THE UNIVERSITY
of EDINBURGH

THE UNIVERSITY *of* EDINBURGH

Values and Recovery in Forensic Mental Health

Doctoral Thesis

Stuart Andrew Cooney

Doctorate in Clinical Psychology

The University of Edinburgh

February 2020

DClinPsychol Declaration of Own Work

Name: Stuart Cooney

Title of Work: Values and recovery in forensic mental health

I confirm that this work is my own except where indicated, and that I have:

- Read and understood the Plagiarism Rules and Regulations
- Composed and undertaken the work myself

- Clearly referenced/listed all sources as appropriate
- Referenced and put in inverted commas any quoted text of more than three words (from books, web, etc.)
- Given the sources of all pictures, data etc. that are not my own
- Not made undue use of essay(s) of any other student(s), either past or present (or where used, this has been referenced appropriately)

- Not sought or used the help of any external professional agencies for the work (or where used, this has been referenced appropriately)

- Not submitted the work for any other degree or professional qualification except as specified
- Acknowledged in appropriate places any help that I have received from others (e.g. fellow students, technicians, statisticians, external sources)
- Complied with other plagiarism criteria specified in the Programme Handbook
- I understand that any false claim for this work will be penalised in accordance with the University regulations

- Received ethical approval from the School of Health in Social Science, University of Edinburgh

  OR

- Received ethical approval from an approved external body and registered this application and confirmation of approval with the School of Health in Social Science's Ethical Committee

Signature … **Date** …28/02/2020……

Acknowledgements

Like the content I explore in this thesis, the journey to write this and complete the doctorate has entailed various challenges and opportunities. Going through this process has challenged and illuminated my understanding of my own values. At times it has reaffirmed my pursuit of these goals and values, whilst at other times has certainly tested this resolve. Despite spending many a solitary evening at my desk or in the library, this has not been a journey I have taken on my own. This would not have been possible without the support, guidance, reassurance and patience of some very special people.

Firstly, I was struck by the openness of the kind nine individuals from the Orchard Clinic who took the time to meet with me. I am so grateful for your time and I hope I do justice to your stories. Thanks also to all of the staff at the Orchard Clinic during my time working and carrying out my research.

Thank you to my supervisors Ethel Quayle and Louise Tansey for everything they have done to help me through these past four years. Also thank you to Ros Evans and Richard Payne for their support across the wider doctoral process. It was also a privilege to share this training journey with a great group of friends and colleagues. A particular thanks goes to David Barker for giving his time and input, being my second marker for my systematic review. Also, to David Carmichael for getting me through the long days and nights in the library together.

I am lucky to have such supportive parents and in-laws. Thanks for everything over the years and for all the practical support and kindness you've shown in getting me through this.

Most importantly I want to thank my wife Yvonne. It's hard to express how important she has been in keeping me going and helping me through all of this. Without complaining (much!) she has put up with countless evenings and weekends of me working away. She is an amazing partner, friend, support and mother to our daughter, Ailsa. Thank you.

In the second year of my doctorate we welcomed our beautiful daughter to the world. Thank you Ailsa, for giving me a reason to keep going with all of this and to finally finish it. I'm sorry that Daddy's always been away working or studying but that'll change now and I can't wait for all of the fun we're going to have together. Lastly, I'd like to dedicate this to our soon to be born baby boy. We're so excited to meet you.

In Loving memory of Janet Bulloch, 1922 - 2020

Table of Contents

Overall Abstract

Background: Strength-based approaches to working with Mentally Disordered Offenders (MDOs) move from a focus on mental disorder and risk to a wider consideration of the individual that considers their strengths, personal priorities and competencies. There is an increasing emphasis on values and recovery in health and forensic mental health services. This represents a shift in perspective from a deficit focus to an abilities focus. There is however a paucity of research into values and strength-based approaches. This thesis portfolio aims to contribute to this area of research.

Methods: A systematic review of the literature was conducted to review strength-based approaches for mentally disordered offenders in forensic mental health settings. Four databases (MELINE, PsycINFO, EMBASE and SCOPUS) were searched and 10 studies were included in the review. The outcomes measures in the included studies were recovery, quality of life, violence/risk, recidivism, mental health symptoms, therapeutic milieu, and engagement.

In the empirical study, a Grounded Theory Methods was used to build a theory of values of men in a medium secure unit who have offended. Interviews were conducted with nine inpatients in a Scottish medium secure unit.

Results: The findings of the systematic review, although limited, suggest that a strength-based approach will facilitate outcomes in quality of life, recovery, mental health symptoms, violence, risk, recidivism, and engagement. Limited evidence was found and there was also a lack of consistent findings. Further consideration of the long-term impact of such an approach and further high-quality research is needed to establish the effectiveness of strength-based approaches.

In the empirical paper, a model of values in mentally disordered offenders was produced. The expressed values of MDOs were made up four separate categories relating to: (1.) connecting with others; (2.) living a healthy life; (3.) being productive and contributing; and (4.) having agency and being in control. As part of the model, a consideration is given to the development of values throughout life and the barriers and opportunities that impact on an individual's life and the impact that has on values.

Conclusions: The findings of this thesis indicate that there is a benefit to using strength-based and values informed approaches to working with mentally disordered offenders. The findings of this research support the view that mentally disordered offenders share similar values to non-offenders. Further research is needed, to be able to clearly support the effectiveness of strength-based

approaches and also to evaluate the use of values to guide clinical care and treatment.

Overall Thesis Word count: 20,551

Lay Summary of Thesis

There has been a recent shift in treatment approaches to offenders with mental disorders. Previously, there has been a focus on managing risk and focusing on mental health difficulties. Strength-based approaches have helped move towards a way of working with people in forensic mental health services that also places an importance on working with the person's strengths, and values, which are the things in life that are important to them.

The first part of the thesis aimed to review how effective new strength-based approaches have been in forensic mental health settings. This was done by bringing together all of the studies that have reported on this. This review found 10 studies, from many data bases that documented strength-based approaches in forensic mental health settings. The review found that there was some evidence to support the effectiveness of strength-based approaches in improving people's quality of life, recovery, mental health symptoms, engagement and a reduction in violence and risk. The conclusions that can be made from this review are limited however, as the quality of studies found was generally poor. Further high-quality research is needed therefore, to establish the effectiveness of this approach in forensic mental health settings.

The second part of the thesis explored the values of men in a Scottish Medium Secure Unit. Nine inpatients were interviewed, and Grounded Theory Methods (a qualitative research approach) was used to understand and develop a theory of the

values of mentally disordered offenders. From the interviews, four categories of values emerged: connecting with others; living a healthy life; being productive and contributing; and having agency and control. This seems to suggest that mentally disordered offenders share similar values to non-offenders. Moreover, the men interviewed discussed the barriers that stop them from living a life in line with their values. This included interpersonal relationships; environment and culture; health challenges; and the consequences of offending. This study helps build an understanding of the values of men in medium secure units and the areas in life that prevent them from living a life in line with their values. It is hoped that this will help inform treatment and care in forensic mental health settings.

Part A: Systematic Review

Systematic Review of Strength-Based Approaches in Forensic Mental Health

Prepared for submission to the

Journal of Aggression and Violent Behaviour

(See Appendix 3 for the journal's guide for Authors)

Systematic Review of Strength-Based Approaches in Forensic Mental Health

Stuart Cooney, Louise Tansey, Ethel Quayle

Abstract

Strength-based approaches to working with MDOs move from a focus on mental disorder and risk to a wider consideration of the individual that considers their strengths, personal priorities and competencies. This represents a shift in perspective from a deficit focus to an abilities focus. Within forensic mental health, the Recovery Model and Good Lives Model have been the most prominent of strength-based approaches that have been adopted with the goal of changing how forensic mental health practitioners work with MDOs. There is however a paucity of treatment literature in both forensic mental health and strength-based approaches.

This systematic review critically reviews the current research literature on strength-based approaches for mentally disordered offenders in forensic mental health settings. Four databases (MELINE, PsycINFO, EMBASE and SCOPUS) were searched and 10 studies were included in the review. The outcomes measured in the included studies were recovery, quality of life, violence/risk, recidivism, mental health symptoms, therapeutic milieu, and engagement.

The findings, although limited, suggest that a strength-based approach can facilitate outcomes in quality of life, recovery, mental health symptoms, violence, risk,

recidivism, and engagement. Further consideration however, of the long-term impact of this approach is needed.

Keywords: strength-based; recover; good lives model; forensic mental health; mentally disordered offender; United Kingdom

1. Introduction

1.1. Mentally Disordered Offenders

Mentally Disordered Offenders (MDOs) are defined as people with a mental illness, personality disorder or intellecutual disability and have a history of significant offending behaviour, and/ or representing a significant risk to others (Forensic Mental Health Matrix, 2011). They are a complex group and diverse population who present with a range of chronic, complex and co-morbid mental health difficulties (Palijan et al., 2010) and are often regarded as difficult to treat (Barnao & Ward, 2015). MDOs are subject to compulsory measures under mental health legislation and require care and management with increased security and by specialist forensic expertise.

From a legal perspective, offenders with mental illness have been treated as objects rather than subjects due to a predominantly risk-driven criminal justice service, and a fear that their mental status would result in recidivism (Vandevelde, 2017). The treatment and management of mentally disordered offenders is informed by two distinct institutions: the criminal justice and the mental health systems, and

therefore has to balance risk centered and psychopathology approaches. This creates difficult conceptual, clinical and ethical issues in forensic populations as the patient's well-being is balanced with a focus on protecting the public through the reduction of risk and recidivism. Balancing the aims of these two distinct institutions is considered problematic (Barnao & Ward 2015) and is thought to contribute to MDOs being disadvantaged with regard to access to mental health care (Grounds, 2019). The challenge of working with MDOs is further compounded by a small evidence base for interventions and paucity of theories and rehabilitation models to guide clinical practice (Robertson et al., 2011).

Interventions for mentally disordered offenders have taken three broad approaches which need to balance the priorities of the criminal justice and mental health systems: (1) treatment targeting metal illness and other psychological issues; (2) interventions based on the principles of the Risk-Need-Responsivity (RNR) model (Andrews et al., 1990), with a focus on reducing recidivism; and (3) strength based approaches that aim to enhance individuals' well-being (Barnao & Ward, 2015). Within forensic mental health, the first two approaches, the risk and psychopathology paradigms, have been utilised by teams in combination to develop a rehabilitation framework. These two approaches however, have diverging aims and assumptions, and values, which have made this combined approach problematic (Barnao & Ward, 2015). Moreover, research with mentally disordered offenders and personality disorders has highlighted the importance of treatment

consisting of more than direct individual interventions but also that effective therapeutic milieus are developed (Long et al., 2012).

1.2. Strength Based Approaches and Forensic Mental Health

A recent critical review explored potential discrimination towards MDOS. It found evidence that offenders with a mental disorder were not able to access the equivalent mental health care to that available for non offenders with a mental disorder (Grounds, 2019). Efforts have been made to promote the voice and rights of MDOs and the adoption of a strength-based approach to criminal justice has resulted in developments facilitating individuals to be able to play a more active role in the whole legal process. This is supported in case law of the European Court for Human Rights, which gives mentally disordered offenders the right to actively participate in the earliest stage of criminal proceedings at the stage of police interrogation (Verbeke et al., 2015).

Strength-based approaches to working with MDOs move from a focus only on mental disorder and risk to a wider consideration of the individual that considers their strengths, personal priorities and competencies. This represents a shift in perspective from a deficit focus to an abilities focus. Strength based approaches have been used within general mental health services for a number of years to inform interventions with patients from a service level to individual interventions with patients, however there is limited evidence currently in support of this shift. A meta-analysis of the strengths-based model of service delivery in general mental

health did not find evidence to support the effectiveness of this approach in improving functioning and quality of life (Ibrahim et al., 2014).

This paradigm shift away from a deficits model is not only within clinical psychology but a shift to strength-based approaches has occurred in different disciplines within forensic mental health, general mental health, criminal and educational domains. These are all part of a strength based movement and include: law (human rights), criminology (desistance paradigm), mental health care (the recovery paradigm), forensic psychology (the Good Lives Model), special needs education (Quality of Life-approach) and family studies (family recovery) (Vandevelde et al., 2017). The term strength-based practice has however, been found to have been used loosely to describe a variety of approaches (Vandevelde et al., 2017) and further research is needed therefore to clarify this.

Within forensic mental health, the Recovery Model and Good Lives Model have been the most prominent of strength-based approaches that have been adopted with the goal of changing how forensic mental health practitioners work with MDOs (Drennan & Alred, 2012). The Recovery Model is one of the most prominent of strength-based approaches, which has been used in mental health services and extended to forensic based populations. The Good Lives Model (GLM) is a psychological intervention that shifts from an offending focus to a broader consideration of personal strengths and goals in the pursuit of living a *"good life"* (Ward & Maruna, 2007). Through the development of strength-based approaches,

there is greater acknowledgment of the difficulties of dual recovery from mental illness and offending behavior as there is an additional process of "offender recovery". This process entails the individual building a non-offender identity. Dual recovery attempts to balance risk management and restoring a meaningful and satisfying life in patients (Drennan & Alred, 2010).

2. Aims of the Review

The overall aim of this review is to present and explore strength-based approaches with a focus on empirical evidence of the effectiveness of these approaches in forensic mental health and, in particular, mentally disordered offenders. There is a recognised paucity of treatment literature in forensic mental health (Davies et al., 2007; Hillbrand & Young, 2008) and this limitation is also true of strength-based approaches (Barnao & Ward, 2015; Vandevelde et al., 2017). The review will, therefore, consider the use of strength-based approaches in a broad sense: from a systemic and therapeutic milieu-based level to direct clinical interventions with patients. It will also consider a range of quantitative designs and use of outcome measures, including studies without controls. These methods should aid the exploration of the efficacy of this emerging approach to forensic mental health, whilst acknowledging and working within the limitations of the current evidence base.

3. Methods

3.1. Literature search strategy

The focus of the review was to examine strength-based approaches in forensic mental health settings and MEDLINE, PsycINFO, EMBASE and SCOPUS databases were searched for peer-reviewed articles, working papers and policy reports, published in English between 1 January 1990 and 7th October 2019. The following search terms were used:

(psychiatr* OR mental*) AND (forensic OR secure OR offender* OR prison*) AND ("strength* based" OR "strength* model*" OR "strength* perspective*" OR "recovery model*" OR "recovery approach*" OR "recovery paradigm*" OR "good lives model*")

All articles including the search terms in either the title or abstract or key words were identified.

3.2. Inclusion and exclusion criteria

To be included in the main review and further analysis, the papers had to meet the following inclusion criteria: (i) Participants included either males or females, aged over 18 years old and diagnosed or defined as mentally disordered offenders (using the definition stated earlier from the Forensic Mental Health Matrix, 2011) ; (ii) Studies were included from low, medium, and high secure units; prison samples; people detained in hospital and described as mentally disordered or forensic

patients; and forensic outpatients who were managed in the community. (iii) The study reported on empirical intervention studies of strength-based approaches (including formal interventions and overarching models of care); (iv) was available in English language; and (v) included pre- and post-intervention measures.

Papers were excluded if they (i) employed non-strength-based approaches; (ii) were qualitative studies, (iii) were single case studies; (iv) or did not report any new data (e.g. review papers).

The inclusion and exclusion criteria were chosen to reflect the relative paucity in the evidence base for psychological approaches within forensic mental health.

3.3. Outcome measures

Studies were included that used psychometric outcome measures and reporting of clinical data, for example violent incidents and PRN medication use. Outcome measures of particular interest were measures of recovery, quality of life, violence, risk, recidivism, mental health symptoms, engagement, and therapeutic milieu.

3.4. Assessment of quality

To rate the quality of papers, quality criteria developed in a previous systematic review (Ross et al., 2013) were adapted for the present review. The 11 quality criteria used were informed by guidelines from the Centre for Research and Dissertations (CRD, part of the National Institute for Health Research, CRD, 2008);

and assessed the following areas: risk of internal and external bias, statistical issues, quality of the intervention, generalisability, and choice of outcome measure. Using the quality criteria, each was scored as either: Well covered = 3, Adequately addressed = 2, Poorly addressed = 1, Not addressed = 0 and Not applicable = 0. Each paper was then given a total score. The quality criteria used are provided in Appendix 1.

To ensure inter-rater reliability, a second marker was utilised to review 50% of the papers. From independently reviewing 5 papers, an exact agreement was found on 76% of ratings, with an intraclass correlation co-efficient (ICC) of 0.97, indicating excellent inter-rater agreement. The ICC estimates were calculated using SPSS Statistical package version 24 (IBM corp., 2016), using a two-way mixed effects model. Through this process, any conflicts of scoring were reviewed and if appropriate, amendments were made.

4. Results

4.1. Search results

The comprehensive literature search of the four databases produced 640 papers. After de-duplication 506 papers remained. 452 studies were excluded during a screening of the title and abstract. Following a full text review of the remaining 54 papers, 10 met all the inclusion criteria for in-depth review and assessment. The other 44 articles did not meet the inclusion criteria for this review due to: ***study design*** (19 papers: qualitative (5); case study (4); commentary/ service description

(9); and review (1) based designs); ***intervention*** (14 papers: interventions based on the Risk-Need-Responsivity (RNR) model or a focus on reducing recidivism (11); no strength based mental health intervention (3)); ***not a mentally disordered offenders population*** (9 papers: sex offenders (4); prison population (4); family members of MDOs(1)). Furthermore, 2 papers were excluded as they utilised the same data from a sample across multiple papers. Figure 1. shows a PRISMA flow chart of the search process in this review:

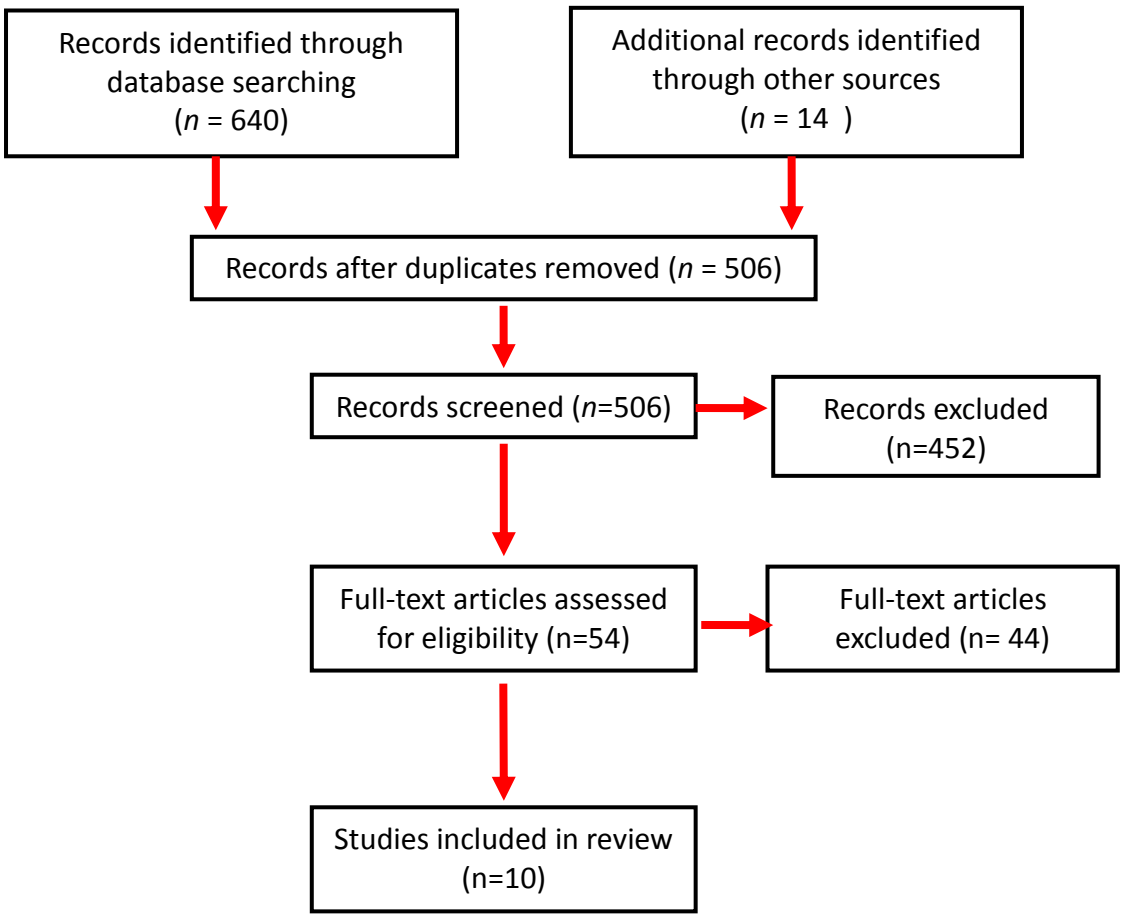


Figure 1. PRISMA Flow diagram of the search strategy.

4.2. Study setting and characteristics

The ten included studies that met all the inclusion criteria are summarised in table 1. One study was a randomised control trial (RCT) design (MacIness et al., 2016). The other nine studies were pre- and post-intervention studies. The participants in the studies were all adults considered to be mentally disordered offenders (MDOs) or offenders not guilty by reason of insanity (NRGI). In 9 of the studies, the participants were predominantly male, with the exception of one study of eight female MDOs (Wiglesworth & Farnworth, 2016). Studies were undertaken in the UK, Netherlands, Canada, USA, and Australia. The settings for the studies included a range of forensic services: low secure unit (2), medium secure units (4), forensic mental health hospitals (3), and forensic outpatient services in the community (2) (one study included both low and medium secure sites). Participants in the included studies had a range of diagnoses including psychotic disorder, personality disorder, and substance misuse. Furthermore, there was a range of recorded offences, predominantly consisting of violent offences but also including sexual offences and property offences.

4.3. Types of intervention

Eight of the included papers presented interventions at a therapeutic milieu or a service level. Two papers described direct interventions. Furthermore, one paper described a case management and direct intervention approach. These different types of interventions were reported as being informed by either a strength-based

approach, the recovery model or the Good Lives model, all of which come under the broader strength-based umbrella.

4.3.1. Therapeutic Milieu

Eight studies describe a strength-based approach as part of the therapeutic milieu. Of these eight, two papers explored interventions informed by the Good Lives Model (Bouman et al., 2009; and Ward & Attwell, 2014). The Good Lives Model proposes that offenders have the same needs and aspirations as everyone else (Ward, 2002). The aim of GLM is to build resources for the individual to live a life that is meaningful, fulfilling, in line with their values and to reduce risk. As such, these principles were utilised in the service design, for example using goal orientated action plans that are created collaboratively, to identify *"primary goods"* and consider ways to achieve this alongside possible obstacles.

Four of the included papers describe the service as being informed by the recovery approach (Corlett & Miles, 2010; Doyle et al, 2012; Gudjonsson et al., 2011; Wiglesworth & Farnworth, 2016), with the aim of increasing treatment motivation and engagement, reducing challenging behavior, violence and risk. Wiglesworth and Farnworth (2016) described the introduction of a sensory room as part of a recovery-based approach, rather than the previously utilized Risk-Need-Responsivity (RNR) based method of seclusion and considers the implications at a service level. Two papers described their interventions as strength based and did not define this further (Livingston et al., 2013; and MacIness et al., 2016). MacIness

et al. (2016) described an approach to increase participation of the patient in their care with the staff team, with the aim of improving quality of life.

4.3.2. Direct Intervention

Two studies described direct interventions using a strength-based approach. Walker and Paton (2015) evaluated *"LifeMusic"*, a recovery-based music therapy group, with the aim of creating ways for individuals to express emotion, connect with others and improve self-esteem. Smith, Jennings, and Cimino (2010) evaluated the *"Stage Progressive Model"*, a program that appears to be both a direct intervention and also a case management-based intervention. The program has 5 levels with the aim of individuals progressing through the program to develop life skills, coping skills and community supports to facilitate a successful transition into the community and increased independence. This approach also used a positive behavioural management approach, with privileges attached to different levels of the program and increases in independence.

Table 1. Characteristics of included studies

Author(s), Year, Country	Participants	Setting	Intervention	Outcome Measures	Design	Main Findings
Bouman et al. (2009) (NL)	135 adult males, MDOs, forensic outpatients.	Forensic outpatient treatment centre	Therapeutic milieu/ service level intervention: Good Lives Model informed service design.	Quality of Life: • Lancashire Quality of Life Profile (LQoLP; van Nieuwenhuizen et al., 1998) Violence/ risk: • Self-reported Delinquent Behaviour Inventory (SRDB; van Dam et al., 1999) Recidivism: • Recidivism data	Prospective multicentre study with random sample No control	24.5% of those that completed the intervention were convicted of a new offence. The study found a modest negative relationship between subjective wellbeing and recidivism. The data suggested that satisfaction with health was significantly correlated with recidivism in relation to violent offences (AUC = 0.72, $p < 0.01$).
Corlett & Miles (2010) (UK)	17 adult males, MDOs, forensic inpatients. 26 staff members.	Medium Secure Unit	Therapeutic milieu/ service level intervention: Application of recovery model in a secure NHS forensic service.	Recovery: • Developing Recovery Enhancing Environments Measure (DREEM; Ridgeway & Press, 2001)	Service evaluation No control	On ratings of 24 recovery elements, MDO's and staff rated all elements as moderately important (above median value). However, it was found that staff rated them as more important and better implemented in the service than MDOs. There was a significant effect on the implementation of recovery elements by the MDO's forensic history, including restriction status and index offence type ($F(2,12)=7.250$, $p < 0.01$).
Doyle et al (2012) (UK)	80 adults (69 male, 11 female), MDOs, forensic inpatients	Medium Secure Unit	Therapeutic milieu/ service level intervention: Application of recovery model in a secure NHS forensic service: Milestones to Recovery (MTR) Framework.	Recovery • Milestones to recovery scale (MTRS; Doyle et al., 2012)	Service evaluation and validation of MTR framework No control	The MTR was found to be a valid tool for clinicians for planning and assessing treatment for MDO's and for promoting patient recovery. Therapeutic engagement in structured activities and treatment (using the recovery model) was found to be associated with recovery and important for progression through the medium secure unit pathway. The therapeutic engagement scale had the lowest AUC = 0.24, $p = 0.008$ and best

						predictive validity.
Gudjonsson et al. (2011) (UK)	75 adults (71 male, 4 female), MDOs, forensic inpatients	Medium Secure Unit (73), Low Secure Unit (2)	Therapeutic milieu/ service level intervention: Application of recovery model in a secure NHS forensic service.	Recovery • Recovery Journey Questionnaire (RJQ; Green et al., 2011) Quality of Life: • The Manchester Short Assessment of Quality of Life (MANSA; Priebe et al., 1999) Mental health: • The Beck Hopelessness Scale (BHS; Beck & Steer, 1988) Engagement • The Patient Motivation Inventory (PMI; Gudjonsson et al., 2007) • Patient Perception Questionnaires (PPQ; Gudjonsson et al., 2007) Behaviour/ Offending: • Disruptive Behaviour and Social Problem Scale (DBSP; Young et al., 2003)	Service evaluation No control	The recovery journey, as measured by the RJQ, correlated positively with treatment motivation (medium effect size, r = 0.39), treatment engagement (large effect size, r = 0.70), and negatively with social problems (large effect size, r = -0.50). Furthermore, recovery correlated positively with quality of life (medium effect size, r = 0.43) and negatively with hopelessness (medium effect size, r = -0.40).
Livingston et al. (2013) (Canada)	25 adults (25 (20 male, 5 female) forensic inpatients	Forensic mental health hospital	Therapeutic milieu/ service level intervention: 19-month intervention to improve engagement and support recovery. Includes: 1. Peer support program 2. Patient advisory committee 3. Patient research team	Recovery • Mental Health Recovery Measure (MHRM; Bullock, 2005) • Recovery Self Assessment Scale (RSA; O'Connell et al., 2005) • Making Decisions Empowerment Scale (MDES; Rogers et al., 1997) Treatment engagement/ therapeutic milieu • Singh O'Brien Level of Engagement Scale (SOLES; O'Brien et al., 2009) • Essen Climate Evaluation Schema (EssenCES; Schalast et al., 2008) Mental health: • Internalized Stigma of Mental Illness scale (ISMI; Ritsher, et al., 2003)	Naturalistic study, Repeated measures design No control	The intervention was found to have a limited impact on recovery, empowerment, internalised stigma, service engagement, and the therapeutic milieu of the service; with most patient scores not being statistically different on pre and post measures. Positive effects were found however from peer support on personal recovery (r = .40, p = .05). Furthermore decreases in internalized stigma after participating in peer support were found (n = 18, M_{diff} = -0.05, SD_{diff} = 0.27).
MacIness et al. (2016) (UK)	55 patients & 47 nurses (interventio	6 medium secure in-patient	Therapeutic milieu/ service level intervention:	Quality of Life: • Manchester Short Assessment of Quality of Life scale (MANSA; Priebe et al., 1999)	Randomised Control Trial (RCT)	Positive effects on quality of life were found at 6 and 12 months as compared to the control group. The quality of life estimated

	n group), 57 patients & 45 nurses (control group) 85% male and 15% female participants	units	Structured patient-clinician communication approach to increase active patient participation in discussions about their care with the aim of improving quality of life in secure settings (DIALOG approach).	Recovery • Recovery - Process of Recovery Questionnaire (QPR; Neil et al., 2009) Treatment engagement/ therapeutic milieu • Engagement with Services - Helping Alliances Scale (HAS; Priebe, 1993) • Ward Climate - Essen Climate Evaluation Schema (EssenCES; Schalast et al., 2008) • Patient Satisfaction - Forensic Satisfaction Scale (FSS; MacIness et al., 2010) Behaviour/ Offending: • Disturbed behaviour was recorded from the ward untoward incident forms and patient progress notes Staff measures • Nurse Stress - Maslach Burnout Inventory (MB; Maslach, 1981I)		treatment effect was 0.2 (95% CI: -0.4 to 0.8) at 6 months and 0.4 (95 % CI: -0.3 to 1.1) at 12 months. There were good response rates and low withdrawal rates. Furthermore, a reduction in *"disturbed behaviour"* was found compared to the control group, including: number of seclusions, physical restraints, attempts to self harm, and violence.
Smith et al. (2010) (US)	73 adults (71 men and 2 women), adjudicated not guilty by reason of insanity (NRGI)	42 Bed secure residential treatment facility	Direct intervention: "Stage progressive recovery model". Recovery model based approach to build life skills, coping skills and community supports. A focus on successful transitions from secure care to the community.	Intervention outcomes: • Recorded readmissions, abstinence, steady housing, and meaningful activity.	Service evaluation No control	The study showed positive outcomes with 90% of participants who completed the program meeting criteria for "overall success". Therefore for 90% there were no readmissions to state hospital; and no rearrests following re-entry. Furthermore, 49% were rated as "highly successful", indicating that for 49% of participants there were no rearrests; no readmission; maintained abstinence; steady housing and meaningful activity in community. Further statistical analysis was not completed on the outcome data.
Walker & Paton (2015) (UK)	Adults, MDOs, forensic inpatients (number	Low secure forensic unit (13 bed)	Direct intervention: Recovery based music therapy group: Lifemusic.	Intervention outcomes: • Qualitative feedback post group (verbal and questionnaires) Violence/ risk • Observations of challenging behaviour	Service evaluation No control group	Attendance at the recovery based music group was associated with a reduction in PRN medication use in the day following attendance, indicating a reduction in distress.

	and gender not stated)			• Recorded PRN medication use	No statistical analysis	There was also a reduction in challenging behaviour, with no episodes for at least 48 hours after group attendance. No statistical analysis completed on outcome data.
Ward & Attwell (2014) (UK)	10 Adults, MDO's, Forensic outpatients (gender not specified)	2 community outreach forensic psychological services	Therapeutic milieu/ service level intervention: Services guided by principles of the Good Lives Model	Intervention outcomes: • Semi-structured interviews Rating scale constructed for the study to measure effectiveness of the service	Service evaluation No control	Semi-structured interviews and rating scale results indicated that both services were found to improve psychological well-being, general quality of life and to manage risk of re-offending. Furthermore, service engagement was found to help form and maintain positive relationships and social integration. No statistical analysis was undertaken on rating scale data.
Wiglesworth & Farnworth (2016) (Aus)	8 Adult females, MDOs, forensic inpatients	forensic mental health hospital	Therapeutic milieu/ service level intervention: Recovery approach at a service level, focusing on the introduction of a sensory room rather than the use of seclusion	Intervention outcomes: • The Adult/Adolescent Sensory Profile (SP) assessment (Brown and Dunn, 2002) • The sensory room evaluation form, based on Novak et al. (2012) which captured ratings of stress. • Focus group with staff.	Service evaluation No control	A reduction in stress was documented following the use of the sensory room. A higher mean change in stress was found for patient initiated use of the sensory room (M = -2.81, n=16) as opposed to staff initiated use (M = -2.66, n = 32). Further statistical analysis was not completed on the outcome data.

