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SECURE SERVICES FOR PEOPLE WITH LEARNING DISABILITIES.

Section A: People with learning disabilities' experiences of secure forensic services within the UK.

A qualitative synthesis
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Section B: The offer of psychology within a low secure learning disability service: Choice without a choice. A grounded theory.

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Thank you to the participants who so generously gave their time to share their views and experiences with me.

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To my friends and family, thank you for all of your support and for understanding when I was less present.

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Statement of Covid-19 Impact

In early 2020, at the start of the Covid-19 pandemic, I had received NHS ethics and trust approval to start recruitment of participants. All non-Covid research was suspended by the trust and the project was put on hold. I came to restart the project in June 2021 however due to needing to request amendments and resubmit certain documents I was not granted trust approval and the green light to start recruitment until January 2022. As a consequence of these changes it had been some time since the research project had been presented to staff at the recruitment site. In person visits to the site were minimised and at times the service was closed to external visitors due to Covid infections. My research supervisor who was supporting the recruitment process was also impacted by Covid, with periods of time when they were unable to be on site. As a consequence of these events the speed of recruitment and access to participants was impacted.

Summary of the Major Research Project

Section A: A review of qualitative literature exploring people with learning disabilities' experiences of secure forensic services. Critical appraisal of the 12 included studies is discussed. Thematic synthesis resulted in three analytical themes with eight sub-themes. Analytical themes included 'it's not the ideal place to live', 'relationships within the unit' and 'change'. Implications for clinical practice are considered, including helpful and unhelpful aspects of secure services as experienced by people with learning disabilities. Recommendations for future research include further exploration of the experience of psychological interventions for people with a learning disability within secure settings.

Section B: A study exploring the process by which psychology is offered within a low secure learning disability service, and resulting willingness to attend psychology. Guided by constructivist grounded theory methodology, the constructed model identifies four domains: 'context of the offer', 'drive to engage patients in psychology', 'navigating making the offer', 'making sense of the offer'. Interactions between these are highlighted. Findings emphasise the challenges of the dual role of staff within a forensic setting and how navigation of this may translate into patient's receiving a mixed message regarding choice, and resulting willingness to attend psychology**.** Implications for further research and clinical practice are discussed.

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People with learning disabilities' experiences of secure forensic services within the UK.

A qualitative synthesis

Word Count: 7953 (174)

ABSTRACT

Introduction: Where there is considered a need to manage risk, people with a learning disability with complex behaviours that challenge, or offending behaviour, are often detained under the Mental Health Act and may be placed in a forensic secure service. Whilst there are existing reviews looking at clinical outcomes, and staff experiences and views of working in secure services for people with learning disabilities, there is limited understanding of how people with learning disabilities experience these services. This paper sought to identify, appraise and evaluate research looking at the experience of secure services by people with learning disabilities.

Method: Systematic searches of four databases (PsycInfo, Ovid, Web of Science and Applied Social Sciences Index) were conducted. Twelve qualitative studies met eligibility criteria.

Literature review: Thematic synthesis resulted in three analytical themes with eight sub-themes. Analytical themes included 'it's not the ideal place to live', 'relationships within the unit' and 'change'.

Clinical and research implications: Findings suggest areas of consideration for those working in or developing secure services for people with learning disabilities. Further research is needed to understand the experience of secure services by people with learning disabilities, with areas of interest highlighted.

Key words: People with learning disabilities, Secure care, Experiences, Forensic

Introduction

Learning disabilities

The terminology concerning learning disabilities (LD) has frequently changed. Whilst terms such as intellectual disability (ID) are increasing in frequency LD is predominantly used by NHS services and UK Government. This paper uses the terms learning disability (LD) and person/people with a learning disability (PWLD). Representing those with a formal diagnosis only, it is estimated that there are over 1.2 million PWLD in England (Kennedy et al., 2001). Within the UK there are core criteria used to diagnose and classify LD. As described by the British Psychological Society (BPS, 2000) diagnosis requires significant impairment of intellectual functioning and significant impairment of adaptive or social functioning, with onset before 18 years of age.

PWLD and offending

PWLD are a heterogenous group, a small proportion of whom may present with behaviour that is considered high risk or in breach of the law (Morrissey et al., 2017). The exact prevalence of offending behaviour within the population of PWLD is unclear, with studies reporting large variations (Lindsay & Taylor, 2018). When there is considered a need to manage risk, PWLD with complex behaviours that challenge and/or offending behaviour are often detained under the Mental Health Act (MHA, 1983, amended 2007). Research suggests that PWLD are disproportionately represented amongst those who are detained under the MHA in the UK, with PWLD making up approximately 2% of the general population but representing 7.7% of those detained under the MHA (Care Quality Commission, 2015; Taylor, 2018). The MHA is currently under review, with one of the areas of proposed change relating to how it can be applied to PWLD, recommending that detention is a last resort (Trewin, 2021).

Secure services

Under the current system, PWLD who are considered to pose risk great enough to require the physical and relational security of a locked unit will be placed in a secure forensic service (Royal College of Psychiatrists, RCP, 2013). Secure services for PWLD aim to provide a safe environment, whilst providing specialist assessment, treatment and care (Devapriam & Alexander, 2012). PWLD detained under the MHA may or may not have been through the criminal justice system. Research suggests that only a small minority of PWLD who commit offences end up being charged (RCP, 2013). This means that decision-making regarding whether someone with a LD is a ‘forensic’ patient is often based on clinical judgement and availability of resources.

There are different levels of secure services in the UK, including beds in low, medium and high security (RCP, 2013). In April 2020 the Mental Health Services Data Set indicated that in England there were 3,365 PWLD and/or autistic spectrum disorders in hospital. 1,300 of these were in a secure setting (NHS Digital, 2020). Burns (2010) argues that PWLD often remain in secure services longer than they should based on their risk and presentation, suggesting that this is due to a lack of appropriate service provision in the community. Data reported in November 2021 indicated an average length of detention under the MHA for PWLD of 5.4 years (NHS Digital, 2021).

Reshaping services

High profile cases such as the Winterbourne View scandal, exposing serious failings in care and abuse of PWLD, have triggered review of services for PWLD (British Broadcasting Corporation, BBC, 2011). Severe shortcomings within NHS, social care and private sectors have been highlighted, with a suggested overreliance on inpatient and secure placements (Department of Health, DOH, 2012). Over the past few decades, multiple government policies and white papers, such as ‘*Valuing People*’, ‘*Valuing People Now*’ and ‘*Transforming Care*’, have been published calling for improved services for PWLD, asserting to prioritise the development of appropriate specialist services for PWLD who present with severe behaviours that challenge (DOH, 2001; DOH; 2010; DOH, 2012).

Unfortunately, there have been repeated failures to implement proposed changes, with transformation an ongoing task (Challenging behaviour foundation, 2022). Gillmer et al. (2010) suggested that the attempted move to deinstitutionalisation recommended by *Transforming Care* and other policy papers, although well meaning, has been conducted in the context of a lack of understanding of the needs of PWLD, limited resources and lack of appropriate alternative services. An absence of appropriate community services for PWLD with complex needs means that there continues to be a reliance on inpatient and secure services (Haves, 2021). Preventative interventions and community placements are most desirable; however, it is also acknowledged that where there are significant risks and treatment under the MHA is required, secure services are an essential part of the care pathway (RCP, 2013). These services should be of high quality and meet the needs of PWLD.

Understanding PWLD's experiences of secure services

The majority of research regarding secure services for PWLD has centred around outcomes, such as recidivism rates and treatment efficacy, as well as financial value (Ratcliffe & Stenfert Kroese, 2021; Walker et al, 2019; Morrissey et al., 2017). Within mental health services more broadly, including within forensic services, there has been a move away from consideration of recovery based on symptoms, to strengths and wellbeing (DOH, 2001b; Mann et al., 2014). Recovery approaches recognise recovery as a subjective experience (Esan et al., 2012). Andresen et al. (2003) highlighted aspects of personal recovery including; finding meaning in life, developing hope, re-establishing identity and taking responsibility and control. As a developing area of practice, there is limited research regarding how recovery approaches can and have been applied within LD secure settings (Mann et al., 2014).

There are commonalities across PWLD that may contribute to unique experiences of services compared to those without an LD. Considering communication difficulties, reduced cognitive abilities and permanence of disability, PWLD who come into contact with specialist services often have complex presentations (NICE, 2021; RCP, 2013). PWLD are more likely to experience traumatic life events and are at greater risk of abuse, both in the community and within care (Brownridge, 2006; Perlin, 2003). The above factors suggest that PWLD have specific needs that need to be understood and catered for by secure services. There is emerging qualitative research looking at secure services for PWLD, for example exploring staff perspectives on elements of these services, and individual case studies (Ashworth et al., 2017; MacDonald et al., 2017). Research into the perspectives of PWLD is lacking across many areas, with secure services no exception. There is limited knowledge of the environment, care and treatment provided by secure services, as experienced by PWLD (Williams et al., 2018). The move towards use of recovery principles within forensic services highlights a need to build a better understanding of subjective experiences of rehabilitation by PWLD accessing secure services (Esan et al., 2012).

Summary and rationale for literature review

Good inpatient care can only be achieved through person-centred services that understand and meet the needs of service-users (RCP, 2013). Understanding the perspectives of PWLD is key to understanding their needs. In the context of increasing scrutiny and service development, it is important to gain a perspective on how secure services are experienced by PWLD. The current review aims to appraise and synthesise the current qualitative literature exploring PWLD’s experiences of secure services in the UK, to understand how PWLD experience these services, what might be helpful or valued and what might be unhelpful. It is hoped that this review may support the views of PWLD to be considered in relation to service development and provision.

Method

Review objective

As recommended by the Cochrane Training group, the 'population, interest, context' (PICo) framework for developing qualitative review questions was used (Noyes et al., 2021). This review aimed to answer the question 'What are PWLD's experiences of secure forensic services within the UK?', including what PWLD value or find helpful about these services, and what they find challenging or unhelpful. As such, this review aims to review qualitative studies relating to experience of UK secure forensic services by PWLD.

Review Design

The review is reported following the 'Enhancing transparency in reporting the synthesis of qualitative research' (ENTREQ) guidelines (Tong et al., 2012). The review will first identify, describe and appraise the current research in this area. Synthesised findings of these studies, following Thomas and Harden's (2008) model of Thematic Synthesis will then be presented. Following this, discussion of the results and their implications are considered.

Literature search method

An initial scoping search identified key terms relevant to the research area. A systematic search of abstracts and titles using four electronic databases; PsycInfo, Ovid, Web of Science and Applied Social Sciences Index and Abstracts (ASSIA) was conducted on 17th October 2021. Databases were searched using pre-planned key terms and Boolean operators to ensure that relevant papers were included. Search terms are detailed in Table 1. A Google search and hand search of reference lists of papers was completed to locate relevant papers not previously identified.

Table 1.

Search terms used in systematic search.

Search topic	Terms used

Learning Disabilities	learning disabilit* OR intellectual disabilit* OR learning difficult* OR special needs AND
Secure forensic setting	secure OR forensic OR inpatient OR detained OR offend* AND
Qualitative	Qualitative OR Thematic analys* OR Interpretative Phenomenological Analys* OR IPA OR Grounded Theory OR Discourse Analys* OR Content Analys* NOT
Excluded population	Child OR Paediatric

Screening process

Following removal of duplicate papers, the inclusion and exclusion criteria summarised in Table 2 were applied, firstly by title and abstract screen before reviewing the full papers of those remaining. No temporal limits were applied to the search or inclusion of papers. The screening process was completed independently by the review author and is detailed in a PRISMA diagram, see Figure 1.

Table 2.

