Forensic service users' experiences of adversity and psychological interventions in secure care

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Jessica Cartwright

Supervised by: Dr C Hartwright and Mr D Lawrence

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Preface

The present thesis recognises that capturing service users' experiences can add insightful information to research and clinical practice. This thesis acknowledges that this collaborative approach can be often underrepresented and particularly in forensic psychiatric settings, where care and treatment are often determined by legal requirements, received on an involuntary basis and where coercive measures may be used. This thesis offers two papers which explored forensic service users' perspectives.

The first paper considered how forensic service users may be expected to engage in psychological treatments as part of their care and treatment plans, and consequently, individuals may comply without feeling personally motivated or invested. Most of the evidence for psychological interventions in forensic psychiatric care is based on quantitative data, which provides tentative and limited evidence to support its effectiveness. The first paper reviewed forensic service users' perspectives on such interventions, and aimed to inform clinicians and services providing such treatments. Paper one followed a meta-ethnography approach to synthesise the findings from 11 qualitative papers. This synthesis described six super-ordinate themes that reflect which aspects of psychological interventions service users found both valuable and not so valuable. The synthesis demonstrated that many individuals comply with these treatments as they believe this is expected of them, perhaps because it is the only way to move towards discharge, or because they have no other choice. Whilst a collaborative approach was recognised as valuable, this can be a challenge to establish in forensic practice and a good therapeutic relationship is pivotal. The results indicated that interventions should be tailored to each individuals' abilities and that many prefer a gradual approach to ease them into the therapeutic process. Service users reported positive changes from engaging in psychological interventions, including increased emotional regulatory skills,

interpersonal skills and personal growth, which enabled them to think more positively about the future. It is recommended that these findings should be used in conjunction with the quantitative evidence available and further research is still needed in this area.

The second paper also considered service users' perspectives, but from a trauma-informed approach. It recognised that forensic service users have often had experiences of adversity and trauma throughout their lives, and research increasingly shows a strong relationship between these experiences, mental health difficulties and offending behaviours. Services are encouraged to adopt a collaborative stance, however, the literature in this area lacks forensic service users' perspectives. Paper two aimed to address this through interviewing forensic service users about their past adverse experiences and how they make sense of these, particularly in relation to their detention in secure care. This paper captured the voices of eight service users, six of whom are male, detained in medium and low secure wards. Four super-ordinate themes are discussed from an interpretative phenomenological analysis (IPA) and relate to: service users' experiences of living amongst adversity; managing these adversities throughout their lives; relating their pasts to their detention in secure care; and how the past still impacts them in the present. Individuals described previously feeling isolated and let down by others, and therefore, they used destructive ways to internalise and externalise their distress. There were differences between how individuals related these past experiences to their detention, with some individuals being more aware of this relationship than others. It seemed that individuals' insight to this relationship was part of a process, which was facilitated by staff input. Service users also tended to use avoidant strategies to cope with their pasts and this was evident in some of the interviews. This paper related these findings to attachment theory from a developmental trauma perspective and proposed the adoption of trauma-informed care in forensic services.

Some aspects of paper one and paper two can be related. For instance, they both acknowledged that service users have interpersonal difficulties and that services can adapt their approaches to minimise the impact of these and to enhance trusting and collaborative relationships. Although limitations of each paper are acknowledged, they both provided clinical implications for forensic psychiatric services. Paper one provided implications for clinicians offering psychological interventions and also for the wider systems, as the importance of collaboration, positive relationships and transparent communication can be considered necessary throughout the services. Paper two also provided implications for service delivery and supports the notion of trauma-informed care. It highlighted that staff should be aware of the impact and consequences of adverse experiences, for both the service users and for themselves when supporting service users. It also referred to the psychological interventions discussed in paper one, which acknowledge the impact of past adverse experiences. Future research is recommended for both papers. Both papers have been written in line with the standards of the Journal of Forensic Psychiatry and Psychology but as per doctorate guidelines, a word limit of 8000 is used for each (Appendix A).

Paper 1

Forensic service users' experiences of psychological interventions: A meta-synthesis

Jessica Cartwright, cartwrightj2@cardiff.ac.uk

Trainee Clinical Psychologist, South Wales Doctorate of Clinical Psychology, Cardiff University

11th Floor, Tower Building, Park Place, Cardiff, CF10 3AT

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Abstract

There is tentative yet limited evidence for the effectiveness of psychological interventions in forensic psychiatric services. However, barriers to implementing these interventions effectively may exist. Capturing service users' perspectives provides a greater understanding of psychological interventions in these settings. This paper reviewed qualitative studies to consider the experiences of psychological interventions from the perspective of service users, including the factors that were considered to both enhance or to impede the effectiveness of such interventions. A systematic review was conducted and eleven papers were identified as meeting the inclusion criteria. Noblit and Hare's (1988) meta-ethnography approach was used to synthesise the data. Six super-ordinate themes emerged which created two master themes: '*setting the scene'* for psychological interventions and *'therapeutic outcomes'*. The notion of empowering service users to engage in psychological interventions was addressed. This was related to the ethos in forensic care and the service users' relationships with professionals. This review supports the need to work collaboratively with forensic service users and to adopt a person-centred approach. Clinical implications for forensic services, particularly when offering psychological interventions are suggested. Limitations of the review are discussed, such as potential biases in sample recruitment and the lack of female service users' opinions.

Key words: Forensic mental health; service user perspective; psychological treatment; intervention; meta-synthesis

1. Introduction

Evidence based psychological interventions are recognised by national policies and 'best practice' guidance as a fundamental element of forensic care and treatment (Georgiou, Oultram, Haque 2019; Joint Commissioning Panel for Mental Health, 2013; Kenney-Herbert, Taylor, Puri & Phull, 2013; National Psychological Therapies Management Committee [NPTMC], 2017; Völlm et al., 2018a; Welsh Government, 2012). Yet many psychological interventions in forensic settings are based on evidence from randomised controlled trials involving non-forensic populations with specific diagnoses (NTPMC, 2017; MacInnes & Masino, 2019). Additionally, such trials typically use inclusion and exclusion criteria that do not accurately reflect the complexity and comorbidity apparent for forensic service users (Barnao & Ward, 2015; Timmerman & Emmelkamp, 2001). Given this, psychological interventions are typically modified and adapted for forensic populations (Rosenfeld, Byars, & Galietta, 2011), without sufficient further evaluation to ascertain efficacy in forensic settings (Barnao & Ward, 2015).

In recent years there has been a shift from a narrative of 'nothing works' in the treatment of forensic service users, to the notion that psychological interventions do positively influence factors such as positive thinking, risk behaviours and recidivism rates (Davies & Nagi, 2017). With this in mind, there has been a growing interest in the efficacy of psychological interventions in forensic care (Davies & Nagi, 2017). McGuire's (2013) review of 'what works' to reduce re-offending provides support for the treatment efficacy of psychologically based interventions in forensic settings, particularly with reference to cognitive-behavioural

programmes that are suitably designed and delivered to the forensic population. Additionally, a recent systematic review looked at the effectiveness of psychological and psychosocial interventions in a range of secure settings and found tentative evidence to suggest such interventions improve psychiatric symptoms (MacInnes & Masino, 2019). However, this conclusion should be interpreted with caution, since they also highlight several methodological limitations, such as the limited sample sizes affecting the generalisability of the findings. Furthermore, this broad assertion does not always appear to be supported by research looking at specific psychiatric presentations. For example, Gibbon et al. (2010) looked at the effectiveness of psychological interventions for antisocial personality disorder (AsPD); a complex mental health difficultly that is highly prevalent in forensic settings (Völlm et al., 2018b). They concluded that there is insufficient evidence in support of psychological interventions for this group. This emphasises the importance of considering individual factors before assuming that psychological interventions are always supported by the evidence base. This has significant implications for service users, particularly those whose liberty depends on their engagement and the effectiveness of mental health treatment (Rosenfeld et al., 2011).

Whilst they share some similarities, forensic psychiatric services are tangibly different in comparison to general mental health services for a number of reasons. For instance, forensic services are typically mandated by the Criminal Justice System and consequently many treatments are a legal requirement of rehabilitation, which individuals are expected to comply with to move forward in their treatment pathway (Edworthy, Sampson & Völlm, 2016; Livingston, Nijdam-Jones & Brink, 2012). Individuals are, therefore, treated on an

involuntary basis and they have many restrictions imposed upon them. Service users generally have complex presentations, as comorbidity is higher in this population compared to general mental health services, with psychotic disorders, personality disorders, substance misuse and neuropsychological disorders being common comorbidities (Palijan, Mužinić, & Radeljak, 2009; Timmerman & Emmelkamp, 2001). Pharmacological interventions are frequently used, with the majority of individuals taking antipsychotic medications, which have been reported to impact cognitive ability, motivation and behaviour (Jones, 2012). Yet even with such side-effects, there is limited evidence to support the effectiveness of pharmacological interventions in forensic care, due to few studies available in forensic settings (Howner et al., 2020). Due to the perceived risk which service users pose to themselves and others, services often adopt a risk-averse approach, where security levels are high and services have the authority to utilise restrictive interventions if necessary (Edworthy et al., 2016; National Institute of Clinical Excellence [NICE], 2017; Mental Health Act, 1983 revised 2007). Research has implied that higher levels of coercion negatively correlate with service users' competence and their likelihood to consent with treatment programmes (Zlodre, Yiend, Burns & Fazel, 2016). Additionally, service users have noted that such coercive practices can be experienced as a form of harassment and punishment, which can be deemed as rejecting and retraumatising (Askola, Nikkonen, Paavilainen, Soininen, Putkonen & Louheranta, 2016; Hui, Middleton & Völlm, 2013; Sequeira & Halstead, 2002; Tomlin, Bartlett & Völlm, 2018). These practices may, therefore, impede the therapeutic relationship between staff and service users, which is deemed an essential contribution to the therapeutic milieu and recovery process (e.g. Coffey, 2006; Long, Knight, Bradley & Thomas, 2012; Mann, Matias & Allen, 2014). Given these factors, it is plausible that forensic psychiatric settings have barriers to implementing effective psychological

interventions, particularly as such interventions recognise the importance of collaboration and trust. This is supported by research which found mandated treatment to be less effective when provided in an institution and when compared to voluntary treatments (Parhar, Wormith, Derkzen & Beauregard, 2008).

To date, little attention has been dedicated to the service users' experience when evaluating such interventions (Hodgetts & Wright, 2007; Tapp, Warren, Fife-Schaw, Perkins & Moore, 2013). This is surprising given that numerous policies and 'best practice' guidelines highlight the importance of collaborative and person-centred care (e.g. Department of Health, 2001, 2005, 2006, 2010; Georgiou et al., 2019; Kenney-Herbert et al., 2013; NPTMC, 2017; Social Care, Local Government and Care Partnership Directorate, 2014; Stay & Stephens, 2013). Some research shows that these approaches positively influence service users' quality of life, satisfaction with services, treatment adherence and rates of violence (Long et al., 2012; Papapietro, 2019; Selvin, Almqvist, Kjellin & Schroder, 2016). According to Selvin et al. (2016), from a service user's perspective the importance of this collaborative work can be under recognised by staff in secure services and instead, service users often comply with decisions made on their behalf. This raises queries about how motivated service users are to meaningfully engage in psychological interventions and whether they attend primarily because they feel they have to. As noted, this would have implications on the effectiveness of these interventions, particularly as involuntary treatments have proven to be less effective (Parhar et al. 2008). Furthermore, if service users do not complete the entire intervention, this may lead to higher rates of recidivism compared to those who do not attend at all (McMurran & Theodosi, 2007). It is plausible that these factors contribute to

the tentative evidence which suggests psychological interventions are less efficacious in forensic settings.

Qualitative analysis is well placed to attempt to capture internal experiences and processes of service users, which are difficult to determine using quantitative measures (Pope & Mays, 1995). Barnao, Ward and Casey (2015) acknowledged this when interviewing forensic service users about their overall experience of rehabilitation. They found both internal and external factors important to their experiences, including a person-centred approach and having a clear understanding of their rehabilitation pathway. Long et al. (2012) found similar findings when interviewing female service users on their perspectives of an effective therapeutic milieu. More specific to psychotherapy, Hodgetts and Wright (2007) completed a qualitative review of service users' experiences in adult mental health settings. They found non-therapy specific factors to be most commonly reported as helpful aspects of psychotherapy, including the therapeutic relationship, staffs' listening skills and their approach to look beyond a diagnosis. Capturing these perspectives increases the understanding of researchers and practitioners, who may then be in a better position to comprehend the experience of psychological interventions (Elliott & James, 1989).

The present paper aimed to review and synthesise the literature investigating forensic service users' perspectives of psychological interventions. To date, there has been no meta-synthesis of this kind in forensic services. It is hoped that this review will add a valuable perspective to the existing literature that is in line with 'best practice' guidelines and policies on collaborative care. It is anticipated that such information will have implications for the

mental health care and treatment forensic service users receive, as services will be in a better position to ensure that they are delivering psychological interventions in line with service users views, thus increasing the likelihood of meaningful engagement as opposed to superficial and/or disengagement. It is also anticipated that this paper will offer professionals supporting forensic service users a valuable insight into the experience of their care, to inform their own practice and the approach of services more broadly.

2. Methodology

2.1. Meta-Ethnography

A meta-ethnography approach was followed to synthesise findings from the included studies (Noblit & Hare, 1988). This is a constructivist and interpretative method, frequently used for conducting qualitative syntheses (Barnett-Page & Thomas, 2009). The meta-ethnography entails a critical examination of multiple accounts of events, that is, translating qualitative studies into one another, whilst preserving the original identity of the papers (Noblit & Hare, 1988). Noblit and Hare (1988) propose seven stages for conducting a meta-ethnography (Figure 1).

Figure 1. Noblit and Hare (1988) the seven stages of a meta-ethnography

1. Getting started: Deciding on an interest that qualitative research informs
2. Deciding what is relevant to the initial interest: Searching the literature to find relevant papers and documents which meet an inclusion criterion.
3. Reading the studies: Familiarising one's self with the identified papers by reading and re-reading them and extracting themes and concepts.
4. Determining how studies are related: This stage looks for relationships between the identified papers by juxtaposing the identified themes and concepts extracted in the previous stage. This allows one to see if the data have similarities (reciprocal translation), differences (refutational translation) or represents a new line of argument and offers a "new interpretive context" (p.64)
5. Translating studies into one another: This stage involves comparing both the metaphors, concepts and themes and their interactions in one account with the metaphors, concepts and themes and their interactions with another account. This approach can take the form of 'one account is like another except…' (p. 28).
6. Synthesising translation: This stage involves the clustering of themes identified in previous stages, allowing for a second level of synthesis which generates a general interpretation.
7. Expressing the synthesis: The synthesis is then presented in a way deemed suitable for the audience.

2.2. Search Strategy

In line with the second stage of Noblit and Hare's (1988) approach, the databases used to search for relevant literature were PsycINFO, MEDLINE, ASSIA and Social Policy and Practice. A librarian experienced in literature reviews assisted in this process. The author's supervisor also completed a literature search to ensure all relevant papers were retrieved. The search terms were identified through an investigation of the terms used in relevant literature. The following search terms were used:

Forensic psychology OR Forensic psychiatry OR (Forensic Mental health or forensic psycholog* or forensic psychiatry or secure care or forensic inpatient).ti,ab
AND
(service user* or client* or patient* or offender*).ti,ab
AND
(experience or perception or perspective or attitude or opinion or satisfaction).ti,ab
AND
Treatment or Clinical Psychology or Intervention or (therapy or mental health treatment or psycholog* intervention).ti,ab.

A second search was completed with the additional search terms 'cognitive behaviour therapy', 'mentalisation based therapy', 'dialectical behaviour therapy', 'acceptance and commitment therapy', 'feedback', 'view' and 'psycho*'. This did not retrieve any further papers.

2.3. Data Collection

The titles and abstracts of all studies retrieved were reviewed to identify relevant papers. The full texts of articles deemed to reach eligibility were then examined independently by the author and their supervisor. Reference lists and citing papers were also reviewed. Additionally, professionals identified in this area of work, including the main authors of the full-texts retrieved, were approached to see if they had knowledge of any further literature.

2.4. Inclusion and Exclusion criteria

Inclusion criteria

- Studies involving psychological interventions delivered to forensic service users in an individual or group format
- Papers which explore forensic service users' experiences of psychological interventions for mental health difficulties, including therapeutic engagement to psychological interventions
- Studies involving participants of 18 years of age and over
- Papers provided in the English language or those translated to the English language
- Papers involving both community and inpatient forensic settings
- Papers which provide qualitative data to analyse, including those which use a mixed methods approach given they have sufficient qualitative data

Exclusion criteria

- Studies which investigate staff or carer experience and perspectives
- Studies which refer to interventions that focus specifically on offending behaviours and/or risk
- Papers that investigate service users' perspectives of other experiences other than psychological interventions, such as overall care or coercive measures
- Studies based in prison settings
- Studies with quantitative data or those which have insufficient qualitative data to synthesise
- Papers not provided in the English language

2.5. Quality Assessment

To assess the quality of the identified papers, the Critical Appraisal Skills Programme (CASP, 2018) tool was used. The CASP is a validated and subjective ten-item rating programme. The checklist refers to the validity, rigour and value of qualitative papers. The CASP was not used to exclude studies but instead to acknowledge the quality of papers and any limitations. The CASP tool was completed for each identified paper by the author, and a separate supervisor assessed four of the papers for reliability. No significant differences between these quality checks were determined. Table 1 provides the CASP checklist and determined quality of the eleven papers assessed.