4.4. Outcomes

Eight domains of outcomes were reported across the studies. Five studies reported recovery-based outcomes; five reported quality of life outcomes; four reported violence/ risk outcomes; one study reported recidivism outcomes; five studies reported mental health symptoms outcomes; two reported outcomes for therapeutic milieu; and 3 studies reported engagement outcomes.

4.4.1. Recovery

Seven recovery outcomes were recorded by five studies. No single measure of recovery was used by more than one study. Service users' personal recovery was measured by four measures across four studies: Milestones to Recovery Scale (MTRS); Recovery Journey Questionnaire (RJQ); Mental Health Recovery Questionnaire (MHRM); and Process of Recovery Questionnaire (PRQ). Outcomes were found to vary regarding the intervention's effect on recovery. A significant association was found from attending at least one peer support group on personal recovery in Livingston et al.'s (2013) study, however evidence was not found that the wider service level intervention improved the service users' personal recovery. Moreover, the introduction of a structured patient-clinician communication approach to increase patient involvement in their care in a medium secure unit, did not find evidence of improved recovery outcomes in service users (MacIness et al., 2016).

Across the studies, it was reported that increased levels of therapeutic engagement and increased opportunities for structured activities and treatment were found to improve individual recovery. Furthermore, recovery was found to correlate positively with quality of life and negatively with social problems. In Gudjonsson's (2011) study, recovery was not found to correlate significantly with disturbed behaviour in an inpatient setting.

Two studies measured how well a service implemented a service design that was aligned with the recovery model (Corlett & Miles, 2010; and Livingston et al., 2016). It was found that the intervention did not have a significant effect on perceptions of recovery orientation services in both patients and staff (Livingston et al., 2013). In Corlett and Miles' (2010) paper, staff and patient perceptions of how well a recovery approach had been implemented differed, with staff consistently rating it as better implemented across ratings on 24 recovery elements, using the Developing Recovery Enhancing Environments Measure (DREEM). Furthermore, MDOs forensic history was found to be predictive of success of implementation of recovery approach, with differences found between sexual and violent offenders; and between MDO's detained under a Section 41 Restriction Order than those on a civil section.

4.4.2. Quality of Life

Five studies reported quality of life outcomes using two different measures: the Lancashire Quality of Life Profile (LQoLP) (Bouman et al., 2009) and the Manchester

Short Assessment of Quality of Life (MANSA) (Gudjonson et al. 2011; and MacIness et al., 2016). Two studies did not use a formal measure of quality of life but gathered clinical data related to quality of life (Smith et al., 2010; and Ward and Attwell, 2014).

In a randomised control trial, positive effects were found on quality of life from recovery focused service level intervention, as compared to controls. The study reports however, that a full trial would be required to estimate the effect with better certainty (MacIness et al., 2016). A further study reported an improvement in quality of life for patients in a community forensic team with a good lives model informed service design (Bouman et al., 2009). This was however a self-rated item on a unvalidated rating scale developed for the study. Based on these two studies, it seems that quality of life improves from a strength-based approach, however, the evidence is somewhat limited currently.

Other studies explored how quality of life related to other outcome domains. There was a positive correlation found between QOL and recovery with a medium effect size found (Gudjonsson et al., 2011). Quality of life and subjective well-being were related to recidivism data, with a modest relationship found with violent reconvictions. Furthermore, satisfaction with health and life fulfilment were found to predict significantly decreased levels of self-reported offences (Bouman et al., 2009).

4.4.3. Violence/ Risk

Four studies reported on outcomes related to violence and risk. Outcome measures were used in two of the studies: the Self-reported Delinquent Behaviour Inventory (SRDB); and the Disruptive Behaviour and Social Problem Scale (DBSP) (Bouman et al., 2009; Gudjonsson et al., 2011). Two further studies used clinical data: clinical notes, untoward incidents forms, and recorded PRN use (MacIness et al., 2011; and Walker & Paton, 2015).

Three of the four studies reported a reduction in violence and risk from strength based interventions. As reported previously one study found a significant association between quality of life and self-reported violent offences, suggesting that as quality of life improves, violence and risk decreases (Bouman et al., 2009). MacIness (2011) found a reduction in challenging behaviour and violence from patients in the treatment group as compared to controls. This included a reduction in recorded seclusions, physical restraints, self-harm attempts and violence. Furthermore, patients who attended a recovery-based music group had a reduction in PRN medication use and challenging behaviour (Walker & Paton, 2015). In one of the studies however, a significant relationship was not found between disruptive behaviour and recovery or quality of life (Gudjonsson et al., 2011).

4.4.4. Recidivism

Bouman et al. (2009) recorded rates of recidivism, by obtaining it from the Central Judicial Documentation register at the Dutch Ministry of Justice. No other studies

reported recidivism data. Recidivism data was collected at follow up at a time between 28 and 46 months. It was found that 24.5% of those that completed the intervention, were convicted of a new offence committed after the engagement with a Good Lives Model informed service. The study found a modest negative relationship between subjective wellbeing and recidivism. The data suggested that satisfaction with health was significantly correlated with recidivism in relation to violent offences.

4.4.5. Mental health symptoms

Four studies reported outcomes related to mental health symptoms, recorded with two outcome measures: the Beck Hopelessness Scale (BHS); and internalised stigma of mental illness scale (ISMI). A negative correlation was found between recovery and BHS (medium effect size), suggesting that as a recovery approach progresses, feelings of hopelessness reduce (Gudjonsson et al., 2011). In Livingston et al.'s (2013) study, the intervention was not found to have a significant effect on internalised shame with the exception of patients who had used peer support, which appeared to reduce internalised stigma.

4.4.6. Therapeutic Milieu

Two studies reported the therapeutic milieu outcome using the EssenCES (Livingston et al., 2013; MacIness et al., 2016). In both studies, the intervention did not have a significant effect on staff and patients' perceptions of therapeutic milieu.

4.4.7. Engagement

Five different types of engagement outcomes were recorded by three studies. Across the three studies, engagement outcomes varied. In Livingston et al.'s (2013) paper, the recovery informed service level intervention, did not have a significant effect on levels of service engagement. In MacIness et al.'s (2016) study it was found that there was a small increase in engagement as the intervention progressed. Furthermore, it was found that there was not a significant treatment effect on reported service user satisfaction. A positive relationship was however, found between recovery and treatment motivation (medium effect size) and treatment engagement (large effect size) in Gudjonsson et al.'s (2011) study of the application of the recovery model in NHS medium and low secure units.

4.5. Quality of included studies

Ratings for all included papers on the 11 quality criteria are given in table 2, which allows for the consideration of each paper's relative strengths. MacInness et al (2016) is the methodically strongest study. Fluttert et al. (2010) was of average quality, however the other eight studies were found to be of low quality overall. Nine of the ten studies were not able to be rated on the first three quality criteria, which assessed the internal validity of the studies as these criteria were not applicable to these studies.

Table 2. Quality assessment of included studies

Author(s)	Randomisation	Allocation	Attrition	Outcome measures	Measure Relevance	Power	Analysis	Intervention Definition	Fidelity	Routine	Follow up	Overall score (/33)
Bouman et al. (2009)	NA	NA	NA	AA	WC	NR	WC	PA	NR	WC	WC	15
Corlett & Miles (2010)	NA	NA	NA	PA	WC	NA	WC	AA	NA	WC	NA	12
Doyle et al (2012)	NA	NA	NA	AA	WC	NR	WC	AA	NA	WC	WC	16
Gudjonsonn et al. (2011)	NA	NA	NA	WC	WC	NR	WC	PA	NR	WC	NA	13
Livingston et al. (2013)	NA	NA	NA	WC	WC	NR	WC	WC	NR	WC	NA	15
MacIness et al. (2016)	WC	WC	PA	PA	WC	NA	WC	WC	WC	WC	WC	26
Smith et al. (2010)	NA	NA	NA	PA	AA	NA	PA	WC	AA	WC	NA	14
Walker & Paton (2015)	NA	NA	NA	PA	PA	NA	NA	AA	NA	WC	NA	7
Ward and Attwell (2014)	NA	NA	NA	PA	PA	NA	NA	AA	NA	WC	NA	7
Wiglesworth & Farnworth (2016)	NA	NA	NA	PA	AA	NA	PA	AA	NA	WC	NA	9

(WC) Well covered = 3, (AA) Adequately addressed = 2, (PA) Poorly addressed = 1, (NA) Not addressed = 0, (NR) Not reported = 0 and (NA)Not applicable = 0.

5. Discussion

5.1. Main findings

A systematic review of strength-based approaches with mentally disordered offenders (MDOs) was conducted. It was demonstrated that MDOs benefited from strength-based approaches, with some improvements noted in the domains of quality of life, recovery, engagement, violence/ risk, recidivism and mental health symptoms. The findings suggest that strength-based approaches are positively applicable in forensic mental health settings, however the conclusions that can be drawn from this are limited as the overall quality of the studies was poor and the outcomes were not consistent across the studies.

5.2. Strengths of the papers

A strength of the papers is that all were conducted in clinical settings as part of routine clinical practise across a range of forensic mental health environments. The sample of participants and the outcomes found are therefore likely to be reflective of the challenges of working with this population and carrying out research with good external validity.

Furthermore, six of the papers were rated as having “well covered” analysis of outcome measures and reporting of results, therefore providing clear and meaningful results. Across the papers, the outcomes measured and recorded in the papers were also mainly very relevant to the intervention and evaluation, with six

papers rated as *"well covered"* and two papers as *"adequately covered"* on ratings of quality criteria.

5.3. Limitations of the papers

Overall, the quality of studies was reasonably poor. Only one study employed a randomised controlled trial design and the nine other studies did not utilise any control groups. It is not clear therefore, whether the results may have been confounded by factors outwith the strength-based approach which may have had an influence on the therapeutic outcomes reported. The lack of use of controls is acknowledged by many of the papers and moreover, is a wider issue within forensic mental health populations (Hockenhull et al., 2015). The use of control and withholding treatment from patients raises ethical considerations and human rights issues (Smith et al., 2010). Furthermore, priority is given to security and risk consideration over the needs of research (Fitspatrick et al., 2010). This, therefore, contributes to a general lack of randomised controlled trials in forensic mental health. Moreover, it is likely that the heterogeneity of the service users included in the study, impacted on the outcomes recorded. There were a range of mental disorders, personality disorders, substance misuse and offence history recorded. Furthermore, the included studies had small samples and power was not reported in any of the studies.

Furthermore, the outcomes were often inconsistent across the studies. There was a lack of follow up in the studies with only three of the ten studies recording follow

up data. There was also little overlap of the same measures used across studies. Only two measures, the Manchester Short Assessment of Quality of life (MANSA); and the Essen Climate Evaluation Schema (EssenCES), were used in multiple studies. Both outcome measures were used in two papers each. This limitation has been acknowledged in previous forensic mental health research with a previous review of interventions of MDOs reporting 345 different measures from 300 trials (Cure et al., 2005).

A further limitation of the papers is the lack of clarity regarding the interventions used. All can be categorised as strength-based interventions at a service and a direct intervention level; however it is not clear as to how this has been operationalised within the service. It is difficult therefore to be confident in making comparisons across these studies. This is a problem and a criticism of the research that has been found in the wider strength-based literature (Ibrahim et al., 2014).

Many of these criticisms are also criticisms of research within forensic mental health generally. It is difficult to standardise outcome measures with this population, due to the multiple targets for intervention and multiple problems, including mental health and substance misuse difficulties. Furthermore, research has focused more on public safety rather than clinical and rehabilitation outcomes (Fitzpatrick et al., 2010). Forensic populations also frequently move through different health and custodial settings and clinically there is a priority for security and duty of care to the individuals, that limits the possibilities of undertaking

randomised controlled trials in forensic mental health research (Fitzpatrick et al., 2010).

5.4. Strengths and limitations of review

The use of an interrater who was independent of the research helped limit the potential subjective bias of the methodological analysis.

A criticism of the review is that it excluded qualitative studies, despite their being a number of qualitative studies undertaken in both forensic mental health and in strength-based approaches (Roychowdhury, 2011; O'Sullivan et al., 2013). Future reviews may benefit from a consideration of taking a mixed research methods approach, for example utilising the mixed methods appraisal tool (MMAT) (Pluye et al., 2011), which would allow for a consideration of qualitative, quantitative and mixed methods studies. Furthermore, given the low quality of included studies and lack of RCTs, future research should consider using a different a quality criteria scale or making further adaptations to that used in this review.

A further limitation of this review is that only studies in English language were included in the review, which could potentially have caused biases in sampling and potentially limited the studies included in the review. Moreover, the inclusion of two service evaluations with no statistical analysis, may limit the findings of this review.

5.5. Implications for further research and clinical practice

Strengths based approaches show promise as a model for service design and direct interventions within forensic mental health. Strength-based and recovery orientated approaches have been increasingly welcomed by policy makers (Tse et al., 2016). Future research and clinical practice would benefit from developing a clearer framework to inform service design and therapeutic milieu. These approaches would benefit from clear definitions and being operationalised or manualised and helping to inform how the recovery model and Good Lives Model compare to each other. This would be assisted from a more consistent and standardised approach to outcome measures across studies.

Operationalising this approach would also aid with staff training. This is important as it is clear that this approach is regularly used at a staff level to inform service design and the therapeutic milieu. This was apparent in the review, with 8 of the 10 included papers reporting a service design methodology. In these papers it is not clear what training that staff have had to implement this and to move away from a deficit and risk focus. Within general mental health settings, a fidelity scale for the strength-based approach has been developed and used in studies to measure the adherence of staff to the elements of this model (Fukui et al., 2012). It could be helpful to adopt the use of this fidelity measure within forensic mental health settings and may assist in implementing and evaluating the effectiveness of this approach.

There is a need for more high-quality studies to further explore the effectiveness of strength-based approaches within forensic mental health. The care of MDOs and the development of strength-based approach approaches would benefit from larger scale studies. Studies that are conducted across multiple forensic services and environments would reduce the heterogeneity of the existing literature. This would help develop the external validity of these studies, which is likely to develop more informed guidance for a range of services that work with this population. It would also benefit from a standardised framework for study protocols, for example using the CONSORT (consolidation standards of reporting trials) guidelines. The use of controls is needed in future studies as only one randomised controlled trial was found in this review.

6. Conclusions

This is the first review to explore strength-based approaches in forensic mental health. Future research within forensic mental health needs to further balance the concerns of public safety, clinical, rehabilitation and humanitarian outcomes, whilst striving to explore more strength-based outcomes. Limited evidence was found and there was also a lack of consistent significant findings. Despite these limitations, strength-based approaches appear to be a promising approach to managing the care and treatment of mentally disordered offenders across a range of forensic and health environments. Moreover, it appears to be a growing approach to service design and for direct interventions. The current, although limited evidence, seems to suggest that a strength-based approach will facilitate outcomes in quality of life,

recovery, mental health symptoms, violence, risk, recidivism, and engagement. Further consideration of the long-term impact of such an approach is needed as only one study looked at longer term rates of recidivism. There is a clear need therefore, for further high-quality research of this approach with mentally disordered offenders to establish its effectiveness and develop evidence based interventions and structured clinical care.

7. References

Andrews, D. A., Bonta, J., & Hoge, R. D. (1990). Classification for effective rehabilitation: Rediscovering psychology. *Criminal Justice and Behavior*, 17(1), 19–52.

Barnao, M., Ward, T., & Robertson, P. (2015). The Good Lives Model: A New Paradigm for Forensic Mental Health. *Psychiatry, Psychology and Law*, *8719*, 1–14.

Beck, A. T., & Steer, R. A. (1988). *Beck hopelessness scale manual*. New York: The Psychological Corporation Harcourt Brace Jovanovich, Inc.

* Bouman, Y. H. A., Schene, A. H., & de Ruiter, C. (2009). Subjective well-being and recidivism in forensic psychiatric outpatients. *The International Journal of Forensic Mental Health*, *8*(4), 225–234.

Brown C, Dunn W (2002). *Adolescent/Adult Sensory Profile*. USA: Pearson.

Bullock, W. A. (2005). Mental health recovery measure. In T. Campbell-Orde, J. Chamberlin, J. Carpenter & H. S. Leff (Eds.), *Measuring the promise of recovery: A compendium of recovery measures* (Vol. II, pp. 133-135). Cambridge, MA: Human Services Research Institute.

Centre for Research and Dissertations (2008). *Systematic reviews: CRD's guidance for undertaking reviews in health care.*

* Corlett, H., & Miles, H. (2010). An evaluation of the implementation of the recovery philosophy in a secure forensic service. *The British Journal of Forensic Practice*, *12*(4), 14–25.

Cure S, Chua WL, Duggan L, Adams C. (2005). Randomised controlled trials relevant to aggressive and violent people, 1955–2000: a survey. *Br J Psychiatry*;186(3):185–9.

Dam, C. van, Janssens, J.M.A.M, Bruyn, E.E.J. van, Koolen, J.J.C.M., & Spee, J.E.J. (1999). Self-report delinquent behaviour inventory. *WODC. K.U.N./ R.I.J.* Nijmegen, The Netherlands: De Hunnerberg.

Davies, J., Howells, K., & Jones, L. (2007). Evaluating innovative treatments in forensic mental health: A role for single case study methodology. J*ournal of Forensic Psychiatry & Psychology*, 18(3), 353–367.

* Doyle, M., Logan C., & Ludlow, A. (2012). Milestones to recovery: Preliminary validation of a framework to promote recovery and map progress through the

medium secure inpatient pathway. *Criminal Behaviour and Mental Health* 22:53–64.

Drennan, G., & Alred, D. (Eds.). (2012). *Secure recovery: Approaches to recovery in forensic mental health settings*. London: Routledge.

Fitzpatrick R, Chambers J, Burns T, Doll H, Fazel S. (2010) A systematic review of outcome measures used in forensic mental health research with consensus panel opinion. *Health Technol Assess,* 14(18).

Fluttert, F. A. J., van Meijel, B., Nijman, H., Bjørkly, S., & Grypdonck, M. (2010). Preventing aggressive incidents and seclusions in forensic care by means of the "Early Recognition Method." *Journal of Clinical Nursing*, *19*(11–12), 1529–1537.

Fukui S, Goscha R, Rapp CA, Mabry A, Liddy P, Marty D (2012). Strengths model case management fidelity scores and client outcomes. *Psychiatr Serv*, 63(7):708–710.

Green, T., Batson, A., & Gudjonsson, G. H. (2011). The development and initial validation of a service-user led measure for recovery of mentally disordered offenders. *The Journal of Forensic Psychiatry and Psychology*, 22, 252–265.

Grounds, A., 2019. Discrimination against offenders with mental disorder. *Criminal Behaviour and Mental Health*, 29(4), pp.247–255.

* Gudjonsson, G. H., Savona, C. S. V, Green, T., & Terry, R. (2011). The recovery approach to the care of mentally disordered patients. Does it predict treatment engagement and positive social behaviour beyond quality of life? *Personality and Individual Differences*, *51*(8), 899–903.

Gudjonsson, G. H., Young, S., & Yates, M. (2007). Motivating mentally disordered offenders to change. Instruments for measuring patients' perception and motivation*. The Journal of Forensic Psychiatry and Psychology*, 18, 74–89.

Hillbrand, M., & Young, J. L. (2008). Instilling hope into forensic treatment: The antidote to despair and desperation*. Journal of the American Academy of Psychiatry and the Law,* 36(1), 90–94.

Hockenhull JC, Cherry MG, Whittington R, et al. (2015). Heterogeneity in interpersonal violence outcome research: an investigation and discussion of clinical and research implications. *Aggress Violent Behav*;22:18–25.

IBM Corp. (2016). IBM SPSS Statistics for Windows, Version 24.0. Armonk, NY: IBM Corp

Ibrahim, N., Michail, M. & Callaghan, P., (2014). The strengths based approach as a service delivery model for severe mental illness: a meta-analysis of clinical trials. *BMC Psychiatry*, 14(1), p.243.

* Livingston, J. D., Nijdam-Jones, A., Lapsley, S., Calderwood, C., & Brink, J. (2013). Supporting recovery by improving patient engagement in a forensic mental health hospital: Results from a demonstration project. *Journal of the American Psychiatric Nurses Association*, *19*(3), 132–145.

Long, C. G., Knight, C., Bradley, L., Thomas, M., Knight, C., Bradley, L., & Effective, M. T. (2012). Effective therapeutic milieus in secure services for women: The service user perspective, 8237.

MacInnes D, Beer D, Keeble P, Rees D, Reid L. (2010). The development of a tool to measure patient satisfaction with in-patient forensic services: the forensic satisfaction scale. *J Ment Health*;19(3):272–81.

* MacInnes, D., Kinane, C., Parrott, J., Mansfield, J., Craig, T., Eldridge, S., Priebe, S. (2016). A pilot cluster randomised trial to assess the effect of a structured communication approach on quality of life in secure mental health settings: The Comquol Study. *BMC Psychiatry*, *16*(1), 1–15.

Maslach C, Jackson SE. (1981). The measurement of experienced burnout. *J Occup Behav.* 1981;2:99–113.

Neil ST, Kilbride M, Pitt L, Nothard S, Welford M, Sellwood W, Morrison AP. (2009). The Questionnaire about the Process of Recovery (QPR): a measurement tool developed in collaboration with patients. *Psychosis*;1(2):145–55

NHS Education for Scotland. (2011). *The Matrix: A guide to delivering evidence-based psychological therapies in Scotland.* Edinburgh: Scottish Government.

Nieuwenhuizen, Ch. van, Schene, A.H., Boevink, W. A., & Wolf, J.R.L.M. (1998). The Lancashire Quality of Life Profile: First experiences in the Netherlands. *Community Mental Health Journal*, 34, 513– 524.

Novak T, Scanlan J, McCaul D, MacDonald N, Clarke T (2012). Pilot study of a sensory room in an acute inpatient psychiatric unit. *Australasian Psychiatry* 20(5): 401–406.

O'Brien, A., White, S., Fahmy, R., & Singh, S. P. (2009). The development and validation of the SOLES, a new scale measuring engagement with mental health services in people with psychosis. *Journal of Mental Health*, 18, 510-522.

O'Connell, M., Tondora, J., Croog, G., Evans, A., & Davidson, L. (2005). From rhetoric to routine: Assessing perceptions of recovery-oriented practices in a state mental health and addiction system. *Psychiatric Rehabilitation Journal*, 28, 378-386.

O'Sullivan, M., Boulter, S. & Black, G. (2013). Lived experiences of recalled mentally disordered offenders with dual diagnosis: a qualitative phenomenological study. *Journal of Forensic Psychiatry & Psychology*, 24(3), 1–18.

Palijan, T. Z., Radeljak, S., Kovac, M., Kovacevic, D. (2010). Relationship between comorbidity and violence risk assessment in forensic psychiatry. The implication of neuroimaging studies. *Psychiatria Danubina*, 22, 253-256.

Pluye, P., Robert, E., Cargo, M., Bartlett, G., O'Cathain, A., Griffiths, F., Rousseau, M. C. (2011). *Proposal: A mixed methods appraisal tool for systematic mixed studies reviews*.

Priebe S, Gruyters T. (1993). The role of the helping alliance in psychiatric community care: a prospective study. *J Nerv Ment Dis*. 1993;181(9):552–7.

Priebe, S., Huxley, P., Knight, S., & Evans, S. (1999). Application and results of the Manchester Short Assessment of Quality Of Life (MANSA). *International Journal of Social Psychiatry*, 45, 7–12.

Ridgway, P., & Press, A. (2001). *Assessing the recovery-commitment of your mental health service: A user's guide for the Developing Recovery Enhancing Environments Measure (DREEM). UK pilot version 1.*

Ritsher, J. B., Otilingam, P. G., & Grajales, M. (2003). Internalized stigma of mental illness: Psychometric properties of a new measure. *Psychiatry Research*, 121(1), 31-49.

Robertson, P., Barnao, M., & Ward, T. (2011). Rehabilitation frameworks in forensic mental health. *Aggression and Violent Behavior*, 16(6), 472–484.

Rogers, E. S., Chamberlin, J., Ellison, M. L., & Crean, T. (1997). A consumer-constructed scale to measure empowerment among users of mental health services. *Psychiatric Services,* 48, 1042-1047.

Ross, J., Quayle, E., Newman, E., & Tansey, L. (2013). The impact of psychological therapies on violent behaviour in clinical and forensic settings: A systematic review. *Aggression and Violent Behavior*, *18*(6), 761–773.

Roychowdhury, A. (2011). Bridging the gap between risk and recovery: a human needs approach. *The Psychiatrist*, 35(2), 68–73.

Schalast, N., Redies, M., Collins, M., Stacey, J., & Howells, K. (2008). EssenCES, a short questionnaire for assessing the social climate of forensic psychiatric wards. *Criminal Behaviour and Mental Health*, 18(1), 49-58.

* Smith, R. J., Jennings, J. L., & Cimino, A. (2010). Forensic continuum of care with assertive community treatment (ACT) for persons recovering from co-occurring disabilities: Long-term outcomes. *Psychiatric Rehabilitation Journal*, *33*(3), 207–218.