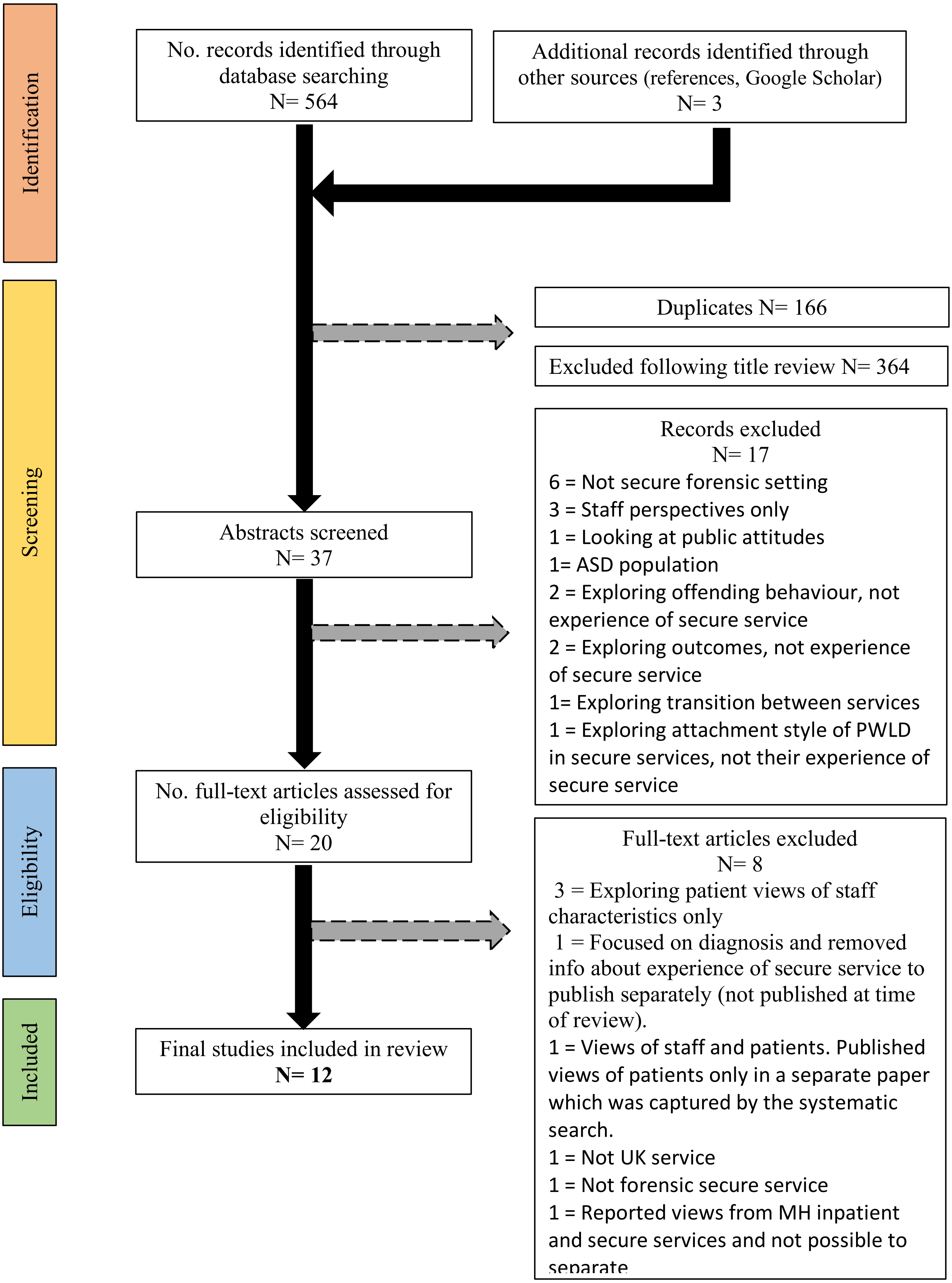
Inclusion and exclusion criteria for literature search.

	Considerations
Inclusion criteria	
UK secure forensic service	
Research reporting service users with LD (borderline to severe) experience of forensic secure service	
Qualitative paper or mixed methods with a significant qualitative element	With the aim to explore experiences, data from qualitative research papers was considered most appropriate.
Published in peer-reviewed journal	
Published in English	With an aim to look at experiences of UK services it was not felt that this would impact inclusion of relevant papers.

Exclusion criteria	
Exploring PWLD views of staff characteristics only	With a large body of research regarding staff characteristics and relationships in LD services, papers addressing this were felt to be appropriate for a separate review.
PWLD views not distinguishable from views of another stakeholder group	Concerned with experiences of PWLD, papers were excluded if there was a heterogenous sample where PWLD views were not distinguishable from the views of others.

Figure 1.

PRISMA flow diagram of screening process.



No. records identified through database searching
N= 564

Additional records identified through other sources (references, Google Scholar)
N= 3

Duplicates N= 166

Excluded following title review N= 364

Abstracts screened
N= 37

Records excluded
N= 17

6 = Not secure forensic setting
3 = Staff perspectives only
1 = Looking at public attitudes
1= ASD population
2 = Exploring offending behaviour, not experience of secure service
2 = Exploring outcomes, not experience of secure service
1= Exploring transition between services
1 = Exploring attachment style of PWLD in secure services, not their experience of secure service

No. full-text articles assessed for eligibility
N= 20

Full-text articles excluded
N= 8

3 = Exploring patient views of staff characteristics only
1 = Focused on diagnosis and removed info about experience of secure service to publish separately (not published at time of review).
1 = Views of staff and patients. Published views of patients only in a separate paper which was captured by the systematic search.
1 = Not UK service
1 = Not forensic secure service
1 = Reported views from MH inpatient and secure services and not possible to separate

Final studies included in review
N= 12

Quality Appraisal

When reviewing qualitative research, appraisal of study quality is indicated prior to synthesis of findings (Garside, 2014). Systematic review methods were initially developed to serve appraisal and synthesis of quantitative studies assessing efficacy (Long et al., 2020). Qualitative studies answer differently framed questions, this needs to be held in mind when considering their appraisal. Agreement on what constitutes 'quality' when appraising qualitative research is limited (Hannes, 2011).

The Critical Appraisal Skills Programme Qualitative Research Checklist (CASP, 2018, Appendix I) is the most commonly used appraisal tool for qualitative reviews within health and social care research and is endorsed by the Cochrane Qualitative and Implementation Methods Group (Long et al., 2020). The CASP Qualitative Research Checklist (CASP, 2018) was used as a tool by which to appraise the quality of the included studies. CASP advise that the checklist is used to determine whether or not research meets certain quality checks, using a 'Yes', 'Can't Tell' or 'No' criteria (CASP, 2018). The tool is designed to support assessment and decision-making and is not a standardised measure, therefore use of a scoring system is advised against and was not used in this review (CASP, 2018). The results of the appraisal exercise were used to inform discussion of the strengths and limitations of included studies. As recommended by Thomas and Harden (2008), studies were not excluded from synthesis based on quality, however the appraisal results were held in mind when reviewing resulting analytical themes.

Synthesis

Qualitative synthesis aims to bring together research findings across qualitative papers in order to provide a richer understanding (Barnett-Page & Thomas, 2009). Thomas and Harden's (2008) method of synthesis was selected as it supports questions related to people's experiences and is appropriate to use when heterogeneous studies are included for review.

Using Nvivo qualitative data analysis software, the author followed Thomas and Harden's (2008) three stages of thematic synthesis, with initial line-by-line coding of data, followed by the development of 'descriptive themes' which were later grouped into 'analytical themes'. Deciding what data to extract can be a challenge of thematic synthesis (Thomas & Harden, 2008). With the research question in mind, the results and discussion sections of papers were included and text was selected if it related to direct quotations from PWLD regarding their experiences of secure services. Appendices II and III demonstrate the development and grouping of themes.

Reflexivity

The author was a trainee clinical psychologist with experience of working with individuals who had been detained involuntarily, some of whom were PWLD. The author was motivated to support the understanding and empowerment of PWLD. A reflexive diary was kept throughout the research process, with the aim to minimize the impact of potential bias.

Results

Twelve papers met eligibility and are included in the following review. Study aims and key characteristics are detailed in Table 3, with studies presented alphabetically.

Overview of studies

As defined by the inclusion criteria, all 12 studies were based in the UK. Studies were published in peer-reviewed journals between 2002 and 2021. Three studies looked at the experience of secure services by PWLD (Heppell & Rose, 2021; Williams et al., 2018, Wood et al., 2008). Other studies looked at PWLD's experiences of particular aspects of secure services, including; therapeutic interventions/support groups (Browne et al., 2019; Tallentire et al., 2020; Thomson & Johnson, 2016), self-harm (Brown & Beail, 2009; Harker-Longton & Fish, 2002), readiness for psychology (Breckon et al., 2013), coping and stress (Burns & Lampraki, 2016), seclusion (Fish, 2018) and service user's representations of staff discourses regarding sexuality and sexual relations (Grace et al., 2020). Although all papers reported the research took place within secure services, they presented varying levels of information regarding the type of service. Nine of the twelve papers provided specific detail that the secure services were specialist services for PWLD. Where level of security was reported, services fell within the categories of low and medium security, with one study also recruiting participants from an enhanced support service (Burns & Lampraki, 2016). Two studies included staff within their samples however PWLD views were clearly identifiable from the findings (Breckon et al., 2013; Fish, 2018).

Table 3.

Key study characteristics.

Paper	Year	Focus	Study type	Method	Service	Participants (gender, diagnosis, role)	Key findings & themes identified
Breckon, Smith & Daiches	2013	What makes offenders with a LD ready to engage with psychology	Qualitative; Grounded theory	Semi-structured interviews	Two secure inpatient services	6 offenders; mild to borderline LD, all male 6 staff; 2 clinical psychologists, 4 nurses	Model of readiness was presented. Elements included stability/predictability, sticking to the rules, feeling safe, developing a sense of purpose and belonging, finding your place, development of trusting relationships with staff, reassurance about progress, being in a good place emotionally, realising that change is needed, willingness to honestly discuss offending, availability if therapy and stability of mental health and impact of LD.
Brown & Beail	2009	Exploration of self-harm among people with LD living in secure services	Qualitative; IPA	Semi-structured interviews	Secure service for people with LD and challenging behaviour	9 residents; 5 men, 4 women,	Three key themes: 1. Self-harm in an interpersonal context 2. Self-harm as an emotional experience 3. Managing self-harm
Browne, Brown & Smith	2019	Service user's experience of adapted dialectical behaviour therapy in	Qualitative; Grounded theory	Semi-structured interviews	Two NHS low/medium secure LD units in North and South England	9 service users; 5 males, 4 females, FSIQ range 59-72 (M=66.7, SD=4.03)	Model developed which described a core category of "uphill and downhill journey of skill use". Core category was positioned within the context of broader categories which included: extrinsic

		forensic LD service					compliance, senses of safety and belief in self.
Burns & Lampraki	2016	Service user's with LD in forensic services, experiences of coping with stress	Qualitative; Thematic analysis	Focus groups	Medium secure (n=7), low secure (n=8) and enhanced support services (n=5) of forensic LD services within on NHS Trust	20 participants; 13 males, 7 female	Three key themes: 1. Experiencing stress 2. Sources of stress 3. Coping with stress
Fish	2018	Experiences of seclusion by women in secure LD unit	Qualitative; Thematic analysis	Observations and semi-structured interviews	NHS LD secure forensic unit for women	16 service users, all female 10 staff; 7 nurses, 2 support workers, 1 clinical psychologist	Four themes reported: 1. The seclusion room environment 2. Reasons for using seclusion 3. Termination of seclusion 4. Alternatives to seclusion
Grace, Greenhill & Withers	2020	What service users hear when staff talk about sex and relationships	Qualitative; Critical discourse analysis	Semi-structured interviews	Secure service in the North of England	8 service users; 5 male, 1 non-binary, 2 female	3 main categories which appeared to be linked in representing control over participants: 1. Maintaining the "integrity" of the institution 2. Facilitating staff's position of authority 3. Acceptance and resistance talk
Harker-Longton & Fish	2002	Exploration of self-injurious behaviour from one service user	Qualitative; Phenomenological approach	Semi-structured interviews	Medium secure unit for adults with LD	1 female service user	Key themes included: 1. Reason's for and functions of self-injury 2. Self-help strategies 3. Service issues 4. Punishment 5. Individual service provision

Heppell & Rose	2021	Exploration of men with LD and sexual offending histories experiences of secure hospital	Qualitative; Thematic analysis	Semi-structured interviews	Single secure hospital for men with LD and associated complex care needs	9 participants, all male, all mild LD (IQ ranging between 56-66 (M=62.2)	Three superordinate themes: 1. Hospital environment 2. Personal journey through secure services 3. Closeness to home
Tallentire, Smith, David, Roberts, Bruce, Morrow, Withers & Smith	2020	Stories of people who attended a Lesbian, Gay, Bisexual and Trans support group in a secure LD service	Qualitative; Participatory approach using narrative analysis	Semi-structured interviews and written information	LD secure service	18 co-researchers; 17 male, 1 female Majority had mild LD 9 participated in interviews, 8 sent written information	A group story was produced. The story indicated that the group helped people in different ways. Going to the group was difficult at first for some people and then got easier. People wanted to help others and this was important in their lives.
Thomson & Johnson	2017	Experiences of women with LD undergoing dialectical behaviour therapy in a secure service	Qualitative; IPA	Semi-structured interviews	Women's pathway of a forensic service with conditions of medium and low security in North West England	7 females with dual diagnosis of LD and borderline personality disorder who had been offered DBT	Three main themes were reported: 1. How you do DBT 2. What we think about DBT 3. Using DBT
Williams, Thrift & Rose	2018	Experiences of women with LD and offending behaviour, exploring their experiences of 'home'	Qualitative; IPA	Semi-structured interviews	One low secure women's unit within an LD secure service	7 females with mild to moderate LD	Four superordinate themes were reported: 1. Hospital as helpful 2. Hospital as undesirable 3. A sense of belonging 4. 'I want to be as independent as I can'

Wood, Thorpe, Read, Eastwood & Lindley	2008	Service user satisfaction in a low secure forensic LD unit	Qualitative; Content analysis	Semi-structured interviews	Low secure forensic hospital unit for adults with LD	7 service users; 5 male, 2 female	Themes in two key areas were reported: 1. Detention 2. Treatment

Appraisal of quality

Critical appraisal of study quality is provided, using the CASP criteria as a guide. A summary table of CASP ratings is included in Table 4, with a detailed table included in Appendix IV.