It is acknowledged that the CASP tool has limitations, including its subjectivity. The CASP does not provide a numerical rating for each paper and is restricted to the responses of 'yes', 'no' and 'can't tell', however, a response of 'somewhat' may have been more representative at times if a paper acknowledged only some of the hint questions suggested. Furthermore, as the CASP is used to assess the quality of the qualitative approach used, it did not facilitate the author to determine the quality of the psychological interventions, nor explore the extent to which a paper was grounded by key constructs such as psychological interventions or the theory of therapeutic engagement.

Table 1. Critical Appraisal Skills Programme (CASP) quality checklist (2018)

Paper	Clear aims	Is the qualitative method appropriate?	Was research design appropriate?	Was recruitment strategy appropriate?	Did data collection address research issue?	Is the relationship between research and participants considered?	Have ethical issues been considered?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings	How valuable is the research?
Davies, Morgan, John-Evans & Deere (2019)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Relates to existing knowledge. Implications, future research and limitations discussed
Russell and Siesmaa (2017)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Relates to existing knowledge. Implications, future research and limitations discussed
Thomson & Johnson (2016)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Does not relate to existing knowledge, discuss limitations or future research in detail. Clinical implications discussed
Aho-Mustonen, Miettinen, Raty (2010)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Relates to existing knowledge and suggests future research. Implications and limitations are not thorough.
Mason & Adler (2012)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Relates to existing knowledge. Limitations discussed. Limited future research suggested.

Table 1. Critical Appraisal Skills Programme (CASP) quality checklist (2018) continued

Paper	Clear aims	Is the qualitative method appropriate?	Was research design appropriate?	Was recruitment strategy appropriate?	Did data collection address research issue?	Is the relationship between research and participants considered?	Have ethical issues been considered?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings	How valuable is the research?
Yakeley &Wood (2011)	Yes	Yes	Yes	Yes	Yes	Unclear	No	Yes	Yes	Relates to existing literature. Limitations and implications discussed. Limited future research discussed
Willmot & McMurran (2013)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Relates to existing literature. Implications, future research and limitations discussed
Lord, Priest, McGowan (2016)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Relates to existing literature. Implications and limitations clear. Future research not discussed.
Ware, Wilson, Tapp & Moore (2016)	Yes	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	Yes	Relates to existing knowledge. Implications, future research and limitations discussed
Finn, Grey & Braham (2013)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Relates to existing knowledge. Implications, future research and limitations discussed
Hussain, Mia & Rose (2020)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Relates to existing knowledge. Discusses implications, limitations and future research

3. **Results**

3.1. Results of Search Strategy

From the electronic databases, 183 papers were retrieved. Fourteen full-text articles were obtained from the screening process. An additional 17 articles were then gathered from reference list checks and cited papers, the titles and abstracts of these were screened for eligibility. After removing duplications, a total of 194 papers were retrieved in total. Following the screening process, 176 articles were excluded as they did not meet the inclusion criteria. Eighteen full texts were deemed applicable and were examined to determine their eligibility. Seven papers were excluded from the study as they addressed service users' overall experience of a setting, interviewed prisoners, or lacked sufficient qualitative findings to review. A total of eleven papers were included in the present review. Ten of these papers are journal articles and one is a university dissertation. This process can be seen in the PRISMA diagram below (Figure 2).

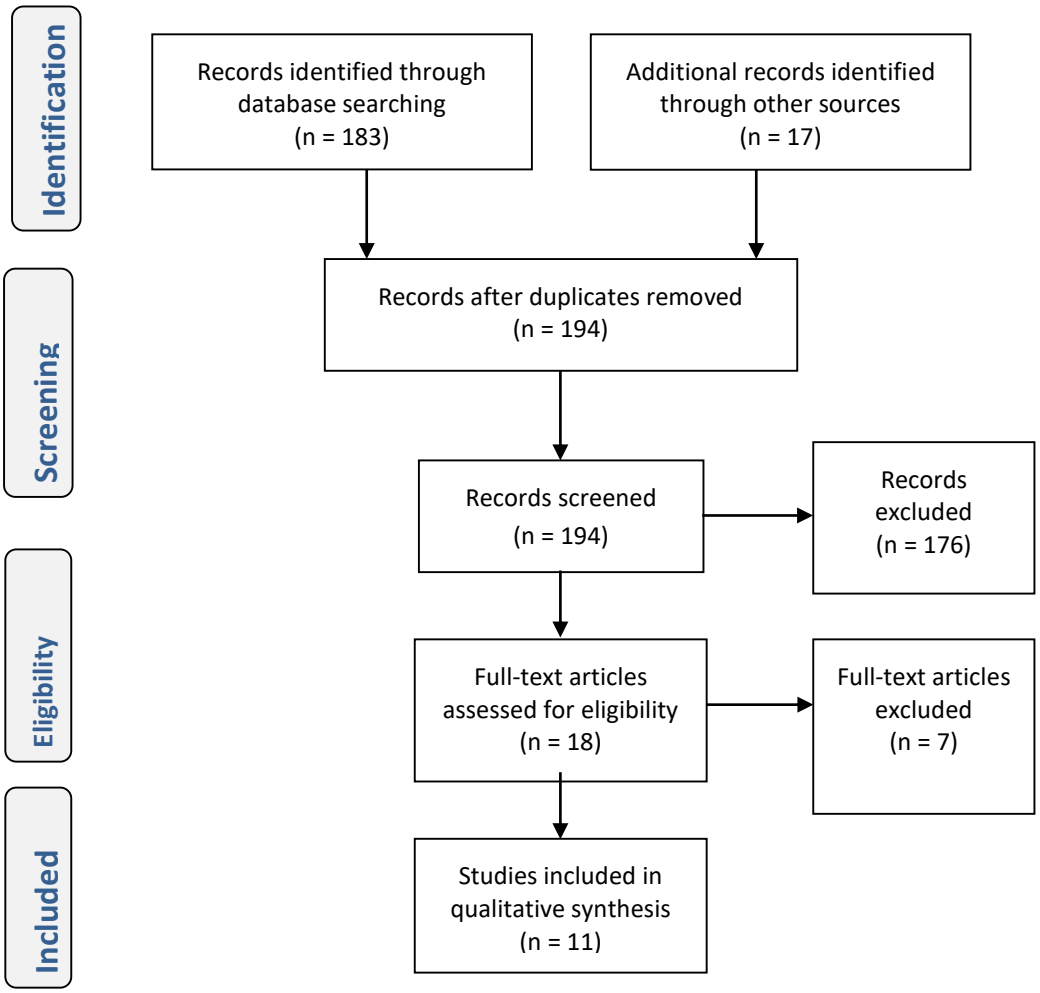

Figure 2. PRISMA Diagram (Moher, Liberati, Tetzlaff, Altman, The PRISMA Group, 2009).

3.2. Overview of papers

Having decided on the aims of the synthesis (step one) and completing the search strategy (step two), step three of Noblit and Hare's (1998) meta-ethnography involves reading and rereading the identified papers. This allowed the author to become more familiar with each paper and retrieve key characteristics (Table 2). The papers were published between 2010

and 2020, demonstrating that this is a relatively novel area of research. Ten of the papers were based in the UK and one in Finland. The author revisited the search terms to ensure they had not missed key words that were more applicable to different countries, but having examined the literature available in other countries it seemed that this was not the case. This finding was also apparent for MacInnes and Masino (2019) as over half of the papers included in their systematic review were based in the UK. It was hypothesised that including the service users' perspectives in the search limited the papers retrieved. It is plausible that the collaborative approach and this area of research is more apparent in UK settings, given possible cultural differences in service delivery. Additionally, it is possible that research in other countries is not translated to English and therefore, would have been overlooked in the present synthesis.

All studies used interview techniques to collect data. A range of settings were included such as community, low, medium and high secure settings. A total of 128 participants were included in the synthesis, 115 of these were male, which reflects the disproportionate ratio of males and females in forensic settings (Duke, Furtado, Guo & Völlm (2018). Three papers specified the ethnicity status of the participants and therefore, this meta-synthesis cannot comment on whether the sample is representative. Of the studies that did report ethnicity status, there was a range of white and black British, African, Caribbean and Asian participants. The education status of participants was not reported in any of the papers. Participants had committed a range of offences from homicide to theft but information on the court orders was not provided. Participants had received a range of psychiatric diagnoses, predominantly personality disorder schizophrenia, or mental disorder not

otherwise specified. Psychological interventions included acceptance and commitment therapy for psychosis (ACTp), dialectical behaviour therapy (DBT) modified for a forensic population, schema therapy, mentalisation based therapy (MBT), psychoanalytic psychotherapy and psycho-education based on cognitive behaviour therapy (CBT) principles. The psychological interventions lasted from eight weeks to a minimum of two years, however, information regarding drop out rates is not available. Three of the studies reported the qualifications of the therapist and therefore, the standard of the psychological interventions delivered is not captured. Three of the studies identified did not evaluate a specific therapy model and instead explored the experience of therapeutic engagement in relation to psychological interventions. Hussain, Mia and Rose (2020) explored this with a particular interest in how the male role impacts the experience of psychological interventions. Data analysis methods such as thematic analysis, content analysis and interpretative phenomenological analysis (IPA) were used. Aho-Mustonen et al. (2010) used both quantitative and qualitative approaches, however the current analysis only considers the latter.

Table 2. Study characteristics

PAPER NUMBER & AUTHOR	1. DAVIES, MORGAN, JOHN-EVANS & DEERE	2. RUSSELL & SIESMAA	3. THOMSON & JOHNSON	4. AHO-MUSTONEN, MIETTINEN & RATY
YEAR	2019	2017	2017	2010
COUNTRY	UK	UK	UK	Finland
SETTING	Medium Secure	Community forensic PD treatment service	Low and Medium secure	High Secure
PSYCHOLOGICAL THERAPY AND THERAPIST TRAINING	ACTp (Acceptance and Commitment Therapy for psychosis), 10 sessions Clinical Psychologist and Assistant Psychologist	Adapted forensic DBT (Dialectical Behaviour Therapy), mean of 18 months DBT therapist training not specified	DBT Therapist training not specified	Psycho-education with CBT elements (Cognitive Behavioural Therapy), 8 sessions Nurses, psychologists, social workers and occupational therapists
PARTICIPANTS (GENDER, MEAN AGE, ETHNICITY)	10, Male 21 – 60 years (age range) Ethnicity not specified	6, Male 47 years Ethnicity not specified	7, Female Age and ethnicity not specified	35, Male 4, Female 39.6 years Ethnicity not specified
DIAGNOSIS AND OFFENDING BEHAVIOUR	Schizophrenia, personality disorder, poly-substance abuse and dependent disorder, depression (moderate and severe) and delusional disorder Offending behaviour not specified	Personality Disorder Violent offending behaviour	Borderline Personality Disorder and Learning Disability Offending behaviour not specified	Schizophrenia Homicide, attempted homicide, aggravated assault, robbery, arson, theft, wilful damage
THERAPY DELIVERY	Individual and group	Individual and group	Individual and Group	Group
DATA COLLECTION	Semi-structured interview	Semi-structured interview	Semi-structured interview	Interview and questionnaire
DATA ANALYSIS	Thematic analysis (TA)	TA	Interpretative Phenomenological Analysis (IPA)	Content analysis
KEY FINDINGS	ACTp deemed positive and recommended as an intervention in forensic care. Four main themes 'recovery', 'insight', 'skill development', 'accessibility' were retrieved.	Themes related to motivation, shared learning, professionalism, reinforcement, personal achievement, increased knowledge and skills application.	Themes relate to the process and difficulties of understanding DBT; 'how you do DBT', 'what we think about DBT' and 'using DBT'.	Service users want information regarding their mental health difficulties, to talk about related issues and support from other service users

Table 2. Study characteristics continued

PAPER NUMBER & AUTHOR	5. MASON & ALDER	6. WARE, WILSON, TAPP & MOORE	7. YAKELEY & WOOD	8. WILMOT & MCMURRAN
YEAR	2012	2016	2011	2013
COUNTRY	UK	UK	UK	UK
SETTING	High Secure	High Secure, low secure and community	Outpatient Forensic	High Secure
PSYCHOLOGICAL THERAPY AND THERAPIST TRAINING	Modality not specified Therapist training not specified	MBT (Mentalisation Based Therapy), 18 month weekly programme Accredited MBT training	Psychoanalytic psychotherapy for a minimum of 2 years. Therapist training not specified.	Predominantly DBT and Schema therapy, 12 – 24 months Therapist training not specified
PARTICIPANTS (GENDER, MEAN AGE AND ETHNICITY)	11, Male Age and ethnicity not specified	4, Male 40.25 years 3 white British, 1 black British	8, Male 2, Female Ethnicity and age not specified	12, Male 44.1 years Ethnicity not specified
DIAGNOSIS AND OFFENDING BEHAVIOUR	Mental illness diagnosed but not specified Offending behaviour not specified	Personality Disorder and paranoid schizophrenia. Violent and sexual offences	Not specified, some members of transgender community Violence, and compulsive sexual behaviour	Personality Disorder (4 comorbid schizophrenia or delusional disorder). Serious violent or sexual offences
THERAPY DELIVERY	Individual and group	Individual and group	Individual and group	Individual and group
DATA COLLECTION	Semi-structured interview	Semi-structured interview	Semi-structured interview	Semi-structured interview
DATA ANALYSIS	IPA	IPA	TA	TA
KEY FINDNGS	Engagement was related to motivation, content of group-work, choice, expected outcomes, external locus of control and relationships.	MBT enhanced the service users' mentalising which had a positive impact on their capacity to manage behaviours and emotions.	Therapeutic relationship was deemed fundamental. Positive changes to service users' perceptions of themselves, interpersonal skills and behaviours were retrieved.	Change apparent in service users' core beliefs, awareness and behaviours. Therapeutic relationship and interpersonal environment also highlighted as paramount.

Table 2. Study characteristics continued

PAPER NUMBER & AUTHOR	9. LORD, PRIEST & MCGOWAN	10. FLINN, GREY & BRAHAM	11. HUSSAIN, MIA & ROSE
YEAR	2016	2013	2020
COUNTRY	UK	UK	UK
SETTING	Medium Secure	High Secure	Medium Secure
PSYCHOLOGICAL THERAPY AND THERAPIST TRAINING	Modality not specified Therapist training not specified	Forward Motion Motivational Group for approximately 12 weeks Therapist training not specified	Modality not specific Therapist training not specified
PARTICIPANTS (GENDER, MEAN AGE AND ETHNICITY)	10, Male 27.5 years Ethnicity not specified	10, Male 36.6 years 7 white British, 2 Caribbean and 1 Asian	9, Male 37 years 1 mixed ethnicity, 1 black African, 1 white Irish, 2 mixed white & Caribbean, 1 African-Caribbean, 1 mixed white & Asian, 2 white British
DIAGNOSIS AND OFFENDING BEHAVIOUR	Major mental disorder Sexual/ violent offending and arson	Predominantly schizophrenia Offending behaviour not specified	Predominantly schizophrenia, 1 bipolar and 1 personality disorder Theft, robbery, manslaughter, grievous bodily harm, assault and wounding, attempted murder
THERAPY DELIVERY	Not specified	Group	Individual and group
DATA COLLECTION	Interview	Semi-structured Interview	Semi-structured Interview
DATA ANALYSIS	IPA	TA	TA
KEY FINDNGS	Engagement was influenced by the worlds staff and service users occupy, what the therapist brings, what therapy entails and perceived level of control	Themes related to expectations, group experience, staff and the programme. Benefits of an introductory group, prior to in depth interventions are discussed.	Three themes related to individuals opening up and developing throughout their therapy journey, which was related to males questioning and redefining their identity. The importance of the therapeutic relationship to facilitate this process is discussed.

3.3. Synthesis

Step three of the meta-ethnography allowed for key themes and concepts of each paper to be retrieved. This information was collated into Table 3 in preparation for steps four and five. Comparing such findings revealed that the studies were similar and allowed for reciprocal translation (Noblit & Hare, 1988). As the CASP assessments revealed no significant differences between the quality of papers, all studies were considered equally in the synthesis. From this process, twelve sub-themes were generated across the eleven papers. Table 4 offers an example of juxtaposing the themes and concepts retrieved from Table 3, to develop the sub-theme 'collaborative decision making'.

Further secondary analysis in step six of Noblit and Hare's (1988) approach revealed six super-ordinate themes. Such themes account for the helpful and unhelpful aspects of psychological interventions from the service users' perspectives. Table 5 provides an overview of these themes, with reference to the relevant papers associated. A detailed description of these findings is included below.