Tse, S., Tsoi, E. W. S., Hamilton, B., O'Hagan, M., Shepherd, G., Slade, M., Petrakis, M. (2016). Uses of strength-based interventions for people with serious mental illness: A critical review. International Journal of Social Psychiatry, 62(3), 281–291.

Vandevelde, S., Vander Laenen, F., Van Damme, L., Vanderplasschen, W., Audenaert, K., Broekaert, E., & Vander Beken, T. (2017). Dilemmas in applying strengths-based approaches in working with offenders with mental illness: A critical multidisciplinary review. *Aggression and Violent Behaviour*, 32, 71–79.

Verbeke, P., Vermeulen, G., Vander Beken, T. and Meysman, M. (2015). Protecting the fair trial rights of mentally disordered defendants in criminal proceedings: exploring the need for further EU action, *International Journal of Law and Psychiatry*, 41, 67-75.

* Walker, S., & Paton, s. (2015). Lifemusic as an aid to recovery in a forensic mental health setting. *Journal of Psychiatric Intensive Care*, *11*(1), 7–12.

* Ward, M., & Attwell, P. (2014). Evaluation of two community outreach forensic psychological services. *Journal of Forensic Practice*, *16*(4), 312–326.

Ward, T. (2002). Good lives and the rehabilitation of offenders: Promises and problems. Aggression and Violent Behaviour, 7, 513-528.

* Wiglesworth, S., & Farnworth, L. (2016). An exploration of the use of a sensory room in a forensic mental health setting: Staff and patient perspectives. *Occupational Therapy International*, *23*(3), 255–264.

Young, S., Gudjonsson, G. H., Ball, S., & Lam, J. (2003). Attention Deficit Hyperactivity Disorder (ADHD) in personality disordered offenders and the association with disruptive behavioural problems. *The Journal of Forensic Psychiatry and Psychology*, 14, 491–505.

Part B: Empirical Research Study

Searching for the self and belonging

An exploration of values of men in medium secure units

Prepared for submission to the

Journal of Qualitative Health Research

(See Appendix 11 for the journal's guide for Authors)

Searching for the self and belonging

An exploration of values of men in medium secure units

Stuart Cooney, Louise Tansey, Ethel Quayle

Abstract

There is an increasing emphasis on values and recovery in health settings and in forensic mental health services. There is currently a paucity of research into values and mentally disordered offenders (MDOs). In this study, we explored the values of men in a medium secure unit who have offended. The study employed Grounded Theory Methods to build a theory of values of men in a medium secure unit who have offended. Interviews were conducted with nine inpatients in a medium secure unit in Scotland.

The model that emerged involves four conceptual stages that captures the dynamic nature of values and the experiences of MDOs. The expressed values of MDOs was made up four separate categories relating to: (1.) connecting with others; (2.) living a healthy life; (3.) being productive and contributing; and (4.) having agency and being in control. The model depicts a process of values across the lifespan in an individual from the: (1.) early development and consolidation of values; (2.) the way in which these values are expressed through behaviour and goals; and (3.) the fluctuating balance and expression of values throughout an individual's life. Each of these components in the lifespan of values are proposed to be sensitive to and influenced by various barriers, restrictions and opportunities that an individual must navigate in life. Participants discussed the impact that their (1.) interpersonal

relationships; (2.) environment and culture; (3.) health challenges; and (4.) the consequences of offending, had on them and their values throughout their lifespan. This dynamic process, which appears to be vulnerable to change throughout people's lives, contributed to the individual's sense of their self. This sense of self appears to be fragile and there is *uncertainty regarding the self and how they fit in with the world around them* (Searching for the self and belonging). The implications of this model are considered in relation to existing theories of values with MDOs and the clinical applications of this study are explored.

Keywords

Values; forensic; mentally disordered offender; medium secure; qualitative; grounded theory method; United Kingdom

8. Introduction

8.1. Values and the political and health context

Recent national health and political campaigns, such as the Well Scotland Initiative, NHS England's RightCare programme and the Recovery model have highlighted the importance of the role of individuals' values and the benefits of pursuing them in addressing mental well-being. There is an increasing emphasis on values and recovery in health settings (Centre for Mental Health, 2011; Hayes, 1999) and in forensic mental health services (Forensic Mental Health Matrix, 2011).

As part of the drive to improve mental wellbeing, the Scottish Government have developed and supported a range of strategies and measures to *"help create a fairer Scotland".* The Mental Health Strategy 2017-2027 (Scottish Government, 2017) sets out commitments to accessing mental health services that reflect the importance that is attached to *"realising the right of every individual to the highest attainable standard of physical and mental health".* Good Mental Health for All (NHS Health Scotland,2016) aims to improve mental wellbeing through promoting values of good mental wellbeing. Within criminal justice, The Justice Strategy: Justice in Scotland: Vision and Priorities (Scottish Government, 2017-2020) further developed a recovery based approach within forensic settings. This states that one of the priorities of the justice system in Scotland is that prison is to be used only when necessary to address offending or to protect public safety. Furthermore, this provision should focus on wellbeing, recovery, rehabilitation and reintegration.

There is clearly an increased and more prominent discourse around values across the media, politics, health care, criminal justice and business domains. This is apparent in health and criminal justice systems through the use of *"value statements"* in their organisation's mission statements. This is a means of shaping what is most important to the organisation, how it strives to conduct itself and is a way of communicating this to its staff and the public (Day & Casey, 2009). It can be seen therefore, that there is a growing consideration of values at an individual, organisational, national and political level and this both reflects and informs behavior and strategy.

8.2. Conceptualising values

Values are defined as what are important to an individual and guiding principles to live by. They are understood as action guiding and relate to specific goals. Furthermore, values are also considered to provide norms and standards which can be used to evaluate specific actions against these norms (Ward & Heffernan, 2017). There have been various ways of conceptualising values within the literature including Sadler (2005); Schwartz's (1992) structural model; and a contextual, behavioural model from Acceptance and Commitment Therapy (ACT) (Hayes, 1999).

An ACT based conceptualisation of values was used in this study to inform the interview and research approach. The ACT based conceptualisation of values, states that values are verbal constructions of *"organising principles for action"* and this provides a long-term framework for an individual's decisions and actions

(Hayes, 1999). From a behavioural perspective, decisions and actions that are carried out in line with their values are positively reinforced (Powers et al., 2009).

In Acceptance and Commitment Therapy, metaphors are used to help clients understand values and also to differentiate between values and goals. The compass metaphor proposes that values are like directions that one wants to move to in life; and goals are the things that they want to achieve (Hayes et al., 1999). The following quote is a way that this is communicated to clients in ACT based therapy:

"Values are like a compass. A compass gives you direction and keeps you on track when you're travelling. And our values do the same for the journey of life. We use them to choose the direction in which we want to move and to keep us on track as we go." (Harris, 2009)

8.3. Mentally disordered offenders and medium Secure Units

There is an increasing focus placed on values based interventions in forensic mental health and working with Mentally Disordered Offenders (MDOs). MDOs are defined as people with a mental illness, personality disorder or learning disability and have a history of significant offending behaviour, and/ or represent a significant risk to others (Forensic Mental Health Matrix, 2011). They are a complex group and diverse population who present with a range of chronic, complex and co-morbid mental health difficulties (Palijan et al., 2010), are subject to compulsory measures under mental health legislation, and are often regarded as difficult to treat (Barnao & Ward, 2015). The treatment and management of mentally disordered offenders is informed by two distinct institutions: the criminal justice and the mental health system, and therefore has to balance risk centered and psychopathology

approaches. This requires care and management by specialists with forensic expertise with increased security. This creates difficult conceptual, clinical and ethical issues in forensic populations as the patient's well-being is balanced with a focus on protecting the public through the reduction of risk and recidivism. Balancing the aims of these two distinct institutions is considered problematic (Barnao & Ward 2015) and may be a barrier to care. A recent critical review found evidence that offenders with a mental disorder were not able to access the equivalent mental health care to that available for non-offenders with a mental disorder (Grounds, 2019).

The challenge of working with MDOs is further compounded by a small evidence base for interventions and paucity of theories and rehabilitation models to guide clinical practice (Robertson et al., 2011). Strength-based approaches to working with MDO's move from a focus just on mental disorder and risk to a wider consideration of the individual that considers their strengths, personal priorities and competencies. The recovery approach is one of the most prominent of strength-based approaches, which has been used in mental health services and extended to forensic based populations. Through the recovery approach and strength-based approaches there is greater acknowledgment of the difficulties of dual recovery from mental illness and offending behavior and an effort to balance risk management and restoring a meaningful and satisfying life in patients (Drennan & Alred, 2010). There is a paucity of empirical research to guide the rehabilitation of MDOS in a forensic mental health context and the majority of published literature

has focused on the application and evaluation of specific interventions rather than on the development of overarching models of care.

8.4. Mentally disordered offenders and values

As discussed, there is an increasing focus on values informed interventions, however there is a paucity of published research in this area, particularly with MDOs. Being detained in a medium secure unit (MSU) presents many challenges in pursuing goals in line with a number of values including, freedom, autonomy and intimate relationships (Mezey, 2010). Furthermore, MDOs within secure facilities and in the community, may be more limited in their pursuit of relationships and employment due to the double stigma that MDOs face of mental illness and offending (Roskes & Feldman, 1999). Moreover, a focus on risk to self and others in medium secure units can limit the pursuit of values and goals (Mezey et al., 2010). Legal restrictions can also be a barrier to achieving goals, for example a goal of being close to family but being unable to pursue this due to restrictions on movement (Stuart, 2015).

Across the literature there is not an agreement on the nature of mentally disordered offenders' values and how these compare to the general population. Within the strengths-based approach, The Good Lives Model (GLM) moves from a previous primary focus on the management of risk, to balancing this with promoting the goals of the individual, their recovery and positive risk taking. This approach was initially used within a sex offender population but is also thought to be a

promising intervention with mentally disordered offenders (MDOs) (Barnao et al., 2016). This model makes an assumption that offenders have the same needs and aspirations as everyone else, whereas previously it was assumed that offenders did not have the same set of values as the general population (Ward, 2002). The aim of the GLM is to build resources for the individual to live a life that is meaningful, fulfilling, in line with their values and to reduce risk. In this model, 11 *"primary goods"* are proposed, which are an individual's values, needs and aspirations. The primary goods are defined as: life; knowledge; excellence in play; excellence in work; excellence in agency; inner peace; relatedness; community; spirituality; pleasure; and creativity (Purvis, 2010). It is posited that criminal behaviour, for example psychotically driven violence may be a method for an individual try to obtain their primary goods (Barnao, et al., 2010). Applied to sexual offenders for example, the Good Lives Model suggests that sexually abusive behaviour may be motivated to achieve the value of intimacy. From this perspective, offenders' values are thought to be congruent with the general population, but it is the way in which they attempt to enact their values that is problematic (Day and Casey, 2009). There have however, been conflicting ways to conceptualise values in MDOs. Research into the narrative roles of MDOs, propose that MDOs have a distorted set of values and an acceptance of antisocial behaviours, as compared to the general population (Spruin et al., 2014).

8.5. The present research

There has been little research into values and mentally disordered offenders previously, and there appears to be conflicting views on how offender's values relate to non offenders. Furthermore, values based approaches, like the Good Lives Model have assumed a set of values based on non-offending populations but there has been little work done to identify the values of this population directly. This study strives to address this limited and conflicting literature, and a qualitative study may be able to offer further insight into the values that are personally meaningful to this population and the barriers to pursuing these values. Qualitative methods have been found to help explore such issues and elicit the personal narratives within the recovery model (Roychowdhury, 2011; O'Sullivan et. al., 2013).

There may be an additional clinical benefit of conducting this research, as discussions of values have been found to be a positive part of recovery and can also improve engagement with therapy and identification of therapeutic goals (Stuart, 2015; Tansey, 2010). Research that seeks to increases engagement in this population is valuable. This has the potential to benefit the care and treatment of this group of patients and additional benefits may be a reduction in risk, which benefits the safety and welfare of the general public also.

1.6. Objectives

The objective of this study was to develop a grounded theory of the values of men in medium secure units. The purpose was to gain an understanding of (a) the values

that are personally meaningful to this population; and (b) the barriers to pursuing these values.

9. Methods

Design

The research used a qualitative design to explore the values and goals of mentally disordered offenders (MDOs) in a medium secure psychiatric unit. Semi structured interviews were undertaken with MDOs at a medium secure unit in Scotland, to gather data. The study adopted a grounded theory methodology to develop an understanding of the values and goals from the patients' perspective to assist in the development of a theory. The research proposal and consent process received approval from NHS Research Ethics (Reference: 12/SS/0219, Appendix 6).

Participants and recruitment

Participants were current residents in a NHS medium secure unit in Scotland, who have severe and enduring mental health problems and have offended. All participants were 18 years old or over, able to give informed consent to participate, fluent in English, and were not currently experiencing acute symptoms of mental illness. Potential participants were excluded if they had significant communication difficulties, an intellectual disability, or were engaged in individual psychotherapy with the researcher. For the purposes of homogeneity and due to the majority of MDOs being male (Gow et al., 2010), the sample was of male MDOs only.

Recruitment was sought initially through the patient's Responsible Medical Officer (RMO), a Consultant Psychiatrist. They advised whether or not someone had capacity to consent to research and those without consent were excluded. Members of the clinical team then discussed the research with their patients who were deemed to have capacity, acting as gatekeepers for the research. The researcher then met with those interested in participating. At this meeting, the patient information sheet (Appendix 7) was reviewed and the patient was given the opportunity to discuss any questions they had. Participants were then given at least 24 hours to decide if they wished to participate in the study. Interviews were undertaken in a clinic room at the medium secure unit. All participants completed a consent form (Appendix 8) immediately before beginning the interview.

11 were approached by the researcher with information on the research study. Two declined to participate, stating that they felt uncomfortable with the interview being recorded. Nine people agreed to participate in this research and completed the interview process. To ensure anonymity, due to the small recruitment population, demographic and diagnostic information will be reported minimally, and details of participants' offences will not be reported. Participants were aged between 28 and 55 years old and the average time spent in the MSU was 40 weeks. All had a diagnosis of psychotic illness and they had been admitted to forensic secure care after a crisis event. Additionally, some participants had a diagnosis of personality disorder, autism spectrum disorder (ASD) and a history of substance abuse. Patients had been transferred to medium secure from three routes: court,

prison and high-security care. The participants who took part in the study were at varying stages in their forensic secure care journeys, with some close to discharge to low secure units, prison or to the community; whilst others had no immediate plans for discharge.

Procedure

All patients identified as suitable and who consented to participate met with the researcher for a face to face interview. This meeting, lasted approximately one hour and took place within the MSU in a quiet and private room. The interview explored values and goals within this population, their valued daily activities; and the impact of offending and mental health on attaining their values. The interview schedule is included in appendix 9. The interviews were audio recorded and stored securely on an NHS computer. Using a grounded theory method, notes were taken during the interview and a preliminary and ongoing analysis of the interviews altered the questions asked in later interviews.

Data Analysis

Anonymised transcripts of the interviews were analysed using Dedoose data management software (Dedoose, version 8.1, 2018). This software was used to organise and order data. The data was evaluated using grounded theory methods. This qualitative approach is a systematic, inductive and comparative method used to understand and evaluate human behaviour with the aim of constructing a theory (Charmaz, 2014). More specifically Charmaz's (2014) version of a constructivist

Grounded Theory approach was used to explore values and goals within MDOs. The main characteristics of grounded theory as outlined by Glaser and Strauss (1967), include the simultaneous collection and analysis of data, making use of memos taken during data collection and the interview transcript. Memoing was used to help increase the awareness of and monitor the researcher's own preconceived ideas and minimise the impact on the analysis and theory. Techniques were then used such as coding and categorisation, to identify categories in the data, make links and to establish the relationship between categories. Efforts were made to use a non-linear method and used a *"constant comparative method"* throughout the data collection and analysis. This was not always possible to adhere to due to the constraints of working in a clinical setting and the need to respond to tight time scales for recruitment of some participants who were due to be discharged imminently. As much as possible, the researcher moved backwards and forwards between the two, until the categories reached theoretical saturation, when there was no new information or insights reported in the data. At this stage in the process, a theory that was generated from the data was formed (Charmaz, 2014).

10. Results

We begin this section by describing a grounded theory of values and their development in mentally disordered offenders (MDOs). This model, informed by patient interviews, is an attempt to capture the dynamic nature of values and is made up of four conceptual stages. The conceptual stages are as follows:

1. Expressed values
2. The lifespan of values: consolidation, expression and change
3. Navigating barriers, restrictions and opportunities
4. Searching for the self and belonging

In Figure 1, a model is presented of the main components of MDO's experience of values. In the following sections, a grounded theory of values in MDOs will be elaborated on with quotations from patients to illustrate the components of the theory.

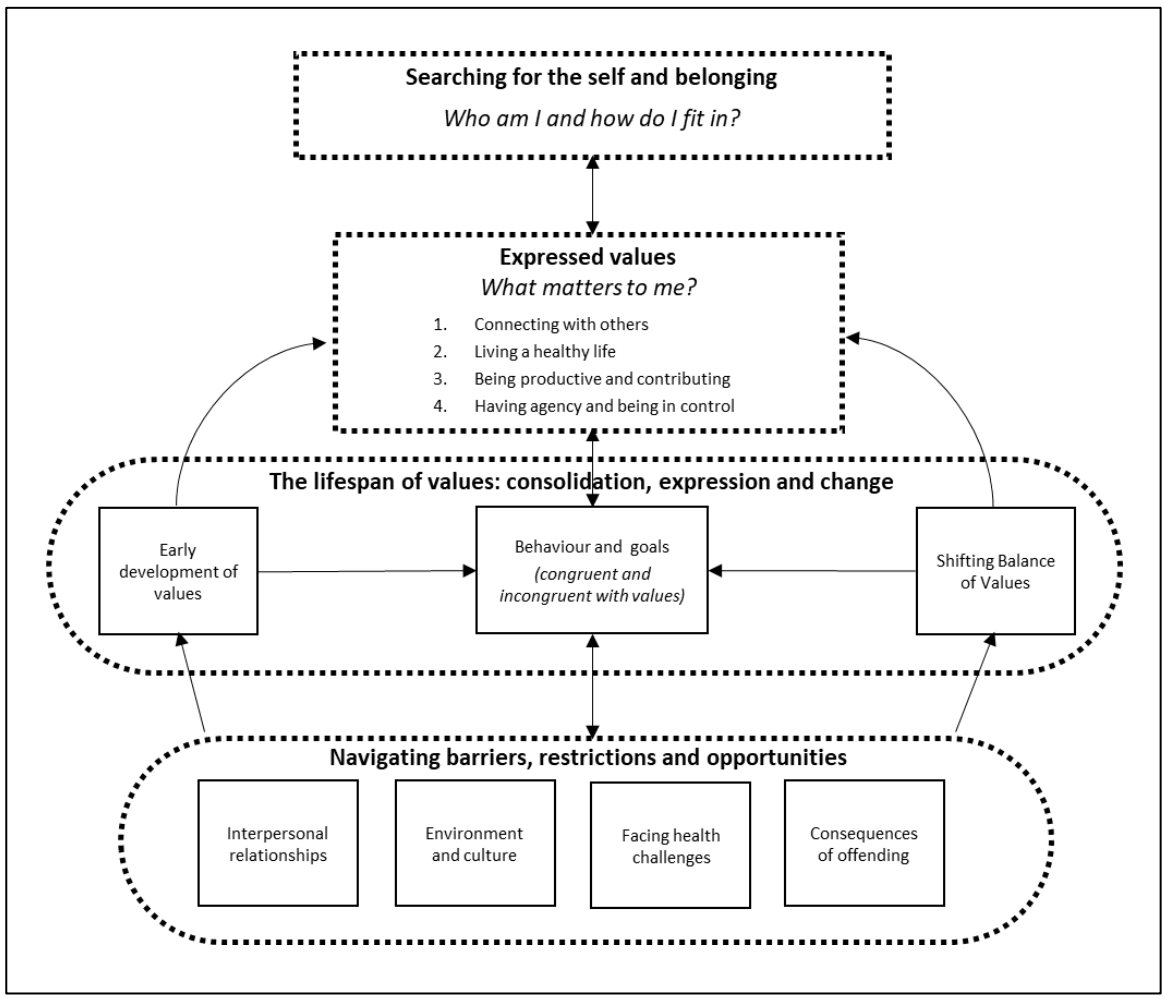


Figure 1. *Searching for the self and belonging:* A model of values of men in medium secure units

The **expressed values** of men in medium secure units were made up four separate categories relating to: *(1.) connecting with others*; *(2.) living a healthy life; (3.) being productive and contributing;* and *(4.) having agency and being in control.*

The model depicts a process of the **values across the lifespan** in an individual from the: (1.) *early development and consolidation of values*; (2.) the way in which these values are expressed through *behaviour and goals*; and (3.) the *fluctuating balance and expression of valu*es throughout an individual's life.

Each of these components in the lifespan of values are proposed to be sensitive to and influenced by various **barriers, restrictions and opportunities** that an individual must navigate in life. Participants discussed the impact that their *(1.) interpersonal relationships; (2.) environment and culture; (3.) health challenges;* and (4.) *the consequences of offending*, had on them and their values throughout their lifespan.

This dynamic process, which appears to be vulnerable to change throughout people's lives, seems to contribute to the individual's sense of their self. This sense of self appears to be fragile and there is *uncertainty regarding the self and how they fit in with the world around them (***Searching for the self and belonging***)*.

Core Category 1: What matters to me? The expressed values of mentally disordered offenders

All participants were asked about their values in the interviews. Most spoke about their values in the context of the difficulties living in line with their values due to the various barriers and restrictions in their lives. The core category of expressed values, *"What matters to me"* is comprised of four subcategories. Participants identified values relating to: (1.) connecting with others; (2.) living a healthy life; (3.) being productive and contributing; and (4.) having agency and being in control. These values shall be detailed below but will explored further in later sections in the context of how they relate to the other core categories.

Subcategory 1: Connecting with others

All participants discussed the importance of *"connecting with others"* throughout the interviews. Being connected to others and having meaningful relationships was something that was important to people across different environments: including the community, forensic and mental health settings. Participants described a number of different means of connecting with others: from peers in the MSU; friendships; family relationships; romantic relationships; professional relationships with staff or others in authority; religion and spirituality; and relationships with pets and animals.

Connecting with others appeared to be important to people for a number of reasons. Many discussed that relationships with peers, fellow patients and

members of staff allowed them to feel as part of a community and provided *"a real big sense of belonging"* (P.7.). Connections with others, can also help normalise difficult experiences or emotions for others:

P.8.:" I try and think of something positive, so I think of the other patients and say, Oh it's not that bad, we're all in here together. So it cheers me up and I'll talk to the nurses… Aye, that's what brings me up again, then I'll see my pals and I feel better after that."

A connection with others seemed to also facilitate caring and nurturing relationships with others. Being in a position of both giving and receiving care, was reported to be something that they valued. This care often came from families, as is shown in the following example:

P1: "It's so important because of the support and love that they've given me through everything. Obviously, eh, I was at (High Secure Hospital) for a very serious index offence and I mean I was pretty much at rock bottom. Em and they stood by me the whole time and also not just stood by me but kept me up on my feet emotionally and with them I was like able to cope."

For many, the experience of losing the support and close relationships with others as a consequence of their offending, was difficult to come to terms with. This process however, appears to have emphasised just how important and valued their relationships with others are, both when they consider relationships that they have lost and ones that they have maintained in the aftermath of their index offence.

P1: "*I lost quite a lot of friends. Not all of my friends stood by me. Em, it still troubles me, it's quite sad but a lot of friends did stick by me and I'm so grateful for that. I appreciate it's not an easy thing for someone to still care for me as a friend. It's a difficult thing to grasp, people getting mentally ill and doing these things but thankfully a lot of my friends have understood and I'm grateful for that."*

With many having lost contact or strained relationships with friends and family, they spoke of developing relationships with fellow patients. It seemed that peoples' shared difficult experiences, for example, experience of psychosis, substance misuse, or being in secure environments was helpful in developing connections between patients and also appeared to facilitate the development of informal peer support or mentoring roles.

P7: "Hope. That's what the guys give you in here. The encouragement. They will always give you hope. You might think, aw fuck I'm never getting anywhere but the boys always try and pick you up and give you that sense of hope like. Ken there's a lot of the boys like that in here. Give you that sense of hope."

Moreover, an additional factor in connecting with others as being an important value, was that it can be a means of protecting oneself and being safe. People described feeling safer, being part of a social group or also from connecting with a religious organisation or set of beliefs.

P8: "*I've been going to church quite regularly and I say my prayers two or three times a day. Em... And eh, I just pray that God has me in his hands and will keep me safe. It's a big bad world out there, I don't trust people"*

Subcategory 2: Living a healthy life

All participants identified being healthy as an expressed value. They discussed the importance of their physical, mental health and general wellbeing throughout the interviews. All spoke about the importance of physical health and considered that being healthy and keeping in good physical health was important.

P9: "*I'm not gambling with my life or my physical health. I don't want to be on my arse, I want to be how I am now."*

Eight participants spoke about their mental health as being highly important to them. They discussed the steps they had taken to maintain this, through engaging with health professionals, psychological therapies, ward and community-based activities and medication.

Living a healthy life appeared to be something that was important to them as they described past experiences of poor physical and mental health as having significant negative consequences on their lives and making it more difficult to live a life in line with their values, impacting on their autonomy and ability to form and sustain relationships.

P1: "I suppose, I would say that what happened eh, the index offence was a massive barrier. It was a terrible thing but my family and friends stood by me. I'd say that, if I wasn't able to cope through that. If I was to continue to be depressed through the whole thing it would be difficult for my family to keep me on my feet. So I suppose em, I suppose that I just need to come back to the priority of making sure my mental health remains well, otherwise that could be a potential barrier, you know."

Subcategory 3: Being productive and contributing

Being productive and contributing to a wider community was discussed throughout the interviews by all nine participants. This was expressed in relation to working hard independently or for the greater good of the community. Moreover, this appeared to contribute to self-esteem through achieving tasks; developing structure and purpose to their day; and also being creative.

P6: "*They had their own kiln and everything was done in house there. They had paint racks and small tubs of paint. Every colour, every shade of ever colour. Everything you needed. I loved it because I treated it like work . I went every day am and pm. See if it was open, I went… That's what I like to do. Be busy. I was*

doing something I enjoyed and there was a product at the end, you can't beat that can you. You're enjoying it plus there's a nice clay model at the end that… That someone would buy."

Many spoke about the perceived benefits and motivation from contributing to their community. For some this appeared to be related to the value of connecting with others, as contributing to society was a means of fitting in and being *"normal"*. Furthermore, for many contributing to their communities and environments was motivated by hopes of reparation for their past offences or behaviour, or to pay back a debt to society to alleviate being a *"burden"*.

P1: "I have goals to... my goal would be to start my own landscape gardening company. A small landscape gardening company and eh, be successful with that. Make my money in that. Em… and eh you know, support myself financially, independently. Em... no longer be a burden on society. That's something I feel, I felt like I had been, you know being in the hospital, the cost on tax payers of hundreds of thousands pounds of money being in hospital. Also through all this being on benefits as well, not being able to support myself but. Eh. Pay my taxes, support myself financially, all this, is important for me to be able to say, you know, I'm now a contributing member of society."

Related to themes of reparation and paying back to society, this appeared to link to long standing values in individuals to be a successful, reliable and contributing member of society:

P8: "As a member of society, if you want the help you join…. And part of that is by getting in the fold. It might sounds nuts but when I got out of hospital last time I really wanted to be a pillar of the community. And eh, try and help where it's needed. You know, em, just want to do it to help out and stuff like that."

Participants spoke about earning money in relation to hard work. Many held the view that having wealth would allow them to live a happier life, by being more able

to engage in valued activities. Furthermore, it seems that there was a relationship between earning money and connecting with others, as it was perceived that that they could more easily acquire material possessions that were valued by society and perceived as a sign of status, success or wealth, thus allowing them to fit in and be seen as *"living a normal life (P4)"*.

Subcategory 4: Having agency and being in control

All participants considered the importance of agency and independence and how their experience of these concepts has varied throughout their lives. This subcategory came up in the interview mainly in the context of participants discussing the impact of losing agency and control. This appeared to be primarily related to themes of being *"free"* or being *"safe"*.

P2: "Having control over my own actions and doing what I want to do. Freedom basically"

It seems that having agency and control over life and the environment is also important to provide security. This was achieved by some through developing *"strength",* through altering their physical appearance to intimidate others or to ward off potential threats.

Core Category 2: The lifespan of values: Consolidation, expression and change

In addition to discussing what matters to them, participants spoke about the way in which their perception of their values and goals has fluctuated throughout their lives. The following section explores the early development of values; and considers the way in which peoples' behaviour and goals can be either congruent or incongruent with their values at different points in their lives. Individuals' values and the balance of what is important in life also appears to shift throughout life, which shall also be considered in this section.

