Security is heavily invested	
524	[Yeah.] Four, five staff. {*Laughing.*) Obviously they are well	in as opposed to HRs.	Risk as opposed to HRs.
525	known. But what's the balance? [Yeah. Absolutely.] And, and	No balance between HRs and risk.	
526	are people- I think it's quite casual, if you say, "Oh, let's		
527	renew their section three for another three months, um…or	Nobody questions MHA renewals. Clinical opinion	But would debate a release.
528	the hostel's not open, but let's renew their section",	taken as gospel.	
529	nobody's gonna say "oohh". Amongst very senior colleagues		
530	no one is gonna say…	No one speaks for HRs.	
531			
532	CI: Question the human rights aspect. [Yeah.] Interesting. So		
533	there's, there's something about that other legislation		
534	making it kind of easier, If you will.		
535			
536	P: Yeah. [Okay.] So I think the other legislation whether it	Other legislations justify and enable HRs breaches.	
537	justifies breaching human rights, the lower levels, the lower		
538	legislation can…make it easier…can give you a rationale, can		

[END OF EXCERPT]

6.8. Appendix H – Selection of Codes Under the Initial Sub-theme of Patient Vulnerabilities and Needs

Our patients are complex.
Complex patients = complex HR decisions.
Absolved of blame/ responsibility if unwell.
Illness overwhelms primitive impulses – feral.
Patients disconnect to cope.
Agitation = risk.
Bad parenting can lead to forensic detention.
Patients want parental care.
Demonstrating severity of patients/work.
Patients are deceptive which is why they have convictions and why they're in the hospital.
Prioritising his feelings of disappointment.
Too much structure of care overwhelming.
Harm as a communication.
Patients so complex cannot 'see' everything.
Step down to community can be too big for some patients.
MI can affect anyone, 'not their fault'.
ACEs cause PD.
Abuse breeds offending.
Patients are ultimate survivors.
Some patients have had such torture.
Patients are traumatised.
Detention in forensics is somewhat indeterminate.
SUs don't have enough HRs knowledge.
SUs have intuitive sense of HRs, but because no legislative knowledge, can be usurped by risk.
Patients need more HRs support.
When distressed SUs are not heard.
Patients blamed for bad choices but actually don't have access to positive options.
Patients blamed for aggression when feel HRs violated/things are unfair.
Aggression when basic needs not met.
Unwell people can't be blamed for actions, needs care/ management.
Distress biggest factor in negative behaviour.
Some SUs like hospital.
Physical health and mental health needs of patients.
Patients are complex.
Acknowledgement that forensic should not have to forfeit privacy.
In forensic services some people can come in just due to risk, not through CJS.
Forensic patients in critical need of service.
Regardless of offending, deserve respect and kindness.
No thinking around morals or HRs of detainees.

Institutionalisation can happen.

Patients can act in order to stay in hospital.

If you're psychotic you cannot be held responsible for actions/breaches

Patients come in as 'unmanageable', unstable, disgusting, but due to own choice/ self-imposed.

Their offences don't fit with value base. Confusing.

Work is not about convictions, need to work with rest of person.

Need to be able to see past offence.

Staff feel scared when they don't know someone.

MI leads to less judgement, PD more judgement.

Moral judgment around abusers and the lives of patients.

Allow patients' 'bad decisions' in relation to families.

Sympathy/ compassion for patients.

People see PD as having capacity and choice.

Idea of choice leads to judgement.

If only focus on individual patient actions and judge then won't consider HRs.

Use MH and unpredictability as excuse for more restrictive practice.

SUs change their mind about treatment.

Judgment negatively impacts care and offending.

Unwell offenders have two sides to them.

MH only one aspect of person.

MH/offending side would not be entitled to HRs, but 'person' is.

Offenders carry inherent risk and stigma.

Deterministic view of mentally unwell people in prison and their risk.

Deterministic/ judgemental view of offenders.

Staff shock at level of distress/trauma.

Stark language needed to make staff realise the impact of their 'care'.

Need to live with discomfort that MH sufferers bring.

Offending doesn't affect humanness.

Offending = 'dark' thing human has done.

Capacity and restrictions frequently happen around moralistic health decisions (smoking, diet).

Clinicians don't understand why patients don't prioritise physical health.

Clinicians don't take patients' choices into account.

Acknowledgment of public stigma around offending.

LD/MH can lead clinicians to mistrust you/deem you 'untreatable' – stuck in system.

People with MH/LD particularly vulnerable to indeterminate sentences that would have been short in gen pop.

Moralistic restrictions made without capacity ax.

Greater awareness of inappropriate moral decisions.

Variety of views of patients amongst staff.

Attitudes towards SUs becomes culture and desensitised.

Most forensic complaints around staff attitudes and therefore care.

Have to connect to regain freedoms.