When considering the analysis of qualitative data, there is the potential for researchers' preconceptions and biases to interfere with the analysis. In the present synthesis, it was important for the author to capture service users' unique and personal experiences, however as this is an analysis of existing papers, it is possible for some of this to get missed throughout the process. To minimise these influences the author read each paper several

times and kept revisiting the original papers to ensure they were represented in the analysis. The author also used the service users' quotes to make certain that their views had been captured. Furthermore, the author considered Ahern's (1999) tips for reflexive bracketing and wrote down all of their preconceptions and beliefs in a reflective diary. For instance, the author acknowledged their position as a Trainee Clinical Psychologist and their belief that psychological interventions are valuable. Additionally, they have an interest in working collaboratively and co-productively with service users and this contributed to the research question. The author reflected on this in supervision and discussed how the findings of the synthesis interacted with their own values and beliefs.

Table 3. Key themes and concepts identified in each paper

Paper	***Themes and concepts***
1. Davies et al. (2019)	Interpersonal development through improved relationships; ACT specific skill development; Increased self-insight and normalisation of experiences; Accessibility of therapy; Preference for intervention to be on a one to one basis; Person-centred approach deemed important; Hope for the future
2. Russell & Siesmaa (2017)	Personal motivations to change; sense of belonging and support; Importance of staff professionalism to aid trust; Therapy seen as a sense of achievement; Skill application; developed self-insight; Responses lacked specific reference to therapeutic content; Therapy modifications for forensic sample
3. Thomson & Johnson (2017)	DBT principles and techniques; greater awareness of emotions; challenges of therapy; Varied experiences; Difficult to trust group members; Skill development; Choice deemed helpful; Staff knowledge was important; Environment should complement therapy principles
4. Aho-Mustonen et al. (2010)	Desire for information about their diagnosis; Desire for new coping strategies; Social support from group setting; Mixed feelings towards group content and format; Different needs for patients; Empowering patients to become active participants in their recovery; The need to modify therapy to cognitive ability
5. Mason & Alder (2012)	Motivation via staff feedback and encouragement; Content of therapy work perceived as challenging; Feelings of disempowerment and lack of choice to engage; Therapy viewed as a progression towards discharge; Staff characteristics seen as important for therapeutic relationship; Degree of distrust with a group setting
6. Ware et al. (2016)	Apprehension towards therapy; Told to complete MBT; Group context could be overpowering; Therapy seen as an 'investment'; Impact of inpatient environment; increased mentalising and self-insight; Increased empathy and making sense of the actions of others; Acknowledging the need to utilise self-regulatory skills; MBT deemed a rehabilitative aid to understand their offending behaviour; Future orientated goals
7. Yakeley & Wood (2011)	Primitive anxieties to attend therapy; Fears of 'opening up' and trusting therapists; Therapist characteristics and attitude deemed important; Structured and contained therapy framework; Interpersonal development and change; Greater self-insight and understanding; Change not related to therapy modality; Holistic approach
8. Wilmot & McMurran (2013)	Personal motivations to change; Greater self-awareness; Improved awareness of other people; Developed self-regulation skills; Acknowledging similarities with other service users; Staff attributes and relationship cited as precipitants to change; Specific therapeutic techniques were not commonly cited as change processes; More hopeful about the future
9. Lord et al. (2016)	Perceived lack of choice to engage and a hierarchy of power; Relating to therapists and 'coming from different worlds'; Therapist attributes associated with engagement and therapeutic relationship; Unconditional positive regard and encouragement from staff; Feeling unsafe in the hospital; Clear and concise information; Desire for personal Development
10. Flinn et al. (2013)	Lack of information prior to therapy; Anticipatory anxiety; Lack of choice to engage; Engagement perceived as related to moving forward; Safe therapeutic environment deemed important; Sense of belonging with other service users; Timing of intervention was important; Clear information; Staff attitude deemed important; Belief in self; Greater awareness of behaviours; Some service users felt no therapeutic value; Suggestions for the programme
11. Hussain et al. (2020)	Unaware of therapy aims; Felt obliged to engage; Anticipatory anxiety; Paranoia and fears of being judged; Power imbalance; Collaboration deemed helpful; Trust; Building therapeutic relationship; Gradual approach to 'opening up'; Positive therapist attributes and listening important; Personal development and change in self-identity

Table 4. An example of how the sub-theme 'collaborative decision making' was devised

Study	**Theme, concept or metaphor**
3. Thomson & Johnson (2016)	Choice to engage was provided and deemed helpful
4. Aho-Mustonen et al. (2010)	Participation in research to improve care and becoming actively involved in their own recovery was seen as positive.
5. Mason & Alder (2012)	Perceived hierarchy of power and lack of choice
6. Ware et al. (2016)	Being told to complete therapy to progress in their care can have negative effects on engagement. Ownership of engagement was deemed beneficial.
9. Lord et al. (2015)	Perceived lack of choice to engage in therapy and hierarchy of power
10. Flinn et al. (2013)	Participants attended the group to comply with the treatment pathway, rather than due to their own incentive
11. Hussain et al. (2020)	Participants felt obliged to engage in therapy as they believed their time in secure care would be prolonged if they decided otherwise

Table 5. Overview of themes

Master Theme	**Super-ordinate theme**	**Sub-theme**	**Relevant papers**
Setting the scene	Empowerment to engage	• Collaborative decision making • A shared agenda	3, 4, 5, 6, 7, 9, 10, 11
	Building a relationship with staff	• The therapist • Trust	2, 3, 4, 5, 7, 8, 9, 10, 11
	Modifying therapy	• Accessibility • Tailoring to individual needs	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11
Therapeutic outcomes	Greater self-awareness and control	• Facilitate self-insight • Regulating emotions	1, 2, 3, 4, 6, 7, 8, 10, 11
	Connecting with and considering others	• Developing relationships with peers • Empathy	1, 2, 3, 4, 6, 7, 8, 11
	Personal growth	• Developing self-worth • Planning for the future	1, 2, 3, 4, 5, 6, 7, 8, 10, 11

3.3.1. **Setting the Scene**

The first three super-ordinate themes were related to setting the scene for the psychological interventions to commence.

Empowerment to Engage

This theme reflects the helpfulness of empowering service users to make informed choices prior to the intervention. Across papers, this was related to service users' level of engagement throughout the intervention.

Collaborative decision making

This theme was acknowledged in seven papers. Many individuals highlighted a lack of choice to engage in psychological interventions and felt that treatment decisions were not collaborative but instead made on their behalf. Service users seemed to be under the impression that attending these interventions was the only option to move forward with their treatment, which strongly influenced their decision to attend.

> "I'm stuck here; I don't want to be stuck here anymore, so I've no choice. It doesn't feel like a choice" (Mason & Alder, 2012, p.9)

This seemed to create a divide between staff and service users, which was described as "a them and an us" (Lord et al., 2016, p.65). Service users created a notion of feeling disempowered and debilitated, which suggested that they were less engaged with the interventions. Only Thomson and Johnson (2016) highlighted that all participants had a choice to participate in the intervention. Collaboratively deciding treatment options was empowering and demonstrated to service users that their opinions mattered, which in turn facilitated their engagement.

> "…they can lead you to water but if you don't want to drink it you don't want to drink it… because if you are forced to do it, you are not going to put the effort into it" (Lord et al., 2016, p.69)

> "You just turn up each week because you've got to, you probably don't fully engage because you don't want to be there" (Ware et al., 2016, p.12)

A shared agenda

Some service users reported feeling apprehensive and anxious before therapy commenced (Flinn et al., 2013; Ware et al., 2016; Yakeley & Wood, 2011). This seemed to be exacerbated by having a limited understanding of the therapy. "I didn't know anything about [MBT] at all" (Ware et al., 2013, p.8). Yakeley and Wood (2011) highlighted that this may relate to disengagement, mental health difficulties and increased use of unhelpful behaviours. Clear informative communication and having a shared agenda for therapy were important, so service users were aware of the therapeutic aims and what to expect.

> "I've constantly found myself irritated and upset by the Portman's reluctance to come forward and say more about what the strategy aims of the work is" (Yakeyley & Wood, 2011, p.109)

> "Come and see me, explain about the course, explain if I have to do it or not, how long the course is going to be…" (Lord et al., 2016, p.67)

Building a relationship with staff

This theme relates to the relational factors which were deemed valuable. Many service users highlighted the importance of specific staff attributes and forming trusting relationships with staff. These both seemed to enhance the level of engagement as over time service users felt more comfortable to participate, open up and trust the staff and psychological interventions.

The therapist

Many service users highlighted the significance of staff characteristics that enhanced the therapeutic relationship and were influential to the process of change. Therapeutic skills such as empathy, active listening, not judging and speaking to people on their 'level' were all deemed helpful.

> "But listening to me, that was one of the best things ever. Not a lot of people listen to people nowadays" (Hussain et al., 2020, p.12)

Such attributes were complimented by receiving positive feedback and encouragement, as this helped to reassure service users that they were "heading in the right direction" (Mason & Alder, 2012, p.6). This seemed particularly significant as service users valued staffs' expertise and knowledge, yet some had concerns that they were not qualified for the role.

> "I'm worried about this whole bunch of people that you use to run groups, whether they're qualified or not to do them" (Mason & Alder, 2012, p.7)

Staffs' backgrounds and gender were also significant for some individuals. Lord et al. (2016) found male participants to have different views on speaking therapeutically with a female clinician, as some felt a lot more comfortable than others. It was therefore important that service users worked with the "right person" (Lord et al., 2016, p.61). When staff had similar backgrounds to service users, this was deemed positive as individuals felt more understood and valued staff sharing some of their own experiences.

> "If someone was from my culture, then I'd find it easier to engage with them because they are quite likely to understand the lives and the situations that you have in my culture everyday..." (Lord et al., 2016, p. 61)

However, although self-disclosure was valued, service users were aware that there was only so much clinicians could disclose and for some the relationship still felt one-sided (Hussain et al., 2020).

Trust

Trust was a key ingredient to a positive experience of psychological interventions. A trusting relationship between staff and service users was deemed fundamental to the whole experience of therapy, as this facilitated service users' engagement and openness. It was evident that this may take time to build, as service users needed to develop confidence that clinicians were there to facilitate their recovery as opposed to impede it. This was reinforced by staff demonstrating trust in the service users, which promoted them to continue with the intervention.

> "…there is no trust in that way of life, you don't trust anybody, you don't talk to anybody, for the fear of actually going to prison, or it getting into the wrong hands, or whatever. Coming here I really felt that she made, it took a long time, but enabled me to have that trust in myself, to trust her, to open up and speak to her without fear of it getting into the wrong hands, you know" (Yakeley & Wood, 2011, p. 109)

> "…they've allowed me to do things, to have scissors out when other people's being around and it makes it go better… That's a big trust in me… so it gave me a good boost that" (Willmot & McMurran, 2013, p.601)

Modifying therapy

This theme resembles the therapy sessions and how helpful it was for service users to be given accessible and modified information. With this in mind, it was important that individuals' abilities and preferences were considered.

Accessibility

The accessibility of the intervention was highlighted as an important factor for many service users' experiences. It seems that some service users did not understand the content and found the homework tasks too difficult.

> "…the homework was so difficult that I should have been a professor to be able to answer the questions… the questions were impossible… it was so annoying" (Aho-Mustonen et al., 2010, p.232.)

Flinn et al. (2013) acknowledged this using a staged model of care to gradually introduce psychological interventions. This seemed to help individuals prepare for more in depth therapeutic work. Hussain and colleagues (2020) findings also support this as it was evident that service users took considerable time before exploring past traumas and therefore it was important to not go "straight into…the deep end" (p.13).

> "I think if they had hoy'd us into one of the more intense one's straight away I would have panicked and thought, nah, it's too much. It would have put us off courses in the future" (Flinn et al., 2013, p.274)

Information provided visually, "jargon-free" (Flinn et al., 2013, p.274) and in handouts, was also deemed helpful, particularly as service users could refer to them in their own time.

Service users seemed to benefit from metaphoric examples, which were often referred to in ACTp.

> "…the bus driver metaphor, that was really helpful. There was a two part drawing of somebody playing tug of war with a monster, he was just like letting things go, pinned that to the back of my door. Visually, it was helpful" (Davies et al., 2019, p.605)

Regular and consistent sessions which were planned in advance were also reported as helpful, as this created a sense of consistency and structure.

Tailoring to individual needs

The individuality of each service user was recognised in three of the papers. Many service users had preferences to attend individual sessions or group interventions and this was driven by individual preference.

> "The thing I liked more was that we had a small group, I like small groups" (Aho-Mustonen et al., 2010, p.231)

> "I prefer it to be 1:1, I think to try and do it in a group therapy would de-personalise it I think and everyone is an individual" (Davies et al., 2019, p.605)

For others, the timing of therapy was important and one individual disengaged as they did not feel ready (Thomson & Johnson, 2016). Some also commented on the side-effects of the medication they were on, which acted as a barrier to attending sessions.

> "I had just started clozapine at the time, so it was hard for me to get to every single session… most of the time I'd be tired. It was very hard" (Ware et al., 2016, p.9)

With these individual differences in mind, a person-centred approach where therapy is tailored to the individuals' needs was deemed helpful and important to the overall experience of psychological interventions.

3.3.2. **Therapeutic Outcomes**

The next three super-ordinate themes were related to therapeutic outcomes which service users referenced.

Greater self-awareness and control

This theme refers to individuals who reported increased self-awareness and understanding, which seemed to alleviate their emotional coping skills.

Facilitate self-insight

Nine of the eleven papers indicated that the psychological interventions helped service users gain a greater understanding of their experiences. This was related to service users making sense of and formulating their current mental health diagnoses, experiences and behaviours. Service users' saw this insight as valuable, yet some were initially reluctant to open up and appear vulnerable.

> "Before I never even used to even bother analysing, now when I have a bad thought or a bad mood swing I think about it, analyse it and wonder why it's happening" (Yakeley & Wood, 2011, p.108)

> "I have learned to recognise my symptoms, understood now my [previous] symptoms… I didn't even know they were symptoms before" (Aho-Mustonen et al., 2010, p.231)

This in turn, allowed service users to become less self-critical and consider how past experiences may have impacted them.

> "I think that one important thing for me is to gain knowledge of my past, instead of growing up being a nobody and rejected and believing that it was my fault for what happened to me many years ago, when it's not my fault, it was other people's fault" (Willmot & McMurran, 2013, p. 599)

Regulating emotions

There was a consistent theme that service users were in a better position to cope with difficult demands and emotions. Many service users highlighted how they had developed practical coping skills which positively influenced their behaviours and thinking. For some, this was a motive for participating in therapy. Specific principles and techniques such as mindfulness were referenced as significant contributions to this development, which were particularly apparent for ACTp.

> "…I found that mindfulness parts of the whole thing to me was one of the major ground breaking things… it has taught me to drop anchor basically when I am having bad thoughts, things about my index offence or any negative thoughts about myself or whatever it is" (Davies et al., 2019, p.603)

One individual highlighted how since learning more emotional regulatory skills, they now rely on using medication less frequently.

> "If you are in the incident, try and breathe and that to calm down and try not to use your medication, your as required, as much and I tend to not use it as much now since I started on this DBT" (Thomson & Johnson, 2016, p.4)

Connecting with and considering others

This theme reflects the interpersonal skills which service users reportedly developed throughout the psychological interventions.

Developing relationships with peers

This theme is particularly relevant to group interventions and is related to the theme of trust, as service users commented on having longstanding difficulties with trusting others. In group therapy, some individuals reported to be weary of other group members, and it is suggested that this may have been exacerbated by mental health difficulties such as psychosis or not wanting to appear weak and vulnerable (Davies et al., 2019; Hussain et al. 2020).

> "You don't know whether you can fully trust other patients, you know there's a worry that if you say something it'll end up all around the hospital" (Mason & Adler, 2012, p. 11)

It seemed however that over time, the interventions helped service users to build relationships with peers, which enabled them to share their experience and become less suspicious.

> "…I always used to think if they talk to me they're after something, but now I realise that people can talk to me and they're not after something, they're interested in me" (Willmot & McMurran, 2013, p.509-600)

Building these relationships seemed to create a sense of belonging, as service users could relate to and learn from others. It appeared that this enhanced individuals' interpersonal skills and helped them to feel less isolated and more connected. This experience was thought to help them progress in their treatment pathway and to open up about their own experiences.

> "…other people with the same problems, dealing with them in the same way…It was quite comforting like, knowing I wasn't the only one" (Davies et al., 2019, p.602)

One participant in Hussain et al's (2020) study also related their enhanced interpersonal skills to their emotional regulatory skills, demonstrating how these themes are associated, as they were in a better position to express themselves and communicate with others.

> "It helped me with relationships in that sense, because now I'm able to like talk to people on a level and not become angry, and I'm able to express emotions and thoughts and things freely" (Hussain et al., 2020, p.14)

Empathy

Although this subtheme had low occurrence, it was considered an important outcome for service users. The psychological interventions facilitated some individuals to be in a better position to consider other individuals' points of view. This was reported as an increase in empathy towards others. For some, this helped them to recognise how their behaviours, including their offending behaviours, could impact other people.