Subcategory 1: Early development of values

Throughout the interviews, many participants considered the ways in which their values may have developed and the factors involved in this process. Participants were not asked directly about this in the interview but this subcategory emerged in discussions with five of the nine participants (P: *1, 2, 7, 8, & 9)*. They reflected on their early relationships with caregivers and the influence of their home environments and communities as having a role in shaping their sense of what is important and developing their values.

Behaviours that were described as pro social were modelled by individuals, with some viewing these people as a role model to themselves and others in the wider community.

P8: "He would basically try and fix out all my worries. He was a pillar of the community, everyone looked up to him".

In addition to the influence from direct care givers, peoples' environments and communities were important in the development of values. Participants described the acquisition of knowledge and morals from the wider community in which they lived.

P7: "I value what the old people have done for us. Pass on their knowledge and experience or looked after me when I was younger."

It appears therefore that there is an important relational role in the development of values, and that the formation of values is informed by others in their interpersonal network. In contrast to the direct modelling of pro social behaviours in the development of values, it appears that in some more difficult interpersonal relationships, that this can motivate an individual to act in the opposite way. This may be in relation to a parent, family member or someone within the wider community whom they perceive as acting in a way that is not congruent with their values. It may be therefore, that by observing others whom they believe have been unsuccessful, made mistakes or acted in ways that they disagree with, can motivate them to act and live their life in a way that is different from this other person.

P5: "my laddie he actually said to me, he said eh... 'the reason I'm such a success is because I didn't want to end up fuck all like you'."

Subcategory 2: Values directed behaviour

Participants discussed behaviours and goals that appeared to be congruent or incongruent with their values. This appeared to alter throughout the lifespan and was influenced by values that had previously been developed; and by a number of barriers, restrictions and opportunities faced throughout their life (as shall be explored further in core category 3).

All participants considered the various influences on their behaviour and goals throughout their lives and that this could have either a negative or positive effect on their actions. For many, interpersonal relationships with others that were associated with substance misuse or criminal behaviour, had a negative impact on an individual's behaviour. Associating with these people and being part of theses social groups may have been an attempt to meet values associated with connecting with others, however, participants reflected that this led them to act in a way that they now view as being wrong and that this was at the expense of their meeting their other values.

P2*: "I'm never going back near it (drugs) because it's too hard a life and leads you all the wrong ways. You end up hanging out with the wrong people. People with no dignity left, no values at all and they just want to waste their life away. And I can't go back to that route. I'm too old now I'm, it's time for me to get my act together and get on with my life."*

Furthermore, having past relationships with these types of social groups also appear to make it difficult for individuals to pursue an offence free life, with some expressing concerns about recidivism. The quote below demonstrates the struggle

faced between people trying to act in a way that fulfils the legal restrictions placed on them after leaving a secure unit or prison whilst trying to protect themselves from threat or being taken advantage of in the community. This highlights the difficulties for MDOs with regard to autonomy in their lives after leaving secure care, with their actions and goals being shaped by legal and medical restrictions and orders but also being shaped by the environment that they are placed in and the people within their interpersonal network. It seems that these two factors are at odds with each other. The participants described that this made it difficult to understand themselves and how they fit in with the world. This links to core category 4 and will be explored in further detail in a later section.

P5: "there would be people coming up all the time saying aw you done this to your misses and bang they would try. They would have me and I'm on a license so I'm going to have it for about 2 year and they'll say this and I'll need to take a kicking. I said that to her I'll just need to take a beating but if it gets too bad then I'll need to hit back but what happens when the police come and even though there's witnesses, they'll just say that the two people that have been fighting: me and somebody, oh (names self) he's on license from the jail. Straight back to jail."

In contrast to the above, there appears to be times when MDOs have considered that when faced with a situation that clashes with their values and morals, that they have not followed their peer group into further offending behaviour. For example, a participant reflected on abstaining from stealing to fund his heroin addiction, despite his peers doing this and the knowledge that this would lead to distress and intense physical symptoms from experiencing withdrawal symptoms.

P2: *"It made me feel a letdown and a junkie basically. I don't like the word junkie, I prefer drug addict. 'cause I still kept my dignity, I wouldn't steal, I wouldn't do anything bad. I would just buy it with my own money. If I had no money, I'd just lie there strung out until I got money. It was a bad existence…*

I: What do you think stopped you from doing that?

P: I just wouldn't do that, I'm not a thief, it's the way I was brought up, I was brought up to never steal."

Many also described their goals and actions as being shaped by their current environment in a medium secure unit as they had to *"abide"* by the *"system"* and *"jump through hoops"* in order to meet the requirements of the legal and health systems.

In the interviews, many spoke about the struggle that they faced of acting in a way that was in line with their values but that was also appropriate to their environment and was congruent with the values and goals set by health and legal systems. For some, to pursue their values of connecting with others or of having agency and being in control, resulted in them offending further. The following example shows the illegal means that an individual took to increase his communication with his family at a difficult time, whilst in a medium secure unit. This action resulted in further restrictions being placed on him, and extending his time spent in a secure setting. Unfortunately, despite it being possible to understand actions like these as being motivated by values of contacting others and supporting family. The consequences of this can result in further and extended barriers to connecting with others and reduced agency in life.

P9: "Me being a bit of a wideo, I'd smuggled a mobile phone in. At the time it helped because I could speak to people. This was round the time of my dad and my gran (dying). I had to phone then and I was chatting to friends and family but I was obviously breaking a major rule so that responsibility was on me."

Subcategory 3: Shifting balance of values

Throughout the interviews a theme of changes in the expression of values emerged. They considered how the balance of their values shifted throughout their life, particularly after significant life events. This category was identified by 6 of the participants and is explored below.

During the interviews, some reflected that at times in their lives, particularly during difficult and stressful periods, that they had a narrower focus of values. At more settled times, however there appeared to be a broader view and greater balance in their values.

P1: "But I think that the balance I had was maybe not right because it was sacrificing a lot of other things that's important and now to have a more rounded balance in your life…I suppose what I'm trying to say is that eh. I think that values that anyone has can shift over time... All these values combined are what kinda make me who I am today, not just one individual like rock climbing and the obsessional attitude I had before."

These shifts in the balance of values appeared to be prompted by a number of significant life events, which shall be considered in the following section (core category 3). Some participants also described that a shift to a more balanced and broader range of values came as they got older.

P3: *"It's just... I need to prioritise what I'm doing with myself because I'm 50 now. I don't have time to just... I've need to try and make good what time I've got left."*

Core Category 3: Navigating barriers, restrictions and opportunities

The participants in our study faced a multitude of challenges, barriers and restrictions that impacted on their ability to live and behave in a way that was in line with their values. Many of these acted as barriers and restrictions, however some of these challenges also appeared to help facilitate behaviours that were congruent to their values. This suggests that these parts of life are likely to cause a change in direction with regard to living a valued life. Therefore these areas seem to cause a change in course in individual's actions which can be either congruent or incongruent with their values.

Subcategory 1: Interpersonal relationships

As has been discussed, there appears to be an important interpersonal component to the development of values. Furthermore, there were a number of values expressed by participants that related to connecting with others across the interviews. In addition to discussing the importance of this, they considered the impact interpersonal relationships had on them. Many considered the negative impact that others had had on their life:

P 9: *"Realising that I was just being used by guys that didn't want to get their hands fucking dirty" P.9.*

It seems that some interpersonal relationships have had a negative impact on their lives and took them away from the things that they valued. This appears to create a tension between the negative influence of others and values of connecting with other people. Some described being taken advantage of by others. This seems to suggest that others can influence their actions in a way that is not congruent with an individual's expressed values:

P8: *"Being with the wrong people was detrimental to my progress and as a human being."*

Subcategory 2: Environment and culture

The environment and culture that participants were in appeared to present various barriers, restrictions and opportunities. Participants spoke about the negative impact that their environments had on their lives and behaviour. In the main, this category refers to the barriers and restrictions posed whilst living in the community, being in secure care, and experiencing an unsettled home life. However, some also discussed the opportunities that their environment could provide, for example, from being in a medium secure unit.

Being in a secure unit appeared to have a negative impact on values relating to connecting with others; and having agency and being in control. Being in a secure unit creates physical barriers for connecting with others, as visits and pass plans in the community are dictated by restrictions placed on them. This can make it

difficult to maintain relationships and some described using phone calls and social media if this was permitted as alternative ways to try and maintain interpersonal relationships. Although this appeared helpful in maintaining contact with families, it appeared to be difficult to sustain or develop romantic relationships through these means. Furthermore, extended periods of time in secure units have also caused them to miss significant life events within the family, which can exacerbate feelings of being disconnected from friends and family and losing agency and control in their lives:

P2: "It was the first time that it happened to me. That I've missed out on anyone that's important in my life, for going to their (referring to brother's) funeral. I can't believe I was the only one that missed it."

Being in a restricted and controlled environment in a medium secure unit results in a loss of autonomy. Participants described having to *"abide"* by the *"system"* in order to make progress.

P2: "That's when I start to feel a bit uneasy. Mostly to do with not being in control as well. Not that I'm a control freak, it's just that I can't be in control of what I'm doing in here. I have to go by the system. Do what I'm told and stick by, adhere to the rules. But eh, I just don't like being like that. I can't wait until that changes… It's not having control I don't like. It's not having control over my own actions and doing what I want to do. Freedom basically."

To progress through the secure setting, they are required to act in a way that is consistent with the "system's" values and goals. Attempting to act in a different

way and overcome barriers to live a life that is congruent with their values, can be challenging to the individual.

Participants also discussed the impact that unstable and threatening homelives and communities had on their values and were barriers to living a life in line with their values, particularly connecting with others, and having agency. Many described the difficulties faced by the separation of parents, bereavements, inconsistent care from care givers and frequent house moves. This also had an impact on the ability to maintain relationships, for example friendships were lost when they moved home or school and furthermore, these changes were out with their control so were at odds with values related to autonomy.

For some, who had periods in their life when they were homeless, they described the threat that they faced from living in this environment. This had an impact on his physical and mental health and on values related to autonomy and health.

P8: "My dad sent us, 250 quid and I got it cashed in at a post box and eh, that night my bag was stolen in the street. Late one night. And there was £250, my passport, all my clothing, my utensils for cooking and all I had was a vest on. So I was starting from scratch then. I was raking the buckets for food."

Some participants also considered the opportunities that their environment gave them. Despite the restrictions imposed by secure care, some described this environment as being stable, safe, consistent and gave them an opportunity to live a life that was more congruent to their values of being healthy, and also being

creative and contributing. It has also allowed some gradual increase in autonomy as have successfully progressed through pass plans, gaining further time and independence in the community. It appears that for some this was an opportunity for safety and stability in their lives that they had not had previously.

P2: "I: And what impact has being here (MSU) had on you being able to fulfil these values then.

P: Well I've been able to think clearer about what I want to do with myself. I've been to abstain from taking drugs so that's... being in here has helped me get better and helped me realise the things I need to do with my life."

Subcategory 3: Facing Health Challenges

Participants identified a number of issues regarding health that impacted on their pursuit of values, including: mental health, physical health, and substance misuse.

All nine participants discussed the impact that mental health had on their lives and identified with the category of this being a barrier in life and to their values. Difficulties with mental health was identified as a barrier to being a parent. Participants spoke of their experience of psychosis, and associated breakdowns in relationships and offending. The example below demonstrates the individual and his son's anguish at being separated when he was unwell:

P3: "I think about him every day… Eh, I remember when they came to take me away that night. I wasn't drunk, I wasn't on drugs, I was just wired up. And I gave the wee one. He didn't want me to let him go... He went crazy as I was taken away and that's it. That night was a horrible night. It was a horrible night"

Participants also discussed the impact that their mental health and experience of psychosis had on employment. They discussed the impact that poor mental health had on their ability to cope with their jobs, or impaired decision making by taking on too many jobs and being unable to organise workload. Another patient reported that they found mental health to be a stigma which may impact on their ability to get a job. This stigma can be compounded by the additional label of being an offender or criminal, as shall be discussed in the following section.

A number of patients spoke about the impact that their mental health had on connecting with others and their relationships. Difficulties regarding sustaining a relationship with friends, partners and family were discussed as barriers.

P1: "you know people have good days and bad days but you know if it's a prolonged bad spell, that can be, em that can be difficult for a relationship."

Three patients identified that unwanted side effects of medication were difficult to manage and impacted negatively on their lives.

P6: "So the barriers are me being in here. Well the obvious barriers are being in here but the barriers to me moving along at any speed are the medicines I've been given at the moment. They're making me feel hellish. They're really impacting on the passes you know. And I really don't feel like (pause) and I don't feel like I can do my passes at all… I feel right down about it."

Many participants discussed a deterioration in their health prompting them to reassess the importance of physical health. This appears to be prompted by fears

that they would become significantly unwell or incapacitated. It is possible that this could lead to a further loss of autonomy. The example below illustrate this:

P3. "Aye, I had a bit of a health scare last year there. I came down with type two diabetes and I had problems with angina and stuff. I was overweight by one hundred and twenty kilos. So I've gradually made positive steps there too as I'm down to 107 now. A good 16 kilos. Slowly...Less portions, more fruit. I've gave up smoking. I've not smoked for the past two years. I don't feel tempted to take it up again. Eh, all the benefits are... I was in some state the last couple of years, health wise.

Many spoke about the costs of substance misuse on their lives and the impact this had on their values. Many described using this as a coping mechanism to deal with difficulties in their life but as some reflected during the interviews, this led to further difficulties and this coping mechanism was instrumental in creating further barriers in their lives.

P2: "I've lost my two hour pass to the (Hospital activity centre). I lost all my passes yesterday… I never done it through anything apart from the way I was feeling. I couldn't handle it, the way I was feeling on Monday. Deep down I also knew that I would feel more depressed after it and that's exactly what's happened. I feel very low at the moment and that's because of the alcohol and the hangover and that fact that I've done it. I feel a bit silly about it as I'm 45 and I'm in here waiting to get released and I shouldn't have done it. It will make it hard for my progress of getting out of here."

The use of substances within medium secure settings, resulted in further restrictions being placed on an individual and often prolonged their time spent in secure settings, resulting in a further reduction in autonomy and control over their lives. Participants described the impact of substance misuse as being a barrier to all of the areas of their values. Substance abuse was reported to have resulted in a

deterioration in physical health, with one participant describing the dramatic change he experienced to his physical appearance and health: P5: "*I was like a walking skeleton, my hip bones were sticking out, my ribs were sticking out, I was fucked… I never ate."* Furthermore, difficulties were identified in being able to sustain work, thus impacting on values based on being productive and contributing. Some also considered that there was a link between their drug use and deteriorating mental health and offending, therefore limiting their ability to live a life in line with values around living a healthy life.

P9: "*obviously the index offence was through cocaine abuse and amphetamine abuse. I was up for nights, working for them, clubbing, just fucking about."*

Subcategory 4: Consequences of Offending

Offending was discussed as having a number of consequences. In addition to the impact of being in a secure environment, as discussed previously, participants considered the wider consequences they experienced from offending and the impact this had on their attainment of their values. This included the impact on one's reputation, relationships with others, parenting, occupation, being able to contribute to society and on their autonomy.

P9: "It makes you think, I could have spent that energy making something of my life and having a family and an honest day's wage if that was the case. But I chose that route because it was fun."

All reflected that their offending had taken them off course from their values and from living a meaningful life. During the interviews, participants reflected on the impact on their reputation and how they and others perceived them after their offences. Patients identified feeling shame and guilt over the past offences and finding this difficult to live with after an improvement in their mental health. One participant described this as "*something I can't change so just kind of, just a burden I have to live with, you know."*

P1: *"the index offences is something that lives with me for the rest of my life. Eh I mean there's not a waking hour, eh, I don't think about what happened and how much regret, remorse, guilt I feel about that, the pain, em eh. Em it's the most difficult thing that's ever happened to me, eh the biggest regret of my life easily"*

Furthermore, this impact on reputation and efforts to repair this lead to many considering what this meant for their sense of self, as shall be discussed in core category 4. Many discussed the impact of their offending and resulting legal restrictions, on their relationship, limiting their ability to maintain or engage in romantic relationships.

P3: "I was married in all for about four years. Got a divorce because my status is a life sentence, I'm really eh... it's detrimental to relationships"

For mentally disordered offenders with children, past offending was also attributed as making it difficult to be a parent. Many described their chaotic lifestyles, past, drug use and offending behaviour as preventing them from being able to be a father

that they would wish to be. Furthermore, they were unable to be present in their lives due to prolonged periods spent in prison and secure hospitals.

P5: "I got my 7 years when he (son) was 5 years old, em... 5 weeks old. I've been a pure fuck up with them all (In reference to all of his children)."

For some, legal restrictions prevent them from being able to be have contact with their children. Many found this barrier difficult as this prevented them from being able to live a life in line with being connected to others or being a good parent.

As has been discussed, offending has consequences on one's autonomy due to the more restricted environments that men in medium secure units find themselves in. Furthermore, some discussed the impact of ongoing offending within a medium secure setting, which could result in a loss of passes, seclusion, prolonged time in secure settings or a move to higher security. This resulted in further restrictions and control being exerted over them. One participant reflected on his recent use of computers for offending based behaviour and the impact this had on his access to technology and lengthening his time spent in a medium secure unit. This resulted in further loss of autonomy and limitations on being able to connect with others.

P6: *"Well I had a bit of a hiccup with my internet IT stuff, you know. It was taken off me and I had lost my passes you know… I do miss it a heck of a lot, I mean you miss your phone and things like that, don't you."*

Men within medium secure settings also considered that the prospects for their careers may be limited by their previous offences, length of time spent in prison or hospital, the legal restrictions associated with this and how others may perceive them. This can result in the loss of careers or narrowing their options for future jobs, thus being a potential further loss of autonomy.

P1: "I would say that in the past, my ambition was to do well in a job. Maybe I had higher expectations of myself in the past before my index offence. You know I graduated with a chemical engineering degree and I was thinking of doing something like that but now with the history that I've got a realise that I kind of, that would be a difficult career path. And I'm thinking I would need to go about things myself and if I'm going to do well at the gardening then maybe I need to make my own business."

Core Category 4: Searching for the self and belonging: *Who am I and how do I fit in?*

From participants' interviews and this paper's proposed model of values of men in medium secure units, it seems their values are a significant part of their identity and sense of self. Furthermore, how congruent an individual's life and actions are to their values also appears to contribute in an important way to the sense of self. This is developed from a young age, from a range of external influences and is shaped by a number of barriers, restrictions and opportunities throughout their life. However, as discussed this seems vulnerable to change and many describe the various factors that can cause a shift in balance of values or impact on how congruent their behaviour and goals are with their values. In the MDO population, it seems that this sense of self and the unstable and fluctuating external factors that

they face, contributes to a sense of self that is particularly vulnerable to change. This appears to establish and perpetuate an uncertain view of the self, with MDO's struggling to establish who they are and to also find a place or a social group that they fit in with.

Participants described being uncertain of their identity at times in their life. At times of difficulty, it appears they question who they are but that family can be grounding and help them fit in.

P8:"Em, there was at one point a fast and loose attitude. Em, so it was being out there, taking drugs and really living in the fast lane. But as they say, you've got to come back to yourself after a while. So I came back and it was all the same eh, catalysts, you could say, like my family to remind me who I was but for a while I was out there on my own."

Many described them of being critical of themselves for their past and current offending behaviour and for being in a forensic setting. Moreover, some noticed that they were at times judgemental of fellow MDOs for their past offences or mental health difficulties.

P9: "they think that because of my past, I'm a scum bag. And the fact that I (describes further breach of restrictions that is removed for purposes of anonymity), I don't think that they like that. Obviously major breach of this but that was a long time ago. But because of that I see myself as not a nice... I got judgemental and started looking down on people. But it was always at the back of my mind that I am just as bad."

As has been discussed MDOs described the difficulty of having a clear and stable understanding of the self. To understand who they are, it appears that they

compared themselves to their peers and those in their environment, and this seemed to emphasise and reinforce that they did not fit in:

P9: "Finding your place in life is what I need to do and find a way to do that without upsetting anyone or taking on too much."

Six participants spoke about the concept of *"normal"* and considered what this meant to them and how they believed that they were not *"normal"* and struggled to fit in throughout their lives. Furthermore, many discussed hopes that by engaging in support offered from the medium secure unit and therefore trying to live a life in line with the values of the system that they would be *"fixed"* and become *"normal"*. Others considered feeling a pressure from society regarding expectations on what it means to be *"normal"* and how they were unable to meet this.

P4: "P: You need friends, you need family support. You need a girlfriend or a wife. If you want to be a decent man. Have children and a family. If you don't make a child, a girl or a boy, don't have a girlfriend or wife. People think you are a failure in life if you don't have a son or daughter"

When fitting in with individual's environments and to form connections with peers, many of the participants discussed the costs of doing this. Participants described making efforts but finding it difficult to assimilate themselves into their surrounding cultures and environments:

P9: Aye to fit into that culture you had to be loyal and if someone told you, one of the people that you are trying to impress and fit in with, tells you to do something that's illegal and violent and gruesome, I had to do that to fit in. And once you're

into that you can't get out. Or if you do get out, you've not got the skills to mix with normal society. It's... I don't want a reputation anymore, I just want to have a quiet life.

I: It sounds like throughout life, you've tried to fit in with the environment like at school, there was the private school...

"I went to private school for a little while. I didn't mix, I didn't fit in. Like I said mud blood. I only got in through a scholarship. Eh and that was at (names school). I kept buggering off. Going home. So they ended up kicking me out the school."

P: Yeah I didn't fit in there and then I went to the local school. I fitted in there alright but that's because it was just a breeding ground for criminals"

This difficulty to fit in with social groups was also apparent for some in medium secure settings as some felt caught between multiple social groups or environments and were therefore not able to fully integrate. For example, one participant described being caught between his immediate environment of a high secure hospital and his desired future environment of a pro social life in the community with his wife. He described that to move towards his desired future and forging connections with his family, that he felt that he had to isolate and distance himself from his immediate environment, from other patients in high security. The example below illustrates the struggle with connection that individuals can face in secure care:

P9: "Usually I would be in the mix of it, like climbing on the roof, doing silly stuff like smuggling drugs in or whatever, when I was married I couldn't do that, I wanted to try and get out for my wife. So that meant excluding myself and making myself a bit of an outcast."

It seems this relationship with *"normal"* and *"fitting in"* with society is further complicated as others described times when they lived in the community, in what could be considered a *"normal"* life, but struggling with this as they were self critical of themselves and did not think that they deserved to live this sort of life.

P8: "I feel like a fat cat when I've got a nice place. To be honest with you, I don't feel like I deserve it."

A further way of connecting with others and fitting in was through religion with two of the participants describing that being part of a church was helpful to individuals who were trying to make a change in their life, to find a purpose and be part of a community. For those that pursue religious interests, it appears that this not only helps them feel a sense of community and fitting in, but is also done with the hope of understanding themselves better.

P7: "I feel a belongingness in the church I do. And you feel a true commonness with... you don't have to be a Christian or you might just be trying to figure out what you want in life and what you're trying to do in life. You're not quite sure about what you're trying to do in life. What sort of journey or path you're wanting to go on or that. So you can go to church and just see how you feel but I am telling you, you'll feel a real big sense of belonging.

We discuss the theoretical and practical implication of these findings below.

11. Discussion

The aim of this study was to develop understanding and build a theory of the values of men in medium secure units. The model that emerged from the data suggested that values are sensitive to various barriers, restrictions and opportunities. These factors appear to have impacted on the make-up of an individual's values throughout the lifespan, from their initial development to significant life events. The model suggested that these experiences and an individual's values contribute to their sense of self. The model proposes that this sense of self is fragile, which can create and contribute to uncertainty as to who they are and how they fit in with their environment. The findings of the study will be discussed in relation to the existing research and theories of values. Furthermore, clinical and further research recommendations will be considered, and the limitations discussed.

Extending Values Research to MDOs

The values that emerged from the data in this study do not appear to support the proposal that mentally disordered offenders have a *"distorted set of values"* (Spruin et al., 2014). Indeed, there seems to be a shared set of values with the general population. The model suggests that there can be a tension however, between expressed values and behaviours that for some, can be enacted in maladaptive or antisocial ways. For example, substance misuse and criminal behaviour may be underpinned by shared values related to connecting with others or having agency, in particular social groups and environments.

There appears to be an overlap of findings of the values of mentally disordered offenders from the present study and the "primary goods" identified in the Good Lives Model (Ward, 2002). This research was undertaken independently of the Good Lives Model literature, using a grounded theory method to develop an understanding of values of MDOs in a MSU. This paper proposes four categories of values, that emerged from the data: connecting with others; living a healthy life; bring productive and contributing; and having agency and being in control. Generally, the 11 categories of the Good Lives Model (GLM) appear to map onto the categories proposed here. The category *"connecting with others"* appears to relate to the following GLM primary goods: relatedness; and community. *"Living a healthy life"* is similar to the primary goods: Life; inner peace; and spirituality. The third category of values in this study, *"Being productive and contributing"* is similar to the GLM's: excellence in play; excellence in work; and creativity. Furthermore, the final category of *"having agency and being in control"* relates to the GLM's primary goods of excellence in agency. The primary good, pleasure, does not directly relate to any of the categories identified in this study. Overall, this research appears to be in support of the GLM literature and the primary goods that the model proposes. This also supports the view that the forensic population, specifically MDOs share the same values as non-offenders.

Clinical Implications and Recommendations

The model of values in MDOs indicates some practical and clinical implications for working with MDOs. Using the structure of the model may provide a framework to

help inform assessments and formulations for this patient group. It may provide a useful way of to help better understand the values of the individual and the barriers that they have faced throughout life and are currently facing within medium secure care. This model may also help discussions with the patient and the team to consider how the patient's values and goals fit with their current circumstances, current restrictions or opportunities available within the unit. Using this model may be a way of facilitating both the patient and MDTs expectations of goals and helping the patient work in a way and set goals that are congruent with their own values but fit with the wider values or restrictive paths set on them by health and criminal authorities.

Metaphors are frequently used within Acceptance and Commitment Therapy (ACT) to explain values, goals and other concepts to patients; and as tools for cognitive defusion (Hayes et al., 1999; Foody et al., 2014). The model proposed in this paper has the potential to inform and develop existing and new metaphors for values-based work, as part of an ACT based approach. A preliminary metaphor was developed from the model that emerged from the data of this study. A script written for use with patients is included in appendix 11 for consideration in future clinical use.

It is proposed that using this model may have additional uses in clinical settings for assessment and formulation. As previously discussed, there is a tendency for treatment planning for men in medium secure units to focus on risk and psychiatric

issues and less on individual preferences and values. There have been recent attempts to focus more on the individual client and their values in approaches such as the Good Lives Model and Recovery Model (Barnao et al., 2015). The model provided in this paper may provide a framework to help explore this with patients and contribute to formulation and treatment planning with this client group that helps explore and determine what is important to the individual and to appreciate the course their life has taken with regard to their values. Furthermore, it may be helpful to consider the role of avoidance and individual values from an ACT based perspective. Within the ACT literature, a tension is proposed between avoidance and values, with emotional pain leading to avoidance, which may take them away from valued activity (Soriano et al., 2004). Using the model proposed in this paper, experiential avoidance can be specifically related to the barriers and restrictions that this population faces and this impacts on the congruence of behaviour and goals with values.

It seems moreover, that this model could be applied to different populations and different clinical settings. In the population interviewed, a number of the restrictions and barriers were specifically related to forensic and hospital environments and populations, however many of the barriers, restrictions and opportunities appeared to be universal themes that could apply to anyone in any population or clinical setting, for example: interpersonal relationships, environment and culture and health challenges. It is proposed therefore that this model and findings could be applied to wider populations and clinical groups. Further research

exploring the utility of this model in other settings and with other populations would be helpful.

Limitations and Research Recommendations

Despite this study making important contributions to research and developing theories of values in mentally disordered offenders, there are some limitations. The study recruited a small sample from one medium secure unit in Scotland. Caution is therefore needed to generalise these findings to other medium secure settings or mentally disordered offenders. Within this one unit all participants were white, British males, whom were either Christians or atheists. It is not clear therefore, how these findings would generalise to females, and people of different nationalities, cultures and faiths. A consideration of cultural values could benefit future research (Ward & Fortune, 2013). Despite the mentioned limitations in diversity of this sample, a strength of this sample was that participants in the study had a range of ages, socio-economic, education and work history backgrounds. A further limitation of the study was that it was not possible to discuss categories with the participants after the formation of a model.

Adverse Childhood Experiences (ACEs) were not asked about directly with the participants in the interviews. There is evidence to support the role of ACEs in the development of mental health difficulties, substance abuse and offending behaviour (Bileas et al., 2016). The model proposed in this paper considers values across the lifespan and considers the formation and development of values. It may

be helpful for future research to focus on the development of values and to explore the role of ACEs and the impact that this has on the development of values and the barriers to living a life congruent with their values.

Further qualitative work is needed to establish the validity of this model within the mentally disordered offender population and with other populations. Future work could use larger samples across medium secure units or consider participants from high secure and community settings also. It may also be helpful for future research to conduct interviews with individuals outwith the MDO population to better explore how this population's values fit with the general populations.