Knowledge = power = freedom.
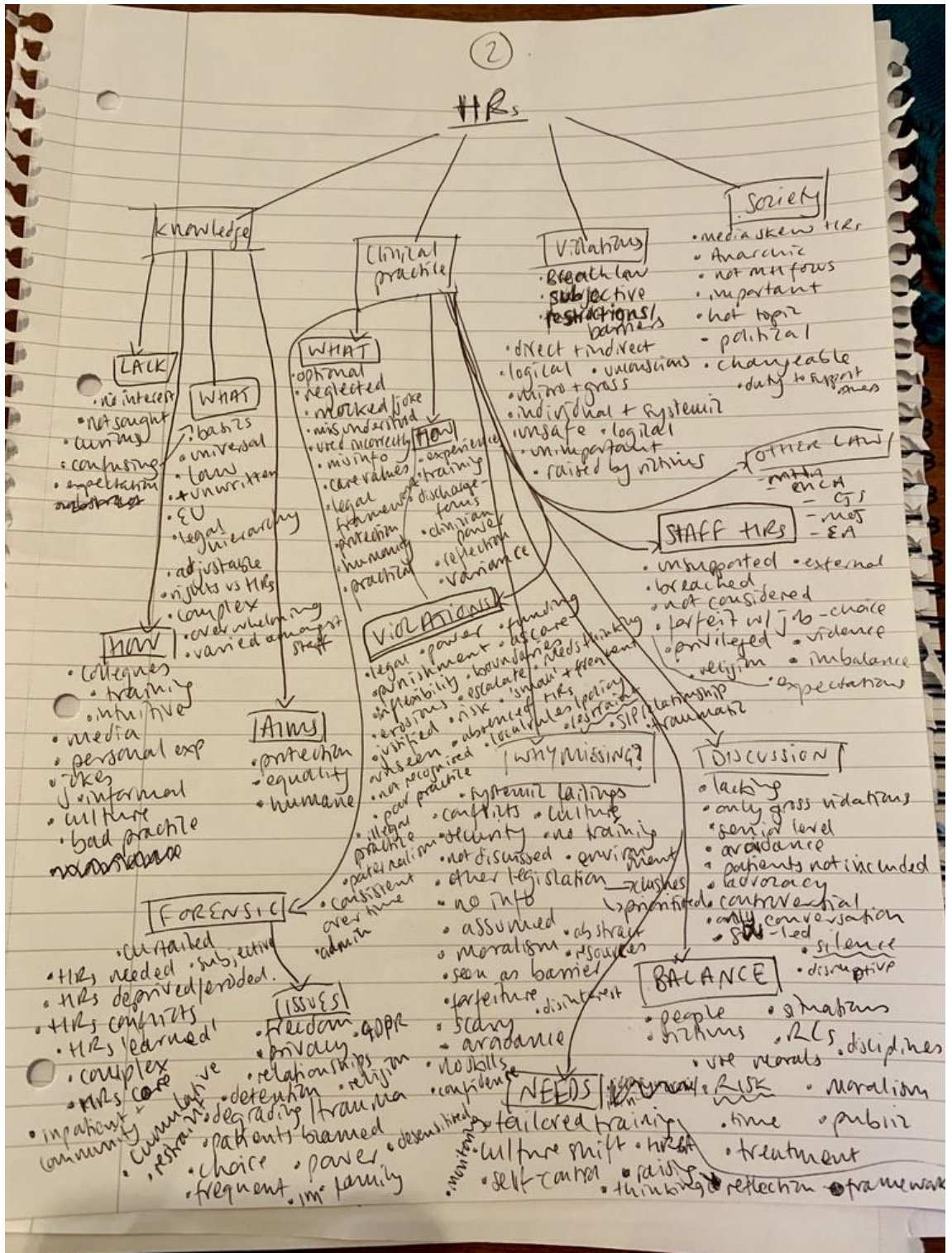
Patients expected to 'open up'.

Most people are open with teams in one way or another.