Research aim and design

All papers clearly stated their research aims. With the main aim of all papers being related to developing a richer understanding of PWLD's experiences, qualitative designs were appropriate (Patton, 2002). A variety of qualitative methods were used including: interpretive phenomenological analysis (IPA), grounded theory (GT), thematic analysis (TA), content analysis (CA), critical discourse analysis (CDA) and narrative analysis (NA). All papers described their choice of design however only one paper (Grace et al., 2020) discussed possible alternatives and gave a detailed description regarding their decision-making process. GT methodology was used in two of the studies where authors identified value in generating a theoretical model from the data that would be useful to practitioners (Breckon et al., 2013; Browne et al., 2019). Tallentire et al.'s (2020) research design stood out for its use of a participatory approach. PWLD were defined as 'co-researchers' and were involved with the design, data collection, analysis of data and reporting of findings. Relatively new within the field of LD, participatory research designs are thought to have multiple benefits including ensuring relevancy of research questions and building relationships between the community under investigation and academia, bridging a gap which is often criticised in research involving PWLD (Jagosh et al. 2012; Walmsley, 2001).

Table 4.

Summary of CASP appraisal.

Paper	Clear aims?	Methodology appropriate?	Appropriate research design?	Recruitment strategy appropriate?	Data collected in way to address issue?	Relationship between researcher and ppts considered?	Ethical issues considered ?	Data analysis sufficient?	Clear statement of findings?
Breckon et al., (2013)	Yes	Yes	Yes	Can't tell	Yes	Can't tell	Can't tell	Yes	Yes
Brown & Beail (2009)	Yes	Yes	Yes	Can't tell	Yes	Can't tell	Can't tell	Yes	Yes
Browne et al. (2019)	Yes	Yes	Yes	Yes	Yes	Can't tell	Can't tell	Yes	Yes
Burns & Lampraki (2016)	Yes	Yes	Yes	Can't tell	Yes	Can't tell	Yes	Can't tell	Yes
Fish (2018)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes
Grace et al., (2020)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Harker-Longton & Fish (2002)	Yes	Yes	Yes	Can't tell	Yes	No	No	Can't tell	Yes
Heppell & Rose (2021)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Tallentire et al. (2020)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Thompson & Johnson (2017)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Williams et al. (2018)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Wood et al. (2008)	Yes	Yes	Yes	Can't tell	Yes	Yes	Can't tell	No	Yes

Recruitment strategy and participants

Sampling method and recruitment procedure were poorly reported across a number of the studies. Only two studies (Heppell & Rose, 2021; Tallentire et al., 2020) explicitly reported their sampling method. For the other studies it was possible to infer the strategy used from the details provided. Studies employed purposive and opportunistic sampling. Non-probability methods of sampling are limited by subjectivity and therefore impact on generalisability of findings; however, they are commonly used within qualitative research where research resources and access to participants may be limited (Leung, 2015). Theoretical sampling, which is a core principle of GT methodology, was reportedly employed by Breckon et al. (2013). Browne et al. (2019), who also used GT methodology, planned to use theoretical sampling but reported it was not possible due to a small participant pool. They responded to this by revisiting previous participants to test and shape theory development.

Recruitment strategy was another poorly reported area across the studies, rated as "can't tell" for five of the papers (Breckon et al., 2013; Brown & Beail, 2009; Burns & Lampraki, 2016; Harker-Longton &Fish, 2002; Wood et al., 2008). It was often unclear how participants were selected and approached and why people declined participation or withdrew. This is important information when considering the representativeness of the sample. It may be that those who have the most positive/negative experiences are more likely to want to share these, biasing the data (Sheridan et al., 2020). Access to participants with LD is a particular barrier for researchers, including practical and ethical challenges (Crook et al., 2016). Researchers in the included studies were often clinical staff at the research site, likely helping to overcome barriers to recruitment but posing other issues discussed later (Lewis & Porter 2004).

Inclusion and exclusion criteria were detailed in eight of the 12 studies and felt appropriate to the research. Where inclusion/exclusion criteria weren't reported it was left for the reader to assume that all PWLD at the specific site or who attended the intervention in question were approached (Breckon et al., 2013; Brown and Beail, 2009; Harker-Longton &Fish, 2002; Wood et al., 2008). In line with the British Psychological Society (BPS) Code of Human Research Ethics, reported inclusion/exclusion criteria necessitated that participants were deemed to have capacity to consent to the research and they were assessed as able to participate in data collection, considering factors such as possible distress and stability of mental health (BPS, 2021).

Demographics are not covered by the CASP but felt important to consider during appraisal. Not reported by all studies, where description of LD was provided, participants were described as having borderline to moderate LD (Breckon et al, 2013; Browne et al. 2019; Fish, 2018; Heppell & Rose, 2021; Tallentire et al. 2020; Williams et al., 2018). A particular issue in research involving PWLD is the exclusion of people with more profound LD. This is thought to be partly due to concerns regarding those with more profound difficulties being able to consent and or communicate at a level which allows participation in interviews. Goldsmith and Skirton (2015) highlight the need to balance protecting a vulnerable group of people with involving them in research that may contribute to best clinical practice and service provision. Fish (2018) described that their use of an ethnographic approach enabled those who are less articulate to be included. Gender was well reported but only three studies reported ethnicity, with the majority of participants identifying as white British (Browne et al. 2019; Fish, 2018; Heppell & Rose, 2021).

Data Collection

Data appeared to be collected in a way that supported the research aims in all of the studies. Burns and Lampraki (2016) used focus groups with semi-structured interviews, citing the benefits of this methodology as allowing service-users to express their views whilst supporting feelings of safety. Their focus group sizes were smaller than recommended however they commented on having adapted the group sizes considering participant characteristics

(Freeman, 2006). All other studies used individual semi-structured interviews. Fish, (2018) used observations in addition to individual semi-structured interviews and Tallentire et al., (2020) used written information in addition to individual semi-structured interviews. Semi-structured interviews support collection of rich data and are an important method for eliciting people's views; however, as acknowledged by Browne et al. (2019), they often rely on participants recalling facts, thoughts and feelings about a past experience (Lewis & Porter, 2004). The majority of studies gave clear descriptions of how their interview topic guide was produced, with Wood et al. (2008) and Tallentire et al. (2020) consulting PWLD on important topics to cover. The inclusion of observation and the opportunity to submit written information were strengths of Fish (2018) and Tallentire et al. (2020) respectively, possibly helping to overcome limitations of interviews that rely on participants verbal communication abilities.

Consideration of participants' relationship with the researcher varied across the studies. There are different schools of thought when conducting research with PWLD. One argument is that it is beneficial to build a relationship with participants in order to develop trust and enable them to communicate and speak freely (Walmsley, 2004; Whitehurst, 2006). Others argue that PWLD are at increased risk of acquiescence and providing answers they believe the researcher desires, particularly if they are known to them and when there is a clear power imbalance (Gilbert, 2004). Seven studies described the relationship of the researcher to the participants, and the impact of this, particularly when the researcher was a member of staff at the secure service (Fish, 2018; Grace et al., 2020; Heppell & Rose, 2021; Tallentire et al., 2020; Thomson & Johnson, 2017; Williams et al., 2018; Wood et al., 2008). Harker-Longton and Fish (2002) reported a phenomenological study in which one service user with a LD was interviewed by the same researcher over a three-month period. The research interviews were conducted by Harker-Longton who was a staff member at the service and had a patient-carer relationship with the service-user. Harker-Longton and Fish (2002) cite benefits of this including a trusting relationship that allowed the service-user to speak freely about her experiences but did not acknowledge the potential unintended negative consequences of this type of participant-researcher relationship.

Ethical Issues

Ethical issues were considered with varying levels of detail. All studies except one reported that they had gained appropriate ethical approval. Harker-Longton and Fish (2002) considered a number of ethical issues however there was not mention of ethical approval for the study being sought or granted, or of the process of obtaining consent to participate. This makes it difficult to determine whether their compliance with ethical principles was adequately scrutinised (BPS ethical guidance; Wu et al., 2019). In contrast, Browne et al. (2019) confirmed ethical approval for the study and described a robust methodology for ensuring participants were able to give informed consent, this included use of a protocol to assess participant comprehension and voluntariness (Thomas & Stenfert Kroese, 2005). Consideration of consent processes are important in all research activities, but arguably of particular importance within research with PWLD, where cognitive and communication abilities may impact capacity (Dunn et al., 2006).

Data analysis and findings

A variety of methods of data analysis were employed, with three studies using thematic analysis (TA), three studies using interpretative phenomological analysis (IPA), two studies using grounded theory (GT), one study using critical discourse analysis, one study using narrative analysis, one study using content analysis and one paper using phenomenological analysis. Most studies gave key information about the analysis process. Eight studies referenced the data analysis methods used, allowing assessment of rigour of analysis and supporting replicability (Breckon et al., 2013; Brown & Beail, 2009; Browne et al., 2019; Burns & Lampraki, 2016; Grace et al., 2020; Heppell & Rose, 2021; Tallentire et al., 2020;

Williams et al., 2018). Wood et al. (2008) set out to do IPA but found that their method of analysis did not align with this and re-classified their analysis as content analysis. No details were provided regarding the process of analysis or theme development. This highlights a challenge with qualitative research where clear procedural and practical description of the analysis process is often lacking.

The influence of the researcher on analysis was generally well-considered with a number of the studies reporting reflexive processes and employing methods such as member checking or triangulation to minimise bias (Breckon et al., 2013; Brown & Beail, 2009; Browne et al., 2019; Grace et al. 2020; Heppell & Rose, 2021; Tallentire et al., 2020; Thompson & Johnson, 2017; Williams et al., 2018). Through seeking to reduce the impact of personal biases reflexive practice supports the credibility and validity of studies. Although not included in the CASP, a shortcoming of nearly all studies was the absence of a clear statement regarding ontological and epistemological position of the researcher(s). Theoretical stance significantly impacts a researcher's approach to research and analysis of data, with lack of information regarding this affecting the ability to understand and assess study quality (Long et al., 2020). Both studies using GT described employing a constructivist GT approach which was appropriately reflected in their method of data collection and analysis (Breckon et al., 2013; Browne et al., 2019).

All papers used quotations to evidence inferences made from the data and linked their findings back to the research question, supporting 'confirmability' with themes grounded in primary data (Given, 2008). Studies were cautious not to make claims which would overgeneralise the results.

Summary

Assessed against the CASP, quality of research across the papers varied however it was felt that overall studies conferred to a moderate to good standard. A key issue noted in the appraisal of studies was missing information which made it difficult to determine whether or not CASP criteria had been met. This may reflect strict publication word limits which may not do justice to lengthier descriptions often inherent in qualitative studies. Despite the relatively small pool of papers included in the review, there were a number of authors who were listed on more than one paper, highlighting that research in this area is limited and certain authors may be disproportionately represented. Overall, despite shortcomings highlighted through the appraisal process, the reviewed studies addressed valuable aims using appropriate methodologies.