> "I've more empathy and compassion for others, which I never really had before… I just didn't consider people to be worthy of consideration and sympathy" (Willmot & McMurran, 2013, p.600)

Personal Growth

This theme relates to the personal growth which was described by individuals as an outcome of the psychological interventions. Two themes emerged which relate to individuals' enhanced relationships with themselves.

Developing self-worth

The psychological interventions seemed to help individuals shift their self-beliefs and provided a sense of achievement which they did not believe they could attain. It seems this

new self-perspective and development of self-worth meant individuals started believing in themselves more.

> "I actually do believe that finally, one day I might be a decent human being" (Yakeley & Wood, 2013, p.108)

> "I just can't believe it really, having done 33 years of being that person […]. I have managed a lot because I have changed my lifestyle" (Russell & Siesmaa, 2017, p.53)

Planning for the future

For many individuals it was apparent that the therapeutic interventions allowed them to develop a sense of hope for the future and make future orientated goals. Thinking about the future seemed to be somewhat related to the process of recovery, which was evident through the planning of goals and decision making.

> "Before I didn't really care about my future, about how things were for me; I lived day to day and didn't set any targets, have any goals, whereas now I do look at my future and I look at setting a goal for where I'm going to be this time next year and having a target for that and my ultimate goal is to be able to get out and run my own tattooist shop" (Willmot & McMurran, 2013, p.601)

> "It has shown me that there is a future beyond hospital" (Davies et al., 2019, p.600)

3.3.3. **Line of Argument**

This line of argument aims to draw upon all of the findings and create an overall concept of forensic service users' experiences of psychological interventions. The synthesis revealed factors throughout the whole therapeutic experience that are deemed valuable and not so valuable from forensic service users' perspectives. Prior to any psychological intervention, it is crucial to recognise service users' perceptions of the relational dynamics and their forensic care. Feelings of disempowerment are not uncommon given forensic service users are detained on an involuntary basis and are expected to comply with interventions as part of their treatment pathway. It can be argued that implementing any psychological intervention amongst these dynamics will reduce their effectiveness. This is particularly evident as many forensic service users engage in psychological interventions because they feel they have no choice and believe this is their only way to move towards discharge. This impacts individuals' engagement with the therapeutic content as service users may feel somewhat guarded to open up about their difficulties in case they cannot move forward in their treatment pathway. This dilemma may also be worsened by therapists having dual roles in the forensic services, for instance they might have to complete risk assessments and progress reports to determine a service user's treatment pathway, in addition to offering psychological interventions. These factors may also be apparent in general inpatient mental health services, but might be exacerbated in forensic settings by the greater emphasis on service users' risk to others and the length of stay typically being much longer. Given these factors it is key that preparatory work is required before any psychological intervention begins.

Gaining a trusting relationship with service users is paramount and this seemed to facilitate service users opening up to the therapeutic content. Yet this may take some time given their lack of trust with others and their concerns that opening up might deter their progress towards discharge, for these reasons persistence and patience is required, suggesting effective psychological interventions should make times for this. Although this is important throughout mental health settings, this might be more apparent in forensic settings given: the higher levels of security; the emphasis on risk to others; the coercive measures which can be used; and because service users are likely to engage on an involuntary basis. Additionally, forensic service users are more likely to have complex presentations compared to non-offending populations which may influence their ability to form trusting relationships. Clear information should be provided to all service users so they have a full understanding of what the intervention entails and what impact this will have on their treatment pathway. This is particularly important in forensic care because as noted, many service users will engage due to the belief that this will move them towards discharge. A stepped care approach may facilitate these factors and help clinicians, with the service user's perspective, to assess individual differences and who they believe is ready to move forward to more detailed interventions. This model is recognised as applicable for both forensic and general mental health service users, however, it is recognised that the forensic context may have more barriers to always offering choice and, therefore, transparent and clear communication is deemed even more essential. Adopting a collaborative stance, where staff 'do with' as opposed to 'do to' is, therefore, fundamental to the basis of care.

Once these factors are in place, interventions should be accessible and person-centred, and clinicians should monitor whether the content can be easily understood by service users. Given forensic service users have high levels of comorbidity and complex presentations, many interventions can be modified to their ability, and therefore, such factors are pertinent to ensure that service users understand the therapeutic content. Visual handouts and metaphoric examples seem to be particularly helpful. In line with a collaborative stance, clinicians may wish to draw upon service users to gain their opinion on an intervention and relevant materials before it is introduced. Interventions which introduce emotional regulatory and interpersonal skills, and normalise difficult experiences through formulation are deemed valuable. Such interventions and skills are likely to be beneficial for both offending and non-offending populations receiving mental health support, however, it is plausible that such difficulties are more apparent in the forensic populations given the complexity of presentations and higher rates of personality traits such as AsPD, and therefore, interventions might have to be tailored to this. Such factors facilitate personal growth, where individuals develop a greater sense of self-worth and think more positively about the future.

4. **Discussion**

This meta-ethnography has highlighted forensic service users' experiences of engaging with psychological interventions. Themes relate to aspects of psychological interventions which service users deem valuable and not so valuable, including: empowering service users

through collaborative care; building close relationships with staff and service users; offering accessible and modified therapy where appropriate; facilitating greater self-insight and emotional coping skills; enhancing interpersonal skills; and facilitating personal growth.

This review is consistent with Barnao et al. (2015) and Long et al. (2012), who explored forensic service users' overall experiences of rehabilitation and therapeutic milieu. The present meta-ethnography compliments these findings and contributes more specifically to the use of psychological interventions in forensic care. Like Barnao et al. (2015), many service users shared perceptions of disempowerment and highlighted the need for clear and transparent communication regarding their treatment pathway. As previously recognised, a collaborative stance where choice is offered is deemed empowering (Tapp et al., 2013). However, in forensic care psychological interventions may be determined by court orders, which individuals are expected to comply with as part of their treatment pathway. The present study reflects this, as some individuals engaged in therapy as they believed they had no other choice, or because they simply saw therapy as a means of moving towards discharge, rather than a vehicle for personal change and growth. This resembles previous findings that forensic service users become passive and comply with those in a position of authority (Barnao et al., 2015; Selvin et al., 2016). Such factors may be detrimental to an individuals' wellbeing and can in fact be retraumatising (Sweeney, Clement, Filson & Kennedy, 2016). It is understood that when one is driven by external factors, such as compliance, fewer outcome changes are retrieved and service users are typically less engaged (Flinn et al., 2013; Parhar et al., 2008). This was related to learned helplessness in some papers (Lord et al., 2015; Mason & Alder, 2012). As previously highlighted, it is

possible that this compliance accounts for the tentative evidence available for psychological interventions in forensic settings.

On the other hand, it is understood that when behaviours are driven by intrinsic motivations, one would expect to see extended and improved performances, including increased wellbeing (Parhar et al., 2008). This is in line with Livingston et al. (2012) who found that higher level of service user recovery is related to greater empowerment. The present findings also highlight that there is the potential for service users to meaningfully engage in psychological interventions and see valuable changes. There were, therefore, differences between superficial and meaningful engagement, which in the present findings was related to how much service users took on board from the interventions. It is recognised that the very nature of the forensic environment means that barriers to service user choice will always exist (Mezey & Eastman, 2009). However, Kaliski and de Clercq (2012) highlight that even in the most secure environments, service users can be involved in decision making and Mezey and Eastam (2009) call for more transparency with regards to the extent choice can be offered. In the present synthesis, service users reported such conversations as valuable and this facilitated their trust in the clinicians.

In line with Barnao et al. (2015), Long et al. (2012) and Hodgetts and Wright (2007), the therapeutic relationship between staff and service users was reported as fundamental in the present findings. Like Long et al. (2012), service users seemed to benefit from staffs' positive encouragement, as it gave them a sense of hope and reassurance that they were

progressing. In some papers, these relational factors were referred to more than specific therapy components. To some extent, this finding relates to the idea that regardless of therapy components, equivalent outcomes are retrieved due to the therapeutic relationship (Luborsky et al, 2002). However, some papers suggested therapy-specific factors are influential to changing internal processes, but this change is too complex for service users to recognise and articulate (Russell & Siesmaa, 2016; Willmot & McMurran, 2013; Yakeley & Wood, 2011). Moreover, some therapy-specific factors were recognised by service users as contributing factors to change in the present findings. These references were particularly apparent for ACTp, as many therapy-specific metaphors and examples were recalled. This suggests that therapy specific components are important, particularly within ACTp, however, this synthesis is unable to specify why this is the case in comparison to other interventions.

For many service users, the contents of the psychological interventions were too challenging and it is possible this may account for why service users did not always recall therapy-specific examples. With this in mind, the cognitive ability of service users was acknowledged in some papers, with therapy adaptions and modifications made for the forensic population. This was relevant to the participants in Thomson and Johnson's (2016) paper, as participants had diagnoses of a learning disability and highlighted that this was associated with difficulties completing the homework. With this in mind, 16% of individuals in high and medium secure care have a diagnosed learning disability and it is recognised that these individuals are significantly more at risk of adversity and discrimination compared to the general population (Horner-Johnson & Drum, 2006; Völlm et al., 2018b). Furthermore, most

service users in forensic settings are prescribed psychotropic medication, which may impact one's cognitive alertness and ability to engage (Jones, 2012). Considering these complexities, along with psychiatric comorbidities (Palijan et al., 2009), clinicians would expect to see only small changes as a result of psychological interventions. These factors might contribute to the tentative evidence available and reiterates limitations in transferring psychological models from adult mental health settings to forensic services (Barnao & Ward, 2015).

Delivering psychological interventions tailored to each individual was paramount for service users, and accessible examples and visual handouts were praised. It is plausible that this is related to one's zone of proximal development (ZPD). This is the notion that individuals have a 'zone' whereby skills and information are too challenging to learn independently, yet with guidance and encouragement they are able to reach their full potential (McLeod, 2019; Vygotsky, 1978). Therapists and clinicians are encouraged to be mindful of this, ensuring they are supporting individuals at an appropriate level, which is also known as scaffolding (Wood, Burner & Ross, 1976). In the present review it seems some individuals received information out of their ZPD, as interventions were too difficult to understand. When considering this, a person-centred approach is deemed essential (Barnao et al., 2015; Livingston et al., 2012) and some service users may benefit from staff input in between therapy sessions to receive further support with the therapy content or homework tasks. Furthermore, the findings of the present synthesis suggest that a stepped-care and gradual approach to psychological interventions may facilitate this. This is because service users suggested that should they have 'dived into the deep end' in therapy, this would have been

overwhelming, particularly as a trusting relationship takes time to build, and consequently they may have disengaged. A stepped-care approach may, therefore, ensure that individuals are introduced to the therapeutic concept at an appropriate pace. It would also provide adequate time to build therapeutic relationships and prepare service users for more detailed interventions that may include exploring their pasts, whilst always acknowledging the importance of collaboration and choice (Bower & Gilbody, 2005).

4.1. Limitations and Future Research

Many participants in the studies were selected due to staffs' perceptions that they had benefited from the psychological interventions. This inevitably misses a proportion of service users who were not perceived to benefit from interventions or who did not participate at all, and this creates a bias in the sample. Thomson and Johnson (2016) were the only authors to interview one participant who disengaged from the intervention and discovered it was the wrong timing for that person. Aho-Mustonen et al. (2010) highlight that those who did not participate generally did not wish to provide an explanation but it seemed that the main reason was due to not wanting to engage in the group therapy format. The present findings suggest this may have been due to issues with mistrust and anxieties about opening up in front of others, which may be enhanced by mental health difficulties or gender stereotypes (Davies et al., 2019; Hussain et al., 2020). As this synthesis is not representative of all forensic service users, future research may wish to address these gaps. Furthermore, it is difficult to determine the outcomes between individuals who actively engaged in therapy and those who attended with reluctance. Future research may

wish to explore this further and also determine whether there is a process of change from superficial to meaningful engagement during the psychological intervention. Researchers may also wish to tailor interview questions to focus more closely on the therapeutic models, as this may contribute to the evidence base for specific psychological models in forensic settings.

When considering the feedback service users provide, it is possible that they wish to portray successful outcomes to move closer to discharge (Davies et al., 2019). This might be particularly pertinent for those with the understanding that psychological interventions impact their treatment pathway. Given this, Selvin et al. (2016) highlight that staff are likely to underestimate service users' ability. This is therefore something for clinicians and researchers to be aware of when considering service users' experiences.

Like MacInnes and Masino (2019) and Barnao et al. (2015), the samples used in this meta-synthesis were predominantly male. Although there were no evident differences in the present findings and they resemble those of Long et al (2012) who interviewed female service users, one should generalise with caution, particularly due to the differences of presentations between males and females highlighted in the literature (Hussain et al., 2020; Russell & Siesmaa, 2017). Future research may, therefore, consider retrieving more data from female service users. Furthermore, most of the studies used in the meta-synthesis were limited to the UK, limiting the generalisability to different countries.

As there is only tentative evidence to support the effectiveness psychological interventions in forensic psychiatric care, future research may wish to combine qualitative and quantitative methods to better understand the effects and experiences from service users' perspectives.

5. **Conclusion and Implications**

The findings from the present meta-ethnography offer key factors from forensic service users' perspectives, which can be considered when introducing psychological interventions in forensic care. Factors such as providing clear information regarding the intervention and how this impacts one's treatment pathway are important. Interventions should be modified and tailored to individuals' abilities and preferences, with staff available in between sessions to support service users with the content if necessary. This process is enhanced by trusting relationships and ensuring a collaborative, person-centred approach is used, whilst recognising potential barriers to this in forensic care. When interventions are introduced at an appropriate pace and offer ways to develop self-insight, emotional regulatory skills and interpersonal development, they are deemed valuable to service users. Services may consider offering stepped-care approaches to psychological interventions, which initially introduce service users to the concept of such approaches and build to more detailed interventions that may explore their past. This will allow service users time to build trust in the therapeutic approach and with clinicians. Metaphors and visual handouts are deemed helpful, but further research is needed to explore the effectiveness of different therapy

models and gain female perspectives. Services should consider how they seek to evaluate psychological interventions in the future, and recognise that listening to the service users' perspectives provides rich and detailed information, which is a valuable source that can inform research and clinical practice. It is possible that the valuable aspects of psychological interventions retrieved in the present meta-synthesis are difficult to capture using quantitative measures, as the qualitative approach allows for greater descriptions of internal processes. The present meta-synthesis may therefore be considered in conjunction with the quantitative evidence available.

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Paper 2

Linking the past and the present: Forensic service users' perspectives of adverse experiences and how they relate to detention in psychiatric services

Jessica Cartwright, cartwrightj2@cardiff.ac.uk

Trainee Clinical Psychologist, South Wales Doctorate of Clinical Psychology, Cardiff University

11th Floor, Tower Building, Park Place, Cardiff, CF10 3AT

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Abstract

The relationship between early adverse experiences and the likelihood of detention in forensic psychiatric services is increasingly acknowledged and yet research from the perspective of service users' remains limited. This paper captured forensic service users' experiences of adversity and how they relate to detention in secure care. Interpretative phenomenological analysis, as described by Smith, Flowers and Larkin (2009), was used to analyse interviews with eight service users, six of whom were male, in low and medium secure care. Four master themes emerged from the data: '*Living amongst adversity'; 'Managing adverse experiences'; 'Making sense of going into secure care';* and '*Coping with the past in the present'*. All participants referred to multiple adverse experiences throughout their lives and used maladaptive coping strategies to manage these. Individual differences in how they related their past experiences to their detention in secure care were evident. These different perspectives were deemed part of a process, which is facilitated by staff input and reflection. Participants discussed their experience of interpersonal difficulties and the significance of staff support. Findings are considered in relation to trauma-informed care and clinical implications for staff working in secure settings. Limitations of the study and ideas for future research are also suggested.

Key words: trauma; adversity; forensic mental health; service user perspective; qualitative; attachment

1. Introduction

A dose-response relationship exists between adverse childhood experiences (ACEs) and a range of negative outcomes later in life, including: chronic health diseases, such as cancer; risk-taking behaviours, including substance misuse; and enduring mental health difficulties, such as personality disorders and schizophrenia (e.g., Carr, Martins, Stingel, Lemgruber, Juruena, 2013; Felitti, 1998; Read, van OS, Morrison & Ross, 2005; Rosenberg, Lu, Mueser, Jankowski & Cournos, 2007; Spataro, Mullen, Burgess, Wells & Moss, 2004). The experience of adversity is particularly pertinent in the forensic population, as forensic service users report increased numbers of ACEs including verbal abuse, physical abuse and sexual abuse, in comparison to the general population (e.g., Ford et al., 2019; Levenson, Willis & Prescott, 2016; Macinnes, Macpherson, Austin & Schwannauer, 2016; Reavis, Looman, Franco & Rojas, 2013; Stinson, Quinn & Levenson, 2016). Ford et al. (2019) highlight that those who experienced four or more ACEs are more likely to be a prolific offender and a recent victim and perpetrator of violence. Adverse experiences have also been associated with substance misuse and psychopathy in this population (Bowen, Jarrett, Stahl, Forrester & Valmaggia, 2018). Research, therefore, evidences that forensic service users are more likely to have experienced early adversity and that this is strongly associated with offending behaviours and high rates of enduring psychiatric diagnoses.