12. Conclusions

The model that emerged from the grounded theory method study creates a framework for understanding values in mentally disordered offenders. MDOs identified four broad categories of values relating to: connecting with others; living a healthy life; being productive and contributing; having agency and being in control. The understanding of MDO's values that emerged from the data in this study do not support the proposal that mentally disordered offenders have a *"distorted set of values"* as compared to non-offenders. Moreover, the findings of this study fits with the predominant conceptualisation of values of offenders in the Good Lives Model.

As part of the model, participants reflected on their values throughout their lifespan from the initial development, to times in their life when the balance of values fluctuated. This appears to be sensitive to and influenced by a number of barriers, restrictions and opportunities. Moreover, there appears to be a connection to individual's values and their sense of self. The model proposes that this sense of self appears to be vulnerable and there is uncertainty regarding the self and how they fit in with the world around them. Further research is required to explore this topic further, to consider other forensic settings, with larger samples and to also evaluate the utility of this model in non-offending populations.

References

Barnao, M. Ward, T. & Robertson, P. (2016). The good lives model: A new paradigm for forensic mental health. *Psychiatry, Psychology and Law* 23(2), 288-301.

Barnao, M., Robertson, P. & Ward, T. (2010). Good Lives Model Applied to a Forensic Population. *Psychiatry, Psychology and Law*, 17(2), 202–217.

Barnao, M., Ward, T., & Robertson, P. (2015). The Good Lives Model: A New Paradigm for Forensic Mental Health. *Psychiatry, Psychology and Law*, *8719*, 1–14.

Bielas, H., Barra, S., Skrivanek, C., Aebi, M., Steinhausen, H. C., Bessler, C., & Plattner, B. (2016). The associations of cumulative adverse childhood experiences and irritability with mental disorders in detained male adolescent offenders. *Child and Adolescent Psychiatry and Mental Health*, 10(1), 1–10.

Centre for Mental Health, (2011). No Health Without Mental Health: a cross-government mental health outcomes strategy for people of *all* ages. HM Government.

Charmaz , K. (2014). *Constructing Grounded Theory*. London: Sage.

Chenail, R. J. (2011). Learning to appraise the quality of qualitative research articles: A contextualized learning object for constructing knowledge. *The Qualitative Report*, 16(1), 236–248.

Crichton, J. H. M. (2009). Defining high, medium, and low security in forensic mental healthcare: the development of the Matrix of Security in Scotland. *The Journal of Forensic Psychiatry & Psychology*, 20(3), 333–353.

Day, A., & Casey, S. (2009). Values in forensic and correctional psychology. *Aggression and Violent Behaviour*, 14(4), 232–238.

Dedoose Version 8.1, web application for managing, analyzing, and presenting qualitative and mixed method research data (2018). Los Angeles, CA: SocioCultural Research Consultants, LLC www.dedoose.com.

Drennan, G., & Alred, D. (Eds.). (2012). *Secure recovery: Approaches to recovery in forensic mental health settings*. London: Routledge.

Foody, M., Barnes-Holmes, Y., Barnes-Holmes, D., Törneke, N., Luciano, C., Stewart, I., & McEnteggart, C. (2014). RFT for clinical use: The example of metaphor. Journal of Contextual Behavioral *Science*, 3(4), 305–313.

Gannon, T. A., King, T., Miles, H., Lockerbie, L., & Willis, G. M. (2011). Good Lives sexual offender treatment for mentally disordered offenders. *The British Journal of Forensic Practice*, 13, 153-168.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory; Strategies for qualitative research.* Chicago: Aldine.

Gow, R. L., Choo, M., Darjee, R., Gould, S., & Steele, J. (2010). A demographic study of the Orchard Clinic: Scotland's first medium secure unit. *The Journal of Forensic Psychiatry & Psychology*, 21(1), 139–155.

Grounds, A. (2019). Discrimination against offenders with mental disorder. *Criminal Behaviour and Mental Health*, 29(4), 247–255.

Harris, R. (2007) *The Happiness Trap.* London, Robinson.

Harris, R. (2009) *ACT Made Simple.* Oakland, CA, New Harbinger Publications.

Hayes, S., Strosahl, K., & Wilson, K. (1999). *Acceptance and Commitment Therapy: An Experiential Approach to Behaviour Change.* New York: The Guilford Press.

Jacques, J., Spencer, S. & Gilluley, P. (2010). Long-term care needs in male medium security. *The British Journal of Forensic Practice*, 12(3), 37–44.

Mezey, G. C., Kavuma, M., Turton, P. et al. (2010). Perceptions, experiences and meanings of recovery in forensic psychiatric patients. *Journal of Forensic Psychiatry and Psychology*, 21(5), 683–696.

NHS Education for Scotland. (2011). *The Matrix: A guide to delivering evidence-based psychological therapies in Scotland.* Edinburgh: Scottish Government.

NHS Health Scotland. (2016). Good Mental Health for All. Edinburgh: Scottish Government.

O'Sullivan, M., Boulter, S. & Black, G. (2013). Lived experiences of recalled mentally disordered offenders with dual diagnosis: a qualitative phenomenological study. *Journal of Forensic Psychiatry & Psychology*, 24(3), 1–18.

Palijan, T. Z., Radeljak, S., Kovac, M., Kovacevic, D. (2010). Relationship between comorbidity and violence risk assessment in forensic psychiatry. The implication of neuroimaging studies. *Psychiatria Danubina*, 22, 253-256.

Picton, H. (2013) Post-stroke depression (PSD) and post-stroke emotional liability (PSEL): a systematic review of non-pharmacological interventions for PSD, and a qualitative study of specialist professionals' conceptualisation of PSEL. *Unpublished Doctoral Thesis, The University of Edinburgh.*

Powers, M., Zum Vorde Sive Vording, M., & Emmelkamp, P. (2009). Acceptance and Commitment Therapy: A meta-analytic review. *Psychother Psychosom* , 78, 73 - 80.

Purvis, M. (2010). Seeking a Good Life: Human Goods and Sexual Offending. *Lambert Academic Press*: Germany.

Robertson, P., Barnao, M., & Ward, T. (2011). Rehabilitation frameworks in forensic mental health. *Aggression and Violent Behavior*, 16(6), 472–484.

Roskes, E., & Feldman, R. (1999). A collaborative community-based treatment program for offenders with mental illness. *Psychiatric Services*, 50, 1614–1619.

Roychowdhury, A. (2011). Bridging the gap between risk and recovery: a human needs approach. *The Psychiatrist*, 35(2), 68–73.

Sadler, J.Z. 2005. Values and psychiatric diagnosis. *International perspectives in philosophy and psychiatry*. New York: Oxford University Press.

Schwartz, S. (1992). Universals in the content and structure of values: theoretical advances and empirical tests in 20 countries. *Advances in Experimental Social Psychology*, 25, 1-65.

Schwartz, S., & Bardi, A. (2001). Value hierarchies across cultures: Taking a similarities perspective. *Journal of Cross Cultural Psychology,* 32 (3), 268-290.

Schwartz, S., & Bilsky, W. (1990). Toward a psychological structure of human values: extensions and cross-cultural replications. *Journal of Personality and Social Psychology*, 58, 878-891.

Schwartz, S., Melech, G., Lehmann, A., Burgess, S., Harris, M., & Owens, V. (2001). Extending the cross-cultural validity of the theory of basic human values with a different method of measurement. *Journal of Cross-Cultural Psychology*, 32 (5), 519-542.

Scottish Government (2009). *Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011.* Edinburgh: Scottish Government.

Scottish Government (2016). *Fairer Scotland Action Plan.* Edinburgh: Scottish Government.

Scottish Government (2017). *Mental Health Strategy: 2017-2027*. Edinburgh: Scottish Government.

Scottish Government, T. (2017). *Justice in Scotland: Vision and Priorities*. Edinburgh: Scottish Government.

Scottish Office (1997). *Framework for Mental Health Services in Scotland.* Edinburgh: HMSO.

Scottish Office (1999). *Health, social work and related services for mentally disordered offenders in Scotland.* Edinburgh: HMSO.

Sellen, J., McMurran, M., Cox, M., Theodosi, E., & Klinger, E. (2006). The personal concerns inventory (offender adaptation). *International Journal of Offender Therapy and Comparative Criminology*, 50 (3), 294-305.

Soriano, C. L., Valverde, M., & Martinez, O. G. (2004). A proposal for synthesizing verbal contexts in experiential avoidance disorder and acceptance and commitment therapy. *International Journal of Psychology and Psychological Therapy*, 4, 377-394.

Spruin, E., Canter, D., Youngs, D., & Coulston, B. (2014). Criminal Narratives of Mentally Disordered Offenders: An Exploratory Study. *Journal of Forensic Psychology Practice*, 14(5), 438–455.

Starks, H. & Trinidad, S. B. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research*, 17(10), 1372–138.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory (2nd ed.)*. Thousand Oaks, CA: Sage.

Stuart, S. R. (2014) Who comes into medium-secure care? An evaluation of admission at Scotland's first medium secure unit. *Unpublished Doctoral Small Scale Research Project, The University of Edinburgh.*

Stuart, S. R. (2015) Exploring recovery from severe and enduring mental illness using qualitative methods: A Portfolio thesis. *Unpublished Doctoral Thesis, The University of Edinburgh.*

Tansey, L. S. B. (2010). An exploration of the relevance of values to clinical interventions and working with Mentally Disordered Offenders. *Unpublished Doctoral Thesis, The University of Edinburgh.*

Thomson, L., Bogue, J., Humphreys, M., Owens, D., & Johnstone, E. (1997). The State Hospital Survey: A description of psychiatric patients in conditions of special security in Scotland. *The Journal of Forensic Psychiatry*, 8(2), 263–284.

Ward, T. (2002). Good lives and the rehabilitation of offenders: Promises and problems. Aggression and Violent Behaviour, 7, 513-528.

Ward, T., & Heffernan, R. (2017). The role of values in forensic and correctional rehabilitation. *Aggression and Violent Behaviour*, 37(July), 42–51.

Ward, T., & Maruna, S. (2007). *Rehabilitation: Beyond the risk paradigm*. London: Routledge

Appendix 1. Quality Criteria for Systematic Review

Adapted from Ross et al. (2013):

A: Study design and potential bias (internal validity)

1. Patients were randomly allocated and this process was sufficiently concealed
2. Participants, facilitators etc. were blind to the allocation
3. Attrition rates were reported

B: Choice of outcome measure

4. Outcome measures are valid, reliable and standardised
5. Outcome is relevant and meaningful to the intervention and the evaluation

C: Statistical issues

6. Study is adequately powered to detect the effect of the intervention
7. Appropriate analysis for outcome measures used and p values and effect sizes reported where appropriate

D: Quality of the intervention

8. The intervention has been appropriately defined
9. Intervention was delivered as planned (good fidelity)

E: Generalisability (external bias)

10. Intervention has been implemented in a way that would be considered 'routine practice'
11. Follow up evaluation undertaken

Appendix 2. Scoring of quality criteria

1. Patients were randomly allocated and this process was sufficiently concealed

Well covered	The process of random allocation and concealment are well described so as the method of both are clear
Adequately addressed	The process of random allocation and concealment are mentioned but without great detail so as the actual method of each is unclear
Poorly addressed	The process of random allocation or concealment are mentioned but not sufficiently described or non-randomisation to groups
Not addressed	The process of random allocation and/or concealment are not addressed
Not reported	The process of random allocation and/or concealment is not reported
Not applicable	The process of random allocation and/or concealment not applicable in this instance

2. Participants, facilitators etc. were blind to the allocation

Well covered	Those who administered the outcome measures were blind to the allocation of participants or different people were involved in the administration of the measures and delivery of intervention. The method of this being ensured is clearly define
Adequately addressed	The process of how researchers were blinded to allocation is described but there is not sufficient detail to fully understand the method by which this was ensured.
Poorly addressed	Blinding of researchers is mentioned, however, no details about how this was done are provided
Not addressed	The issue of blinding the researchers was not discussed.
Not reported	The blinding of researchers to allocation was not reported.
Not applicable	The blinding of researchers to allocation is not applicable in this instance.

3. Attrition rates were reported

Well covered	Attrition rates are described for both intervention and control groups and are similar, and where differences exist, intention to treat analyses are described and carried out
Adequately addressed	Attrition rates are described, although differences exist between groups. Where these differences exist, intention to treat analyses are carried out, although they are less clearly described.
Poorly addressed	Attrition rates are described, differences exist between groups, and however, it is less clear whether intention to treat analyses were carried out.
Not addressed	The issue of attrition rates are mentioned but not clearly described and the issue of intention to treat analyses are not discussed.
Not reported	The issue of attrition rates and intention to treat analyses are not reported.
Not applicable	The issue of attrition rates and intention to treat analyses are not applicable in this instance.

4. Outcome measures are valid, reliable and standardised

Well covered	The psychometric properties of the outcome measures used are clearly described along with details of their validity and reliability within the forensic or clinical population utilised in the study.
Adequately addressed	The outcome measures are described but less well so and details around their validity, reliability or standardisation within the particular population are less clear. The measure is less well standardised with forensic populations.
Poorly addressed	The use of outcome measures are mentioned but little information is given about the tools used or their properties in terms of validity and reliability or the tool used is not standardised with the forensic or clinical sample nor has poor reliability or validity.
Not addressed	The use of outcome measures are mentioned but not further information is given.
Not reported	The use of outcome measures are not reported.
Not applicable	The use of outcome measures are not applicable in this instance.

5. Outcome is relevant and meaningful to the intervention and the evaluation

Well covered	The rationale for working towards a particular outcome is explained in terms of the relevance to the intervention being delivered and the evaluation of this in the broader context of strengths

	based approaches in forensic areas.
Adequately addressed	The outcome is described but is less relevant either to the specific intervention being delivered or to the field of clinical or forensic practice with strength based approaches.
Poorly addressed	The outcome is mentioned but is less well covered and its usefulness to the evaluation of the intervention or broader improvements in practice are less clearly described.
Not addressed	The overall outcome is not related to the intervention specifically or the broader context of violence reduction sufficiently.
Not reported	How the outcome is related to intervention and evaluation is not reported.
Not applicable	How the outcome is related to intervention and evaluation is not applicable in this instance

6. Study is adequately powered to detect the effect of the intervention

Well covered	Power calculation was completed using a reasonable effect size estimation and is clearly reported along with sufficient sample size within each group.
Adequately addressed	Power calculation is carried out, however, arbitrary effect size estimation used.
Poorly addressed	Power calculation is completed, however, effect size estimation not mentioned and no evidence of this having informed the sample size in each group.
Not addressed	Power calculation not completed or paper failed to meet the power calculation with sufficient sample size meaning any difference is not statistically significant.
Not reported	Power calculation not reported.
Not applicable	Power calculation not applicable in this instance.

7. Appropriate analysis for outcome measures used and p values, confidence intervals and effect sizes reported where appropriate

Well covered	Method of quantitative analysis used provides meaningful results of outcome and the confidence intervals, p-values and effect sizes are reported where appropriate. The analysis is described in sufficient detail so as statistical significance as well as descriptive in- formation is clearly presented.
Adequately addressed	The quantitative analysis used provides meaningful results, however, the details of this such as the p-values, confidence intervals and effect sizes are less well covered.
Poorly addressed	The method of analysis used has not been well considered and does not provide the best presentation of results from the study. The p- values, effect sizes and confidence intervals may have mentioned but are not sufficient in this case.
Not addressed	There has not been any quantitative analysis used in this case, rather inconclusive findings have been provided.
Not reported	The methods of analysis have not been reported.
Not applicable	The methods of analysis are not applicable in this instance.

8. The intervention has been appropriately defined

Well covered	The intervention is covered in sufficient detail including reference to the theoretical underpinnings and the potential impact on level of violence within the target population. The content and procedures of the intervention are clearly described so as it could be replicated by the reader, as are any 'rest periods'.
Adequately addressed	The intervention is described in relatively sufficient detail, although is less well covered. The theoretical underpinnings and impact of intervention are discussed but in less detail. The content and procedures are also mentioned but lack the acute detail necessary for the intervention to be accurately replicated.
Poorly addressed	The intervention is described; however, there is a lack of reference to the theoretical underpinnings and potential impact within sample. The content and procedures are not discussed.
Not addressed	The overall aim of the intervention is mentioned but the underpinnings and procedures of the intervention are lacking.
Not reported	Details of the intervention itself are not reported.
Not applicable	Details of the intervention are not applicable in this instance.

9. Intervention was delivered as planned (good fidelity)

Well covered	Details ofhow the intervention should be operationalised are provided and adhered to, as are

	fidelity checks such as supervision and reflective practice.
Adequately addressed	Details of operationalisation of the intervention are provided and adhered to, however, no fidelity check are described.
Poorly addressed	Details of how the intervention should be operationalised are mentioned, however, there is no evidence of this being adhered to AND/OR there are no fidelity checks evidenced.
Not addressed	Operationalisation of the intervention AND/OR fidelity checks are mentioned but not elaborated on.
Not reported	Operationalisation of the intervention AND fidelity checks are not reported.
Not applicable	Operationalisation of the intervention AND fidelity checks are not applicable in this instance.

10. Intervention has been implemented in a way that would be considered 'routine practice'

Well covered	The intervention took place in a forensic or clinical setting and the article discusses external validity and applicability to intervention across these settings.
Adequately addressed	The paper describes external validity and the applicability of the intervention across the forensic and clinical settings, however, did not take place in this setting.
Poorly addressed	External validity is not elaborated on in the paper and it does not take place in a forensic or clinical setting.
Not addressed	The paper does not discuss external validity and does not take place in a forensic or clinical setting.
Not reported	Neither external validity nor intervention setting was reported in the paper.
Not applicable	Neither external validity nor intervention setting was applicable in this instance.

11. Follow up evaluation undertaken

Well covered	Follow up evaluation described in detail and implemented at pre- arranged intervals which were described clearly, along with the outcome of this evaluation.
Adequately addressed	Follow up evaluation was referred to and the benefits of this were highlighted, however, it was not completed OR the findings from it were not provided within the paper.
Poorly addressed	The rationale for a follow up evaluation was mentioned, however, it was not elaborated on nor was it completed.
Not addressed	The rationale for a follow up evaluation was not addressed.
Not reported	The rationale for a follow up evaluation was not reported in the paper.
Not applicable	A follow up evaluation was not applicable in this instance.

Appendix 3. Aggression and Violent Behaviour Journal

AGGRESSION AND VIOLENT BEHAVIOR

AUTHOR INFORMATION PACK

TABLE OF CONTENTS

ISSN: 1359-1789

DESCRIPTION

Aggression and Violent Behavior, A Review Journal is a multidisciplinary journal that publishes substantive and integrative reviews, as well as summary reports of innovative ongoing clinical research programs on a wide range of topics germane to the field of **aggression** and **violent behavior**. Papers encompass a large variety of issues, populations, and domains, including homicide (serial, spree, and mass murder: sexual homicide), sexual deviance and assault (rape, serial rape, child molestation, paraphilias), child and youth violence (firesetting, gang violence, juvenile sexual offending), family violence (child physical and sexual abuse, child neglect, incest, spouse and elder abuse), genetic predispositions, and the physiological basis of aggression.

Manuscripts that articulate disparate orientations will be welcomed, given that this journal will be cross-disciplinary and cross-theoretical. Indeed, papers will emanate from numerous disciplines, psychology, psychiatry, criminology, criminal justice, law, sociology, anthropology, genetics, social work, ethology, and physiology.

Papers describing the study of aggression in normal, criminal, and psychopathological populations are acceptable. Reviews of analog investigations of aggression and animal models will be considered if the contribution is likely to lead to significant movement in the field. The emphasis, however, will be on innovativeness of presentation and clarity of thinking.

Benefits to authors
We also provide many author benefits, such as free PDFs, a liberal copyright policy, special discounts on Elsevier publications and much more. Please click here for more information on our author services.

Please see our Guide for Authors for information on article submission. If you require any further information or help, please visit our Support Center

IMPACT FACTOR

2018: 1.983 © Clarivate Analytics Journal Citation Reports 2019

ABSTRACTING AND INDEXING

Sociological Abstracts
Social Sciences Citation Index
Research Alert
Social SciSearch
Current Contents - Social & Behavioral Sciences
Current Contents
Scopus

EDITORIAL BOARD

GUIDE FOR AUTHORS

Your Paper Your Way

We now differentiate between the requirements for new and revised submissions. You may choose to submit your manuscript as a single Word or PDF file to be used in the refereeing process. Only when your paper is at the revision stage, will you be requested to put your paper in to a 'correct format' for acceptance and provide the items required for the publication of your article.
To find out more, please visit the Preparation section below.

Submission checklist

You can use this list to carry out a final check of your submission before you send it to the journal for review. Please check the relevant section in this Guide for Authors for more details.

Ensure that the following items are present:

One author has been designated as the corresponding author with contact details:
• E-mail address
• Full postal address

All necessary files have been uploaded:
Manuscript:
• Include keywords
• All figures (include relevant captions)
• All tables (including titles, description, footnotes)
• Ensure all figure and table citations in the text match the files provided
• Indicate clearly if color should be used for any figures in print
Graphical Abstracts / Highlights files (where applicable)
Supplemental files (where applicable)

Further considerations
• Manuscript has been 'spell checked' and 'grammar checked'
• All references mentioned in the Reference List are cited in the text, and vice versa
• Permission has been obtained for use of copyrighted material from other sources (including the Internet)
• A competing interests statement is provided, even if the authors have no competing interests to declare
• Journal policies detailed in this guide have been reviewed
• Referee suggestions and contact details provided, based on journal requirements

For further information, visit our Support Center.

BEFORE YOU BEGIN

Ethics in publishing

Please see our information pages on Ethics in publishing and Ethical guidelines for journal publication.

Declaration of interest

All authors must disclose any financial and personal relationships with other people or organizations that could inappropriately influence (bias) their work. Examples of potential competing interests include employment, consultancies, stock ownership, honoraria, paid expert testimony, patent applications/registrations, and grants or other funding. Authors must disclose any interests in two places: 1. A summary declaration of interest statement in the title page file (if double-blind) or the manuscript file (if single-blind). If there are no interests to declare then please state this: 'Declarations of interest: none'. This summary statement will be ultimately published if the article is accepted. 2. Detailed disclosures as part of a separate Declaration of Interest form, which forms part of the journal's official records. It is important for potential interests to be declared in both places and that the information matches. More information.

Submission declaration and verification

Submission of an article implies that the work described has not been published previously (except in the form of an abstract, a published lecture or academic thesis, see 'Multiple, redundant or concurrent publication' for more information), that it is not under consideration for publication elsewhere, that

its publication is approved by all authors and tacitly or explicitly by the responsible authorities where the work was carried out, and that, if accepted, it will not be published elsewhere in the same form, in English or in any other language, including electronically without the written consent of the copyright-holder. To verify originality, your article may be checked by the originality detection service Crossref Similarity Check.

Preprints
Please note that preprints can be shared anywhere at any time, in line with Elsevier's sharing policy. Sharing your preprints e.g. on a preprint server will not count as prior publication (see 'Multiple, redundant or concurrent publication' for more information).

Use of inclusive language
Inclusive language acknowledges diversity, conveys respect to all people, is sensitive to differences, and promotes equal opportunities. Articles should make no assumptions about the beliefs or commitments of any reader, should contain nothing which might imply that one individual is superior to another on the grounds of race, sex, culture or any other characteristic, and should use inclusive language throughout. Authors should ensure that writing is free from bias, for instance by using 'he or she', 'his/her' instead of 'he' or 'his', and by making use of job titles that are free of stereotyping (e.g. 'chairperson' instead of 'chairman' and 'flight attendant' instead of 'stewardess').

Author contributions
For transparency, we encourage authors to submit an author statement file outlining their individual contributions to the paper using the relevant CRediT roles: Conceptualization; Data curation; Formal analysis; Funding acquisition; Investigation; Methodology; Project administration; Resources; Software; Supervision; Validation; Visualization; Roles/Writing - original draft; Writing - review & editing. Authorship statements should be formatted with the names of authors first and CRediT role(s) following. More details and an example

Changes to authorship
Authors are expected to consider carefully the list and order of authors **before** submitting their manuscript and provide the definitive list of authors at the time of the original submission. Any addition, deletion or rearrangement of author names in the authorship list should be made only **before** the manuscript has been accepted and only if approved by the journal Editor. To request such a change, the Editor must receive the following from the **corresponding author**: (a) the reason for the change in author list and (b) written confirmation (e-mail, letter) from all authors that they agree with the addition, removal or rearrangement. In the case of addition or removal of authors, this includes confirmation from the author being added or removed.
Only in exceptional circumstances will the Editor consider the addition, deletion or rearrangement of authors **after** the manuscript has been accepted. While the Editor considers the request, publication of the manuscript will be suspended. If the manuscript has already been published in an online issue, any requests approved by the Editor will result in a corrigendum.

Copyright
Upon acceptance of an article, authors will be asked to complete a 'Journal Publishing Agreement' (see more information on this). An e-mail will be sent to the corresponding author confirming receipt of the manuscript together with a 'Journal Publishing Agreement' form or a link to the online version of this agreement.

Subscribers may reproduce tables of contents or prepare lists of articles including abstracts for internal circulation within their institutions. Permission of the Publisher is required for resale or distribution outside the institution and for all other derivative works, including compilations and translations. If excerpts from other copyrighted works are included, the author(s) must obtain written permission from the copyright owners and credit the source(s) in the article. Elsevier has preprinted forms for use by authors in these cases.

For gold open access articles: Upon acceptance of an article, authors will be asked to complete an 'Exclusive License Agreement' (more information). Permitted third party reuse of gold open access articles is determined by the author's choice of user license.

Author rights
As an author you (or your employer or institution) have certain rights to reuse your work. More information.

Elsevier supports responsible sharing
Find out how you can share your research published in Elsevier journals.

Role of the funding source
You are requested to identify who provided financial support for the conduct of the research and/or preparation of the article and to briefly describe the role of the sponsor(s), if any, in study design; in the collection, analysis and interpretation of data; in the writing of the report; and in the decision to submit the article for publication. If the funding source(s) had no such involvement then this should be stated.

Open access
Please visit our Open Access page from the Journal Homepage for more information.

Elsevier Researcher Academy
Researcher Academy is a free e-learning platform designed to support early and mid-career researchers throughout their research journey. The "Learn" environment at Researcher Academy offers several interactive modules, webinars, downloadable guides and resources to guide you through the process of writing for research and going through peer review. Feel free to use these free resources to improve your submission and navigate the publication process with ease.

Language (usage and editing services)
Please write your text in good English (American or British usage is accepted, but not a mixture of these). Authors who feel their English language manuscript may require editing to eliminate possible grammatical or spelling errors and to conform to correct scientific English may wish to use the English Language Editing service available from Elsevier's Author Services.

Submission
Our online submission system guides you stepwise through the process of entering your article details and uploading your files. The system converts your article files to a single PDF file used in the peer-review process. Editable files (e.g., Word, LaTeX) are required to typeset your article for final publication. All correspondence, including notification of the Editor's decision and requests for revision, is sent by e-mail.

PREPARATION

NEW SUBMISSIONS
Submission to this journal proceeds totally online and you will be guided stepwise through the creation and uploading of your files. The system automatically converts your files to a single PDF file, which is used in the peer-review process.
As part of the Your Paper Your Way service, you may choose to submit your manuscript as a single file to be used in the refereeing process. This can be a PDF file or a Word document, in any format or lay-out that can be used by referees to evaluate your manuscript. It should contain high enough quality figures for refereeing. If you prefer to do so, you may still provide all or some of the source files at the initial submission. Please note that individual figure files larger than 10 MB must be uploaded separately.

References
There are no strict requirements on reference formatting at submission. References can be in any style or format as long as the style is consistent. Where applicable, author(s) name(s), journal title/book title, chapter title/article title, year of publication, volume number/book chapter and the article number or pagination must be present. Use of DOI is highly encouraged. The reference style used by the journal will be applied to the accepted article by Elsevier at the proof stage. Note that missing data will be highlighted at proof stage for the author to correct.

Formatting requirements
There are no strict formatting requirements but all manuscripts must contain the essential elements needed to convey your manuscript, for example Abstract, Keywords, Introduction, Materials and Methods, Results, Conclusions, Artwork and Tables with Captions.
If your article includes any Videos and/or other Supplementary material, this should be included in your initial submission for peer review purposes.
Divide the article into clearly defined sections.

Please ensure the text of your paper is double-spaced—this is an essential peer review requirement.

Figures and tables embedded in text
Please ensure the figures and the tables included in the single file are placed next to the relevant text in the manuscript, rather than at the bottom or the top of the file. The corresponding caption should be placed directly below the figure or table.

Peer review
This journal operates a single blind review process. All contributions will be initially assessed by the editor for suitability for the journal. Papers deemed suitable are then typically sent to a minimum of two independent expert reviewers to assess the scientific quality of the paper. The Editor is responsible for the final decision regarding acceptance or rejection of articles. The Editor's decision is final. More information on types of peer review.