Thematic synthesis results

All studies were included in the following synthesis, with the results discussed below. Three meta-themes and eight sub-themes were developed from the data. Meta-themes included “it isn’t the ideal place to live”, “relationships within the unit” and “change”. Owing to the challenge of categorising individuals’ experiences, overlap can be seen between the themes. Table 5 details analytical themes and sub-themes, with the contribution of each paper to these. This was used to check relative contributions, demonstrating that no final analytic themes were based solely on data from lower quality papers (Thomas & Harden, 2008). Example quotations for each theme are provided in Appendix V.

Table 5.

Contribution of papers to theme development.

	“It isn’t the ideal place to live”			**Relationships within the unit**		**Change**		
	(Loss of) Autonomy & privacy	***Impact on relationships***	***Experience of negative thoughts and feelings***	***Difficulties of living with other patients Vs. value of peer support***	***Treated as “ a person, not a patient” Vs. “ a patient, not a person”***	***Facilitators***	***Intrinsic Vs extrinsic motivators***	***Barriers***
Breckon, et al. (2013)	x		x	x	x	x	x	
Brown & Beail (2009)	x		x	x	x	x	x	
Browne, et al. (2019)		x	x	x	x	x	x	x
Burns & Lampraki (2016)	x	x	x	x	x	x		
Fish (2018)	x		x	x	x		x	
Grace et al. (2020)	x	x			x		x	
Harker-Longton & Fish (2002)	x	x		x	x	x	x	
Heppell & Rose (2021)	x	x			x			
Tallentire, et al. (2020)	x		x	x	x	x	x	
Thomson & Johnson (2016)	x		x	x	x	x	x	x
Williams et al. (2018)	x	x		x	x	x	x	
Wood et al. (2008)	x	x	x	x	x	x	x	x

Analytical theme: "It isn't the ideal place to live" (Williams et al., 2018, p.136)

A theme identified across all of the studies related to the idea that the secure service was not an "*ideal place to live*" (Williams et al., 2018, p.136). Within this theme PWLD spoke about different aspects of secure services. Participants discussed how their lives were impacted as a result of being in the service. Experiences of feeling upset, scared or distressed during admission were described.

(Loss of) Autonomy & privacy

Loss of autonomy was experienced in relation to a number of aspects of being in a secure service with participants describing loss of control, choice and freedom during their admission. The secure unit was described as a "*cage*" by one participant (Harker-Longton & Fish, 2002, p.146). Participants lacked control over elements of the physical environment such as the temperature. Restrictions in the units, such as not being able to have certain personal items, added to patients feeling that they lacked choice and control. Participants spoke about being restricted in the activities they could engage in. Limited access to leave and feeling "*stuck on the ward*" was described, in some instances this was due to staffing issues (Burns & Lampraki, 2016, p.78). Participants also described that staff made decisions about their care or future placements and that they were not a part of this decision-making process. The impact of reduced autonomy on mood and wellbeing was discussed, with participants describing feeling "*gutted*", "*tormented*" and "*annoyed*" (Brown & Beail, 2009, p.507,509). For a few participants restrictions represented containment and safety and were perceived as helpful.

Lack of privacy was discussed across a number of the papers, with participants describing that it was difficult to spend time alone, due to sharing living space with other patients and being under the observation of staff. Some participants acknowledged a relationship between observations and lack of privacy with level of risk. Across a number of the papers PWLD described that, where they did feel that they were afforded freedom, choice or privacy this was helpful in managing living within this environment. In six papers, participants described finding the time they had away from the ward or engaging in educational or vocational activities helpful.

Impact on relationships

The impact of being in the secure unit on relationships was spoken about in seven of the papers. This included impact on relationships with friends and family and on intimate or romantic relationships. Participants spoke about missing family and wanting to be with them. Some spoke about the geographic location of the service impacting the number of visits they had. Others spoke about the restrictions on the unit impacting physical relationships. In one of the papers, participants described that intimate or romantic relationships were not permitted within services, with a proportion of participants expressing disagreement with this and feeling that they should be allowed (Grace et al., 2020). Some acknowledged that these restrictions were informed by concerns regarding risk. A proportion of participants described the hope of seeing family and loved ones as something that helped them to cope during the admission and a motivator/reason for wanting to leave the unit.

Experience of negative thoughts and feelings

Participants' experiences of difficult feelings were interwoven across the themes described however; it felt important to include this separately, allowing insight into participants' internal experiences during their admission to a secure service. Across eight papers participants spoke about experiencing distressing feelings including; feeling stressed, angry, vulnerable, nervous, scared and upset. At the extreme end participants spoke about experiencing thoughts about wanting to die or take their own lives. Elements described as contributing to difficult feelings included; being placed in seclusion, having to speak to staff or in ward round meetings, attending therapeutic activities and being around other patients. A proportion of participants spoke about their feelings changing during their admission, for example they initially felt scared or upset but that this had improved, highlighting the help that they had received as a mechanism for this change.

Analytical theme: Relationships within the unit

Experience of relationships within the secure unit came up in some form in all of the 12 papers. Relationships with staff and with other patients were commented on, with both positive and negative experiences discussed.

Difficulties of living with other patients Vs. value of peer support

Identified in 10 papers, relationships with and presence of other patients was spoken about both as helpful, and as a significant challenge for PWLD in secure services. Challenges of sharing a living space with other patients "*with all different problems…different ages all different personalities*" was a factor that came up for multiple participants (Williams et al., 2018, p.137). Difficult experiences included being the victims of conflict and bullying which ranged from feeling that other patients might talk behind their back to physical aggression. The impact of sharing a space with people who were unsettled or displaying behaviours that challenge was also discussed. PWLD spoke about other patients making them feel unsafe or vulnerable and a few participants described this impacted their engagement in therapeutic activities.

On the other hand, being around other patients was also spoken about as offering peer support and people to share activities and free-time with. Some participants described that they were able to relate to other patients and there was a sense of "*we're all in it together*" (Browne et al. 2019, p.799). Relationships with other patients offered closeness and support that may be missing either through not having existing supportive relationships, or limited access to friends and family. Being able to relate to other patients helped some participants feel better about their own struggles.

Treated as a person, not a patient Vs. a patient, not a person

Relationships with staff was something that appeared an important contributor to participants' experiences, discussed in 11 of the 12 studies. There were elements of relationships with staff that were described as helpful and supportive, conceptualised within the theme as feeling treated like a person. Where these elements were perceived as lacking, patients described challenging experiences with staff and feeling treated as a "*nobody*", or a patient not a person (Brown & Beail, 2009, p.507).

Participants in a number of studies described staff as being there to help, or indeed being helpful, suggesting a positive perception of the role of staff within the secure service. Some participants considered that staff were there to maintain their safety and/or to support them to progress towards discharge. Talking with staff was described as something of value by a number of participants. This related to both informal interactions and interactions within talking therapies. Having someone there when they wanted to talk and to help problem solve difficulties were both helpful. Some participants described talking to staff as a way to reduce risky behaviour, for example helping to manage thoughts of self-harm. Availability and consistency of staff was something that influenced how helpful staff were and how well participants felt treated by them. A proportion of participants spoke about a lack of staff availability, either due to limited staffing numbers, staff being busy, or turnover of staff meaning that they were not able to speak with someone they knew. Availability and consistency was linked with familiarity which was experienced as helpful. As well as lack of access to familiar faces, one participant also spoke about "*constant unfamiliar faces*" being something that was difficult (Burns & Lampraki, 2016, p.79).

Feeling treated as a 'person' appeared to be influenced by being listened to, not being judged, being treated with respect and feeling understood by staff. A proportion of patients spoke about difficult interactions or experiences with staff. In some instances, this was in relation to staff enforcing restrictions on the unit. In other instances, patients felt that staff had been disrespectful, examples included staff “*taking the mickey*”, “*winding*” them up, or being perceived as holding a prejudiced attitude (Harker-Longton & Fish, 2002, p.146). A few participants indicated a lack of trust in staff, feeling that they were not doing what they said, that they might break confidentiality, or use information against them.

Analytical theme: Change

The experience of change was a meta-theme running through the papers reviewed. This related to change in a specific moment, or longer-term change. This included positive changes to behaviour, mood, well-being and situation. A proportion of participants spoke about feeling happier and calmer. Some participants described positive change regarding their hopes for the future. Facilitators, motivators and barriers to change were described.

Facilitators

In a number of the papers participants described how their admission resulted in access to support. Some participants described not expecting to receive this support and being glad or grateful for what it had helped them to achieve. Support included access to professionals and therapeutic interventions, such as psychological therapy and occupational activities. In two papers participants mentioned that medication was helpful.

Although not the case for all, a number of participants in the two studies looking at the delivery of group dialectical behaviour therapy (DBT) described it as helpful (Browne et al. 2019; Thompson &Johnson, 2017). These interventions offered participants a space to talk to professionals and peers about their difficulties, develop increased understanding of themselves and factors contributing to their risk, and develop skills for managing difficult thoughts, feelings and behaviours. Participants described that they had learnt to handle situations differently, indicating more socially desirable or less risky responses as a result.

Intrinsic Vs extrinsic motivators

Although positive change and the helpfulness of support was spoken about by participants, not all participants wanted to, or felt able to engage with this. Participants spoke about their motivations to engage, or change during their admission. Both intrinsic and extrinsic motivators were discussed.

Motivators were thought of as extrinsic when participants spoke about external motivators based on consequence. There were more examples of participants describing extrinsic than intrinsic motivators. Being observed by staff who made decisions about their progress led to participants adjusting their behaviour, to "*give enough evidence*" that they were making changes (Browne et al. 2019, p.798). Participants described attending therapeutic interventions despite not wanting to, or continuing attendance when they wanted to drop out. As well as being aware that demonstrating the 'right' behaviours could result in positive consequences such as access to leave, participants spoke about negative consequences to certain behaviours, such as being placed in seclusion or losing their leave. For some, these consequences were motivators to modify behaviour. Motivators were thought of as intrinsic where they related to participants describing being self-motivated to engage or make changes. Intrinsic motivators included participants wanting to feel better, to reduce their struggles with anger, to change for their family and to make a better life for themselves.

Barriers

In three papers, participants described barriers to accessing support or making changes. Barriers included; comprehension, ability and self-belief. Participants spoke about struggling to understand therapeutic material and finding it inaccessible. The use of "*big names*" for therapeutic concepts, the amount of information to hold in mind, and the use of abbreviations all contributed to this (Browne et al. 2019, p.797). Participants in these studies spoke about not possessing or having mastered the skills needed to affect behavioural or emotional change. Possibly linked with this was lack of self-belief which appeared to be a barrier to engaging in or utilising therapeutic interventions. Some participants lacked confidence in speaking to staff and asking for help, particularly in front of other people, such as in ward rounds. Participants spoke about looking stupid, getting it wrong or looking like they were not trying if things did not work. This was also associated with worry that engagement may expose them to judgement from other patients or staff.

Discussion

This review aimed to appraise and synthesise existing qualitative literature, drawing out PWLD's experiences of secure services in the UK and considering aspects of services that PWLD value or find helpful about these services, as well as aspects that are challenging or unhelpful. As an under researched area, just 12 publications met the inclusion criteria. Discussion of the results of the review in relation to the aims and existing literature is provided below. One thing that stood out was that participants described challenges with, and distress relating to, admission to a secure service however, there were also reports of admissions being supportive and facilitating positive change. This is felt to be reflected in the nature of the themes that are reported, with many concepts being discussed as both helpful and challenging.

The analytical theme of '*it isn't the ideal place to live'* highlights the challenges and distress that PWLD can face during admission to a secure service. Although, it is understood that by the nature of the admission, PWLD entering secure services are likely to be experiencing difficult thoughts and feelings, the review indicates that aspects of secure service admissions may further contribute to this. Perlin (2003) argued that the environment of secure services may add to or exacerbate existing difficulties for PWLD. The review indicated reduced autonomy as a factor contributing to the challenges of living within a secure service. Similar findings have been reported by research into the experience of secure services for people who do not have a LD, highlighting reduced autonomy at individual, relational and systemic levels (Ratclife & Stenfert Kroese, 202; Tomlin et al, 2018). Tomlin et al. (2018) describe the need for secure services to balance competing roles of being both "caring and custodial". This task may be particularly challenging in services for PWLD, who due to associated difficulties with communication and cognitive abilities, as well as power relations, may be at increased risk of feeling disempowered or lacking autonomy (Sines, 1995; Carlson, 2010).