Although the detrimental impact of ACEs is increasingly recognised, many psychiatric diagnoses that are highly prevalent in forensic settings still do not consider these in their diagnostic classifications. For example, diagnoses of personality disorders and schizophrenia are significantly more likely following early adversity (Carr et al., 2013; Rosenberg et al.,

2007; Spataro et al., 2004) and yet such experiences are not acknowledged in either of the diagnostic classifications. Forensic psychiatric services in the United Kingdom (UK) are strongly influenced by the medical model (Edworthy, Sampson & Völlm, 2016) and mental health diagnoses, in turn, determine service users' care and treatment plans. Treatment is governed by mental health legislation, hence service users are detained on an involuntary basis under the Mental Health Act (MHA, 1983, revised 2007), due to their mental health diagnoses and the risk they pose to themselves and others (Edworthy et al., 2016). Since this detention is determined by the medical model, it would be unsurprising if services are primarily focused on the assessment and treatment of psychiatric disorders, as opposed to thoroughly exploring and addressing the past experiences of service users, including experiences of abuse, neglect and trauma. This is supported by research which suggests staff are unlikely to ask mental health service users about their past experiences, particularly male service users and those diagnosed with schizophrenia (Read, Harper, Tucker & Kennedy, 2018; Read, Sampson & Critchley, 2016). Given that these groups constitute the vast majority of service users in forensic care, staff may be missing vital information when developing care and treatment plans. Read and colleagues (2007, 2018) highlight that in general mental health settings this lack of questioning could be for several reasons including: staff not wanting to further distress service users; their beliefs that such experiences are irrelevant to the presenting difficulties; that enquiry could be misleading; and because staff do not feel equipped to respond appropriately.

Given the body of research demonstrating the significance of trauma and adversity, it seems paramount that forensic services look beyond individuals' offences and mental health

diagnoses and consider the broader context of their lives. This will help staff to view individuals as a person and not just a service user, by having an increased understanding of what led to their presenting difficulties (Edwards, Dube, Felitti & Anda, 2007; Hörberg, 2018). This will further enable them to formulate individual treatment needs and adopt a caring and compassionate approach (Hörberg, 2018; Read, Hammersley & Rudegeair, 2007). Hörberg (2018) highlights that it is staffs' role to help forensic service users gain a better understanding of themselves, and to introduce them to discussions about how the past impacts the present and future, and how the present is influenced by the past. However, this role cannot be fulfilled if services do not thoroughly acknowledge service users' lives and any adversities they have encountered, particularly as service users are unlikely to disclose such experiences spontaneously (Read et al., 2007). Policies and 'best practice' guidelines encourage a collaborative approach to service users' care (e.g. Department of Health, 2001, 2005, 2006, 2010; Georgiou, Oultram & Haque, 2019; Kenney-Herbert, Taylor, Puri & Phull, 2013). However, the very nature of the setting, including the restrictive nature of forensic care, may prevent staff from always being able to implement this approach. If discussions around the past and the present do not take place, it brings into question whether individuals will reach their full potential in recovery, as some service users have highlighted the significance of having such discussions in relation to them moving forward (Laithwaite & Gumley, 2007). This is in line with many psychological models, for instance schema therapy (Young, 1999), which acknowledges that in order to address present problems one must address what has happened in the past. Therefore, it is possible that if service users do not recognise a relationship between their past and their present, this may limit their ability to change and progress with their treatment.

In keeping with the idea of a collaborative approach and contributing to the trauma-informed literature, Lothian and Read (2002) discovered that many mental health service users recognise a relationship between their experiences of abuse and their mental health difficulties. Yet this perspective is not understood from forensic service users' points of view. To date, most of the research in this area has focused on non-forensic populations, or has acknowledged a relationship between past adversity, offending behaviours and mental health difficulties, without considering the service users' perspectives. However, service users can add rich and valuable insight, which may help determine service development and has been argued to be the foundation of effective treatment (Carey, 2016; Stay & Stephens, 2013). The present study, therefore, offers a view of this relationship from the forensic service users' perspectives. Firstly, it aims to explore how service users' make sense of their past adverse experiences. Secondly, it aims to explore whether service users consider their adverse experiences to be related to their detention in secure care. It is hoped this information will contribute to our understanding of the life experiences of forensic service users and will inform clinicians and researchers of how they relate such experiences to their detention in secure care, which Hörberg (2018) argues is a vital role for forensic services. This, in turn, will help to inform the forensic services approach to the development and implementation of service models and interventions that recognise and address past adverse experiences.

2. Methodology

2.1 Design

A qualitative design was used with semi-structured interviews to gather information from service users. Interpretative phenomenological analysis (IPA; Smith, Jarman & Osborn, 1999) was used to identity themes related to how participants make sense of their past experiences and coming into secure care.

2.2 Research Site

The research took place in the UK, in a secure hospital for adults in medium and low secure wards. This hospital has seven wards, predominantly for males, as only one ward is a medium secure unit for female service users. The hospital uses a multi-disciplinary approach with psychiatry, psychology, occupational therapy, social workers and nurses, but is predominantly determined by the medical model. The psychological approaches used are typically integrative, and range from positive behavioural support, cognitive behavioural therapy, dialectical behavioural therapy, acceptance and commitment therapy, and compassionate focused therapy. All service users were detained under the MHA (1983, revised 2007) and were deemed to be an ongoing risk to themselves or others.

2.3 Participants

Eight participants were interviewed in the present study, based on the recommendations made by Turpin et al. (1997). The researcher had no pre-existing relationships with the participants. Six participants were male, representing the larger proportion of males at the research site. Six participants were transferred to the hospital from prison and the remaining two participants were transferred from secure hospitals. The average age of participants was 41 and an overview of the participant details can be seen in Table 1. Pseudonyms have been used for confidentiality purposes.

Inclusion criteria

- Aged 18 years old and over
- Can provide informed consent
- Assessed by responsible clinician, nurse in charge or ward psychologist as able to participate in relation to their risk to self and others
- Has no significant communication difficulties that might impair their ability to describe their experiences and thoughts
- Is able to communicate in the medium of English

Exclusion criteria

- Aged 17 years old or younger
- Cannot provide informed consent
- Has been assessed by responsible clinician, nurse in charge or ward psychologist as unable to participate due to the level of risk to self or others
- Has significant communication difficulties, which impair their ability to describe their experiences and thoughts
- Is unable to communicate in the medium of English

Table 1. Overview of participants

Participant	Gender, age range in years	Ethnicity	Ward security	Length of stay in secure services	Length of stay at research site	Diagnosis
1. David	M, 20 – 29	White, British	Medium	6 - 10 years	<1 year	Schizophrenia
2. Edward	M, 30– 39	White, British	Medium	6 - 10 years	<1 year	Antisocial and borderline personality disorder
3. Adam	M, 30 - 39	White, British	Low	11 - 15 years	2 - 5 years	Schizophrenia
4. Mel	F, 30 – 39	White, British	Medium	11 -15 years	2 - 5 years	Psychotic Depression
5. Tom	M, 20 – 29	White, British	Low	11 - 15 years	2 - 5 years	Learning disability
6. Brian	M, 50 – 59	White, British	Low	6 - 10 years	2 - 5 years	Major depressive disorder with psychotic features
7. Graham	M, 60+	White, British	Low	<1 year	< 1 year	Psychosis
8. Emma	F, 20 - 29	White, British	Medium	1 – 5 years	<1 year	Borderline personality disorder

2.4 Recruitment

The researcher attended a clinical governance meeting at the hospital site to discuss the proposed research project. Both staff and service users were present at this meeting, which enabled the researcher to gather feedback and promote the research throughout the hospital. Psychologists within each multi-disciplinary team (MDT) were given participant information sheets (Appendix B) and consent forms to be contacted by the researcher for potential participants (Appendix C), which they shared amongst their teams. In line with IPA, the MDT purposefully considered and approached participants who met the inclusion criteria (Smith et al., 1999). The researcher contacted the psychologists at the research site to arrange an interview time for those who had signed a consent form. On the day of the

interview, the responsible clinician, psychologist or nurse in charge ensured that the participant was able to participate.

Fifty-three potential participants across five wards on site were considered by MDTs. Out of these, 29 were deemed suitable to be invited to take part and the remaining service users were typically deemed unsuitable due to their current mental state. The MDTs purposely approached those who they believed would be best able to engage at interview based on the severity of their mental health symptoms and how likely these would be to impact their ability to engage, in order to minimise disappointment for those no longer required once they had agreed to be contacted. Sixteen individuals gave consent to be contacted by the researcher and seven service users declined due to a lack of interest. Two wards on the hospital site did not approach any individuals as enough participants had been retrieved. The final eight participants were determined on the basis of: clinical judgement on how much detail they would be able to provide in the interview based on the severity of their mental health symptoms and their availability on the dates for interview. One individual decided not to participate on the day of the interview and so another participant was asked.

2.5 The interview

A draft interview schedule was presented at the clinical governance meeting and service users in attendance were invited to comment and make suggestions. Service users agreed that the interview questions were appropriate for the aims of the research. They also

suggested providing a copy of these during the interview which was done. An overview of the interview schedule can be seen in Appendix D.

Prior to the interview, the researcher and participant went through the participant information sheet together before the participant gave their signed consent to take part (Appendix E). The interview was audio recorded and took place in a private room off the ward. A psychologist based at the secure hospital was present during each interview as an escort, due to the hospital's lone working policy. Participants were provided with a copy of the core interview questions and an overview of common adverse experiences to refer to during the interview (Appendix F). The interview lasted between 25 and 50 minutes. Following the interview, participants received a debrief form (Appendix G) and £5 Amazon voucher. Each interview was manually transcribed by the author and anonymised for confidentiality purposes. Once transcription had taken place, the audio recordings were deleted.

2.6 Analytic strategy

The IPA six stage process outlined by Smith, Flowers and Larkin (2009) was followed (Figure 1). IPA aims to capture an individual's relatedness to the world, through the meanings they make of particular experiences. IPA recognises that participants are experts on their own experiences and they can offer rich and insightful understandings of these (Reid, Flowers & Larkin, 2005). This methodology felt fitting given the research aim to explore how service

users make sense of their past experiences and in relation to their detention in secure care. Each transcript was analysed individually and an extract of this can be seen in Appendix H. The author ensured they left at least one week in between each transcript to minimise any bias from previous analyses.

The researcher was a Trainee Clinical Psychologist who was interested in working collaboratively with individuals who receive mental health support and they recognised that this contributed to the development of the research question. The researcher also had a special interest in trauma-informed approaches. The researcher had no experience in forensic settings and predominantly worked with children in mental health services. The author made a note of their pre-existing assumptions in a reflexive diary and spoke about them openly with their supervisor. To adhere to practices of triangulation and to ensure that the researcher's own preconceptions had not influenced the results, two supervisors separately analysed a proportion of the data to compare to the researcher's analysis (Carter, Bryant-Lukosius, DiCenso, Blythe & Neville, 2014; Reid et al., 2005). Although it is acknowledged that there is no single interpretation of the data, no significant differences were retrieved in this process. The researcher also followed Ahern's (1999) reflexive bracketing advice throughout the analysis to minimise bias and enhance validity. A reflective diary and regular supervision were used to highlight the researcher's values and preconceptions, as noted above, and to record and discuss any thoughts, feelings and preconceptions which arose throughout the project. An extract of the author's reflective diary can be seen in Appendix I. Although it is recognised that IPA does require some level of

interpretation, it was believed that the reflexive bracketing helped to minimise how much the researcher's biases and assumptions influenced the interpretation of the data retrieved.

Each transcript revealed numerous themes and these were pulled together to create overarching subthemes (see Appendix J for an example of how the sub-theme 'being let down by others' was devised). These sub-themes were then organised into master themes (Table 2). The criteria of these themes was determined by their relevance to the research question and the depth of interview data which supported them.

Figure 1. The six steps of IPA (Smith, Flowers and Larkins, 2009)

1. Reading and re-reading: The analyst immerses themselves into a transcript to become more familiar with the data
2. Initial noting: In the right margin, the analyst notes anything of interest and examines the semantic content and language use in the data.
3. Developing emergent themes: Draw upon the data and analysis retrieved in step two to retrieve patterns, repetitive topics and emergent themes. This is noted in the margin to the left of the data
4. Searching for connections across emergent themes: The analyst maps how they think these themes fit together to form super-ordinate themes
5. Moving to the next case: The analyst then moves on to the next transcript and completes the above process
6. Looking for patterns across cases: This stage looks for higher order concepts which the cases share and retrieves overarching themes of the whole data set

2.7 Ethics

Sponsorship was obtained from Cardiff University (Appendix K) and ethical approval from the NHS IRAS system (Appendix L). The project was also approved by the host organisations research and governance committee.

3. Results

Four master themes were identified using IPA. An overview of these together with the sub-themes are provided in Table 2, along with the participants these themes relate to.

Table 2. Master and sub-themes retrieved from the interviews

Master Themes	Sub-themes	Participants
Living amongst adversity	1. *Victims of abuse and adversity*	David, Edward, Adam, Mel, Brian, Tom, Graham, Emma
	2. *Being let down by others*	David, Adam, Mel, Tom, Brian, Emma
	3. *Seeking acceptance and approval*	David, Edward, Tom, Brian, Graham, Emma
Managing adverse experiences	1. *Internalising the pain*	Edward, Adam, Mel, Tom, Brian
	2. *Externalising distress*	David, Edward, Adam, Brian, Emma
Making sense of going into secure care	1. *Taking responsibility for actions*	David, Edward, Adam, Mel, Brian, Tom, Emma
	2. *Acknowledging the impact of past experiences*	Edward, Tom, Brian, Adam, Graham, Emma
Coping with the past in the present	1. *Avoiding the past*	David, Edward, Adam, Brian, Graham
	2. *Living in fear of rejection*	Edward, Adam, Brian, Emma
	3. *The benefits of talking*	David, Edward, Adam, Mel, Brian, Tom, Emma

3.1 "It was the worst time": Living amongst adversity

This theme reflects what it was like for participants living amongst adversity before going into secure care.

"I haven't had a life": Victims of abuse and adversity

All participants spoke about being a victim of abuse at some point in their "chaotic" lives (Edward). They referred to multiple adverse experiences including physical, emotional, sexual and verbal abuse, being bullied at school, adoption, living away from parents, bereavement, having parents in prison, exposure to substance misuse and parental separation. Individuals referred to themselves as a "target" (Edward) for this abuse, particularly from their parents, and it seems that these experiences made them feel like they "haven't had a life" (David). Instead, there was a sense of grief and sadness as they thought about their lives and "how it could [have] been" (David).

> "Anything that went wrong in the house, I'd get blamed for you know and, on the occasion, beaten" (Edward)

> "I had a father that took the micky out of me and a mother that treated me with contempt, always putting me down" (Brian)

Many grew up with parents in a violent relationship and would "get in between them" (Mel), wanting the violence to stop but felt powerless to do this. Participants created the impression that they felt invisible, even when they were the "target". Three of the participants (David, Tom and Graham) described experiencing childhood sexual abuse, either by a trusted figure or a stranger, and some had more vivid memories of this than others.

> "…he was like asking me to touch his below parts and kiss him all the time and stuff" (Tom)

Being a “target” was also apparent for some throughout adulthood, for example, Mel referred to being “on the run a lot” (Mel) and having to change her identity due to being in an abusive relationship.

“I feel abandoned”: Being let down by others

Throughout their lives participants said that they had a lack of support and no one to turn to. This was reinforced by cultural expectations and not feeling listened to when they did seek help from professionals and their families. Participants described how this made them feel “unwanted” (David), “abandoned” (Emma) and “very lonely” (Brian), which created the impression that they felt helpless and let down by others.

> “I told the police everything… they weren’t listening to me” (Emma)
>
> “I remember telling my nan and grandad…that mum and dad…used to slap us, and my nan and grandad said well just put books down your arms, because I was from an Irish family… it’s just the norm” (Adam)

“I would do anything to fit in”: Seeking acceptance and approval

Many participants described feeling rejected and inferior to others throughout their lives. Yet they longed for approval, to feel good enough and to receive love and acceptance from others. For instance, Emma regularly compared herself negatively to her sister, suggesting

she did not feel good enough in comparison. Brian seemed to dedicate his life to seeking his parents' approval and proving to them that he was good enough.

> "I wanted to prove that I wasn't a lost cause" (Brian)

As participants did not receive this acceptance and approval from their families, some sought it elsewhere, leading them to associate with antisocial peers and in some cases, engage in offending behaviours.

> "I would do anything to fit in and I started rolling with gangs and stuff like that, and... I was selling drugs" (Edward)

Despite the abuse that participants were subjected to by their caregivers, it was evident that they still wanted to maintain a connection with them and found ways to rationalise their abusive behaviours. Edward for example said "I forgive you and I know that all you wanted was the best in me" when referring to his father who physically and emotionally abused him.

3.2 "That person [I] was hurting so much": Managing adverse experiences

This theme refers to how individuals managed the impact of adverse experiences before going into secure care. Two themes emerged which refer to participants internalising and externalising their difficulties and distress.