REVISED SUBMISSIONS
Use of word processing software
Regardless of the file format of the original submission, at revision you must provide us with an editable file of the entire article. Keep the layout of the text as simple as possible. Most formatting codes will be removed and replaced on processing the article. The electronic text should be prepared in a way very similar to that of conventional manuscripts (see also the Guide to Publishing with Elsevier). See also the section on Electronic artwork.
To avoid unnecessary errors you are strongly advised to use the 'spell-check' and 'grammar-check' functions of your word processor.

Article structure
Subdivision - numbered sections
Divide your article into clearly defined and numbered sections. Subsections should be numbered 1.1 (then 1.1.1, 1.1.2, ...), 1.2, etc. (the abstract is not included in section numbering). Use this numbering also for internal cross-referencing: do not just refer to 'the text'. Any subsection may be given a brief heading. Each heading should appear on its own separate line.

Introduction
State the objectives of the work and provide an adequate background, avoiding a detailed literature survey or a summary of the results.

Material and methods
Provide sufficient details to allow the work to be reproduced by an independent researcher. Methods that are already published should be summarized, and indicated by a reference. If quoting directly from a previously published method, use quotation marks and also cite the source. Any modifications to existing methods should also be described.

Theory/calculation
A Theory section should extend, not repeat, the background to the article already dealt with in the Introduction and lay the foundation for further work. In contrast, a Calculation section represents a practical development from a theoretical basis.

Results
Results should be clear and concise.

Discussion
This should explore the significance of the results of the work, not repeat them. A combined Results and Discussion section is often appropriate. Avoid extensive citations and discussion of published literature.

Conclusions
The main conclusions of the study may be presented in a short Conclusions section, which may stand alone or form a subsection of a Discussion or Results and Discussion section.

Appendices
If there is more than one appendix, they should be identified as A, B, etc. Formulae and equations in appendices should be given separate numbering: Eq. (A.1), Eq. (A.2), etc.; in a subsequent appendix, Eq. (B.1) and so on. Similarly for tables and figures: Table A.1; Fig. A.1, etc.

Essential title page information
• ***Title.*** Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible.

• ***Author names and affiliations.*** Where the family name may be ambiguous (e.g., a double name), please indicate this clearly. Present the authors' affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lower-case superscript letter immediately after the author's name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name, and, if available, the e-mail address of each author. **The title page is to be the first page of the manuscript; the second page is the abstract with key words.**
• ***Corresponding author.*** Clearly indicate who will handle correspondence at all stages of refereeing and publication, also post-publication. **Ensure that telephone and fax numbers (with country and area code) are provided in addition to the e-mail address and the complete postal address.**
• ***Present/permanent address.*** If an author has moved since the work described in the article was done, or was visiting at the time, a "Present address" (or "Permanent address") may be indicated as a footnote to that author's name. The address at which the author actually did the work must be retained as the main, affiliation address. Superscript Arabic numerals are used for such footnotes.

Highlights
Highlights are mandatory for this journal as they help increase the discoverability of your article via search engines. They consist of a short collection of bullet points that capture the novel results of your research as well as new methods that were used during the study (if any). Please have a look at the examples here: example Highlights.

Highlights should be submitted in a separate editable file in the online submission system. Please use 'Highlights' in the file name and include 3 to 5 bullet points (maximum 85 characters, including spaces, per bullet point).

Abstract
A concise (no more than 200 words) and factual abstract is required. This should be on a separate page following the title page and should not contain reference citations.

Graphical abstract
Although a graphical abstract is optional, its use is encouraged as it draws more attention to the online article. The graphical abstract should summarize the contents of the article in a concise, pictorial form designed to capture the attention of a wide readership. Graphical abstracts should be submitted as a separate file in the online submission system. Image size: Please provide an image with a minimum of 531 × 1328 pixels (h × w) or proportionally more. The image should be readable at a size of 5 × 13 cm using a regular screen resolution of 96 dpi. Preferred file types: TIFF, EPS, PDF or MS Office files. You can view Example Graphical Abstracts on our information site.
Authors can make use of Elsevier's Illustration Services to ensure the best presentation of their images and in accordance with all technical requirements.

Keywords
Immediately after the abstract, provide a maximum of 6 keywords, using American spelling and avoiding general and plural terms and multiple concepts (avoid, for example, 'and', 'of'). Be sparing with abbreviations: only abbreviations firmly established in the field may be eligible. These keywords will be used for indexing purposes.

Abbreviations
Define abbreviations that are not standard in this field in a footnote to be placed on the first page of the article. Such abbreviations that are unavoidable in the abstract must be defined at their first mention there, as well as in the footnote. Ensure consistency of abbreviations throughout the article.

Acknowledgements
Collate acknowledgements in a separate section at the end of the article before the references and do not, therefore, include them on the title page, as a footnote to the title or otherwise. List here those individuals who provided help during the research (e.g., providing language help, writing assistance or proof reading the article, etc.).

Formatting of funding sources
List funding sources in this standard way to facilitate compliance to funder's requirements:

Funding: This work was supported by the National Institutes of Health [grant numbers xxxx, yyyy]; the Bill & Melinda Gates Foundation, Seattle, WA [grant number zzzz]; and the United States Institutes of Peace [grant number aaaa].

It is not necessary to include detailed descriptions on the program or type of grants and awards. When funding is from a block grant or other resources available to a university, college, or other research institution, submit the name of the institute or organization that provided the funding.

If no funding has been provided for the research, please include the following sentence:

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Math formulae
Please submit math equations as editable text and not as images. Present simple formulae in line with normal text where possible and use the solidus (/) instead of a horizontal line for small fractional terms, e.g., X/Y. In principle, variables are to be presented in italics. Powers of e are often more conveniently denoted by exp. Number consecutively any equations that have to be displayed separately from the text (if referred to explicitly in the text).

Footnotes
Footnotes should be used sparingly. Number them consecutively throughout the article. Many word processors build footnotes into the text, and this feature may be used. Should this not be the case, indicate the position of footnotes in the text and present the footnotes themselves separately at the end of the article.

Artwork

Electronic artwork
General points
- Make sure you use uniform lettering and sizing of your original artwork.
- Preferred fonts: Arial (or Helvetica), Times New Roman (or Times), Symbol, Courier.
- Number the illustrations according to their sequence in the text.
- Use a logical naming convention for your artwork files.
- Indicate per figure if it is a single, 1.5 or 2-column fitting image.
- For Word submissions only, you may still provide figures and their captions, and tables within a single file at the revision stage.
- Please note that individual figure files larger than 10 MB must be provided in separate source files.

A detailed guide on electronic artwork is available.
You are urged to visit this site; some excerpts from the detailed information are given here.
Formats
Regardless of the application used, when your electronic artwork is finalized, please 'save as' or convert the images to one of the following formats (note the resolution requirements for line drawings, halftones, and line/halftone combinations given below):
EPS (or PDF): Vector drawings. Embed the font or save the text as 'graphics'.
TIFF (or JPG): Color or grayscale photographs (halftones): always use a minimum of 300 dpi.
TIFF (or JPG): Bitmapped line drawings: use a minimum of 1000 dpi.
TIFF (or JPG): Combinations bitmapped line/half-tone (color or grayscale): a minimum of 500 dpi is required.
Please do not:
- Supply files that are optimized for screen use (e.g., GIF, BMP, PICT, WPG); the resolution is too low.
- Supply files that are too low in resolution.
- Submit graphics that are disproportionately large for the content.

Color artwork
Please make sure that artwork files are in an acceptable format (TIFF (or JPEG), EPS (or PDF), or MS Office files) and with the correct resolution. If, together with your accepted article, you submit usable color figures then Elsevier will ensure, at no additional charge, that these figures will appear in color online (e.g., ScienceDirect and other sites) regardless of whether or not these illustrations are reproduced in color in the printed version. **For color reproduction in print, you will receive information regarding the costs from Elsevier after receipt of your accepted article.** Please indicate your preference for color: in print or online only. Further information on the preparation of electronic artwork.

Figure captions
Ensure that each illustration has a caption. A caption should comprise a brief title (**not** on the figure itself) and a description of the illustration. Keep text in the illustrations themselves to a minimum but explain all symbols and abbreviations used.

Tables

Please submit tables as editable text and not as images. Tables can be placed either next to the relevant text in the article, or on separate page(s) at the end. Number tables consecutively in accordance with their appearance in the text and place any table notes below the table body. Be sparing in the use of tables and ensure that the data presented in them do not duplicate results described elsewhere in the article. Please avoid using vertical rules and shading in table cells.

References

Citation in text
Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full. Unpublished results and personal communications are not recommended in the reference list, but may be mentioned in the text. If these references are included in the reference list they should follow the standard reference style of the journal and should include a substitution of the publication date with either 'Unpublished results' or 'Personal communication'. Citation of a reference as 'in press' implies that the item has been accepted for publication.

Web references
As a minimum, the full URL should be given and the date when the reference was last accessed. Any further information, if known (DOI, author names, dates, reference to a source publication, etc.), should also be given. Web references can be listed separately (e.g., after the reference list) under a different heading if desired, or can be included in the reference list.

Data references
This journal encourages you to cite underlying or relevant datasets in your manuscript by citing them in your text and including a data reference in your Reference List. Data references should include the following elements: author name(s), dataset title, data repository, version (where available), year, and global persistent identifier. Add [dataset] immediately before the reference so we can properly identify it as a data reference. The [dataset] identifier will not appear in your published article.

References in a special issue
Please ensure that the words 'this issue' are added to any references in the list (and any citations in the text) to other articles in the same Special Issue.

Reference management software
Most Elsevier journals have their reference template available in many of the most popular reference management software products. These include all products that support Citation Style Language styles, such as Mendeley. Using citation plug-ins from these products, authors only need to select the appropriate journal template when preparing their article, after which citations and bibliographies will be automatically formatted in the journal's style. If no template is yet available for this journal, please follow the format of the sample references and citations as shown in this Guide. If you use reference management software, please ensure that you remove all field codes before submitting the electronic manuscript. More information on how to remove field codes from different reference management software.

Users of Mendeley Desktop can easily install the reference style for this journal by clicking the following link:
http://open.mendeley.com/use-citation-style/aggression-and-violent-behavior
When preparing your manuscript, you will then be able to select this style using the Mendeley plug-ins for Microsoft Word or LibreOffice.

Reference formatting
There are no strict requirements on reference formatting at submission. References can be in any style or format as long as the style is consistent. Where applicable, author(s) name(s), journal title/book title, chapter title/article title, year of publication, volume number/book chapter and the article number or pagination must be present. Use of DOI is highly encouraged. The reference style used by the journal will be applied to the accepted article by Elsevier at the proof stage. Note that missing data will be highlighted at proof stage for the author to correct. If you do wish to format the references yourself they should be arranged according to the following examples:

Reference style
Text: Citations in the text should follow the referencing style used by the American Psychological Association. You are referred to the Publication Manual of the American Psychological Association, Sixth Edition, ISBN 978-1-4338-0561-5, copies of which may be ordered online or APA Order Dept., P.O.B. 2710, Hyattsville, MD 20784, USA or APA, 3 Henrietta Street, London, WC3E 8LU, UK.
List: references should be arranged first alphabetically and then further sorted chronologically if necessary. More than one reference from the same author(s) in the same year must be identified by the letters 'a', 'b', 'c', etc., placed after the year of publication.
Examples:
Reference to a journal publication:
Van der Geer, J., Hanraads, J. A. J., & Lupton, R. A. (2010). The art of writing a scientific article. *Journal of Scientific Communications, 163*, 51–59. https://doi.org/10.1016/j.Sc.2010.00372.
Reference to a journal publication with an article number:
Van der Geer, J., Hanraads, J. A. J., & Lupton, R. A. (2018). The art of writing a scientific article. *Heliyon, 19*, e00205. https://doi.org/10.1016/j.heliyon.2018.e00205.
Reference to a book:
Strunk, W., Jr., & White, E. B. (2000). *The elements of style.* (4th ed.). New York: Longman, (Chapter 4).
Reference to a chapter in an edited book:
Mettam, G. R., & Adams, L. B. (2009). How to prepare an electronic version of your article. In B. S. Jones, & R. Z. Smith (Eds.), *Introduction to the electronic age* (pp. 281–304). New York: E-Publishing Inc.
Reference to a website:
Cancer Research UK. Cancer statistics reports for the UK. (2003). http://www.cancerresearchuk.org/aboutcancer/statistics/cancerstatsreport/ Accessed 13 March 2003.
Reference to a dataset:
[dataset] Oguro, M., Imahiro, S., Saito, S., Nakashizuka, T. (2015). *Mortality data for Japanese oak wilt disease and surrounding forest compositions*. Mendeley Data, v1. https://doi.org/10.17632/xwj98nb39r.1.
Reference to a conference paper or poster presentation:
Engle, E.K., Cash, T.F., & Jarry, J.L. (2009, November). The Body Image Behaviours Inventory-3: Development and validation of the Body Image Compulsive Actions and Body Image Avoidance Scales. Poster session presentation at the meeting of the Association for Behavioural and Cognitive Therapies, New York, NY.

Journal abbreviations source
Journal names should be abbreviated according to the List of Title Word Abbreviations.

Video
Elsevier accepts video material and animation sequences to support and enhance your scientific research. Authors who have video or animation files that they wish to submit with their article are strongly encouraged to include links to these within the body of the article. This can be done in the same way as a figure or table by referring to the video or animation content and noting in the body text where it should be placed. All submitted files should be properly labeled so that they directly relate to the video file's content. In order to ensure that your video or animation material is directly usable, please provide the file in one of our recommended file formats with a preferred maximum size of 150 MB per file, 1 GB in total. Video and animation files supplied will be published online in the electronic version of your article in Elsevier Web products, including ScienceDirect. Please supply 'stills' with your files: you can choose any frame from the video or animation or make a separate image. These will be used instead of standard icons and will personalize the link to your video data. For more detailed instructions please visit our video instruction pages. Note: since video and animation cannot be embedded in the print version of the journal, please provide text for both the electronic and the print version for the portions of the article that refer to this content.

Data visualization
Include interactive data visualizations in your publication and let your readers interact and engage more closely with your research. Follow the instructions here to find out about available data visualization options and how to include them with your article.

Supplementary material
Supplementary material such as applications, images and sound clips, can be published with your article to enhance it. Submitted supplementary items are published exactly as they are received (Excel or PowerPoint files will appear as such online). Please submit your material together with the article and supply a concise, descriptive caption for each supplementary file. If you wish to make changes to supplementary material during any stage of the process, please make sure to provide an updated file. Do not annotate any corrections on a previous version. Please switch off the 'Track Changes' option in Microsoft Office files as these will appear in the published version.

Research data
This journal encourages and enables you to share data that supports your research publication where appropriate, and enables you to interlink the data with your published articles. Research data refers to the results of observations or experimentation that validate research findings. To facilitate reproducibility and data reuse, this journal also encourages you to share your software, code, models, algorithms, protocols, methods and other useful materials related to the project.

Below are a number of ways in which you can associate data with your article or make a statement about the availability of your data when submitting your manuscript. If you are sharing data in one of these ways, you are encouraged to cite the data in your manuscript and reference list. Please refer to the "References" section for more information about data citation. For more information on depositing, sharing and using research data and other relevant research materials, visit the research data page.

Data linking
If you have made your research data available in a data repository, you can link your article directly to the dataset. Elsevier collaborates with a number of repositories to link articles on ScienceDirect with relevant repositories, giving readers access to underlying data that gives them a better understanding of the research described.

There are different ways to link your datasets to your article. When available, you can directly link your dataset to your article by providing the relevant information in the submission system. For more information, visit the database linking page.

For supported data repositories a repository banner will automatically appear next to your published article on ScienceDirect.

In addition, you can link to relevant data or entities through identifiers within the text of your manuscript, using the following format: Database: xxxx (e.g., TAIR: AT1G01020; CCDC: 734053; PDB: 1XFN).

Mendeley Data
This journal supports Mendeley Data, enabling you to deposit any research data (including raw and processed data, video, code, software, algorithms, protocols, and methods) associated with your manuscript in a free-to-use, open access repository. During the submission process, after uploading your manuscript, you will have the opportunity to upload your relevant datasets directly to *Mendeley Data*. The datasets will be listed and directly accessible to readers next to your published article online.

For more information, visit the Mendeley Data for journals page.

Data statement
To foster transparency, we encourage you to state the availability of your data in your submission. This may be a requirement of your funding body or institution. If your data is unavailable to access or unsuitable to post, you will have the opportunity to indicate why during the submission process, for example by stating that the research data is confidential. The statement will appear with your published article on ScienceDirect. For more information, visit the Data Statement page.

AFTER ACCEPTANCE

Online proof correction
To ensure a fast publication process of the article, we kindly ask authors to provide us with their proof corrections within two days. Corresponding authors will receive an e-mail with a link to our online proofing system, allowing annotation and correction of proofs online. The environment is similar to

MS Word: in addition to editing text, you can also comment on figures/tables and answer questions from the Copy Editor. Web-based proofing provides a faster and less error-prone process by allowing you to directly type your corrections, eliminating the potential introduction of errors.
If preferred, you can still choose to annotate and upload your edits on the PDF version. All instructions for proofing will be given in the e-mail we send to authors, including alternative methods to the online version and PDF.
We will do everything possible to get your article published quickly and accurately. Please use this proof only for checking the typesetting, editing, completeness and correctness of the text, tables and figures. Significant changes to the article as accepted for publication will only be considered at this stage with permission from the Editor. It is important to ensure that all corrections are sent back to us in one communication. Please check carefully before replying, as inclusion of any subsequent corrections cannot be guaranteed. Proofreading is solely your responsibility.

Offprints

The corresponding author will, at no cost, receive a customized Share Link providing 50 days free access to the final published version of the article on ScienceDirect. The Share Link can be used for sharing the article via any communication channel, including email and social media. For an extra charge, paper offprints can be ordered via the offprint order form which is sent once the article is accepted for publication. Both corresponding and co-authors may order offprints at any time via Elsevier's Author Services. Corresponding authors who have published their article gold open access do not receive a Share Link as their final published version of the article is available open access on ScienceDirect and can be shared through the article DOI link.

AUTHOR INQUIRIES

Visit the Elsevier Support Center to find the answers you need. Here you will find everything from Frequently Asked Questions to ways to get in touch.
You can also check the status of your submitted article or find out when your accepted article will be published.

Appendix 4. Thesis Proposal Form:

Doctorate in Clinical Psychology

Thesis Research Proposal

(Research 1 Assessment)

This form should be completed and submitted as the assessment for Research 1. It will then be reviewed by a member of the academic team and will receive a grade and detailed feedback. The feedback will include an evaluation of the viability of the project and any recommendations. If there are significant concerns about viability, the project will be flagged to the research director and the research committee will decide whether the project can proceed in its current form.

Exam Number
B082138

Provisional Thesis Title
Exploring Values and Goals in a Mentally Disordered Offender Population within Medium Secure Psychiatric Units: A Qualitative Study.

Proposed Setting
The Orchard Clinic, Royal Edinburgh Hospital, Morningside Terrace, Edinburgh, EH10 5FH

Allocated Thesis Project Supervisors	
Clinical	Dr Ethel Quayle
Academic 1	Dr Louise Tansey

Academic 2	N/A
Others Involved	N/A

Anticipated Month / Year of Submission Must be final year for full-time trainees. For flex trainees, the month and year of submission will depend you the individual Training and Development Plan. Trainees from 2011 intake onwards must submit in May. Trainees who started in 2010 or earlier are advised to submit in May to reduce potential for HCPC registration difficulties.
May 2018

Please Note: Whilst this is not an ethics review process, where questions have some similarities to questions contained in the NHS IRAS Research Ethics form, the corresponding IRAS question numbers are given in parentheses. This is intended to facilitate completion of NHS ethics where such approval is needed.

Section 1: Introduction

1.1 Provide a brief critical review of relevant literature, which should clearly demonstrate the rationale and scientific justification for the research
1000 – 1500 words
Relevant to IRAS A12

Values and the political and health Context

Recent national health and political campaigns, such as the Well Scotland Initiative and the Recovery model have highlighted the importance of the role of individual's values and the benefits of pursuing them in addressing mental well-being across Scotland. There is an increasing emphasis on values and recovery in health settings (Centre for Mental Health, 2011; Hayes, 1999) and in forensic mental health services (Forensic Mental Health Matrix, 2011). Within the recovery approach, The Good Lives model moves from a previous primary focus on the management of risk, to balancing this with promoting the goals of the individual, their recovery and positive risk taking. This approach was initially used within a sex offenders population but is also thought to be a promising intervention with mentally disordered offenders (MDOs) (Barnao et al., 2016). Its aim is to build resources for the individual to live a life that is meaningful, fulfilling, in line with their values and to reduce risk. Despite the endorsement of values based approaches, values have not been clearly defined or operationalised in clinical settings (Tansey, 2010). Moreover, it is not clear if similar values are shared across populations (Tansey, 2010; Stuart, 2015), despite the Good Lives Model assuming that the values of the MDO population are the same as the general population (Sellen et al., 2006). In light of this increased focus on values in MDOs and in the development of clinical interventions, a greater understanding of values within this population is required to ensure that interventions are evidence based.

Conceptualising values

There are currently two main approaches used within the literature to conceptualise values: Schwartz's (1992) structural model; and a contextual, behavioural model from Acceptance and Commitment Therapy (ACT) (Hayes, 1999). Schwartz's model proposes that values are guiding beliefs, which are transsituational and represent desirable end states (Schwartz and Bilsky, 1987). Within this model, values are thought to be a product of their upbringing, social and cultural environments (Schwartz and Bardi, 2001). Schwartz's (1992) model of universal values, proposes ten value types, which can be separated into four higher-order value groups: conservation, openness to change, self-enhancement, and self-transcendence. The ACT based conceptualisation of values, states that values are verbal constructions of "organising principles for action" and this provides a long term framework for the individual's decisions and actions (Hayes, 1999). From a behavioural perspective, decisions and actions that are carried out in line with their values are positively reinforced (Powers et al., 2009).

Quantitative measures of values, such as the Valued Living Questionnaire (Wilson et al., 2010) and the Portrait Values Questionaire (Scwartz et al., 2001) are used clinically and in research. There are criticisms however, using these measures to explore values, particularly with MDOs. It can be argued that reducing values to a limited number of options will not capture everything that is important to an individual, and may limit the meaning of this. Furthermore, this restricted list will fail to capture any anti-social values, if these are present in an individual, as the values in these measures are mainly pro-social based (Tansey, 2010).

Mentally disordered offenders and medium Secure Units

Mentally Disordered Offenders (MDOs) are defined as people with a mental illness, personality disorder or learning disability who have offended and are involved in the criminal justice system (Jacques, Spencer, & Gilluley, 2010; Scottish Office, 1999).

The Orchard Clinic is one of three medium secure units in Scotland and was the first to open in 2000. Prior to this, the State Hospital at Carstairs was the sole high secure unit for MDOs in Scotland. A change to the management and treatment of MDOs was prompted by a number of government and health led reviews of services and risk. The Mental Health Act (2003), reviews by the Scottish Office (1997, 1999), and the State Hospital survey (Thomson et al., 1997), highlighted the need for medium and low secure units and also community resources. The Orchard Clinic is 40 bed unit and provides inpatient facilities for the assessment, treatment and rehabilitation of people with complex needs, who are involved in the criminal justice system. MDOs at the Orchard Clinic are thought to be a risk to themselves or others but they do not require high security care (Crichton, 2009). Recent reviews of the Orchard Clinic's admission have highlighted that the majority of patients are male and aged under 40 and have a primary diagnosis of schizophrenia.

Many also had a secondary diagnosis of personality disorder or substance misuse (Gow et al., 2010). The average length of admission was 40.7 weeks and admissions were predominantly from legal establishments, with an increasing proportion admitted on treatment orders pre trial (Stuart, 2014).

Mentally disordered offenders and values

As discussed, there is an increasing focus on values informed interventions, however there is a paucity of published research in this area, particularly with MDOs. A previous doctoral thesis (Tansey, 2010) was undertaken with the same client group at the Orchard Clinic, suggesting that a values based approach can assist with treatment planning, therapeutic engagement and goal setting. In this research, it was found that living in accordance with values was positively related to quality of life and negatively related to psychological distress. It also found some similarity in values of MDOs with the general population, however MDOs are often not able to live in accordance to these values. There were also some differences in personally meaningful values between populations, with greater importance placed on the values concerning safety, freedom and independence for MDOs. Furthermore, different goals were also identified, for example the goal of recovery and stability in mental health. It is thought that these differences in goals and values may be due to their current environment in the medium secure unit (Tansey, 2010).

Being detained in a medium secure unit presents a number of challenges in pursuing goals in line with a number of values including, freedom, autonomy and intimate relationships (Mezey, 2010). Furthermore, MDOs within secure facilities and in the community, may be more limited in their pursuit of relationships and employment due to the double stigma that MDOs face of mental illness and offending (Roskes, 1999). Moreover, a focus on risk to self and others in medium secure units can limit the pursuit of values and goals (Mezey et al., 2010). Legal restrictions can also be a barrier to achieving goals, for example a goal of being close to family but being unable to move to be with family in another part of the country due to restrictions on movement (Stuart, 2015).

There has been little research into these areas previously, therefore a qualitative study may be able to offer further insight into the values that are personally meaningful to this population; the barriers to pursuing these values; and to explore the differences between MDOs and the general population. Qualitative methods have been found to be important in exploring these issues and facilitating personal narratives within the recovery model (Roychowdhury, 2011; O'Sullivan et. al., 2013). A discussion of values has been found to be a positive part of recovery and can also improve engagement with therapy and identification of therapeutic goals (Stuart, 2015; Tansey, 2010). Furthermore, this research is important as attempts to increase engagement with therapy and management of offending behaviour will add to the evidence base and help inform current clinical practice, which has the potential to reduce the risk of this client group, impacting on the safety and welfare of the public.

Section 2: Research Questions / Objectives
2.1 What is the principal research question / objective? *IRAS A10*
What role do values and goals play in the lives of mentally disordered offenders? The research question will be kept generic inline with a grounded theory methodology (Charmaz, 2014).
2.2 What are the secondary research questions / objectives, if applicable? Keep these focused and concise, with a maximum of 5 research questions *IRAS A11*
What are the barriers in pursuing these values?

Section 3: Methodology
3.1 Give a full summary of your design and methodology It should be clear exactly what will happen at each stage of the project *IRAS A13*
Design This research will use a qualitative design to explore the values and goals of mentally disordered offenders (MDOs) in a medium secure psychiatric unit. Semi structured interviews will be undertaken with MDOs at the Orchard Clinic to gather data. The study will adopt a grounded theory methodology to develop an understanding of the values and goals from the patients' perspective to assist in the development of a theory. It is hoped that this will help facilitate the development of future interventions with this client group. There is a current paucity in the literature and a qualitative approach was chosen to develop an understanding of what is important in this population. Specifically, grounded theory was chosen as it is a good fit for the aims of this research as will be discussed later. Furthermore it is a well established method and is often used in offender populations (Hinsby & Barker, 2004; Mezey et al., 2010). **Participants and Recruitment** Participants will be recruited from the Orchard Clinic, a medium secure unit. The sample will be current residents of the clinic who have severe and enduring mental health problems and have offended. They will be 18 or over, able to give informed consent to participate, and not currently experiencing acute symptoms of mental illness. For the purposes of homogeneity and due to the majority of MDOs being male (Gow et al., 2010), the sample will be of male MDOs only. Recruitment will be sought initially through the patient's Responsible Medical Officer (RMO), a Consultant Psychiatrist, who is in charge of the patients care. Plain-English patient information sheets will be developed and a clinical

psychologist in the team will present an overview of the research to the clinical team meeting. At this meeting the RMO will say whether or not someone has capacity to consent to research and those without consent will be excluded. Members of the clinical team will then discuss the research with their patients who are deemed to have capacity, acting as gatekeepers for the research. If the patient is interested in participating, the researcher will then meet with them. During this meeting, the patient information sheet will be reviewed and the patient will have the opportunity to discuss any questions they may have. If they wish to participate in the study, they will be given at least 24 hours to review and sign the consent form.

Procedure

All patients identified as suitable and who have consented to participate will meet with the researcher for a face to face interview. This meeting, lasting approximately one hour, will take place within the Orchard clinic in a quiet, private and secure room. The interview will explore values and goals within this population, asking open ended questions. In particular, patients will be asked what is important in their life; their valued daily activities; and the impact of offending and mental health on attaining their values. These interviews will be audio recorded and secured securely on an NHS computer. Using a grounded theory method, notes will be taken during the interview and a preliminary analysis of the interviews may alter the questions asked in later interviews.

Data Analysis

All interviews will be transcribed and Dedoose software used to manage the anonymised data. The transcribed interviews will be analysed using a grounded theory method (Charmaz, 2014) as described below. Once theoretical saturation is reached, this will be used to generate a theory. This process will be reviewed in supervision and guidelines and checklists such as Chenail (2011) and Spence et al. (2003) will be used to ensure methodological rigour and help reduce researcher bias.