The analytic theme '*relationships within the unit'* highlights the importance of interactions with others during admission to a secure service and the both positive and negative impact these can have on PWLD. In secure or inpatient settings where PWLD have limited access to friends and family, staff and patients play a vital role in meeting relationship needs (Fish & Morgan, 2021). The helpfulness of peer support within mental health services has been reported on previously, being associated with increased well-being, companionship and reduced isolation (Basett et al., 2010; Lawton-Smith, 2013). This review highlighted experience of feeling victimised or vulnerable to other patients within LD secure services. This fits with research indicating PWLD are disproportionately affected by exclusion and more likely to experience bullying and abuse (Scior & Werner, 2015). Previous research has highlighted the presence of patient-to-patient bullying in secure services and called for further exploration of how contextual factors may contribute to this type of bullying (Sasse & Gough, 2005; Ireland & Clarkson, 2005).

PWLD's relationships with staff in inpatient settings have previously been cited as being as, if not more, important than specific interventions (Clarkson et al., 2009, Head et al., 2018). Shaw (2014) discussed that the length of admission experienced by PWLD in secure services makes this particularly relevant. In keeping with previous research, helpful elements of relationships with staff described in this review included, being listened to, having opportunities to talk, being treated with respect and dignity and availability and consistency (Clarkson et al., 2009). Conversely, the review indicated that where these qualities were lacking patients experienced interactions with staff as unhelpful or distressing. Research indicates that PWLD in inpatient settings are at increased risk of mistreatment by staff. With higher rates of abuse reported for PWLD than those without LD in these settings (Beadle-Brown et al., 2010). Availability of staff was highlighted as a key factor in this review, likely associated with difficulties with recruitment and retention of staff in this area (McKenzie, 2021).

Finally, the analytic theme of *change* suggests that secure services may support a process of positive change from the perspective of some PWLD. This mirrors the reduction in patient-rated clinical measures reported in the outcome data from the National High Secure Learning Disability Service (Morrissey et al., 2017). However, outcomes data for LD secure services is mixed and Morrissey et al. (2017) described the complexities of measuring the effect of secure LD services on patients, with manifold outcomes (emotional wellbeing, risk, length of stay, recidivism) and no agreed core outcome measures.

When considered together, the sub-themes of *facilitators*, *extrinsic Vs intrinsic motivators* and *barriers* to change, provide a narrative of PWLD in secure services sometimes feeling unsure or unable to access support but being aware that engagement and change is necessary to move on or avoid negative consequences. Participants indicated experience of perceived pressure, or coercion, to engage with interventions within secure services. Similar experiences were reported by Simms-Sawyers et al. (2020) in their research in a low secure forensic mental health service. There is limited research regarding this concept within secure services for PWLD.

The review highlighted barriers to engaging with support that may be particularly pertinent for PWLD, such as comprehension and self-belief. Evans and Randle-Phillips' (2020) review into PWLD's experiences of psychological therapy, reported similar findings in relation to comprehension as a barrier, commenting on the need for further adaptations to ensure the accessibility of talking therapies for PWLD. Self-belief was also a barrier to participants engaging in therapeutic interventions. Given high rates of oppression and stigmatisation of PWLD, along with cognitive and communication difficulties, it may be expected that PWLD are more likely to lack belief in their ability (Jones et al., 1997). It may be helpful to consider this in the context of self-determination theory, which highlights perceived competence as a psychological need contributing to motivation to change (Deci & Ryan, 2012).

As discussed, in some areas, the themes developed mirrored research regarding experiences of secure services by people without a learning disability. However, the review also indicated aspects of the experience of secure services which may be unique to PWLD.

Strengths & Limitations

The review adds to the collection and dissemination of information regarding the experience of secure services by PWLD, highlighted as a need by the Government White Paper Equity and Excellence: Liberating the NHS (DOH, 2010). A strength of this review is its use of a systematic process of data extraction and synthesis, allowing the author to ‘go beyond’ the data, whilst maintaining transparency of theme development (Thomas & Harden, 2008).

The review included papers involving participants in different levels of security and in different UK locations. Although not clear from the information available, it is likely that PWLD were at different stages of their admissions. This makes it difficult to generalise the findings across services and settings. Small sample sizes of the studies also impact this. However, it is acknowledged that the review was exploratory in nature and generalisability was not a key priority.

Data coded for the review included only direct quotes from participants. The rationale for this was to capture the views of PWLD, rather than an interpretation of these by authors. However, quotations included in results sections have been selected as important or representative by authors, introducing a level of interpretation at this stage. It is difficult to determine how representative these are from the data available. Coding of direct quotations only was considered a limitation of the review, impacting the amount of data available to analyse. Expanding the selection of data may have led to richer theme development. The richness of themes was also impacted by the review including studies with diverse aims. However, this was considered necessary given the pool of research available.

Studies provided limited information regarding PWLD who chose not to participate, or those who dropped out. It is possible that those who did participate may have had particular experiences of secure services, potentially introducing bias to the findings. The voices of people with more significant LD were missing from the studies.

Clinical implications

The review highlighted factors that may contribute to the experience of distress by those being cared for in secure LD services. Awareness of these factors may help clinicians to take steps to minimise these. This may be more challenging for some factors than for others, for example it may not be possible to remove restrictions employed by secure services to maintain safety. However, acknowledging the impact of these restrictions on PWLD and exploring how they can be applied with the least impact might be beneficial. It is important for clinicians working in secure services to be aware of experiences of patient-to-patient conflict or bullying and consider ways to safeguard individuals in their care.

The findings of the review highlight the important role of staff within LD secure services. It would be helpful for services to consider how to achieve the desired availability and consistency of staff described by participants. Peer support was also identified as important. Where this is not already being done, services may want to consider methods of facilitating this, for example through facilitated peer support groups or peer mentors.

The review indicated that although there may be overlap with other patients, PWLD in secure services have unique needs and experiences. It is recommended that PWLD are consulted with in the design and implementation of services and interventions to ensure that these are acknowledged and addressed. For example, it may be beneficial for service-users to be consulted on the development of therapy materials to maximise accessibility.

Research implications

This review aimed to be explorative in nature, providing insights into the experiences of PWLD in secure services. Given the limited number of studies that met inclusion criteria, further qualitative research in this area would be useful. The review captured studies that explored various aspects of secure service provision, including environment, relationships and support. It would be helpful for future research in this area to consider stage of admission and how this may relate to described experiences, what is valued, and the helpfulness of certain aspects of care.

The review highlights that PWLD can be meaningfully involved in research regarding experiences of service provision. It would be helpful to consider ways to make research participation regarding this topic more accessible to those who struggle with verbal communication, for example through arts-based methods as described by Dew et al. (2019).

Therapeutic interventions were discussed as helpful in facilitating change. However, this was only covered by two studies, looking at group DBT interventions only. Further research into the experience of talking therapies offered within LD secure services, particularly regarding how these can be best adapted for PWLD is indicated. It would also be helpful to explore the experiences of being offered therapeutic interventions in this setting, particularly in relation to self-determination and perceived pressure to engage.

Conclusions

This review provides a critique and synthesis of current literature relating to PWLD’s experiences of secure services within the UK, based on 12 papers. The review offers an insight into PWLD’s perceptions of elements of secure services. Through synthesis of findings the review captured challenges of being admitted to a secure service and also valued or helpful aspects of these services. Themes including relationships, autonomy and access to help were noted to be associated with contrasting experiences. Given the reliance on secure services to support PWLD who present with challenging or high-risk behaviour, it is important for professionals working within these services to understand how they might be experienced by PWLD and what contributes to helpful for unhelpful aspects of the environment and care. Further research into PWLD's experiences of secure services and how these can best meet their needs is indicated.

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Section B

Major Research Project: Section B

The offer of psychology within a low secure learning disability service: Choice without a choice. A Grounded Theory.

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ABSTRACT

Aims: The aims of the research were to explore the process of offering psychology within a low secure learning disability service and how this is perceived, including perceived coercion to engage.

Design: Guided by constructivist grounded theory, this study utilised an exploratory, qualitative design. Data was collected via interviews.

Methods: Six staff and five patients participated in semi-structured interviews. Analysis of interviews followed CGT guidelines.

Results: A grounded theory model of the process of engaging patients in psychology within a low secure learning disability service is presented. The constructed model identifies four domains: 'context of the offer', 'drive to engage patients in psychology', 'navigating making the offer' and 'making sense of the offer', including 10 categories and four sub-categories, with three further subcategories. Interactions between these are highlighted.

Conclusions: The study explored the process by which staff in a low secure learning disability service negotiate trying to engage patients in psychology. Findings emphasise the challenges of the dual role of staff within a forensic setting and how navigation of this may translate into patient's receiving a mixed message regarding choice. Factors influencing willingness to attend psychology are outlined**.** Implications for further research and clinical practice are discussed.

Key words: People with learning disabilities, Grounded Theory, Secure care, Psychology, Coercion

Introduction

A socially constructed concept, the terminology describing people who meet the criteria used to diagnose a learning disability (LD) has changed over time. As the terms currently used by most NHS services, this paper chose to use LD and person/people with a learning disability (PWLD). A LD is diagnosed based on the presence of significant impairment in intellectual and adaptive functioning, onset before a person is 18 years old (BPS, 2015). Where a PWLD presents with behaviours that are considered high risk, in breach of the law, or at risk of offending they might be detained under the Mental Health Act (MHA 1983, amended 2007) in a secure forensic service (RCP, 2013). There are different levels of secure care, including low, medium and high. In June 2020, NHS data indicated there were 995 PWLD in a secure bed in the UK (NHS Digital, 2020). Specialist LD secure services manage risk to individuals and the public whilst providing assessment and treatment for those in their care (RCP, 2013).

Psychological assessment and treatment form a key aspect of the multidisciplinary care and rehabilitation provided within secure LD services, typically including risk assessment, risk management plans and delivery of therapeutic interventions targeting risk behaviours (BPS, 2011). Offenders with LD are recognised as a distinct group with specific needs in relation to care and treatment (Hellenbach et al., 2015). A number of psychological interventions have been adapted for use within forensic LD settings, for example adapted Sex Offender Treatment Programs (SOTPs, Lindsay et al., 1998) and adapted cognitive behavioural therapy for anger and fire-setting (Taylor & Novaco, 2005; Taylor et al. 2004). Empirical studies indicate that adapted interventions may be beneficial in: increasing motivation to change, increasing victim empathy, reduction of cognitive distortions and reduced self-reported anger (Cohen & Harvey, 2016; Patterson et al., 2018; Jones & Chaplin, 2007; Taylor & Lindsay, 2010). However, research is limited regarding the efficacy of these interventions in reducing recidivism (Cohen & Harvey, 2015; Taylor & Lindsay, 2010).

Despite being an area of emerging evidence, engagement with psychology is often considered a key part of rehabilitation and risk reduction and is frequently discussed during care and discharge planning within LD secure services. Existing evidence suggests that in forensic settings, patients may not be intrinsically motivated to engage with psychology and may resist therapeutic interventions (Kaliski & de Clerc, 2012; Burns & Lampraki, 2016; Browne et al., 2019). Professionals working within secure settings face the dual burden of balancing safety of the individual and others, with promoting person-centred recovery (Mann et al. 2014).

Detained involuntarily under the MHA (1983, amended 2007), PWLD in secure services may be mandated to comply with certain interventions. Under this legislation, where considered necessary to manage risk, coercive practices such as forced administration of medication and restriction on freedom may be applied (Department of Health, DOH, 2015). Unlike medical or restrictive interventions, it is not possible to physically force active engagement in psychology (Day et al., 2004). However, research into rehabilitation of offender populations indicates that individuals may experience other types of pressure to comply with psychological treatment, such as awareness of negative consequences of not engaging (e.g. delayed discharge) and social pressure (Day et al., 2004; Wild et al., 2006). This may be thought of as informal coercion. Within existing literature, the term ‘perceived coercion’ has been used to capture the internal state of feeling compelled to behave in a certain way, associated with reduced autonomy and choice, capturing both formal and informal coercion (Eriksson & Westrin, 1995; Simms-Sawyers et al., 2020).