"I'm a self-destructor": Internalising the pain

Participants regularly made sense of their abusive experiences by blaming themselves and reacted by "shutting down" (Tom) and keeping things "bottled up" (Adam). This was related to the theme 'being let down by others' as participants had no one to turn to. Consequently, participants developed negative self-concepts that there "must have been something wrong" with them (Brian) and they "can't do anything right" (Edward). They described how there is only so much an individual can tolerate and that they "just couldn't cope with life" (Mel). With no one to turn to, they used self-destructive coping strategies to "escape" (Adam) from their realities, including self-harm, suicide attempts and substance misuse.

> "I think you sort of internalise it... you try and hurt yourself because you can't tell anyone… it's like a balloon, if you carry on putting water into it, and water into it and water into it, until it gets massive and all of a sudden it just explodes" (Adam)

Participants, therefore, experienced distress that was unbearable but did not have sufficient ways to cope with this, and so, resorted to extreme measures to try and alleviate some of this pain.

> "I just wanted to die, I wanted to die quickly. Several suicide attempts [pause], but they were all half-hearted because I didn't really mean it" (Brian)

Feeling alone and helpless, participants also used these self-destructive behaviours as extreme measures to seek support or a response from others. For example, Mel referred to

setting herself on fire, which was interpreted as a desperate cry for help. Participants were, therefore, willing to put their lives on the line to get support, suggesting how desperate they felt.

> "It was lucky it was caught [fire] when it did. I was in hospital on an acute ward when I did it, and…I rang the emergency button" (Mel)

"If I hurt five people, I'm not hurting anymore": Externalising distress

In addition to internalising this distress and taking it out of themselves, participants also externalised their distress on to others. This seemed to have multiple functions, including a way to express and get rid of the pain they felt. Emma for example refers to "taking it out" on her family, suggesting that aggression and violence physically released some of her internal distress. Hurting others was therefore used as a way to manage distress and distance themselves from these difficult feelings.

> "If… I hurt you… part of me wants you to take some of my pain… so if I hurt five people, I'm not hurting anymore" (Adam)

Some participants also seemed to hold the narrative that "violence works" and "the strongest and fittest survive" (Adam) and, therefore, it seems that violence was also used as a way to earn respect and status. This was also interpreted as a way to protect themselves from feeling vulnerable like they had been before. Additionally, some participants seemed

to feel so helpless that they used violence as way to provoke others to hurt them, therefore, relating to the theme of self-destruction.

> "I attacked the nurses, the patients and the staff… Kept having dirty protests, flicking food and faeces all around the room, shouting at night, banging the door until someone came [in prison]. I wanted someone to kill me you see. I didn't have the guts to do it myself, so I wanted someone to do it for me." (Brian)

3.3 "All life experiences sort of shape you": Making sense of going into secure care

This theme reflects service users' perceptions of how their past could be related to their current circumstances in secure care. Two themes emerged which suggest that there is a process to developing such insight and individual differences were evident.

"It was my decision": Taking responsibility for actions

When asked how they make sense of their detention in secure care, most of the participants referred to their offending behaviours and described feeling responsible for their admission. They talked about blaming themselves and "self-loathing" (Edward) over their pasts. David emphasised the control he had over his offending behaviours, which he reinforced by using repetitive language to enhance the point that he was not susceptible to others.

> "It was my decision. Yeah. Full stop. It was my decision" (David)

In contrast, Graham seemed to relate his detention to the individual who rang the police and informed them about his offence. Graham, therefore, did not take responsibility for his

actions like the other participants, nor did he describe feelings of regret or shame. Instead, he described a happy lifestyle and minimised his actions against the victim, suggesting he did no harm and implied their accountability for his actions.

> "She [victim] was always climbing on my lap, always jumping up and down on me… I used to say 'no'…I'd say 'look I'm going to have a shower…don't come in' and she'd still come in" (Graham).

"If it didn't happen, other things wouldn't have happened later": Acknowledging the impact of past experiences

There were varying degrees to how participants made sense of their pasts and how they could have impacted them throughout life in the research interviews. Some participants did not describe a relationship between their past and present circumstances in the interviews, and it seemed that they were unable to, or did not want to, articulate or envisage this relationship when asked about it. Mel for example noted that she "can't really explain that one", as it seemed too complex to explore. At times it was wondered whether the participants had understood the questions and, therefore, the researcher adopted more direct questioning to facilitate this. This did not reveal any further information however and these participants still seemed to have the perception that the past was not influential to the present.

In contrast, others discussed their view that there could be a relationship between the past and the present. Tom for example, noted that there is a "link to behaviours and chains of

behaviours that's happened in the past". When asked to elaborate on this relationship however, participants seemed to find this more difficult. It seemed that this perspective was facilitated by staff input, as some made reference to working with a psychologist who had helped introduce them to this outlook and things they "need to understand more about" (Tom). This was apparent for Adam who seemed conflicted by such views, as he first highlighted that he could not be affected by the past but later noted that his psychologist introduced him to this new perspective.

> "…I think every…life event…makes you the person that you are. We've done some work on that and you [psychologist] were saying like if you were… kidnapped and with drug cartels… then you'd be a completely different person than you are now. So I think… all life experiences sort of shape you yeah" (Adam)

It seems that for most participants this perspective facilitated greater self-insight, whereas for Graham, this relationship between the past and the present may have been used to help justify his offending behaviour.

> "I would say at the time I didn't see any, it didn't give me any harm, in fact a bit exciting… the fact that someone did that [sexual abuse], strange, unusual, exciting and… didn't do me any harm… if it didn't happen other things [sexual offence] wouldn't have happened later" (Graham)

3.4 "I sit with these things on a daily basis": Coping with the past in the present

Participants described different ways which they coped with their pasts in the present, including avoidant strategies, a reluctant approach to relationships and the benefits of support and someone to talk to.

"I just don't think about it": Avoiding the past

It was evident that some participants used avoidant strategies to cope with the adversity they had experienced throughout their lives.

> "…[I] just carried on with my life the best I could but I was very upset and I hid it, that upset, from others" (Graham)

This was apparent during the interviews, as participants seemed reluctant and hesitant to talk about difficult experiences. This may be because they were not used to thinking about such experiences, as they noted that they usually try to avoid difficult memories and "just don't think about it" (Mel). It is possible that this avoidance was also apparent when thinking about how the past impacts the present, as many participants provided shorter answers, such as "I don't know" (Emma), or "the past is the past" (Mel), in comparison to the rest of their interviews. This was interpreted as difficult for participants to think about, and the use of short and concise language may have been a strategy to protect themselves from exploring this further. Furthermore, some responses were given in third person and

this was interpreted as another way to protect themselves from re-experiencing difficult emotions.

> "… they often say with divorce, people don't realise how the children cry at night, wishing that their parents were back together again, because a lot of people experience that" (Graham)

"I'm a push and puller": Living in fear of rejection

Some of the participants discussed their lack of trust in others, including the staff in secure care. Participants provided insightful descriptions of being conflicted between forming relationships and pushing people away, in case they are hurt or rejected. Participants, therefore, described living in fear of rejection, which created a "weird relationship" (Emma) with staff, where they were conflicted between wanting support and not wanting to get hurt.

> "I push people away and pull them back, I push people away, I pull them back…. When I put a bit of trust in people, I think they're going to, automatically think they're going to hurt me, they're going to go out of their way to hurt me, so, I push them away" (Edward)

This impacted participants' approaches to relationships with staff, as they were unsure whether they would respond to their concerns and they worried that they "could be there one minute and gone the next" (Emma).

> "If I report it [bullying] to the staff… I don't know if they're doing anything about it" (Tom)

When prompted to explore this further, some participants made insightful links to how their previous experiences of being let down by others, including their families, impacted their trust and approaches to relationships.

> "Say my dad or something like that, that someone you are supposed to trust or someone that you look up to or someone you respect, they're supposed to look after you, end up hurting you, then you can't trust anyone really then can you?" (Adam)

"It feels good getting it off my chest": The benefits of talking

When asked what may have prevented them from coming into secure care, some suggested having support and someone to "come and talk to me every day" (Mel). Secure care seemed to offer this opportunity, as many referred to the importance of having staff support. This contrasted the theme 'being let down by others' and highlighted the significance of support to participants, even though they had minimal trust in others. Graham was the only participant who did not discuss this, but it was wondered whether this is because he was fairly new to the service and relied on his faith in God for support. Most participants

referred to the staffs' availability to talk to them as being the most helpful aspect of their detention in secure care, and more specifically, some highlighted the benefits of the psychology input they had received. Participants seemed to relate this to moving forward, as they felt acknowledged and learnt new ways of coping with difficult experiences.

> "Knowing I'm talking to someone who cares, someone that's interested in what I have to say, it means a lot, just half hour chat with someone, it means a lot, it helps make me feel a bit better… They give me some good advice, and tools and techniques... to cope with things when I'm feeling low and… I use my mindfulness" (Brian)

Some participants also commented on the benefits of the research interview. For Graham, the interview was the first time he disclosed his experience of childhood sexual abuse. The interview seemed to help some of the participants feel listened to, develop insight and reflect on their current circumstances and coping strategies.

> "I feel a bit choked up like, but um… it's just like getting things off my chest… it's good like that because I uh, I feel a bit better when I've talked about it, it's like people are listening you know" (David)

> "I didn't think I knew so much about myself… I didn't know I had as much insight as I do… it's opened my eyes to a few things, like my self-destructiveness" (Edward)

4. Discussion

This study aimed to explore forensic service users' perspectives of their adverse experiences and discover how they relate such experiences to their detention in secure care. Using IPA, four master themes emerged, which related to: living amongst adversity; managing this adversity before secure care; linking their past to their current circumstances; and coping with the past in the present.

All participants described experiencing multiple adversities throughout their lives. This is not surprising given the high rates of adverse experiences reported by those in the prison population and by those is secure care (e.g. Ford et al., 2019; Levenson et al., 2016; Reavis et al., 2013; Stinson et al., 2016). Bowlby's attachment theory (1969) and its relation to developmental trauma (Rahim, 2014), provide a useful theoretical framework to give meaning to the participants' experiences. Bowlby (1969) asserts that our early experiences of relationships, particularly with our primary caregiver, form an individuals' internal working model. This model provides a template of an individual's beliefs about themselves and their expectations of others. When a secure attachment is not available and a child is maltreated by their primary caregiver, individuals may develop negative self-concepts and beliefs that their external world is dangerous and that others cannot keep them safe (Rahim, 2014; Tezel, Kislak & Boysan, 2015; van der Kolk, 2005). This was apparent for most participants in the present study, who showed that such negative self-concepts led to blaming themselves for their adverse experiences, which is consistent with research that associates developmental traumas to higher feelings of shame (Schimmenti, 2012; Wilson, Droždek, & Turkovic, 2006). These factors can, in turn, contribute to individuals experiencing

difficulties tolerating their own emotional states and forming stable relationships (Rahim, 2014; Tezel et al., 2015; van der Kolk 2005). In line with Nehls (1999), participants in this study made use of self-destructive behaviours, such as self-harm, as one way to cope with these experiences. Avoidant strategies were also used to cope with past traumas and participants tended to employ such strategies during the interviews, by providing shorter and more concise answers when exploring difficult topics. Additionally, participants tended to use language to distance themselves from the trauma or by talking about these experiences in the third person; this has been shown to reduce physiological responses in the short-term (Wisco, Marx, Sloan, Gorman, Kulish & Pineles, 2016). This avoidant approach is common for individuals who have been exposed to adversity, as they are likely to try and avoid the recurrence of such emotions (van der Kolk, 2005).

During the interviews, some participants noted that if support had been available in the community, their lives might have turned out differently. This raises the question of the importance of community services for those more vulnerable to adversity, which aim to prevent and minimise incarceration/detention in hospital and unhelpful coping strategies (Lamberti, Weisman & Faden, 2004; Harrington & Bailey, 2003). However, none of the participants referred to such support until they discussed their detention in forensic psychiatric services. Instead, they discussed having no one to turn to or feelings of being let down and rejected by the services they had approached. It could be inferred that the 24-hour support available in secure care helps individuals to feel safer, both physically and emotionally. This notion may be reinforced by the present findings as participants did not refer to the secure environment as retraumatising; contrary to Muskett's (2014) paper,

which suggests some restrictive practices in forensic care can be perceived as retraumatising. The supportive environment in secure care might, therefore, be particularly helpful, as Adshead (1998) suggests it could resemble a positive attachment figure for service users, which helps them to form more secure attachments and challenges their maladaptive beliefs about others and the world. Future research may explore how the secure environment, in comparison to community services, helps individuals to feel more contained and perhaps interplays with individuals' interpersonal difficulties and beliefs about themselves and others.

There were evidently varying degrees to which participants spoke about the relationship between their past adverse experiences and their detention in secure care. It is acknowledged that factors such as the interview content and the participants' relationship with the researcher may have influenced how much participants opened up about this, and therefore, this finding does not necessarily reflect participants' limited understanding of the relationship between the past and the present. When participants did describe a relationship between their past and present, this seemed to be part of a process that is facilitated by staff enabling them to begin to explore and make sense of this relationship. For instance, some participants did not seem to overtly link their past and their current situation in secure care during the interview. It seemed that this was difficult for them to explore, either because this was too emotionally challenging or because they were not used to thinking about this relationship. By comparison, other participants did acknowledge the personal impact of their past in the interviews, as found by Lothian and Read (2002). However, participants seemed to find this difficult to discuss in any detail. In line with

Hörberg's (2018) suggestions, some participants implied that their work with psychology had developed their insight into this relationship and had helped them to make sense of their current circumstances. Acknowledging this relationship, therefore, seemed to facilitate greater self-insight for most participants, whereas, for one individual it seemed to help justify their offending behaviour. One explanation for this difference could be that this participant had recently been admitted to secure care and, therefore, had not been given the opportunity to work more intensely with a psychologist or other professionals. It could be inferred that the process by which individuals make sense of their past and present circumstances may, therefore, be related to formal psychological interventions, which explore this relationship in detail. However, this was not examined in the present findings and may be an area for future research to explore. For example, future research may focus on comparing individuals who are open to thinking about the impact of the past, with those less inclined to do so, and determine how much staff input, particularly formal psychological interventions, plays a role in this.

Participants were able to provide insightful accounts of their approaches to relationships and their continuous fears of being rejected and hurt. This was described by one participant as the notion of 'push and pull', wanting to form close relationships but pushing people away in case they get hurt and rejected. With prompting, some participants were open to associating these interpersonal difficulties with their past adverse experiences. This supports the notion that there is a process by which participants can make insightful connections between their past and present, that is facilitated by staff input. This interpersonal style is common for individuals who have experienced adversity throughout

their lives and this relationship is thought to be mediated by early maladaptive schemas (Tezel et al., 2015). Such interpersonal styles are often displayed by those diagnosed with borderline personality disorder (BPD); a common psychiatric diagnosis in forensic psychiatric settings (Carr et al., 2013). For staff, this can be perceived as resistant and emotionally distressing, and consequently, staff may face challenges to form therapeutic alliances, which may impede progress in service users' treatments and require further supervision (Bourke & Grenyer, 2013). This may be exacerbated if staff resemble an attachment figure for service users, as service users may become increasingly distressed when this relationship is threatened, for example, when approaching discharge or if a staff member leaves (Adshead, 1998). However, as the present findings imply, it is important for staff to recognise that such interpersonal approaches often stem from a place of fear, as opposed to service users wishing to cause any distress to others or simply being a symptom of a disorder. This notion supports Nehls (1999) who highlights how destructive behaviours are a way to control individuals' pain, instead of controlling other people.

4.1 Clinical Implications

Trauma-informed care (TIC) refers to delivering services that recognise the impact of past traumas across the lifespan, to influence organisational initiatives, workforce development and trauma-focused interventions (Hanson & Lang, 2016; Levenson & Willis, 2019 Levenson et al., 2016; Muskett, 2014; Sweeney, Clement, Filson & Kennedy, 2016; Sweeney, Filson, Kennedy, Collinson & Gillard, 2018). The present findings support the need for all forensic services to adopt this approach, whilst considering the impact of developmental trauma from an attachment-based perspective (Rahim, 2014).

For services to adopt a trauma-informed approach, it is vital that staff have a thorough understanding of the long-term impacts of adversity. Services including both community and inpatient settings, could facilitate staff to recognise their significance in service users' recovery, for example, how they may resemble an attachment figure for service users, which may lead to service users becoming increasingly distressed when this relationship is disrupted (Adshead, 1998). Training on trauma-informed approaches and attachment theory might therefore be considered, which could be supported further via reflective practice sessions and trauma-informed supervision. Services could also consider how they minimise disruptions in the staff and service user relationship, for instance, by introducing long-term key workers for services users and, where possible, communicating any changes to this relationship in advance. A safe environment that encourages reliable and persistent relationships will help service users learn to build trust and feel safe. These factors should also be considered by community services, given many participants described feeling let down or unsupported until they were detained in secure care. Future research could determine whether staff in forensic services support this trauma-informed approach and whether further training and organisational initiatives are required to enhance their understanding in this area.