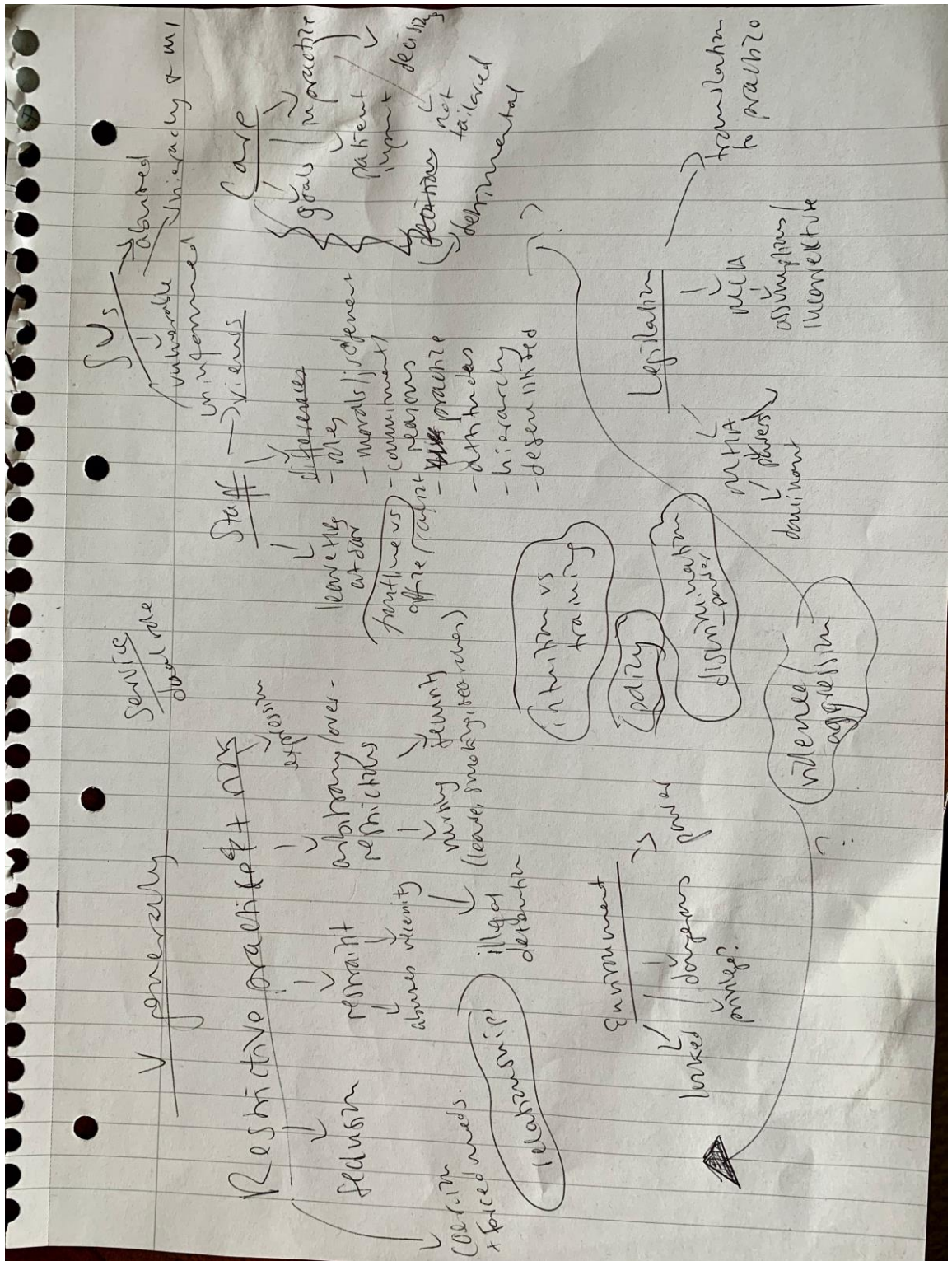Collective assumption of physical health priority for patients.

Assumption that restrictions will 'enlighten'/ persuade patients to better health choices.

6.9.1. Human Rights

6.9.2. FIPS Practice

6.10.   Appendix J – Final Thematic Tree

6.11. Appendix K – HRA Ethical Approval Letter

Ymchwil Iechyd
a Gofal Cymru

Health and Care
Research Wales

NHS
Health Research
Authority

Miss Lucy Rands
100 Li
Londo
SE5 8

18 November 2019

Dear Miss Rands

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

Study title: **Understanding Human Rights in Forensic Psychiatric Services: Staff perceptions of human rights issues in an inpatient forensic psychiatric service.**
IRAS project ID: 271122
Sponsor **University of East London**

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

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

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

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

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The *"After HRA Approval – guidance for sponsors and investigators"* document on the HRA website gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:
- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **271122**. Please quote this on all correspondence.

Yours sincerely,

Gemma

Approvals Specialist

Email: hra.approval@nhs.net

6.12. Appendix L – Key for Analysis Quotes

Symbol	Meaning
…	Participant paused, approximately 5 seconds
.,	Short pauses in speech
Example-	Participant cutting off speech and starting a different sentence or idea
Example – example interjection –	Participant interjecting in their own speech, then returning to their original point
( )	Laughing or non-verbal activity
Underlined	Participant emphasis on a word
[*italicised*]	Word removed or replaced for confidentiality, e.g. name of hospital, or clarity, e.g. explaining an acronym
[…]	Some text removed for the sake of brevity, within the same data extract
""	Denotes the participant referring to the speech or thought of another person or themselves
(P1), (P2) etc.	Participant identification number