The British Psychological Society’s Code of Ethics and Conduct (British Psychological Society, 2021) emphasises consent and self-determination as key values that should inform psychologists’ practice, yet these values may be obstructed by the environment and procedures within forensic services, suggesting challenges associated with offering psychology within secure settings. Research in this area is sparse and has largely employed quantitative methodologies. Using qualitative methodology, Simms-Sawyers et al. (2020) explored forensic mental health (FMH) patients' experiences of perceived coercion to engage in psychology within a secure service. They reported coercive power experienced in multiple forms, including leverage, use of authority and power, verbal threats and negative consequences associated with non-compliance. This was associated with psychological distress, feelings of resistance and superficial engagement. However, it was suggested that therapeutic alliance was established in spite of this (Simms-Sawyers et al., 2020).

Within literature exploring coerced treatment more broadly, Ryan and Deci's (2000) Social Determination Theory (SDT) has often been cited (Lamberti et al., 2014; Wild et al., 2006). SDT highlights the importance of conditions of autonomy, choice and trust for individuals' motivation for change, suggesting that the context and beliefs around the offer of psychology may be important in the acceptance and effectiveness of interventions (Ryan & Deci, 2008). For example, SDT implies that perceived coercion would likely reduce intrinsic motivation to engage, with an impact on treatment outcomes (Wild et al., 2006). It is likely that the way in which psychology is offered and the motivation behind attending may impact the experience and outcomes of interventions. It is not clear whether this theory offers explanatory power when thinking about PWLD, particularly the population of PWLD within the unique conditions of a low secure setting.

Research concerning how engagement in psychological interventions is achieved within LD secure settings is sparse. PWLD are thought to experience greater power imbalances with staff, be more likely than others to have difficulties with understanding and comprehending the legal system and their rights, and be at greater risk of acquiescence when engaging with legal or health professionals (Jingree et al., 2006; Hyun et al., 2014; Finlay & Lyons, 2002). Therefore, the processes involved in attempting to engage PWLD in psychology may be different to other populations, with the context of secure care likely adding further complexity to this.

In their grounded theory (GT) model of adapting dialectical behaviour therapy (DBT) within forensic LD services, Browne et al. (2019) indicated that despite a DBT group not being mandated, patients perceived engagement as a "non-choice", motivated by perceived coercion (pp.796). Browne et al. (2019) recommended further exploration of this phenomena. In their review of current research and practice with offenders with a LD, considering the context in which psychological therapy is offered, Taylor and Lindsay (2018) argued that the extent to which offenders with LD can make entirely voluntary treatment decisions is a "matter that needs to be aired openly" (pp.464). There are considerable gaps in the understanding of delivery of psychological interventions in LD secure settings, with few studies exploring factors such as motivation to change and motivation or readiness to engage with psychology (Breckon et al., 2013; Taylor & Lindsay, 2018).

Rationale & aims

Little is known about the processes of offering psychological interventions within LD secure services. Through exploration of the experiences of patients and staff, the current study aimed to develop a Grounded Theory (GT) of the processes involved in attempting to engage PWLD in psychology within a low secure service. This included exploration regarding perceived coercion to engage in psychology within this context, and the impact of this.

This project was guided by questions including:

1) What is the process by which psychology is offered to offenders within a LD low secure service?
2) What are the factors contributing to motivation to engage in psychology?
3) What are the views of professionals and PWLD regarding perceived coercion to engage with psychology within this setting?

Method

Design

Different qualitative methodologies were considered before deciding on the use of Grounded Theory (GT) methodology. GT is a systematic approach to data collection and analysis enabling production of a theoretical model, developed inductively from participant data (Smith, Harre & Langenhove, 1995). With the aim to construct an explanatory theory, GT allows exploration of experiences and is appropriate for inquiring about areas in which little is known (Foley & Timonen, 2015; Chun Tie et al., 2019).

A social constructionist epistemological position was taken, guided by Charmaz's (2014) Constructivist Grounded Theory (CGT). This approach assumes a subjective reality arrived at through the interrelationship between the researcher and participant, recognising the impact of the context of each, and the researcher's values and interpretations on the results (Mills et al., 2006; Charmaz, 2014). Due to challenges with recruitment and the timeframe of the study, an abbreviated form of CGT was employed (Willig, 2008). Participants engaged in semi-structured interviews about their experiences and perceptions regarding the offer of psychology.

Recruitment

Patients and staff were recruited from an NHS low secure forensic learning disability service in the South of England for male patients. It was considered that staff across all disciplines are involved in the process of offering psychology within secure settings. For example, psychiatrists may discuss psychology in ward rounds and healthcare assistants may remind patients about the time of their appointments. As a result, staff from all disciplines were invited to participate. Recognising the multiplicity of perspectives CGT supports exploration of what happens amongst heterogeneous participants, thought to be a strength when research is likely to consider the effects of uses of power (Charmaz, 2015). A low secure service was primarily chosen based on access. It was also considered that the majority of PWLD in secure services are within low secure services (NHS Digital, 2020).

Sample sizes of 6-13 are reported in GT research in similar settings (Isherwood, Burns & Rigby, 2006; Laithwaite & Gumley, 2007; Scanlon, 2006). This was used as a guide. Sampling was purposive, using specified inclusion and exclusion criteria detailed in Table 1. It was planned to use theoretical sampling to guide recruitment, unfortunately this was limited due to the research timeframe and challenges in recruitment (including impact of Covid and a small participant pool). As a result, opportunistic sampling was used. Recruitment and interviews continued until theoretical sufficiency was reached, conceptualised as when categories were well-developed, with further data adding little to the theoretical understanding and model (Corbin & Strauss, 2008).

The researcher informed staff about the research through presentation of the project at a clinical governance meeting and discussion during two staff handovers (Appendix VI). An email was sent to all staff at the site (Appendix IX). Patients were informed about the research by a research supervisor (psychologist in the service) during patient community meetings. Information sheets were provided (Appendix VII and VIII).

Table 1.

Eligibility criteria for patients and staff

	Inclusion criteria	**Exclusion criteria**
Patients	Aged 18 years or over Current patient at XX or XX Had an opportunity to engage in psychology at XX	Being assessed by the clinical team as a risk to themselves or the researcher. The clinical team assessing mental health symptoms as not stable enough for the person to engage safely. Unable to give informed consent. Unable to participate in the interview verbally and in English.

		Being a patient on a prison transfer (Section 47/49 of the Mental Health Act). It was felt that this would not reflect the usual experience of patients in this setting.
Staff	Aged 18 years or over Currently working at XX	Involved in the research project (other than as a participant). The only person in the team to hold their role/title meaning that confidentiality may be compromised.

Participants

A total of 11 participants were involved in the research, five patients and six staff. Pseudonyms are assigned to maintain confidentiality. Due to difficulties with recruitment from the low-secure service, three patient participants who had previously been offered psychology during admission to the low secure service were recruited from the step-down unit at the same site. This had been granted ethical approval as a contingency measure. Eight interviews were conducted face to face, with three staff interviews conducted via videocall. Demographic information for patient participants is detailed in Table 2. Secondary diagnoses given to patients included: recurrent Depressive Disorder, Autism Spectrum Disorder, Emotionally Unstable Personality Disorder, Paranoid Schizophrenia and Mental and behavioural disorders due to substance use.

Table 2.

Summary of demographic information for patient participants.

Pseudonym	Unit	Age range (years)	Ethnicity	Time since admission	Learning disability	Mental Health act section
Paul	Low secure	30-40	White British	<1 year	Mild LD	37/41 - Hospital order with restrictions
Joe	Low secure	20-30	White British	1-2 years	Mild LD	Section 3 – admission for treatment

William	Low secure	20-30	White British	2-3 years	Mild LD	Section 3 – admission for treatment
David	Step down	30-40	White British	2-3 years	Mild LD	Section 3 – admission for treatment
Richard	Step down	20-30	White British	2-3 years	Mild LD	Section 3 – admission for treatment

Table 3 provides details regarding patients who declined to participate or did not meet eligibility criteria. This only includes those who approached a member of the research team to discuss participation and not all who were invited to participate. Staff participant demographics are in Table 4. All staff who expressed interest went on to participate.

Table 3.

Reasons for non-participation of potential patient participants.

Reason for non-participation	**Number of patients**
Not eligible due to MHA section	3
Clinical team deemed not eligible due to mental state	1
Clinical team deemed unable to give informed consent	2
Declined offer to participate at information giving stage	6
Declined to participate at consent stage	1
Unavailable/away from ward during recruitment process	2

Table 4.

Summary of demographic information for staff participants.

Pseudonym	**Designation**	**Years qualified**	**Time in post**
Psychologist	Psychologist	<1	<1
HCA1	HCA	N/A	1-3

HCA2	HCA	N/A	4-10
HCA3	HCA	N/A	<1
RC	RC	4-10	1-3
Psychiatrist	Psychiatrist	4-10	<1

Notes.
HCA=Healthcare assistant
RC = Responsible Clinician

Data collection

Patient interviews took place in a visiting room on the unit. For the purpose of risk management, a member of staff (independent to the research and psychology team) sat outside the room. All patient interviews were face-to-face, although video interviews were offered also. Staff interviews took place via Microsoft Teams or face-to-face. Interviews ranged from 10 to 69 minutes. Interviews were audio recorded and transcribed verbatim.

Interview guides (Appendix X and XI) based on the interview schedule used by Simms-Sawyers et al. (2020) were used. Schedules were adapted for the current research through consultation with psychologists who worked within the secure setting, a research supervisor and guidance on constructivist interviewing in GT provided by Charmaz (2014). The accessibility of questions for patient participants was checked by a psychologist at the service who was involved with the research. In line with CGT methodology interview guides were adapted during the research to allow refinement of concepts developed during data analysis (Charmaz, 2014).

Ethics

The study was granted ethical approval by an NHS Research Ethics Committee (Appendix XII), NHS Health Research Authority (Appendix XIII), and the participating Trust’s Research and Development team (Appendix XIV, Appendix XV). The Health and Care Professions Council (2008) and British Psychological Society Code of Human Research Ethics (BPS, 2021) were adhered to throughout the research.

Consent

The patient information sheet and consent form were prepared using MENCAP's (2002) guidelines for accessible writing and reviewed for accessibility by an Expert by Experience as well as a speech and language therapist at the recruitment site. After receiving information about the project, patients were given a minimum of seven days to express interest in participating via returning an expression of interest form (attached to the information sheet) or approaching a member of staff. To minimise possible pressure to participate, patients were not approached by the researcher unless they had expressed interest. At least one member of the patient's clinical team was consulted with by the research supervisor at the site to ensure that patients met eligibility criteria. For those who were eligible, the researcher then met patients individually to go through the information sheet again, with information given both verbally and in writing. A framework provided by Thomas and Stenfert Kroese (2005) (Appendix XVI) was used to assess comprehension, with principles of the Mental Capacity Act (MCA 2005) held in mind. Written consent was then obtained (Appendix XVII). Interviews were conducted at least 24 hours later, allowing patients time to change their mind.

Staff were also given a minimum of seven days to express interest in participating, by speaking with a research supervisor at the site or emailing the researcher directly. The researcher met with those who expressed interest. Staff were given the opportunity to read and discuss the information sheet (Appendix VII). Written consent was obtained for those who wished to participate (Appendix XVIII). Both staff and patients were reminded immediately prior to the interview that participation was voluntary and that they may change their mind or end the interview at any time with no consequences. The researcher checked with participants during interviews that they were comfortable to continue and provided opportunities for them to ask for a break or to end the interview. A visual prompt sheet was available to patient participants to aid this (Appendix XIX).

Confidentiality

All research data was anonymised and stored in a secure location at the research site or on an encrypted memory stick. Audio data from interviews was deleted following transcription. Pseudonyms were applied to ensure confidentiality of participants. To ensure confidentiality of staff, those who were the only person to hold their job title at the site were not eligible to participate.

Acquiescence

PWLD may tend to answer in line with what they believe is the desired response, to choose the last option on a list, or answer with "yes" (Rogers, 1999). Use of a mixture of both open and closed questions can support PWLD engage meaningfully in interviews (Booth & Booth, 1996). This approach guided interviews with patients, who also had access to a visual prompt to support communication where desired (Appendix XIX).