3.2.1 In which aspects of the research process have you actively involved, or will you involve, patients, service users and/or their carers or members of the public?
Highlight as appropriate.
IRAS A14-1

Design of the research	Analysis of results
Management of the research	Dissemination of findings
Undertaking the research	None of the above

3.2.2 Give details of involvement, or if none, please justify the absence of involvement

The researcher will meet with peer support workers in the Orchard Clinic to discuss the planning and design stages of the research. It will not be possible to have further service user involvement in the project, at other stages due to time restraints, nor at the stages of management of research or analysis of results due to the confidential nature of the raw data.

3.3 List the principal inclusion and exclusion criteria
IRAS A17-1 and IRAS A17-2

Inclusion criteria:

- Fluency in English
- Over the age of 18
- Considered able to provide informed consent as judged by the Responsible Medical Officer (RMO)
- Male

Exclusion Criteria:

- Considered unable to provide consent by the Responsible Medical Officer (RMO)
- Decline to hear more information when asked directly by the "gatekeeper"
- Are currently acutely psychotic, as assessed by the RMO
- Are engaged in individual psychotherapy with the researcher
- Have a learning disability
- Have significant communication difficulties
- Female

3.4 How will data be collected?
If quantitative, list proposed measures and justify the use of these measures. If qualitative, explain how data will be collected, giving reasonable detail (don't just say "by interviews".)

As discussed above, all participants taking part in the research will meet the researcher for individual face to face semi-structured interviews. The interviews will last approximately one hour using open ended and non judgemental questions to explore the values and goals of this group and barriers to achieving them. After the interview, participants will be given the opportunity to ask any questions in a post interview debriefing. Notes will be taken during the interview, in line with a grounded theory method, as will be discussed below. The interview will be audio recorded using encrypted digital audio recorders and the data will be transcribed, stored securely on a NHS computer in the Orchard Clinic, and anonymised data managed using Dedoose software. Each interview will be analysed and new questions formulated using grounded theory prior to the next interview.

Section 4: Sample Size

4.1 What sample size is needed for the research and how did you determine this?
For quantitative projects, outline the relevant Power calculations and the rationale

for assuming given effect sizes. For qualitative projects, outline your reasoning for assuming that this sample size will be sufficient to address the study's aims
IRAS A59 and IRAS A60

It is estimated that I will be able to recruit approximately 8 to 12 patients from the Orchard Clinic for this study. In grounded theory, it is difficult to estimate accurately beforehand, the size of a sample required, as it is difficult to predict when saturation of the data will occur (Stern, 2007). An average of eleven participants, with a range of six to sixteen participants were found to be used in qualitative studies using grounded theory with this population (Mezey et al., 2010; Krishnan & Evans, 2004; Van Hout & Phelanm 2014). Moreover, a recently completed thesis using grounded theory, had a sample of seven participants and found the saturation of categories after six interviews (Picton, 2013).

4.2 Outline reasons for your confidence in being able to achieve a sample of at least this size
E.g. give details of size of known available sample(s), percentage of this type of sample that typically participate in such studies, opinions of relevant individuals working in that area

I have met with my academic and clinical supervisors for this research to discuss sample size and they agree that this sample size is achievable given experience of past researchers at the Orchard Clinic. Of the 40 patients at the unit, it is estimated that 20 will fit inclusion criteria and a longer time frame for patient recruitment should allow for adequate recruitment, making it highly likely that I will be able to recruit 8-12 participants. Moreover, an unpublished thesis undertaken in the Orchard Clinic with the same client group (Tansey, 2010) was able to recruit a sample size of fifteen participants.

Section 5: Analysis

5.1 Describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative methods) by which the data will be evaluated to meet the study objectives
IRAS A62

The data will be evaluated using grounded theory methods. This qualitative approach is a systematic, inductive and comparative method to understand and evaluate human behaviour with the aim of constructing a theory (Charmaz, 2014). More specifically Charmaz's (2014) modern version of constructivist Grounded Theory approach will be used to explore values and goals within MDOs. The main characteristics of grounded theory as outlined by Glaser and Strauss (1967), include the simultaneous collection and analysis of data, making use of memos taken during data collection and the interview transcript. Memoing is used in Charmaz's (2014) constructivist grounded theory to increase awareness of and monitor the researchers own preconceived ideas and minimise the impact on the analysis and theory. Techniques are then used such as coding and categorisation, to identify categories in the data, make links and establish the relationship between

categories. This method is non linear and uses a "constant comparative method" throughout the data collection and analysis. The researcher moves backwards and forwards between the two, until the categories reach theoretical saturation, where there is no new information or insights reported in the data. At this point a theory that is generated from the data can be formed (Charmaz, 2014).

A qualitative approach was considered most suitable for this study as there is a current paucity of research with this population (Tansey, 2010). A qualitative approach is useful for exploring individual's personal experience (Strauss & Corbin, 1998), which fits with the subjective nature of this research, exploring individual's values. More specifically a grounded theory methodology was chosen as: it is systematic and transparent in its approach to data collection and analysis, in contrast to other qualitative methods which use more broad principles (Starks & Trinidad, 2007). This adds rigour and credibility to the product of this method, the theory (El Hussein, 2014). A grounded theory method is consistent with the aim of the research, to develop an explanatory theory from patients' perspective which will help to shape future research and interventions for this client group. It is also the most widely applied qualitative methodology with client group (Mezey, et al., 2010; Hinsby & Barker, 2004). Furthermore, grounded theory is a good fit for these goals as it does not begin with an existing hypothesis or a priori assumptions (Charmaz, 2014) but that categories and the resulting theory emerges naturally from the data.

Section 6: Project Management / Timetable

6.1 Outline a timetable for completion of key stages of the project

E.g. ethics submission, start and end of data collection, data analysis, completion of systematic review

Year 1 (2016)	July 2016	Submit Thesis Proposal Form to university Submit Substantial Amendment for IRAS Visit Orchard Clinic and meet team
	August 2016	Meet with academic and clinical supervisors. Complete Patient information Sheet, Patient Consent Form and Interview Schedule and submit to IRAS
	September 2016	Once receive IRAS approval, meet with clinical team and begin recruitment Begin semi structured interviews
	October 2016	Begin write up of methods section
	November 2016	Begin literature search for systematic review
	December 2016	Complete draft methods section
Year 2 (2017)	January – November 2017	Ongoing interviews, transcription and analysis of interviews
	November 2017	Complete semi structured interviews Ongoing data analysis using GTM
	December 2017	Complete systematic review draft
Year 3 (2018)	January 2018	Complete data analysis and write results section
	January – February 2018	Write Discussion section
	March 2018	Completion of systematic review
	May 2018	Completion of write up and submission
	June –July 2018	Viva
	July 2018	Corrections
	September 2018	Submit systematic review and research papers for publication in relevant journal

Section 7: Management of Risks to Project

7.1 Summarise the main potential risks to your study, the perceived likelihood of occurrence of these risks and any steps you will or have taken to reduce these risks. Outline how you will respond to identified risks if they should occur

There are not any anticipated risks or burdens for the individuals taking part in this research. The interview should not include any topics that are upsetting or embarrassing for the individual. In previous work exploring similar topics (Tansey, 2010 and Gannon et al., 2011) participants have found it enjoyable and a positive experience to speak about their values. A potential risk for this research would be a participant disclosing risk of harm to themselves, others, or previous offending that was not known about. In this instance the researcher would disclose the risk and relevant information to the clinical psychologist on the team who would ensure that

the clinical team were aware.

Further potential risks for this research include failure to recruit enough people or to get rich data. To maximise the potential numbers of participants, I plan to begin recruitment early in the research process to increase the time of the recruitment window. This is helped as this project has previously received ethical approval through IRAS, so recruitment can potentially begin in late summer 2016. I will review participant numbers regularly with supervisors and will consider contacting other medium secure units in Scotland if this looks to be problematic. If there is failure to get adequately rich data, for example vague or irrelevant responses from the interview, the option for supplementary interviews will be explored.

Another potential risk in this research is the potential for loss of data, including interview recordings and transcripts. I plan to use Dedoose software to manage and backup my data which will reduce the likelihood of data loss. Furthermore, I will use two audio recorders for the interviews and test them prior to use to minimise the impact of equipment malfunction.

A final risk that must be considered, is the researcher failing to adequately facilitate semi structured interviews. Interviews will be carefully planned with supervisors and Chenail's (2011) interviewing the investigator approach will be considered. Using this approach, the researcher will role play the role of interviewer and interviewee during supervision to develop interview skills and highlight any biases or assumptions about the client group. Furthermore, as mentioned previously, guidelines and checklists will be used to ensure methodological rigour and reduce research bias.

Section 8: Knowledge Exchange

8.1 How do you intend to report and disseminate the results of the study?
IRAS A51

This research will be written up as a doctoral thesis in line with the requirements for the University of Edinburgh Clinical Psychology Doctorate Programme. I also intend to submit sections of this thesis, for example the systematic review and the research study, to relevant peer-reviewed journals for publication. The findings will also be presented to the Orchard Clinic and other local forensic units. Furthermore, participants in the study will be given the opportunity to receive a summary of the results. This will be done by meeting with the individual to give general feedback or by sending a written summary of the research findings to the individual.

8.2 What are the anticipated benefits or implications of the project?
E.g. if this is an NHS project, in what way(s) is the project intended to benefit the NHS?

This research aims to fill a gap in the existing understanding of values and goals within an MDO population. This is hoped to help inform future research and therapeutic directions for this client group. This will be of benefit to MDOs as developing an understanding of the values of this group will help professionals work in ways that are respectful of the individual and congruent with what is important to them. Further benefits to engaging in values based work have shown an improvement in quality of life and reduction of psychological distress (Tansey, 2010). It is hoped that this will facilitate engagement in therapy and also reduce stigma.

8.3 Are the any potential costs for the project?

Outline any potential financial costs to the project, including the justification for the costs (why are these necessary for the research project?) and how funding will be obtained for these costs (how will they be met?) Please separate these into potential costs for the University and potential costs for your NHS Board and note that you should ask your NHS Board to meet stationery, printing, postage and travel costs.

Printing costs for information leaflets and consent forms which will be covered by NHS Lothian. Dedoose software will be used for data management, coding and analysis. The monthly subscription few is $10.95 when used and I will apply for funding for this through the university.

Section 9: Any Other Relevant Information

This research was previously approved by IRAS in 2012 but not started. At the time of submission for the Thesis Proposal (R1), a resubmission for a change of name is currently in progress.

Section 10: Key References

Barnao, M., Ward, T., & Robertson, P. (2015). The Good Lives Model: A New Paradigm for Forensic Mental Health. *Psychiatry, Psychology and Law*, *8719*, 1–14.

Charmaz , K. (2014). *Constructing Grounded Theory*. London: Sage.

Chenail, R. J. (2011). Learning to appraise the quality of qualitative research articles: A contextualized learning object for constructing knowledge. *The Qualitative Report*, 16(1), 236–248.

Crichton, J. H. M. (2009). Defining high, medium, and low security in forensic mental healthcare: the development of the Matrix of Security in Scotland. *The Journal of Forensic Psychiatry & Psychology*, 20(3), 333–353.

Gannon, T. A., King, T., Miles, H., Lockerbie, L., & Willis, G. M. (2011). Good Lives sexual offender treatment for mentally disordered offenders. *The British Journal of*

Forensic Practice, 13, 153-168.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory; Strategies for qualitative research.* Chicago: Aldine.

Gow, R. L., Choo, M., Darjee, R., Gould, S., & Steele, J. (2010). A demographic study of the Orchard Clinic: Scotland's first medium secure unit. *The Journal of Forensic Psychiatry & Psychology*, 21(1), 139–155.

Hayes, S., Strosahl, K., & Wilson, K. (1999). *Acceptance and Commitment Therapy: An Experiential Approach to Behavior Change.* New York: The Guilford Press

Jacques, J., Spencer, S. & Gilluley, P. (2010). Long-term care needs in male medium security. *The British Journal of Forensic Practice*, 12(3), 37–44.

Mezey, G. C., Kavuma, M., Turton, P. et al. (2010). Perceptions, experiences and meanings of recovery in forensic psychiatric patients. *Journal of Forensic Psychiatry and Psychology*, 21(5), 683–696

NHS Education for Scotland. (2011). *The Matrix: A guide to delivering evidence-based psychological therapies in Scotland.* Edinburgh: Scottish Government.

O'Sullivan, M., Boulter, S. & Black, G. (2013). Lived experiences of recalled mentally disordered offenders with dual diagnosis: a qualitative phenomenological study. *Journal of Forensic Psychiatry & Psychology*, 24(3), 1–18

Picton, H. (2013) Post-stroke depression (PSD) and post-stroke emotional liability (PSEL): a systematic review of non-pharmacological interventions for PSD, and a qualitative study of specialist professionals' conceptualisation of PSEL. *Unpublished Doctoral Thesis, The University of Edinburgh.*

Powers, M., Zum Vorde Sive Vording, M., & Emmelkamp, P. (2009). Acceptance and Commitment Therapy: A meta-analytic review. *Psychother Psychosom* , 78, 73 - 80.

Roychowdhury, A. (2011). Bridging the gap between risk and recovery: a human needs approach. *The Psychiatrist*, 35(2), 68–73.

Schwartz, S. (1992). Universals in the content and structure of values: theoretical advances and empirical tests in 20 countries. *Advances in Experimental Social Psychology* , 25, 1-65.

Schwartz, S., Melech, G., Lehmann, A., Burgess, S., Harris, M., & Owens, V. (2001). Extending the cross-cultural validity of the theory of basic human values with a different method of measurement. *Journal of Cross-Cultural Psychology*, 32 (5), 519-542.

Schwartz, S., & Bardi, A. (2001). Value hierarchies across cultures: Taking a similarities perspective. *Journal of Cross Cultural Psychology,* 32 (3), 268-290.

Schwartz, S., & Bilsky, W. (1990). Toward a psychological structure of human values: extensions and cross-cultural replications. *Journal of Personality and Social Psychology*, 58, 878-891 .

Scottish Office (1999). *Health, social work and related services for mentally disordered offenders in Scotland.* Edinburgh: HMSO.

Scottish Office (1997). *Framework for Mental Health Services in Scotland.* Edinburgh: HMSO.

Sellen, J., McMurran, M., Cox, M., Theodosi, E., & Klinger, E. (2006). The personal concerns inventory (offender adaptation). *International Journal of Offender Therapy and Comparative Criminology*, 50 (3), 294-305.

Starks, H. & Trinidad, S. B. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research*, 17(10), 1372–138

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory (2nd ed.)*. Thousand Oaks, CA: Sage.

Stuart, S. R. (2014) Who comes into medium-secure care? An evaluation of admission at Scotland's first medium secure unit. *Unpublished Doctoral Small Scale Research Project, The University of Edinburgh*

Stuart, S. R. (2015) Exploring recovery from severe and enduring mental illness using qualitative methods: A Portfolio thesis. *Unpublished Doctoral Thesis, The University of Edinburgh*

Tansey, L. S. B. (2010). An exploration of the relevance of values to clinical interventions and working with Mentally Disordered Offenders. *Unpublished Doctoral Thesis, The University of Edinburgh*

The Scottish Government (2009). Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011. Edinburgh: Scottish Government.

Thomson, L., Bogue, J., Humphreys, M., Owens, D., & Johnstone, E. (1997). The State Hospital Survey: A description of psychiatric patients in conditions of special security in Scotland. *The Journal of Forensic Psychiatry*, 8(2), 263–284.

Van Hout, M. C., & Phelan, D. (2014). A Grounded Theory of Fitness Training and

Sports Participation in Young Adult Male Offenders. *Journal of Sport & Social Issues*, *38*(2), 124–147.

Wilson, K., Sandoz, E., Kitchens, J., & Roberts, M. (2010). The valued living questionnaire: defining and measuring valued action within a behavioural framework. *The Psychological Record* , 60, 249 - 272.

Section 11: Confirmation of Supervisors' Approval	
"I confirm that both my Academic and Clinical Supervisors have seen and approved this research proposal and have both completed the supervisors' appraisal forms below." *Delete as appropriate*	
Yes	

Appendix 1

Main Academic Supervisor's Appraisal of Project Risk

Supervisor's Name
Ethel Quayle

Date
13/07/16

Do you consider that the project should proceed in broadly its current form? *Delete as appropriate*		
Yes	Yes, subject to the revisions outlined below	No

Outline the reasons for the above response Highlight any areas of risk to the completion of the project that have not been fully addressed within the proposal and any steps that could be taken to reduce risks
This proposal relates to an earlier research project which was not started but was reviewed, has IRAS approval which has been submitted for a change of name and has been sponsored by the University. It fits well with the Orchard Clinic's portfolio of research and, as it requires a relatively small sample, should be achievable.

Appendix 2

Clinical Thesis Supervisor's Appraisal of Project Risk

Supervisor's Name
Dr Louise Tansey

Position
Clinical Psychologist

Date
13/07/16

Do you consider that the project should proceed in broadly its current form? *Delete as appropriate*		
Yes	~~Yes, subject to the revisions outlined below~~	~~No~~

Outline the reasons for the above response Highlight any areas of risk to the completion of the project that have not been fully addressed within the proposal and any steps that could be taken to reduce risks
This is an interesting project which fits with department and Orchard Clinic interests and objectives. A sample size of between 8 and 12 seems achievable, especially because of a lengthier period available for recruitment due to the project already having ethics approval.

Appendix 3

Lay Summary

Provide a summary of your project in language suitable for a layperson 500 words
This research aims to explore values and goals of mentally disordered offenders (MDOs) within the Orchard Clinic, a medium secure psychiatric unit. This group consist of people with a mental illness, personality disorder or learning disability who have offended and are involved in the criminal justice system. This research will explore ways to help this group of patients live a meaningful and fulfilling life as part of their recovery. Values are defined as what is important to the individual and give a sense of purpose, meaning and satisfaction to life. There can be a number of barriers that prevent individuals from living a meaningful life in line with their values, particularly in the mentally disordered offender population. Recent health and political campaigns, such as the Well Scotland Initiative and the Recovery model, have highlighted the importance of individual's values and that living consistently with one's values may enhance wellbeing, quality of life and reduce psychological distress. Values based approaches have been used clinically and early research suggests that this can assist with treatment planning, therapeutic engagement and goal setting within this client group. Despite this recognised importance for mentally disordered offenders and increasing use of values based treatments, there has been little research exploring individual values and what is personally meaningful and relevant to this client group in medium secure psychiatric units. A greater understanding of values within this population is therefore required to ensure that interventions are evidence based. Furthermore, values have not been clearly defined in clinical settings and it is not clear if values are the same in mentally disordered offenders as with the general population. A qualitative approach is useful to explore individual personal experiences. Semi structured interviews with MDOs at the Orchard Clinic will be used to explore individual values (what is important in their life) and barriers to pursuing these. A grounded theory methodology will be used to explore to explore these topics and to construct a theory, which is hoped will contribute to future research in this area and clinical practice. This is important as it is hoped that this research will inform ways to improve engagement with therapy with MDOs, by making it more meaningful to the individual and better manage offending behaviour. This has the potential to reduce the risk of this population, impacting on the safety and welfare of the public.

Appendix 5. Caldicott Approval

Lothian NHS Board

Waverley Gate
2-4 Waterloo Place
Edinburgh
EH1 3EG
Telephone 0131 465 5452
Fax 0131 536 465 5494

www.nhslothian.scot.nhs.uk

NHS Lothian

Date 8th March 2017
Your Ref
Our Ref CG/DF/16155
Enquiries to Caldicott Office
Extension 35452
Direct Line 0131 465 5452
Email Caldicott.Guardian@nhslothian.scot.nhs.uk

Dr Stuart Cooney
The Orchard Clinic
The Royal Edinburgh Hospital
Morningside Terrace
Edinburgh

Dear Dr Cooney

CALDICOTT APPLICATION 16155

Thank you for the information supplied

Request received from	Dr Stuart Cooney
Summary of proposal	Exploring values and goals in a mentally disordered offender population with medium secure psychiatric units: A qualitative study.
Patient identifiable information requested	CHI, Gender, Other: patient audio recording, length of time as inpatient at clinic, number of total admissions, reason for admission
Approved	
Advice	

Yours sincerely

Professor Alison McCallum
Director of Public Health & Health Policy

Appendix 6. Ethical Approval

University Hospitals Division

NHS Lothian

Queen's Medical Research Institute
47 Little France Crescent, Edinburgh, EH16 4TJ

RESEARCH & DEVELOPMENT
Room E1.12
Tel: 0131 242 3330
Email:
R&DOffice@nhslothian.scot.nhs.uk

Director:
Professor David E Newby

KS/LM

25 August 2016

Mr Stuart Cooney
The Orchard Clinic
Royal Edinburgh Hospital
Morningside Terrace
Edinburgh
EH10 5FH

Dear Mr Cooney

REC No:	12/SS/0219
R&D Project ID No:	2013/P/PSY/01
Amendment:	Substantial amendment No 1 dated 20 June 2016
Title of Research	Exploring values and goals in a mentally disordered offender population within medium secure psychiatric units: A Qualitive study

I am writing in reply to recent correspondence in relation to an amendment(s) to the above project as follows.

- Change of Principal Investigator and Chief Investigator from Miss Marie Halton to Mr Stuart Cooney

We have now assessed any consequential changes and can confirm that NHS Lothian management approval is extended to cover the specific changes intimated.

Yours sincerely

Mr Kenny Scott
NRS Generic Review Manager

Appendix 7. Patient Information Sheet

Participant Information Sheet

"An exploration of the values of people in a medium secure unit"

- We are inviting you to take part in a research study.
- We want to make sure that you understand what it is, and what it would involve.
- Please take time to read the information sheet. If you have any questions you can speak to the psychologist on your team, or speak to Stuart, the Trainee Clinical Psychologist who is running the study.

What is the research about?

The Orchard Clinic wants to help patients to live a meaningful life as part of their recovery. Part of this is about discovering your values (what is important to you) and helping you to achieve them. We hope that this study finds out more about what you value and the things that might stop you from living a life that you find meaningful.

Why have I been asked to take part?

We are asking all men who are staying in the Orchard Clinic to take part in this study.

Do I have to take part?

No, it is up to you. To help you decide, Stuart will describe it to you. You will have the chance to ask questions. After this you will be asked if you want to take part.

If you decide to take part, you can change your mind at any time. You do not have to give a reason for this. Your decision **will not affect** the care that you receive or your legal rights.

What will happen if I take part?

Stuart, the researcher will meet with you. He will ask you about your values and what's important in your life. The meeting will last around 45 minutes. You can leave at any time or spend longer discussing this if you wish. It can also be split into more than one meeting.

The discussion about your values will be recorded. This is so that Stuart will have an accurate record of your views. This interview will be stored securely in his office at the Orchard Clinic. It will then be typed up as soon as possible. The recording will be destroyed. Following this meeting, your part will have finished.

What do I do if I want to take part?

After reading this information sheet, ask Stuart any questions that you have. You will be asked to sign a consent form to say that you agree to take part. The consent form is a way of making sure you know what you have agreed to. You will be given a copy of this. A copy of it will be kept in your medical notes.

What are the benefits of taking part?

Taking part may help you to think about your recovery and what is important to you. This study is about listening to people's experiences and views. This will help us understand what is important to people and the difficulties they may face. We hope this can help improve the care the NHS offers in future. It will also help with future research.

Are there any disadvantages to taking part?

It is not thought that taking part in this study will make anyone upset or unhappy. However, if you feel you need to discuss anything after the interview, you can let Stuart or another member of staff know. They will make sure that the right person provides you with support.

Will my taking part in the study be kept confidential?

Yes. All the information we collect will be kept private. Details of what you say will not be saved with your name. Members of your clinical team will know you are taking part but not what we discuss. All documents will be anonymous and stored securely. No one reading it will be able to identify you. The recordings will be destroyed at the end of the study.

A copy of this information sheet and your consent form will be kept in your medical notes. Your answers will not be written in your notes. The only time that the Clinical Team will be told what you say is if the researcher is concerned about risks to yourself or to others.

What will happen to the results of the research study?

Stuart is happy to provide you with a summary of the results. This study is being carried out as part of his training to become a Clinical Psychologist. Once it is finished, a copy of the study will be held at the University of Edinburgh. The results may also be published in a journal or presented at a conference.

Who has reviewed the study?

The University of Edinburgh, the Research Ethics Committee, NHS Lothian and The Orchard Clinic have approved the study.

Who do I contact if I have any questions?

If you have any questions, you can ask the team at the Orchard Clinic to put you in touch with Stuart, the researcher: *Stuart Cooney, Trainee Clinical Psychologist; or Dr Louise Tansey, Clinical Psychologist*

If you would like to discuss this study with someone independent of the research, please contact: *Dr Shauneen Porter, Clinical Psychologist, who works at the Orchard Clinic.*

If you wish to make a complaint about the study please contact: *Patient Experience Team, NHS, Lothian, 2nd Floor, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG, Tel: 0131 536 3370, Email: feedback@nhslothian.scot.nhs.uk*

Thank you for reading this information sheet.

Appendix 8. Consent Form

PARTICIPANT CONSENT FORM

"An exploration of the values of people in a medium secure unit"

		PLEASE INITIAL BOX
1.	I confirm that I have read and understood the information sheet dated 18th April (version 2) for the above study. I have had the chance to think about the study and to ask any questions.	
2.	I understand that taking part is voluntary. I understand that I am free to withdraw at any time, without giving a reason. This will not affect my medical care or my legal rights.	
3.	I understand that taking part in the research will involve a conversation being recorded. This conversation will then by typed up and the recording destroyed. I give permission for this to happen.	
4.	I understand that the data collected during the study may be looked at by individuals from the Orchard Clinic or the University of Edinburgh. This data will be anonymous. I give permission for these individuals to have access to this.	
5.	I understand that the anonymised findings of the research may be published or shared with other professionals. This does not include any details that identify you personally.	
6.	I would like to receive a summary of the results.	YES / NO
7.	I agree to take part in the above study.	

Name of participant	Date	Signature
Name of person taking consent	Date	Signature

1x copy to the participant

Appendix 9. Interview Schedule

Semi-Structured Interview Schedule
An exploration of the values of people in a medium secure unit

What is important to you in your life/ What really matters in your life?

- Have the same things always been important to you, or has it been different things at different times?
- Do you think you have achieved this?
- How have you gone about achieving this?
- What have you done in your life that meets this value?
- If participant struggles to discuss values or focuses on goals use ACT techniques for clarifying values:
    - Magic wand
    - Childhood dreams
    - Character strengths
    - Role models
    - Disapproval

What holds you back/ What has got in the way of you fulfilling (insert previously discussed value)?

- What impact has being in here (The Orchard Clinic), had on you fulfilling (insert value)?
- What impact has your offending had on you fulfilling (insert value)?
- What impact has your mental health had on you fulfilling (insert value)?
- How does that make you feel?
- How do you cope when you feel that way?

We've talked about what has happened in your life and where that fits with what you value most. How do you see your life moving forward?

- How does (insert value) relate to your goals for the future?
- How does doing what you value, fit with the way you see yourself or feel about yourself?

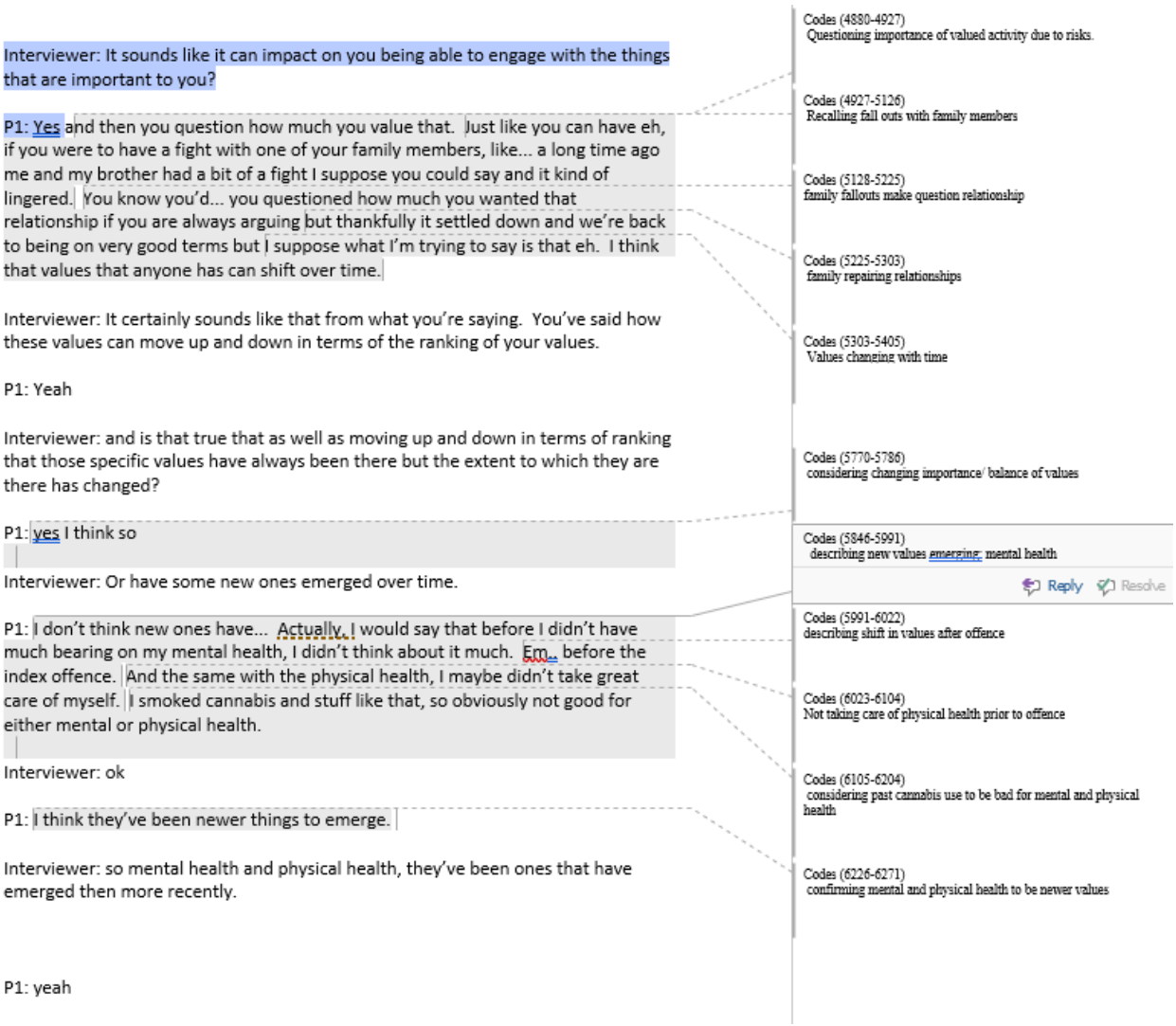
Ending:

- Is there something else I should know to understand (you/ your experience) better?
- Is there anything you would like to ask me?