Participants' insight regarding the relationship between their past and present circumstances varied and seemed to be facilitated by staff input. As Read et al. (2007) suggest, this highlights the importance for staff facilitating trauma-informed conversations and using direct questioning, particularly because service users are unlikely to disclose these experiences spontaneously. This was evident in the present research, as participants

generally talked more broadly about their pasts until they were asked directly about adverse experiences. This approach facilitated individuals to open up, and for one participant, the interview was the first time he disclosed his experience of childhood sexual abuse. These findings support Hörberg (2018) and highlights the importance of encouraging such discussions with service users, to see them as a whole person and to formulate how their past impacts the present and the future, and how the present is impacted by the past. This means staff should be supported to feel confident to have such conversations, particularly as they may not feel competent to respond appropriately (Read et al., 2007; 2018).

In some cases, when service users had been introduced to or were more open to this formulation, it seemed to provide individuals with greater self-insight and understanding; an approach in line with TIC (Levenson & Willis, 2019; Levenson et al., 2016; Muskett, 2014; Sweeney et al., 2016; 2018). Such findings support the use of specific psychological interventions, which consider this relationship and aim to facilitate some of the difficulties individuals may consequently experience. Compassion focused therapy, for instance, aims to help individuals who experience shame and self-criticism develop compassion towards themselves and others (Gilbert, 2010). This has been used for those who experience shame in relation to trauma (Au, Sauer-Zavala, King, Petrocchi, Barlow & Litz, 2017; Lucre & Corten, 2012; Irons & Lad, 2017). Dialectical behaviour therapy aims to introduce individuals to emotional regulatory and interpersonal skills, which as demonstrated in the present study participants found difficult (Linehan, 1993). Schema focused therapy addresses early maladaptive schemas and individuals' maladaptive coping strategies (Young, 1999), and has been adapted for forensic settings (Bernstein, Arntz & de Vos, 2007). As the trauma-

informed literature and present findings suggest, individuals' care and treatment should be determined by a detailed person-centred formulation, which moves away from the medical model perspective of 'what is wrong with this person?', to a more trauma-informed approach of 'what has happened to this person?' (Rahim, 2014; Sweeney et al., 2016; 2018).

Given some of the coping strategies participants had adopted, for example, avoidance, or in one case, minimising their offending behaviours, it is important to consider the impact this could have on staff and teams (Adshead, 1998). Graham, for example, seemed to minimise the effects for the victim and blamed them for his actions, which is common for individuals who have committed offences of a sexual nature (Nunes & Jung, 2013). During the analysis process, the researcher recognised feelings of discomfort when trying to empathise with Graham's perspective (see Appendix I). Supervision and reflexive bracketing were, therefore, paramount to minimise bias and transference in the data. This implies the significance of regular supervision for staff working clinically in secure care (Davies, Maggs & Lewis, 2010; Hörberg, 2018; Moore, 2012). Furthermore, services could ensure that resources such as team formulations, psychological training and reflective practice are available to provide staff with a shared understanding of how an individuals' past experiences may impact on them now (Lake, 2008; Hörberg, 2018). It is believed that this understanding will enhance staffs' empathy in their approach to care (Summers, 2006).

4.2 Limitations

It is possible that having a psychologist present in each of the interviews impacted the data retrieved. For instance, participants may have purposefully talked about their experience of working with a psychologist to project a positive impression. Although service users were made aware that participation would not influence their care. Additionally, participants' answers may have been influenced by their relationship with the researcher. Adam, for example, highlighted that he felt embarrassed talking to the researcher as he did not want to appear "weak". Some of the participants also provided contradictory information or seemed to minimise the impact of some of their experiences, and it is possible that this approach was related to their interpersonal styles to avoid rejection from the researcher. On the other hand, Emma highlighted that she found it easier talking to the interviewer as she did not have a pre-existing relationship. Individual differences were, therefore, apparent and it is plausible that they did influence responses, however, this was not reflected in the data and participants generally seemed to be very honest about their experience of the interview.

It is recognised that this study did not explore the psychology input participants had previously received. As suggested, it is plausible that formal psychological interventions introduce individuals to the relationship between the past and the present. It is possible that in the present study, those who had more insight to this relationship were more likely to have engaged in psychological interventions, however, this cannot be concluded from the present findings. Future research is suggested to explore this further. Additionally, this study recommends that forensic services adopt a wider trauma-informed approach, and this would involve all interactions and discussions with staff, including more informal support. However,

this study did not determine how this informal support may be influential, nor did it determine how such support may compare to more formal interventions; future research could explore this, to further inform the overall environment of forensic settings.

Additionally, IPA employs a double hermeneutic, which means interpreting and making sense of individuals' accounts and understandings of their lives. Steps were taken to ensure validity and the themes retrieved reflected individuals' experiences of adversity and how they made sense of these now in secure care. Yet it is recognised that this study was based on eight individuals' experiences, predominantly males, from one low and medium secure hospital in the UK. These factors impact on how much the findings can be generalised outside of this context. Furthermore, it is recognised that if replicated, it is possible that different themes may emerge due to individual differences in experiences and interpretations.

5. Conclusion

In conclusion, the forensic service users who participated in the present study had all experienced multiple traumas throughout their lives. These experiences led to them internalising and externalising the resultant pain and use avoidant strategies. There were differences with how participants related their past experiences to their current situation in secure care and this was related to an ongoing dynamic process, which seemed to be facilitated by staff input. These findings have implications which support the utility of a trauma-informed approach in forensic services, and suggest that further research needs to

explore whether staff are on board with this. Findings are described from an attachment and developmental trauma perspective, which support the use of trauma-informed care. Further implications are related to the importance of the staff and service user relationship, shared formulations, trauma-informed interventions and staff knowledge and support. Limitations of the present study have been outlined, including potential bias in data collection and an IPA approach.

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Appendices

Appendix A. Journal of Forensic Psychiatry and Psychology instructions for author

About the Journal

The Journal of Forensic Psychiatry & Psychology is an international, peer-reviewed journal publishing high-quality, original research. Please see the journal's Aims & Scope for information about its focus and peer-review policy.

Please note that this journal only publishes manuscripts in English.

Preparing Your Paper

Original manuscripts

- Should be written with the following elements in the following order: title page (including Acknowledgements as well as Funding and grant-awarding bodies); abstract; keywords; main text; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figure caption(s) (as a list).
- Should be no more than 5000 words, inclusive of the abstract, tables, figure captions, footnotes, endnotes.
- Should contain an unstructured abstract of 200 words.
- Should contain between 3 and 6 **keywords**. Read making your article more discoverable, including information on choosing a title and search engine optimization.
- Please include a word count.

Review articles

- Should be written with the following elements in the following order: title page (including Acknowledgements as well as Funding and grant-awarding bodies); abstract; keywords; main text; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figure caption(s) (as a list).
- Should contain an unstructured abstract of 200 words.
- Should contain between 3 and 6 **keywords**. Read making your article more discoverable, including information on choosing a title and search engine optimization.
- Review papers (e.g. systematic reviews, meta-analyses, law reviews) and some empirical studies may require greater length than regular articles and the Editors are happy to receive longer papers. We encourage brevity in reporting research.
- Please include a word count.

Format-Free Submission

Authors may submit their paper in any scholarly format or layout. Manuscripts may be supplied as single or multiple files. These can be Word, rich text format (rtf), open document

format (odt), or PDF files. Figures and tables can be placed within the text or submitted as separate documents. Figures should be of sufficient resolution to enable refereeing.

- There are no strict formatting requirements, but all manuscripts must contain the essential elements needed to evaluate a manuscript: abstract, author affiliation, figures, tables, funder information, and references. Further details may be requested upon acceptance.
- References can be in any style or format, so long as a consistent scholarly citation format is applied. Author name(s), journal or book title, article or chapter title, year of publication, volume and issue (where appropriate) and page numbers are essential. All bibliographic entries must contain a corresponding in-text citation. The addition of DOI (Digital Object Identifier) numbers is recommended but not essential.
- The journal reference style will be applied to the paper post-acceptance by Taylor & Francis.
- Spelling can be US or UK English so long as usage is consistent.

Note that, regardless of the file format of the original submission, an editable version of the article must be supplied at the revision stage.

Further information can be retrieved at the following link:
https://www.tandfonline.com/action/authorSubmission?show=instructions&journalCode=rjfp20#prep

Appendix B. Participant Information Sheet

NHS WALES GIG CYMRU

School of Psychology
Ysgol Seicoleg

South Wales Doctoral Programme in Clinical Psychology
De Cymru Rhaglen Doethuriaeth mewn Seicoleg Glinigol

CARDIFF UNIVERSITY
PRIFYSGOL CAERDYDD

Cardiff University
Tower Building
Park Place
Cardiff CF10 3AT
Wales UK
www.cardiff.ac.uk/psych

Prifysgol Caerdydd
Adeilad y Tŵr
Plas y Parc
Caerdydd CF10 3AT
Cymru Y Deyrnas Unedig

PARTICIPANT INFORMATION FORM

TITLE: What factors do service users in secure care associate with their admission, continued detention and recovery?

SPONSOR: Cardiff University

INVESTIGATORS: Jessica Cartwright; Dr Chris Hartwright; Dr Daniel Lawrence

If you need help to read this form, a person who is not part of the research team can read it to you. They will act as a witness who will sign this form to show it has been read to you. Please sign the form at the end to show you have read the form or that you have had this read to you.

Hello, my name is Jess and I am a trainee psychologist. I am talking to people in secure care to find out their thoughts about what brought them into services and what they feel is important for recovery.	

I would like to know your thoughts on what brought you into forensic services and what you think will help your recovery. This might involve talking about upsetting things from your childhood or past, but only if you want to. You will not be asked to explain these upsetting experiences in detail, but I am interested in knowing if you think they are related to your current situation in secure care. This is for a research project.	
It is important that you have all the information about the project before you decide if you want to be involved.	
Taking part in the study will involve talking about past experiences which might be upsetting for some individuals.	
If you want the interview to stop then you can talk to the interviewer. If you are upset during or after the interview, the team will be available to support you.	
It is up to you if you want to take part in the research. You are able to say no without giving a reason. Your medical care will not be affected. If you decide to take part and later change your mind, this is OK and you do not have to give a	

reason. You will be able to withdraw from the study up until the thesis is submitted in May 2020.	
If you agree to take part, the interview could last for around 1 hour.	
Your answers to my questions will be confidential. This means that I will not tell anyone else what you said, unless you tell me something that makes me worried that you or others are at risk. I will also need to tell others if you tell me about a crime that has not been reported. If I do need to tell someone else, I will try to talk to you first.	
I will be audio recording the interviews with a dictophone to make sure I record everything you say before typing it up. This will be stored securely. Once the interview has been typed up, the audio recording will be deleted unless you disclose anything related to an unreported crime.	
If you disclose information about an unreported crime, I will have to discuss this information with	

your clinical team and possibly the police. If that happens, the audio recording will not be destroyed straight away.	
You may find that some of the things we discuss are upsetting. If you become upset, you can take a break or stop the interview at any time. Support will be available from your clinical team and the interview both during and following the interview.	
The personal information (like your name) you provide will be kept private. Cardiff University is responsible for looking after your personal information and keeping it safe. You can find out more about this by looking at the Cardiff University data protection webpages: https://www.cardiff.ac.uk/public-information/policies-and-procedures/data-protection or by contacting the University's Data Protection Officer: inforequest@cardiff.ac.uk Any personal information that could identify you will be removed. No one will know it is you except us.	 
You will receive a £5 Amazon voucher to say thank you for taking the time to be interviewed.	

If you would like a copy of the results when the project is finished, I can send you a summary of these or the full report. Please let me know if you would like this, or speak to Dr Hartwright or Dr Lawrence after the study using the contact details below.	
NHS research needs to be agreed by a group of people called the Research Ethics Committee. This is to make sure you are protected. This study has been agreed by them.	 
This research will be submitted as part of a Doctorate in Clinical Psychology. It will also be submitted for publication and might be presented at conferences. No-one will be able to identify you in the project or any publications or presentations.	 
One of your care team will ask you if you want to know more about the project. Please let them know your decision. If you choose to take part an appointment will be arranged by myself (Jess). We will go through this information sheet and a consent form you will be asked to sign.	☑ I Agree
If you have any concerns about the study, you can ask to speak to speak to Dr Chris Hartwright or to	

Dr Lawrence who are helping me with the study. They can be contacted at:	

Name of Participant (Please Print):

Date:

Signature:

Name of Researcher (Please Print):

Date:

Signature:

Name of Witness (Please Print) (*if applicable*):

Date:

Signature:

Appendix C. Consent to be contacted

NHS WALES GIG CYMRU

School of Psychology
Ysgol Seicoleg

South Wales Doctoral Programme in Clinical Psychology
De Cymru Rhaglen Doethuriaeth mewn Seicoleg Glinigol

CARDIFF UNIVERSITY
PRIFYSGOL CAERDYDD

Cardiff University
Tower Building
Park Place
Cardiff CF10 3AT
Wales UK
www.cardiff.ac.uk/psych

Prifysgol Caerdydd
Adeilad y Tŵr
Plas y Parc
Caerdydd CF10 3AT
Cymru Y Deyrnas Unedig

CONSENT TO BE CONTACTED FORM

I agree to meet Jessica Cartwright  to discuss taking part in the research titled

'What factors do service users in secure care associate with their admission, continued detention and recovery?'

Please put your initials in the box if you agree ☐

_____

Hospital Ward

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person	Date	Signature

Appendix D. Interview schedule

Interview prompt sheet

Ensure confidentiality is discussed. Show the participant the participant information sheet and ensure they understand everything on there. Ask participant to complete the consent form before starting the interview.

General discussion about the study – I'm interested in having a chat with you today about your life experiences before coming into secure care and your experience of being in services. I'm going to ask you a few questions, please let me know if you feel uncomfortable and we can talk about this.

Background information:

- Age
- How long have they been at research site?
- Are they on a medium or low secure ward?
- How long have they been in secure care altogether?
- Have they received a diagnosis?

Theme: before admission

- **I'm interested to know what life was like for you before you came into services, can you tell me what your day to day looked like?**
  - What was your family life like?
  - What was your relationship like with your mum/dad
  - What was school life like?
  - What about when you were younger? What was life like growing up?
  - How did you cope with these experiences?
  - What was that like for you at the time?

- **You don't need to go into a lot of detail, but looking at the sheet in front of you, did you experience any of these or other difficult situations growing up?**
  - How did you make sense of this at the time?
  - How did you feel about that?
  - How did you cope with this?
  - Did anyone mistreat you as a child?
  - Can you tell me a bit more about this?
  - What was that like for you?
  - How did you manage this at such a young age?
  - Did you feel you had support or people to help you?

- **What impact do you think these experiences had on your life?**
  - How do you make sense of this now?
  - How did this make you feel?

Theme: admission

- **How do you make sense of your past experiences and your current situation in secure care?**
  - How do you relate your past experiences to your current situation?
  - What do you think led to you coming into secure care?
  - How do you manage this?
  - What thoughts do you have about this experience?

- **What was it first like coming into services?**
  - How were you feeling at the time?
  - What did it mean to you?
  - What was your first reaction?

- **What do you think would have had to be different to prevent coming in to secure care?**
  - can you tell me a bit more about this?
  - What would that have meant to you?

Theme: Present

- **In what way do your past experiences impact you now?**
  - Do you think your past experiences ever effect you in your present day to day?
  - Does anything in secure care remind you of your past experiences?
  - What is that like for you?
  - How does that make you feel?
  - How do you cope with this?

- **Has anything helped you manage these experiences?**
  - What helps you cope when things are difficult?

- **What we have discussed today can be difficult for some people to talk about, I wonder how has been for you?**
  - What makes it okay/ difficult to talk about it?
  - What would make it easier if you were to have a similar conversation again?

Appendix E. Consent to participate

NHS WALES GIG CYMRU
School of Psychology
Ysgol Seicoleg
South Wales Doctoral Programme in Clinical Psychology
De Cymru Rhaglen Doethuriaeth mewn Seicoleg Glinigol
CARDIFF UNIVERSITY
PRIFYSGOL CAERDYDD
Cardiff University
Tower Building
Park Place
Cardiff CF10 3AT
Wales UK
www.cardiff.ac.uk/psych
Prifysgol Caerdydd
Adeilad y Tŵr
Plas y Parc
Caerdydd CF10 3AT
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CONSENT FORM TO PARTICIPATE

Title: 'What factors do service users in secure care associate with their admission, continued detention and recovery?'

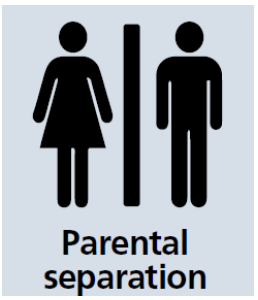
		Please put your initials in in each box below
I have read and understand the participant information sheet.		
I have had time to think about the information and have been able to ask questions and had them answers.		
I understand that taking part in this study involves talking about past experiences which might be upsetting.		