Risks

Potential risks of participation were outlined in information sheets for both staff and patients. Patient participation was reviewed by at least one member of the patient's clinical team prior to interview, with risks of participation considered, including risk of distress to the patient. A distress protocol for both patients and staff was included within the ethics application. During interviews, clinical judgement was used to assess participant well-being throughout. All participants were debriefed following the interview with signposting to available support. One participant chose to end the interview after 10 minutes, reporting that they were tired. No participants reported or appeared distressed during the interviews.

Service-user consultation

The researcher met with an Expert by Experience who offered consultation on the project. The aims of the project and possible value of the results were discussed. Feedback on the information sheet, consent form and interview schedule was provided, informing modification of these documents.

Data Analysis

NVivo 12 qualitative data analysis software was used to analyse transcribed data. Data was transcribed by the researcher and read a number of times to enable familiarity. Charmaz's (2014) stages of analysis were followed, described in Table 5. Diagram 1 denotes the simultaneous process of data collection and analysis, with constant comparison and checking of codes against new data and revision of interview guides to explore concepts (Charmaz, 2014). In line with GT methodology, diagramming and memos were completed throughout data collection and analysis. This supported connection with and recording of the development of theoretical ideas (Birks et al., 2008). Appendices XX to XXII provide examples of this process.

Table 5.

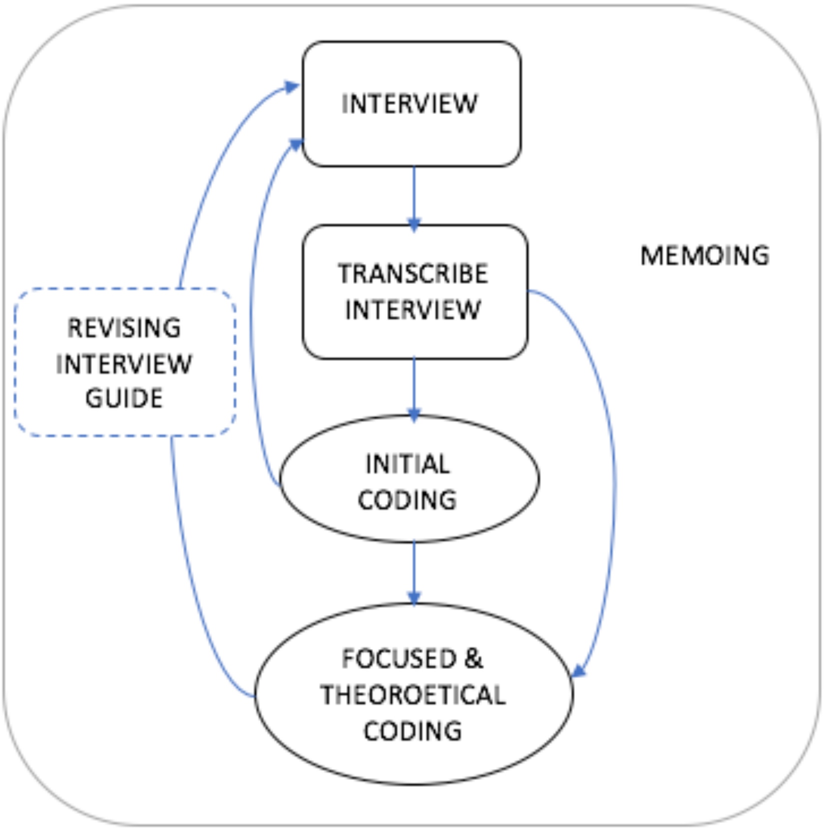
Stages of CGT analysis

Stage of analysis	Description
Initial coding	Initial line-by-line coding was completed for six interviews. 'In vivo' codes and gerunds were used to describe the data.
Focused coding	The following five interviews were coded using focused codes, using the most significant codes to categorise larger segments of data, assessing which codes best explained the data. Focused coding was more conceptual than initial coding.
Theoretical coding	This involved considering how the codes generated during focused coding related to each other. Relationships between categories of codes were hypothesized and codes became more abstract. The

theoretical model evolved through this process of theoretical integration (Charmaz, 2014).

Diagram 1.

CGT process of data analysis, based on the method described by Charmaz (2014).



Quality assurance

Research quality was held in mind throughout the study, with steps taken to ensure rigor. Tong et al.'s (2007) consolidated criteria for reporting qualitative research (COREQ) was used to consider quality and reporting of the research (Appendix XXIII). CGT acknowledges the influence of the researcher on the process of data collection, analysis and results. Charmaz (2014) describes the importance of reflexivity of the researcher in capturing bias and allowing the reader to understand the researcher's position (Groen et al., 2017). A bracketing interview was completed prior to starting the research, allowing exploration of researcher assumptions and preconceptions (Appendix XXIV). The reflexive process was iterative, with the use of a reflective research diary (Appendix XXV), research supervision, memoing and diagramming aiding this (Charmaz, 2014; Groen et al. 2017). These processes informed a positioning statement, see Appendix XXVI, with an abbreviated version below. During analysis, quotes were selected to demonstrate grounding of themes within the data, examples are provided within the results section. Peer supervision with other researchers supported discussion of the analysis process and refinement of coding and theoretical development.

Positioning statement

Currently in my 30s, I am a white British female living in the south of England. The research study was completed in partial fulfilment of a Doctorate in Clinical Psychology. Prior to training I had experiences as an Assistant Psychologist offering psychological input to detained individuals, some of whom had a LD. I saw staff trying to engage patients who were unwilling to attend psychology in treatment and the challenges this posed. I experienced my therapeutic relationship with patients being impacted by experiences of perceived coercion. Through this study I hoped to develop an understanding of the processes by which psychology is offered to detained patients, particularly PWLD, for whom this process may be even less understood and potentially more complex.

Results

Overview of the model

The results present a model of how staff within a low secure LD service navigate the task of attempting to engage patients in psychology and how this is experienced by patients, including resulting willingness to attend. Research questions informed interview guides and initial exploration; however, theory building was guided by participant data meaning that research questions are not specifically addressed. Findings were constructed across four domains, including 10 categories and four sub-categories, with three further sub-categories (Table 6). A narrative description of the model is provided, including illustrative quotes. This is followed by a visual representation of the model (Diagram 2).

Table 6.

Processes in the grounded theory model.

Domain	Category	Subcategory	Further subcategory
Context of the offer	**Coercive systems**		
	Living with a LD		
Drive to engage patients in psychology	**Psychology is helpful**		
	Reducing risk		
	Psychology is necessary		
Navigating making the offer	**Caregiver**		
	Agent of security		
	A mixed message		
Making sense of the offer	**Choice without a choice**	***Perceived choice***	*Understanding and expectation*
		External motivation	
	Willingness to attend	***Internal motivators***	*Wanting help*
			Social gain
		Challenges of psychology	

Context of the offer

Staff participants highlighted the importance of the broader context in which the attempt to engage PWLD within the low secure service takes place.

Coercive systems

The low secure service exists within multiple other systems including legal and health care systems and broader society. Staff participants described these systems as being built on paternalistic ideation, reinforcing ideas of hierarchy and power that likely influence many elements of both staff and patient choice and behaviour. Patients are detained involuntarily and experience a multitude of restrictions on freedom and choice.

> *"...most decision making in mental health services is coercive to some respect just because of the nature of the whole system, the health care system and the criminal justice system means that, like there are always external factors that influence patients' decisions..." Psychiatrist*

Living with LD

Perceived by society and health and legal systems as people who require support and who may struggle to make independent choices, some staff participants described that PWLD have a pervasive experience of stigma, disempowerment and dependence on others. The label of LD and the experiences and characteristics associated with this were referred to as having an influence across the processes described by the model, these are highlighted throughout.

> *"If there isn't enough stigma attached to being a detained patient and/or having a label of someone who is learning disabled ...on top of that you then add you know very stigmatized roles in society." RC*

Drive to engage patients in psychology

Within this concept 'engaging' patients refers to encouraging attendance at psychology sessions or groups. Staff participants described psychological input as highly valued by the systems, service and staff working within it. Staff participants across disciplines were motivated to support patients to engage in psychological assessment and intervention.

Reducing risk

In working with offenders, understanding, managing and reducing risk were spoken about as key tasks of the service. Psychological assessment and intervention were seen as important in achieving this.

> *"It is good because we see them changing... We see them on admission and we see them how they have improved... yeah, it works. It helps it helps. Even the behaviour, everything changes, no more confrontation or no more aggressiveness, all that they treat it and they treat it and they treat it." HCA3*

Psychology is helpful

Psychology is seen as helpful in supporting patients to develop understanding and learn skills that can improve quality of life. One participant described that psychology may be particularly valued within LD services where medication may be perceived as having less of a role.

> *"psychology is really pivotal in learning disability services because err because lots of the issues that patients are having are sort of relational, around like social communication, interpersonal sort of dynamics, long term problems with like relationships... understanding like normal social interactions...so I think that's another area that psychologists can be really helpful..." Psychiatrist*

Psychology is necessary

Staff described experiences of MHA tribunal panels and step-down services emphasising a need for patients to complete psychological assessment and intervention. Associated with its perceived helpfulness and role in risk management, psychology was described as a core intervention, with staff perceiving engagement in psychology as a necessary condition for patients to progress.

> *"it's just really crucial for their treatment."* HCA2
>
> *"some places say, well, we will only take this patient if they have done X, Y or Z". Psychiatrist*

Navigating making the offer

The 'offer' of psychology covers the initial recommendation to patients, inviting them to psychology sessions and encouraging attendance. When navigating how to make this offer within the context described, staff indicated that their thoughts and actions were influenced by different motivations, responsibilities and aims. These were conceptualised in the model under two categories, *caregiver* and *agent of security*.

Caregiver

The *caregiver* category represents staff valuing individualised patient care, in which patient choice and autonomy is highly esteemed and strived for. Staff spoke about wanting to improve patients' quality of life and support them to achieve goals meaningful to them. All staff described being influenced by the concepts captured by the *caregiver* category. Staff described feeling strongly that patients should not feel forced or pressured to engage in psychology.

> *"to provide erm 1:1 care, personal centred erm care, of course all the patients are different, so we have to analyse what their needs and tailor made their needs and trying to so to help them so that they can be be better and go back to the community…to make sure that we we serve them, and protecting them …whilst giving them quality top-quality service". HCA3*
>
> *"…so it's for a long time even before I was an RC, it was something that concerned me how to help people make informed non-coerced choices…"RC*

Agent of security

The *agent of security* category represents staff experiencing responsibility to the service, legal system and other stakeholders to manage risk and keep people safe. Staff described a pressure to engage patients in psychology as a way of evidencing reduced risk, with an aim to progress patients though the system. Staff felt a responsibility to relay information to patients regarding what is required by the system, although aware that this may in turn pressure patients to engage. The extent to which staff members described being influenced by the *agent of security* category appeared to be dependent on their role within the service. Staff who held clinical decision-making responsibility and were involved in delivery of interventions appeared to be more aligned with this category than others.

> *I do believe that they are here to reduce their risk to others and we can't just hold them here and then let them out because what's the point then? There would have been no change …". Psychologist*
>
> *"I have said to patients that they're very unlikely to consider unescorted leave until you've completed offence related work." RC*

Where motivations were aligned with both the *caregiver* and the *agent of security* categories this was experienced as conflicting.

> *"The patient is our client, the public is our client, the court is our client. There are so many competing clients…" Psychologist*
>
> *"…so there's a conflict between like patient centred care and yeah but then also being very paternalistic about care. There is a conflict that's built into the system …" Psychiatrist*

A mixed message

Staff described negotiating this dissonance by trying to find ways to fulfil both roles, often trying to compensate for possible pressure on patients to engage. This included being clear about the importance of psychology and associating engagement with psychology with increased likelihood of positive consequences such as Section 17 leave or discharge but also emphasising patient choice and power to choose whether or not to engage. The navigation of the *caregiver* and *agent of security* roles both within and between staff results in contrasting messages being delivered to patients regarding their engagement in psychology. Patients are given the message that engagement is their choice but that it is also likely to be necessary for, or speed up, discharge from the service. Staff participants reported that discharge was not made conditional on engagement with psychology but that patients are made aware of how psychology can help them progress and how lack of engagement may be viewed by tribunals and key professionals within the legal system.