General prompts throughout interview:

- Can you tell me more about that?
- Can you explain what you mean by that?

Appendix 10. Interview Transcript Example



Interviewer: But then the others: family and friends; occupation; having fun; keeping busy...

P1: Yeah, they've been there. Just trying to think if there's any other... em.. say em.. creativity

is quite important to me now. I do... At the state hospital I did a lot of painting, I really enjoyed that and I've done art therapy here and hoping to do some more art therapy. And em, I mean, eh, that side of things have... also helps with your emotions and mental state as well. I would say I didn't really have that in my life before. Being in a therapeutic setting I suppose.

Interviewer: So that's is it that creativity has been something that's new or is it just something that's new in a therapeutic sense or something that's been there previously..

P1: I would say it's new in a therapeutic sense. Definitely, I've never had like art therapy before. And I mean I did do art in school to like standard grade but I wasn't really doing much. Just doing it in the class and that would be it. Maybe did a few sketches and stuff but I mean id never done it to the extent that I've done it now: the art work. I would say it's something that I value because of all that it gives me and with the finished product, I mean I can give art pieces to family and friends and that makes me feel good as well. And all that good stuff.

Interviewer: so having that finished product, being able to give it people that you care about is important to you.

P1: Yeah

Codes (6491-6563)
considering all values

Codes (6563-6696)
Being creative/ doing creative activities important now

Codes (6698-6767)
engaging in art therapy

Codes (6768-6872)
describing creativity as helpful for mental health

Codes (6873-6972)
Previously lacking means to help mental health

Codes (7150-7254)
Participating in art therapy as new experience

Codes (7255-7508)
Participating in art therapy as new experience

Codes (7508-7610)
describing satisfaction of completing art

Codes (7611-7725)
Feeling good giving artwork to family and friends.

Appendix 11. All at Sea: A metaphor of values of men in medium secure units:

Metaphors are frequently used within Acceptance and Commitment Therapy (ACT) to explain values, goals and other concepts to patients; and as tools for cognitive defusion (Hayes et al., 1999; Foody et al., 2014). The model proposed in this paper has the potential to inform and develop existing and new metaphors for values-based work, as part of an ACT based approach.

A preliminary metaphor was developed from the model that emerged from the data of this study. As previously discussed, The Compass Metaphor (Hayes et al., 1999) is a way of communicating values and goals to clients and relating this to navigating with a compass. Further metaphors such as the *"Demons on the Boat"* (Harris, 2007) and *"Passengers on the Bus"* (Hayes et al., 1999) are also used to communicate values and other aspects of the ACT Hexaflex to patients. In line with this theme of journeys and navigation, this paper proposes a related metaphor called *"All at Sea"*. This takes into account individual's relationships with values, and is informed by the model proposed of values in men in medium secure units that emerged from the data. This new metaphor aims to capture the participants' values but also the relationship with these across the lifespan; the impact of barriers, restrictions and opportunities; and the impact this has on the understanding of the self and how they fit in. Below is an explanation of this metaphor written as if spoken to a patient, in line with the compass metaphor detailed previously:

All at Sea: A metaphor of values of men in medium secure units:

"Imagine you are on a boat at sea. On board the ship are a number of crew members. Many of these crew members boarded at the dock when the ship was preparing to set sail. The crew members available were dependent on the environment that the boat was built and docked. Furthermore, the crew members that joined the boat were selected, trained and influenced by those in authority of

the boat: be it the captain or shipping company. Imagine that the boat is the self and each crew member is a different value, representing something important to you. Each crew member therefore, represents a value and influences the direction in which the boat is steered and the direction it is going in.

Throughout the journey, there may be several barriers, restrictions and opportunities that the boat (the self) may face. Stormy seas may knock the ship off course and in these more difficult sailing conditions, some crew members may be better able to weather the storm than others, resulting in them taking more control over the ship and the direction that it is heading. At times there may be conflict between the crew members with them placing conflicting demands to steer the ship in their desired direction. Unfortunately, this is likely to mean that the boat may shift between directions, go off course or become lost at sea under these conflicting demands. Some seas may be calm and others dangerous. Furthermore, the boat may be vulnerable to the influence of others that they meet on their journey. Other boats may try and influence the direction that the boat is headed, perhaps assisting the crew members chart a better and more successful journey in their chosen direction. They may be able to offer a map, help maintain and upgrade the boat's engine or get on board and help steer the ship. Just as stormy seas can knock the boat off course, other boats could attack or seek to take over the boat for their own purposes.

Moreover, there may be times where the ship may be steered into waters that are subject to strict regulations and prescribed shipping lanes, with severe penalties placed for deviations from these routes. At these times it may feel like the boat is being directed, guided or forced to follow a direction that is in line with and important to the waters and place that they are in but does not fit wholly with the crew members. At these times, the crew may have little control over the direction of the boat, having to be steered by external forces, perhaps escorted by other government boats in these areas. For some, they may try to deviate from these

regulated and restricted shipping lines but this is likely to result in increased control and restrictions being placed on the boat. Perhaps presenting them with a limited choice of directions they can travel in or preventing them from sailing to specific destinations.

For some, who may have faced hostile and restrictive waters throughout their lives, the boat has had little freedom to safely explore the sea and to allow the crew members to take the lead and to develop a balance between the roles of the crew that take the ship in a direction that is true to the boat and the crew as a whole. Sailing in such a boat, may result in the boat drifting, perhaps with little purpose or direction, making it further vulnerable to the influence of the environment and a chaotic and disorganised crew. Being in this manner, <u>all at sea</u>, it is likely that the boat will not have a stable sense of what makes the boat itself and despite entering and sailing in different seas, oceans, docking at different ports, and meeting others on their journey, it may be hard to feel at home or able to fit in and maintain itself in any one situation or location."

Appendix 12. Qualitative Health Research (journal)

Relevant information is included here, from the outline guides for authors:
https://uk.sagepub.com/en-gb/eur/journal/qualitative-health-research#submission-guidelines;
https://mc.manuscriptcentral.com/societyimages/qhr/QHR%20Author%20Submission%20Guidelines.pdf

Qualitative Health Research (*QHR*) is an international, interdisciplinary, refereed journal for the enhancement of health care and furthering the development and understanding of qualitative research methods in health care settings. We welcome manuscripts in the following areas: the description and analysis of the illness experience, health and health-seeking behaviors, the experiences of caregivers, the sociocultural organization of health care, health care policy, and related topics. We also consider critical reviews; articles addressing qualitative methods; and commentaries on conceptual, theoretical, methodological, and ethical issues pertaining to qualitative inquiry.

Article Format (see previously published articles in QHR for style):

- Title page: Title should be succinct; list all authors and their affiliation; keywords. Please upload the title page separately from the main document.
- Blinding: Do not include any author identifying information in your manuscript, including author's own citations. Do not include acknowledgements until your article is accepted and unblinded.
- Abstract: Unstructured, 150 words. This should be the first page of the main manuscript, and it should be on its own page.
- Length: QHR does not have a word or page count limit. Manuscripts should be as tight as possible, preferably less than 30 pages including references. Longer manuscripts, if exceptional, will be considered.
- Methods: QHR readership is sophisticated; excessive details not required.
- Ethics: Include a statement of IRB approval and participant consent. Present demographics as a group, not listed as individuals. Do not link quotations to particular individuals unless essential (as in case studies) as this threatens anonymity.
- Results: Rich and descriptive; theoretical; linked to practice if possible.
- Discussion: Link your findings with research and theory in literature, including other geographical areas and quantitative research.
- References: APA format. Use pertinent references only. References should be on a separate page.

Additional Editor's Preferences:

- Please do not refer to your manuscript as a "paper;" you are submitting an "article."
- The word "data" is plural.

Journal layout

In general, QHR adheres to the guidelines contained in the Publication Manual of the American Psychological Association [“APA”], 6th edition (ISBN 10:1-4338-0561-8,softcover; ISBN 10:1-4338-0559-6, hardcover; 10:1-4338-0562,spiral bound), with regard to manuscript preparation and formatting. These guidelines are referred to as the APA Publication Manual, or just APA. Additional help may be found online at ttp://www.apa.org/, or search the Internet for “APA format.” 4.6 Reference style QHR adheres to the APA reference style. Click here to review the guidelines on APA to ensure your manuscript conforms to this reference style.

Full Reference List:

Andrews, D. A., Bonta, J., & Hoge, R. D. (1990). Classification for effective rehabilitation: Rediscovering psychology. *Criminal Justice and Behavior*, 17(1), 19–52.

Barnao, M. Ward, T. & Robertson, P. (2016). The good lives model: A new paradigm for forensic mental health. *Psychiatry, Psychology and Law* 23(2), 288-301.

Barnao, M., Robertson, P. & Ward, T. (2010). Good Lives Model Applied to a Forensic Population. *Psychiatry, Psychology and Law*, 17(2), 202–217.

Barnao, M., Ward, T., & Robertson, P. (2015). The Good Lives Model: A New Paradigm for Forensic Mental Health. *Psychiatry, Psychology and Law*, *8719*, 1–14.

Beck, A. T., & Steer, R. A. (1988). *Beck hopelessness scale manual*. New York: The Psychological Corporation Harcourt Brace Jovanovich, Inc.

Bouman, Y. H. A., Schene, A. H., & de Ruiter, C. (2009). Subjective well-being and recidivism in forensic psychiatric outpatients. *The International Journal of Forensic Mental Health*, *8*(4), 225–234.

Brown C, Dunn W (2002). *Adolescent/Adult Sensory Profile*. USA: Pearson.

Bullock, W. A. (2005). Mental health recovery measure. In T. Campbell-Orde, J. Chamberlin, J. Carpenter & H. S. Leff (Eds.), *Measuring the promise of recovery: A compendium of recovery measures* (Vol. II, pp. 133-135). Cambridge, MA: Human Services Research Institute.

Centre for Mental Health, (2011). No Health Without Mental Health: a cross-government mental health outcomes strategy for people of *all* ages. HM Government.

Centre for Research and Dissertations (2008). *Systematic reviews: CRD's guidance for undertaking reviews in health care.*

Charmaz , K. (2014). *Constructing Grounded Theory*. London: Sage.

Chenail, R. J. (2011). Learning to appraise the quality of qualitative research articles: A contextualized learning object for constructing knowledge. *The Qualitative Report*, 16(1), 236–248.

Corlett, H., & Miles, H. (2010). An evaluation of the implementation of the recovery philosophy in a secure forensic service. *The British Journal of Forensic Practice*, *12*(4), 14–25.

Crichton, J. H. M. (2009). Defining high, medium, and low security in forensic mental healthcare: the development of the Matrix of Security in Scotland. *The Journal of Forensic Psychiatry & Psychology*, 20(3), 333–353.

Cure S, Chua WL, Duggan L, Adams C. (2005). Randomised controlled trials relevant to aggressive and violent people, 1955–2000: a survey. *Br J Psychiatry*;186(3):185–9.

Dam, C. van, Janssens, J.M.A.M, Bruyn, E.E.J. van, Koolen, J.J.C.M., & Spee, J.E.J. (1999). Self-report delinquent behaviour inventory. *WODC. K.U.N./ R.I.J.* Nijmegen, The Netherlands: De Hunnerberg.

Davies, J., Howells, K., & Jones, L. (2007). Evaluating innovative treatments in forensic mental health: A role for single case study methodology. J*ournal of Forensic Psychiatry & Psychology*, 18(3), 353–367.

Day, A., & Casey, S. (2009). Values in forensic and correctional psychology. *Aggression and Violent Behaviour*, 14(4), 232–238.

Dedoose Version 8.1, web application for managing, analyzing, and presenting qualitative and mixed method research data (2018). Los Angeles, CA: SocioCultural Research Consultants, LLC www.dedoose.com.

Doyle, M., Logan C., & Ludlow, A. (2012). Milestones to recovery: Preliminary validation of a framework to promote recovery and map progress through the medium secure inpatient pathway. *Criminal Behaviour and Mental Health* 22:53–64.

Drennan, G., & Alred, D. (Eds.). (2012). *Secure recovery: Approaches to recovery in forensic mental health settings*. London: Routledge.

Drennan, G., & Alred, D. (Eds.). (2012). *Secure recovery: Approaches to recovery in forensic mental health settings*. London: Routledge.

Fitzpatrick R, Chambers J, Burns T, Doll H, Fazel S. (2010) A systematic review of outcome measures used in forensic mental health research with consensus panel opinion. *Health Technol Assess,* 14(18).

Fluttert, F. A. J., van Meijel, B., Nijman, H., Bjørkly, S., & Grypdonck, M. (2010). Preventing aggressive incidents and seclusions in forensic care by means of the "Early Recognition Method." *Journal of Clinical Nursing*, *19*(11–12), 1529–1537.

Foody, M., Barnes-Holmes, Y., Barnes-Holmes, D., Törneke, N., Luciano, C., Stewart, I., & McEnteggart, C. (2014). RFT for clinical use: The example of metaphor. *Journal of Contextual Behavioral Science*, 3(4), 305–313.

Fukui S, Goscha R, Rapp CA, Mabry A, Liddy P, Marty D (2012). Strengths model case management fidelity scores and client outcomes. *Psychiatr Serv*, 63(7):708–710.

Gannon, T. A., King, T., Miles, H., Lockerbie, L., & Willis, G. M. (2011). Good Lives sexual offender treatment for mentally disordered offenders. *The British Journal of Forensic Practice*, 13, 153-168.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory; Strategies for qualitative research.* Chicago: Aldine.

Gow, R. L., Choo, M., Darjee, R., Gould, S., & Steele, J. (2010). A demographic study of the Orchard Clinic: Scotland's first medium secure unit. *The Journal of Forensic Psychiatry & Psychology*, 21(1), 139–155.

Green, T., Batson, A., & Gudjonsson, G. H. (2011). The development and initial validation of a service-user led measure for recovery of mentally disordered offenders. *The Journal of Forensic Psychiatry and Psychology*, 22, 252–265.

Grounds, A., 2019. Discrimination against offenders with mental disorder. *Criminal Behaviour and Mental Health*, 29(4), pp.247–255.

Gudjonsson, G. H., Savona, C. S. V, Green, T., & Terry, R. (2011). The recovery approach to the care of mentally disordered patients. Does it predict treatment engagement and positive social behaviour beyond quality of life? *Personality and Individual Differences*, *51*(8), 899–903.

Gudjonsson, G. H., Young, S., & Yates, M. (2007). Motivating mentally disordered offenders to change. Instruments for measuring patients' perception and motivation*. The Journal of Forensic Psychiatry and Psychology*, 18, 74–89.

Harris, R. (2007) *The Happiness Trap.* London, Robinson.

Harris, R. (2009) *ACT Made Simple.* Oakland, CA, New Harbinger Publications.

Hayes, S., Strosahl, K., & Wilson, K. (1999). *Acceptance and Commitment Therapy: An Experiential Approach to Behaviour Change.* New York: The Guilford Press.

Hillbrand, M., & Young, J. L. (2008). Instilling hope into forensic treatment: The antidote to despair and desperation*. Journal of the American Academy of Psychiatry and the Law,* 36(1), 90–94.

Hockenhull JC, Cherry MG, Whittington R, et al. (2015). Heterogeneity in interpersonal violence outcome research: an investigation and discussion of clinical and research implications. *Aggress Violent Behav*;22:18–25.

IBM Corp. (2016). IBM SPSS Statistics for Windows, Version 24.0. Armonk, NY: IBM Corp

Ibrahim, N., Michail, M. & Callaghan, P., (2014). The strengths based approach as a service delivery model for severe mental illness: a meta-analysis of clinical trials. *BMC Psychiatry*, 14(1), p.243.

Jacques, J., Spencer, S. & Gilluley, P. (2010). Long-term care needs in male medium security. *The British Journal of Forensic Practice*, 12(3), 37–44.

Livingston, J. D., Nijdam-Jones, A., Lapsley, S., Calderwood, C., & Brink, J. (2013). Supporting recovery by improving patient engagement in a forensic mental health hospital: Results from a demonstration project. *Journal of the American Psychiatric Nurses Association*, *19*(3), 132–145.

Long, C. G., Knight, C., Bradley, L., Thomas, M., Knight, C., Bradley, L., & Effective, M. T. (2012). Effective therapeutic milieus in secure services for women: The service user perspective, 8237.

MacInnes D, Beer D, Keeble P, Rees D, Reid L. (2010). The development of a tool to measure patient satisfaction with in-patient forensic services: the forensic satisfaction scale*. J Ment Health*;19(3):272–81.

MacInnes, D., Kinane, C., Parrott, J., Mansfield, J., Craig, T., Eldridge, S., Priebe, S. (2016). A pilot cluster randomised trial to assess the effect of a structured communication approach on quality of life in secure mental health settings: The Comquol Study. *BMC Psychiatry*, *16*(1), 1–15.

Maslach C, Jackson SE. (1981). The measurement of experienced burnout. *J Occup Behav.* 1981;2:99–113.

Mezey, G. C., Kavuma, M., Turton, P. et al. (2010). Perceptions, experiences and meanings of recovery in forensic psychiatric patients. *Journal of Forensic Psychiatry and Psychology*, 21(5), 683–696.

Neil ST, Kilbride M, Pitt L, Nothard S, Welford M, Sellwood W, Morrison AP. (2009). The Questionnaire about the Process of Recovery (QPR): a measurement tool developed in collaboration with patients. *Psychosis*;1(2):145–55.

NHS Education for Scotland. (2011). *The Matrix: A guide to delivering evidence-based psychological therapies in Scotland.* Edinburgh: Scottish Government.

NHS Health Scotland. (2016). Good Mental Health for All. Edinburgh: Scottish Government.

Nieuwenhuizen, Ch. van, Schene, A.H., Boevink, W. A., & Wolf, J.R.L.M. (1998). The Lancashire Quality of Life Profile: First experiences in the Netherlands. *Community Mental Health Journal*, 34, 513– 524.

Novak T, Scanlan J, McCaul D, MacDonald N, Clarke T (2012). Pilot study of a sensory room in an acute inpatient psychiatric unit. *Australasian Psychiatry* 20(5): 401–406.

O'Brien, A., White, S., Fahmy, R., & Singh, S. P. (2009). The development and validation of the SOLES, a new scale measuring engagement with mental health services in people with psychosis. *Journal of Mental Health*, 18, 510-522.

O'Connell, M., Tondora, J., Croog, G., Evans, A., & Davidson, L. (2005). From rhetoric to routine: Assessing perceptions of recovery-oriented practices in a state mental health and addiction system. *Psychiatric Rehabilitation Journal*, 28, 378-386.

O'Sullivan, M., Boulter, S. & Black, G. (2013). Lived experiences of recalled mentally disordered offenders with dual diagnosis: a qualitative phenomenological study. *Journal of Forensic Psychiatry & Psychology*, 24(3), 1–18.

Palijan, T. Z., Radeljak, S., Kovac, M., Kovacevic, D. (2010). Relationship between comorbidity and violence risk assessment in forensic psychiatry. The implication of neuroimaging studies. *Psychiatria Danubina*, 22, 253-256.

Picton, H. (2013) Post-stroke depression (PSD) and post-stroke emotional liability (PSEL): a systematic review of non-pharmacological interventions for PSD, and a qualitative study of specialist professionals' conceptualisation of PSEL. *Unpublished Doctoral Thesis, The University of Edinburgh.*

Pluye, P., Robert, E., Cargo, M., Bartlett, G., O'Cathain, A., Griffiths, F., Rousseau, M. C. (2011). *Proposal: A mixed methods appraisal tool for systematic mixed studies reviews*.

Powers, M., Zum Vorde Sive Vording, M., & Emmelkamp, P. (2009). Acceptance and Commitment Therapy: A meta-analytic review. *Psychother Psychosom* , 78, 73 - 80.

Priebe S, Gruyters T. (1993). The role of the helping alliance in psychiatric community care: a prospective study. *J Nerv Ment Dis*. 1993;181(9):552–7.

Priebe, S., Huxley, P., Knight, S., & Evans, S. (1999). Application and results of the Manchester Short Assessment of Quality Of Life (MANSA). *International Journal of Social Psychiatry*, 45, 7–12.

Purvis, M. (2010). Seeking a Good Life: Human Goods and Sexual Offending. *Lambert Academic Press*: Germany.

Ridgway, P., & Press, A. (2001). *Assessing the recovery-commitment of your mental health service: A user's guide for the Developing Recovery Enhancing Environments Measure (DREEM). UK pilot version 1.*

Ritsher, J. B., Otilingam, P. G., & Grajales, M. (2003). Internalized stigma of mental illness: Psychometric properties of a new measure. *Psychiatry Research*, 121(1), 31-49.

Robertson, P., Barnao, M., & Ward, T. (2011). Rehabilitation frameworks in forensic mental health. *Aggression and Violent Behavior*, 16(6), 472–484.

Rogers, E. S., Chamberlin, J., Ellison, M. L., & Crean, T. (1997). A consumer-constructed scale to measure empowerment among users of mental health services. *Psychiatric Services,* 48, 1042-1047.

Roskes, E., & Feldman, R. (1999). A collaborative community-based treatment program for offenders with mental illness*. Psychiatric Services*, 50, 1614–1619.

Ross, J., Quayle, E., Newman, E., & Tansey, L. (2013). The impact of psychological therapies on violent behaviour in clinical and forensic settings: A systematic review. *Aggression and Violent Behavior*, *18*(6), 761–773.

Roychowdhury, A. (2011). Bridging the gap between risk and recovery: a human needs approach. *The Psychiatrist*, 35(2), 68–73.

Sadler, J.Z. 2005. Values and psychiatric diagnosis. *International perspectives in philosophy and psychiatry*. New York: Oxford University Press.

Schalast, N., Redies, M., Collins, M., Stacey, J., & Howells, K. (2008). EssenCES, a short questionnaire for assessing the social climate of forensic psychiatric wards. *Criminal Behaviour and Mental Health*, 18(1), 49-58.

Schwartz, S. (1992). Universals in the content and structure of values: theoretical advances and empirical tests in 20 countries. *Advances in Experimental Social Psychology*, 25, 1-65.

Schwartz, S., & Bardi, A. (2001). Value hierarchies across cultures: Taking a similarities perspective. *Journal of Cross Cultural Psychology,* 32 (3), 268-290.

Schwartz, S., & Bilsky, W. (1990). Toward a psychological structure of human values: extensions and cross-cultural replications. *Journal of Personality and Social Psychology*, 58, 878-891.

Schwartz, S., Melech, G., Lehmann, A., Burgess, S., Harris, M., & Owens, V. (2001). Extending the cross-cultural validity of the theory of basic human values with a different method of measurement. *Journal of Cross-Cultural Psychology*, 32 (5), 519-542.

Scottish Government (2009). *Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011.* Edinburgh: Scottish Government.

Scottish Government (2016). *Fairer Scotland Action Plan.* Edinburgh: Scottish Government.

Scottish Government (2017). *Mental Health Strategy: 2017-2027*. Edinburgh: Scottish Government.

Scottish Government, T. (2017). *Justice in Scotland: Vision and Priorities*. Edinburgh: Scottish Government.

Scottish Office (1997). *Framework for Mental Health Services in Scotland.* Edinburgh: HMSO.

Scottish Office (1999). *Health, social work and related services for mentally disordered offenders in Scotland.* Edinburgh: HMSO.

Sellen, J., McMurran, M., Cox, M., Theodosi, E., & Klinger, E. (2006). The personal concerns inventory (offender adaptation). *International Journal of Offender Therapy and Comparative Criminology*, 50 (3), 294-305.

Smith, R. J., Jennings, J. L., & Cimino, A. (2010). Forensic continuum of care with assertive community treatment (ACT) for persons recovering from co-occurring disabilities: Long-term outcomes. *Psychiatric Rehabilitation Journal*, *33*(3), 207–218.

Soriano, C. L., Valverde, M., & Martinez, O. G. (2004). A proposal for synthesizing verbal contexts in experiential avoidance disorder and acceptance and commitment therapy. *International Journal of Psychology and Psychological Therapy*, 4, 377-394.

Spruin, E., Canter, D., Youngs, D., & Coulston, B. (2014). Criminal Narratives of Mentally Disordered Offenders: An Exploratory Study. *Journal of Forensic Psychology Practice*, 14(5), 438–455.

Starks, H. & Trinidad, S. B. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research*, 17(10), 1372–138.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory (2nd ed.)*. Thousand Oaks, CA: Sage.

Stuart, S. R. (2014) Who comes into medium-secure care? An evaluation of admission at Scotland's first medium secure unit. *Unpublished Doctoral Small Scale Research Project, The University of Edinburgh.*

Stuart, S. R. (2015) Exploring recovery from severe and enduring mental illness using qualitative methods: A Portfolio thesis. *Unpublished Doctoral Thesis, The University of Edinburgh.*

Tansey, L. S. B. (2010). An exploration of the relevance of values to clinical interventions and working with Mentally Disordered Offenders. *Unpublished Doctoral Thesis, The University of Edinburgh.*

Thomson, L., Bogue, J., Humphreys, M., Owens, D., & Johnstone, E. (1997). The State Hospital Survey: A description of psychiatric patients in conditions of special security in Scotland. *The Journal of Forensic Psychiatry*, 8(2), 263–284.

Tse, S., Tsoi, E. W. S., Hamilton, B., O'Hagan, M., Shepherd, G., Slade, M., Petrakis, M. (2016). Uses of strength-based interventions for people with serious mental illness: A critical review. International Journal of Social Psychiatry, 62(3), 281–291.

Vandevelde, S., Vander Laenen, F., Van Damme, L., Vanderplasschen, W., Audenaert, K., Broekaert, E., & Vander Beken, T. (2017). Dilemmas in applying strengths-based approaches in working with offenders with mental illness: A critical multidisciplinary review. *Aggression and Violent Behaviour*, 32, 71–79.

Verbeke, P., Vermeulen, G., Vander Beken, T. and Meysman, M. (2015). Protecting the fair trial rights of mentally disordered defendants in criminal proceedings: exploring the need for further EU action, *International Journal of Law and Psychiatry*, 41, 67-75.

Walker, S., & Paton, s. (2015). Lifemusic as an aid to recovery in a forensic mental health setting. *Journal of Psychiatric Intensive Care*, *11*(1), 7–12.

Ward, M., & Attwell, P. (2014). Evaluation of two community outreach forensic psychological services. *Journal of Forensic Practice*, *16*(4), 312–326.

Ward, T. (2002). Good lives and the rehabilitation of offenders: Promises and problems. Aggression and Violent Behaviour, 7, 513-528.

Ward, T., & Heffernan, R. (2017). The role of values in forensic and correctional rehabilitation. *Aggression and Violent Behaviour*, 37(July), 42–51.

Ward, T., & Maruna, S. (2007). *Rehabilitation: Beyond the risk paradigm*. London: Routledge

Wiglesworth, S., & Farnworth, L. (2016). An exploration of the use of a sensory room in a forensic mental health setting: Staff and patient perspectives. *Occupational Therapy International*, *23*(3), 255–264.

Young, S., Gudjonsson, G. H., Ball, S., & Lam, J. (2003). Attention Deficit Hyperactivity Disorder (ADHD) in personality disordered offenders and the association with disruptive behavioural problems. *The Journal of Forensic Psychiatry and Psychology*, 14, 491–505.