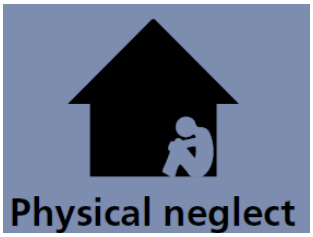
I understand that if I get upset before or after the interview, the team will be able to support me with this.		
I understand that taking part in the study is voluntary and I can withdraw without giving a reason without my care of legal rights affected.		
I understand that the interview will be audio-recorded. I understand it is possible that some of my words may be made anonymous for writing quotes in the research report.		
I understand my information will be stored securely in a filing cabinet and will be anonymised for the study.		

I understand that if I disclose anything related to either risk to myself or other people, this information will have to be shared with the Nurse in Charge on my ward.		
I understand that if I disclose an unreported crime, this information will be passed on to clinicians and police, and the interview recording will be kept.		
I agree to take part in the above study		
I would like a copy of the findings once they study has finished.		

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

Appendix F. Difficult experiences





Appendix G. Debrief form

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School of Psychology
Ysgol Seicoleg
South Wales Doctoral Programme in Clinical Psychology
De Cymru Rhaglen Doethuriaeth mewn Seicoleg Glinigol
CARDIFF UNIVERSITY
PRIFYSGOL CAERDYDD
Cardiff University
Tower Building
Park Place
Cardiff CF10 3AT
Wales UK
www.cardiff.ac.uk/psych
Prifysgol Caerdydd
Adeilad y Tŵr
Plas y Parc
Caerdydd CF10 3AT
Cymru Y Deyrnas Unedig

DEBRIEF FORM

Title: 'What factors do service users in secure care associate with their admission, continued detention and recovery?'

Thank you for taking part in this research.	
We aimed to explore service users' thoughts or what they associate with coming into secure care, their continued detention and their recovery.	
Research shows that people in mental health and forensic services are likely to have experienced adverse childhood experiences (ACEs) growing up. These might include sexual abuse, physical abuse, emotional neglect, having parents who drink and misuse substances, being fostered or witnessing domestic violence. We were interested to find out if service users relate these experiences, if they have experienced them, to their current situation and their recovery.	

It is hoped that this will improve forensic services' understanding of service users' perspectives and how they make sense of their experiences. This will help develop the design and delivery of services to ensure that a collaborative approach is used.	
If you would like a summary of the research, I can send you this after it has been submitted in May 2020.	
Please contact Dr Chris Hartwright, in the psychology department, for further information about the study: xxx He will be happy to meet with you if you have any further questions of concerns.	

Appendix H. Extract of analysis

Chaotic life An outsider Wanting to belong Substance misuse Blames self	P: I didn't, I just went into a very chaotic world of, I am, umm, I don't want to chat shit and I'm not chatting shit and he can back me up [psychologist], I found it in other resources, and I I would do anything to fit in and I started rolling with gangs and stuff like that, and, you know I was selling drugs and all that, you know what I'm saying. That's what I mean I went from everything to nothing because I became a user myself, you know.	Couldn't make sense of abuse. Went into chaos. Uses hesitant language which suggests he doesn't want to say what he did, is he worried the interviewer will judge? Felt left out, would go to extreme measures to fit it and feel accepted after not having this at home and school. Seems to not want to go into detail but checks the interviewer understands. Used drugs to cope but these took everything away from him. Blames himself for having nothing.
	R: And do you feel you had anyone to support you at that time?	
Out of control Given up	P: I didn't care man, I was, out, I was out of control, I didn't care, I didn't care what happened to me and I didn't care what happened to other people. I was too over that shit	Feels like he had given up trying. He had once cared but this didn't get him anywhere, he had to take a different approach to cope. He became 'out of control' with his behaviours?
	R: So what, what impact, you know those difficult experience you talked about when you were young, at home and in school what impact do you think they had on your life?	
Difficult topic Drug use	P: Well I didn't finish school, I just, like I said I just started finding solace in other things, you know, and, yeah.	Due to becoming 'out of control'? Found comfort using substances Hesitant and avoids going into detail, seems like a difficult topic to reflect on

	R: How do you make sense of that now when you look back?	
Emotive topic Distancing language	P: I think that person was hurting so much, and, yeah, [pause] sorry I'm a bit of a crier so yeah don't worry about it	Talks in third person, a way to help him discuss a difficult topic? Does this imply he is not hurting now? Becomes emotions. Makes a point about crying, tries to minimise by making sure the interviewer does not worry about it. Appears uncomfortable. Emotionally hurting.
	R: Are you okay?	Checks to see if he wants to carry on.
Self-blame Suffering	P: Yeah I'm alright I'm alright, umm, but that hurt and that's ending on itself and turning on me, and now I suffer from, from all of that I suffer from self-loathing and I blame myself for a lot, a lot, a lot, a lot, do you mind if I swear?	'turning on me' seems to be directing the pain he feels towards himself with self-blame. Repetition. Emphasises that he suffers a lot, it seems that he is finding it difficult to put into works how much he suffers. He blames himself for things
	R: No	
Self-blame Responsibility No control Aggression	P: Shit, that went wrong with my uh, I won't mention no names, like my us my sisters in services as well and I blame that on me because my life was so chaotic, she started off with anorexia because she couldn't control nothing around her, because every time I come home there was an argument, every time I come home, there was a dispute with my dad, you know what I mean. Because he was stubborn, I'm stubborn, no one would back down, do you know what I mean?	Blames self for what went 'wrong'. Takes responsibility for his sisters lives, does not see how there could be other factors involved. Seems to have some understanding that his sister found ways to take control in her life, but does not seem to have this understanding for himself. He blames himself for the 'chaos' in everyone's lives and his life choices. Seems to blame self just as much as his dad for the disputes.
	R: Mmh. And what was your relationship like with your mum?	

Praises mum Forgiveness Relationship with dad	P: My mum's brilliant, my mum is absolutely brilliant the way she's holded everything together. The way she is, you know, my dad's chilled out a lot with me now, I don't know whether that's down to him, or me, because yeah, it's hard and I said do you know what I forgive you and I know that all you wanted was the best in me, and he didn't know how to deal with it, so he dealt with it in the best way he could, do you know what I mean. R: Mmh P: So yeah, but um what did you say sorry? R: So how do you make sense of those past experiences, and your current situation right now in secure care?	Emphasises his praise towards his mum. Uses language to suggest she contained the chaos, to stop it falling apart? How is she? Relationship with dad has changed. Forgiving towards dad. Believes his dad was trying his best, this is a contrast to the way he speaks about himself. Is forgiving easier?
Moving forward Self-destruction Self blame Mental health	P: mmh. I've come a long way in secure care, well I did come along way, I was the only one on this ward with leave, you know, I was doing really well and then the self-loathing kicked in and I self-destructed a little bit. A tiny bit yeah R: And what was that like? P: That was like, you've done it again mate, you can't do anything right can you, you know what I mean, because I suffer from voices, and my self-loathing plays	He has made positive changes in secure care. Corrects himself, suggests that he has not maintained these changes. Having leave is a sign of things going well. Compares himself to others on the ward. Self-loathing is seen as a setback, takes it out on himself. Minimises how he does this using 'small' language. Is this the message he has been given all of this life? The way he speaks to himself seems to

Feeling trapped Limited control Violence Protecting self Rejected Self-awareness Substance misuse	into my voices and then it goes round in a big circle that I can't get myself out of, but I've sort of got myself out now, if that makes sense? If I'm talking in riddles please tell me, do you know what I mean? R: What do you feel led to you coming into secure services? P: I was out of control in prison, I was going from prison to prison to prison, I was quite violent in prison, ummm, at times, you know, towards crews and inmates. Ermm, a lot of places come to see me but they said no due to his current state of mind, and, and, and uh, violent behaviour we can't have him on the ward because he'd destruct the ward, so sorry but knock back, and every time I got knocked back I had an incident, do you know what I mean. <u>Because I uhh, one this is I don't, give me one minute [pause], I don't suffer with rejection lightly.</u> So uh yeah, it was yet again chaotic, and like, I sourced people who had the drugs, get a few lads on board and then burn on them, you know what I mean. And yeah, the prison services know all this, so I'm not telling you anything anyone doesn't know you know what I mean?	reflect how he notes his dad used to speak to him when he was younger. Experiences voices. Seems to feel trapped in a vicious cycle. Feels like he is out of a vicious cycle he used to be in Life in prison was also chaotic. Was he living in this 'battle' again and having to fight his side? Used aggression Was assessed by services and felt rejected Self-fulfilling prophecy – would become violent to cope with the pain of rejection but this violence meant services did not accept him. It seems violence was used as a way cope and protect himself. Acknowledges that he finds rejection difficult, why does he think this is? Shows he is aware of what he finds difficult and Seems difficult for him to talk about this which is emphasised by his pause – he seemed to be thinking about this. Sought drugs as a way to cope with rejection. Reassures interviewer that staff are aware of these behaviours.

Appendix I. Extract from reflective diary

After interview with Tom

Tom appeared to want to form a good relationship with me. Before the interview started he talked to me as if he knew me very well and noted to the psychologist present that he knows me, however we had only met in the clinical governance meeting very briefly. I wondered whether this reflected Tom wanting to please other people. Throughout the interview he contradicted himself quite a bit, for example he would imply that things were really difficult at home and he was struggling with this, but then when asked how he managed this, he provided positive responses such as talking it through calmly with his mother. I had the feeling that this might not have been the case and I wondered whether he was worried about me judging him for some of his actions. At times it seemed that Tom did not understand all of the questions asked of him and therefore I tried to rephrase the questions so they were easier to understand. I was very weary of my questions not becoming too direct with this and leading Tom to provide me with answers I might want to hear.

After interview with Graham

I found this interview more challenging than the others. At first I wondered whether it is because the service user had sexually abused a young child, which I found difficult to hear. But reflecting on this, I was aware that other service users had completed similar offences and it did not affect me like this. Reflecting on the interview, I think I found it somewhat more challenging because the service user minimised his actions and seemed to blame the young victim for the offence. With the other interviews I have found it very easy to empathise with the participants and get a good sense of their world and the experiences they have gone through. However, in this instance I found this more challenging, perhaps because I found myself in a place where I found it difficult to empathise with his position of blaming a young child for these actions. I am aware of these unsettling feelings and I do not think they impacted my interview, in some way I think it made me explore more in the interview, as part of me wanted to gain more information from this participant's perspective. I do not want this to impact my data analysis and will discuss this further with my supervisors.

General reflections of interviews

I was weary of too much repetition during the interviews and it potentially being a difficult topic for participants to discuss. I was aware of my own understanding from the relevant literature that past experiences are strongly related to later adverse outcomes and I did not want to impose this on participants. At times I wondered whether further exploration may have drawn out participants understanding of this relationship but I was cautious of exploring this too much in case the interview became leading and biased by my own knowledge. I therefore found it helpful to remind myself to be 'curious' and open minded with participants' views, as I would do in clinical practice.

At times I found it difficult to not employ my clinical skills such as reflection and validation, particularly when participants were referring to difficult experiences in their lives. It was difficult to just sit with this and not necessarily do anything therapeutic. I found it reassuring to know that psychologists were in the room so they were aware of the content and were able to provide support to the service users if needed after the interviews. I was quite surprised however, that quite a lot of the participants said that the interview had been fine and they did not mind talking about these experiences. It made me wonder whether this is because they had become desensitised to these difficult stories and I found it upsetting that these stories seemed so normal for them.

Appendix J. The development of the theme 'being let down by others'

Participant	Theme	Example
David	Feeling invisible in an intrusive world	"I just feel like abandoned really" "they haven't done nothing for me"
Adam	Having to deal with things alone	"never told no one a single thing, just kept it all bottled up"
Mel	Feeling powerless amongst power	"I just didn't have support, I got no friends, uhh yeah, just not having no support didn't help"
Tom	Helpless as others take control	"I didn't have much of a life because there was a lot of things which mum took control of and um managed"
Brian	Loneliness	"very lonely"
Emma	Feeling abandoned	"they weren't listening to me"

Appendix K. Letter of sponsorship

Dear Dr Hartwright,

What factors do service users in secure care associate with their admission, continued detention and recovery?

I understand that you are acting as Chief Investigator and Academic Supervisor for the above DClinPsy project to be conducted by Jessica Cartwright.

I confirm that Cardiff University agrees in principle to act as Sponsor for the above project, as required by the UK Policy Framework for Health and Social Care Research.

Scientific Review
I can also confirm that Scientific Review has been obtained from the DClinPsy supervisory team (Cardiff University).

Insurance
The necessary insurance provisions will be in place prior to the project commencement. Cardiff University is insured with UMAL. Copies of the insurance certificate are attached to this letter.

Approvals
On completion of your IRAS form (required for NHS REC permission), you will be required to obtain signature from the Research Governance team for the 'Declaration by the Sponsor Representative'.
Please then submit the project to the following bodies for approval:

- an NHS Research Ethics Committee;
- Partnerships in Care (for permission to commence the study at Llanarth Court, Ty Catrin and Ty Cwm Rhondda Hospitals).

The University is considered to have accepted Sponsorship when Research and Innovation Services has received evidence of the above approvals.

Roles and Responsibilities
As Chief Investigator you have signed a Declaration with the Sponsor to confirm that you will adhere to the standard responsibilities as set out by the UK Policy Framework for Health and Social Care Research. In accordance with the University's Research Integrity & Governance Code of Practice, the Chief Investigator is also responsible for ensuring that each research team member is qualified and experienced to fulfil their delegated roles including ensuring adequate supervision, support and training.

If your study is adopted onto Health & Care Research Wales Clinical Research Portfolio you are required to upload recruitment data onto the portfolio database.

Contracts

- Roles and responsibilities are detailed adequately in the research protocol- no contract required (unless requested by Partnerships in Care).

May I take this opportunity to remind you that, as Chief Investigator, you are required to:

- register clinical trials in a publicly accessible database before recruitment of the first participant and ensure that the information is kept up to date
- ensure you are familiar with your responsibilities under the UK Policy Framework for Health and Social Care Research;
- undertake the study in accordance with Cardiff University's Research Integrity & Governance Code of Practice (available on the Cardiff University Staff and Student Intranet) and the principles of Good Clinical Practice;
- ensure the research complies with the General Data Protection Regulation 2016/679;
- where the study involves human tissue, ensure the research complies with the Human Tissue Act and the Cardiff University Code of Practice for Research involving Human Tissue (available on the Cardiff University Staff and Student Intranet);
- inform Research and Innovation Services of any amendments to the protocol or study design, (including changes to start /end dates) and submit amendments to the relevant approval bodies;
- respond to correspondence from the REC and NHS organisation R&D offices within the required timeframes;
- co-operate with any audit, monitoring visit or inspection of the project files or any requests from Research and Innovation Services for further information.

You should quote the following unique reference number in any correspondence relating to Sponsorship for the above project:

SPON 1700-18

This reference number should be quoted on all documentation associated with this project.

Yours sincerely

KJ Pittard Davies

Dr K J Pittard Davies
Head of Research Governance and Contracts
Direct line: +44 (0) 29208 79274
Email: resgov@cardiff.ac.uk

Cc Jessica Cartwright.

Appendix L. Ethical approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

Gwasanaeth Moeseg Ymchwil
Research Ethics Service

Ariennir gan Lywodraeth Cymru
Funded by Welsh Government

Wales REC 7
c/o Public Health Wales
Building 1
Jobswell Road
St David's Park
SA31 3HB

Telephone : 01267 61 1164
E-mail : sue.byng@wales.nhs.uk
Website : www.hra.nhs.uk

Mr Chris Hartwright
South Wales Programme in Clinical Psychology
Floor 11, Tower Building, 70 Park Place
Cardiff
CF10 3AT

7 May 2019

Dear Mr Hartwright

Study title:	**Service user perspectives on how their early experiences relate to their detention in secure care**
REC reference:	**19/WA/0068**
IRAS project ID:	**257451**

Thank you for your email of 24 April 2019, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).
Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System, at www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Costing template (commercial projects) [Estimated costs]		10 December 2018
Covering letter on headed paper		28 November 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Letter of insurance]		02 July 2018
Interview schedules or topic guides for participants	1	22 November 2018
IRAS Checklist XML [Checklist_22022019]		22 February 2019
Letter from sponsor	1	20 November 2018
Letters of invitation to participant [consent form to be contacted]	1	28 November 2018
Other [Debrief Form]	2	28 March 2019
Participant consent form	2	28 March 2019
Participant information sheet (PIS)	2	06 April 2019
REC Application Form [REC_Form_22022019]		22 February 2019
Referee's report or other scientific critique report [Review feedback for research protocol]		10 August 2018
Research protocol or project proposal	2	28 March 2019
Response to Request for Further Information email		24 April 2019
Summary CV for Chief Investigator (CI) Mr Chris Hartwright		

Summary CV for student Miss Jessica Cartwright		
Summary CV for Supervisor Mr Chris Hartwright		

Statement of compliance

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

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

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

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: https://www.hra.nhs.uk/planning-and-improving-research/learning/

19/WA/0068	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

pp. Dr John Buchan
Chair

Email:Wales.REC7@wales.nhs.uk

Enclosures: "After ethical review – guidance for researchers"

Copy to: *Helen Falconer*