> *"I would never say you've got to do this work, or I'm not going to write to the MOJ for your leave until you've done this work but I will say … one reason why the MOJ might say no to your leave is you haven't finished your offence related work yet. Erm I think they have a right to know that that's maybe how it will be seen, and that's why it's so complicated…" RC*
>
> *"we remind them like it's not a case of do this and get that, the choice is always completely up to them…" HCA2*
>
> *"…to me offering is like here's something, do you want it? Whereas I'm not sure if we do that really generally speaking, I think we say you need to do it…" Psychiatrist*

Making sense of the offer

Choice without a choice

Patients described experiencing choice *(*constructed as *perceived choice)* regarding whether or not they attended psychology, but at the same time said they *had* to engage with psychology to be able to be discharged (constructed as *external motivation*). This experience was constructed within the model as *choice without a choice***.** The majority of patients did not express explicit awareness of this juxtaposition; however, one patient referred to having a choice whether or not to attend psychology whilst at the same time feeling that they did not have a choice but to complete psychology treatment in order to leave hospital.

Perceived choice

Mirroring the messages given by staff, patients reported experiencing choice regarding whether or not they engaged with psychology. They described that they could either attend or not attend, say yes or no. Where patients perceived choice regarding attending psychology, the recommendation from staff to attend was received positively rather than as something to resist, influencing willingness to attend.

> *"I chose to go…No never [feel pressured to attend] …no no, no, not a billion years. Not here." Paul*

> *"It's up to me if I want to do psychology or not...One day if you woke up and you didn't want to do the session they wouldn't force you." William*

Understanding and expectations

Staff described experiences of patients not questioning their choice in the process, possibly not understanding influence of external factors on their decisions, or being aware of coercive pressure but not seeing this as impacting self-determination. Staff suggested that this may be impacted by comprehension and communication abilities of patients and past experiences of dependency or reduced autonomy.

> *"…I almost feel I feel a bit sad for them in that they might not even realize you know that they but there is this contention and this kind of yeah, but they're kind of happy to go along with it." Psychologist*

External motivation

All patients described that attending psychology was necessary for them to progress from the service. Patients were aware that attendance at psychology is recorded by staff and fed back to the multidisciplinary team and during meetings. Some perceived negative consequences of not attending psychology, such as decision makers viewing this negatively. This message came from staff within the service, but also external staff such as solicitors, Care Programme Approach (CPA) meetings and tribunals, highlighting the influence of the wider systems in the process of engaging patients in psychology within this setting. External motivation was a significant factor driving patients' willingness to attend psychology, appearing to carry significant weight in comparison to other influencing factors, emphasised by the heavier line on the diagram. Although staff reported that when *navigating the offer* discharge was not presented as conditional on engagement, patient participants expressed that this was the message they received.

> *"They, the lady [member of psychology team] just said I've gotta do it…" David*
>
> *"I've been told if I don't do psychology and do my treatment in hospital I have to stay here longer, til I have finished them." Joe*
>
> *"…because if you do psychology sessions and all your sessions it'll go in your favour and like in tribunals, CPA, CTR…". Paul*

Willingness to attend

Patients described experiencing different levels of inclination to engage in psychology; however, the majority of patients reported that they felt willing to access psychology. Staff reported that patients largely respond positively when invited to or offered psychology, recalling experiences of patients requesting psychology or eagerly waiting for the psychologist to arrive on the ward. *Willingness to attend* psychology was described as influenced by *external motivation* and *perceived choice* but also by *internal motivators* and *challenges of psychology*.

Internal motivators

Wanting help

Internal motivators to attend psychology included patients wanting help to understand themselves, develop coping strategies and reduce risk of recidivism. Patients described seeing psychology sessions as a helpful space to talk about any difficulties. Presence of internal motivators that aligned with what was being offered or requested by staff appeared to be associated with increased *perceived choice* regarding attendance. With the contrast being described by one patient who reported no internal motivators to attend.

"... get the thoughts off my mind." David

"just like someone to talk to...about any issues about problems." Richard

"I think people who have been in the community as well, might know that it's quite difficult to access that support and so feel quite grateful to have it you know in hospital..." Psychologist

Social gain

Attending psychology was described as a social opportunity and a way to reduce boredom. Patients described positive regard for psychology staff. Staff reflected that they experience patients as seeking positive social relationships. One staff member proposed that this may be influenced by living with a LD and experiencing challenges forming relationships in other areas of life. Staff described observing a desire to have a relationship with staff as a motivator for patients' attendance at psychology.

"*"...something to do." David*

"...actually sitting in a room with somebody who's an adult and talking appeals to a lot of a lot more to learning disability patient ...". HCA3

Challenges of psychology

Participants described that the idea of psychology could be anxiety-provoking and that talking to a psychologist can feel hard. This was associated with presence of offending histories with participants describing possible experience of shame regarding discussing offending, or concern that disclosing information to a psychologist may lead to negative consequences. Difficulty engaging with the content or structure of the sessions was also described. These factors negatively impacted willingness to attend.

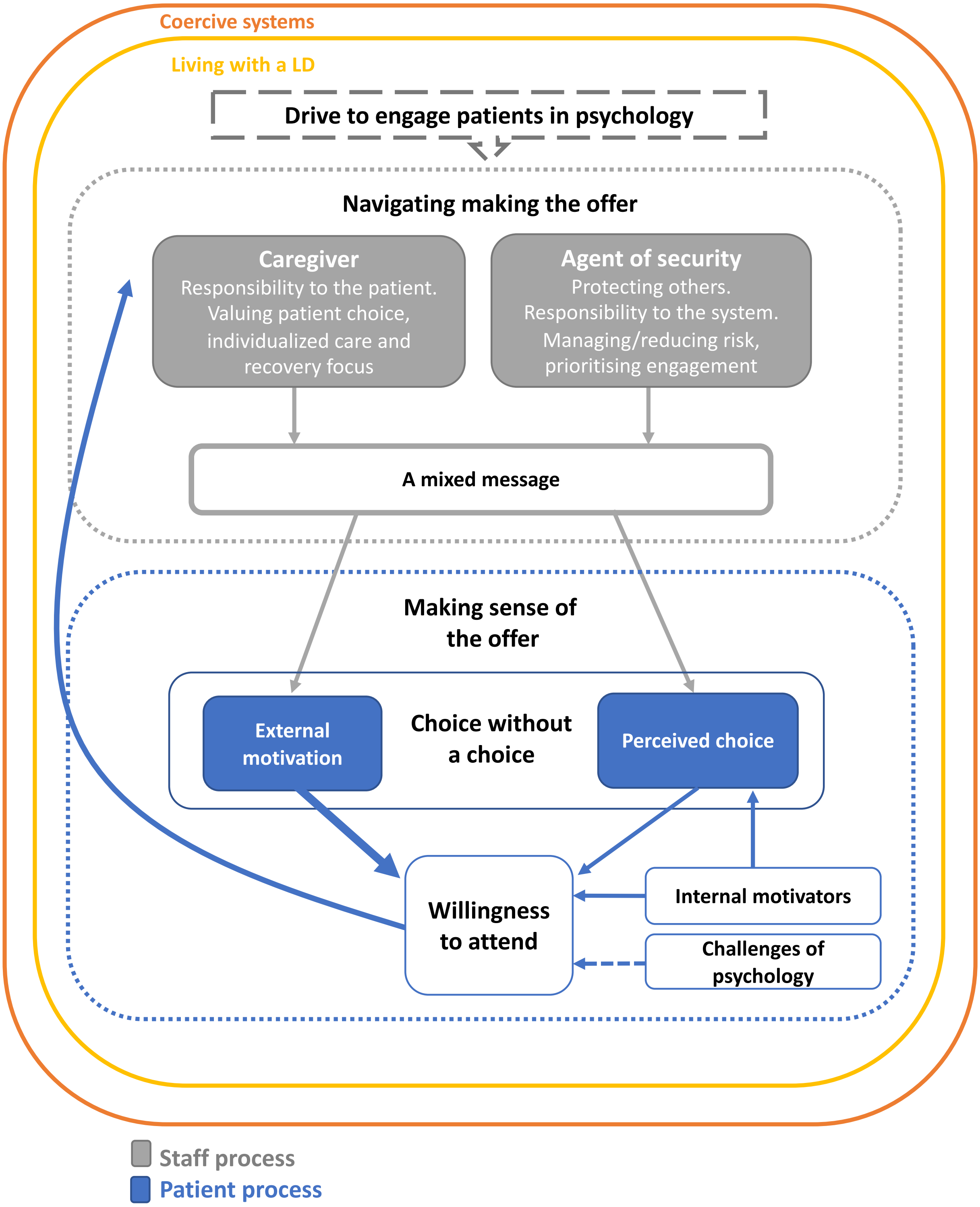
> *"The first time I was here I wasn't so keen because like the psychologist my psychologist was [name] and she said, well we will be talking about some tough, some tough bits, about what happened why you're here." Richard*
>
> *"Groups make me feel stressed and upset…" William*
>
> *"I think that is is one reason why people don't want to engage 'cause it's too painful" Psychologist*

Due to the drive to engage patients in psychology, where patients are ambivalent or not willing to attend or engage with psychology staff described returning to the *navigating making the offer* stage. A continual process of staff trying to engage patients in psychology was portrayed. This entailed repeatedly offering psychology and reminding patients of the benefits and/or need for it.

> *"...start to kind of panic about you know what we're gonna do with this person…and when people say you know, I don't want to engage, it's never OK…everybody has a as a go at persuading them." Psychologist*
>
> *"You should come…. It's an easier way of getting out of hospital." Joe*

Diagram 2.

Grounded theory model.



Discussion

This study aimed to develop a GT of the process by which psychology is offered to patients within a low secure LD service and resulting motivation to engage. The constructed model highlights four overarching domains: *context of the offer*, *drive to engage patients in psychology*, *navigating making the offer* and *making sense of the offer*. The model highlights staff experiences of trying to promote patient choice and individualised care within an inherently coercive system, that places high value on engagement in psychology in managing risk to others. Staff navigate this by reinforcing a message of choice to patients whilst at the same time making clear that engagement in psychology is valued by the system in order to be perceived as ready for discharge. In receiving this message patients hold a contradictory position of feeling they have a choice whilst also experiencing engagement as the only option. Engagement as a currency by which to achieve discharge was a key motivator for patient's willingness to attend psychology. Within the constructed model, willingness to attend is also mediated by internal motivators and perceived challenges of attending psychology, with the former appearing to influence perceived choice regarding engagement.

Relation to existing literature

Paternalistic attitudes within forensic care

The presence of paternalistic attitudes within inpatient and forensic settings are well documented (Peltro-Piri et al., 2013; Volm & Nedopil, 2016). Staff within this study described that paternalism is amplified within the low secure LD context, by a disposition to hold a paternalistic position when working with PWLD. This is supported by evidence of paternalistic attitudes towards PWLD in other contexts (Deeley, 2002; Ward, 2011).

Staff described a top down pressure to engage patients in psychology, rooted in the value placed on attendance at psychology by key decision makers within the system, such as tribunal panels. "Extra-legislative" conditions such as "compliance", placed on patients within secure settings by mental health tribunal panels was similarly reported by Freckelton (2003, pp.53). Freckelton (2003) highlighted the influence of responsibility to keep others safe on decision-making, indicating that paternalism can "lurk" in these decisions (pp.60). Responsibility for risk management was also reported as an influencing factor by participants within this study.

Dual role of clinicians

The conflicting motivations described by staff when trying to engage patients in psychology align with existing literature regarding the dual role of clinicians within forensic contexts (Jacob 2012; Laskey, 2017). The previously described "opposing forces" of care and security, are akin to the concepts of *caregiver* and *agent of security* within the constructed model (Reeder & Meldman, 1991, pp.41). Congruent with Festinger's (1957) Theory of Cognitive Dissonance staff described feeling discomfort as a result of these conflicting roles, motivating attempts to alleviate this by emphasising patient choice. The model highlights influence of the wider social context on the process of psychology being offered. Current government policy and NHS plans (NHS England, 2015; NHS England, 2019) emphasise choice promotion and delivery of individualised care for PWLD. Values raised in public awareness as a result of high-profile cases of abuse of power within LD settings, such as those at Whorlton Hall (CQC, 2022). This context may be understood to influence the pull towards the *caregiver* role when working with PWLD, increasing the dissonance felt when also working with PWLD as an *agent of security*. The model proposed *a mixed message* being conveyed to patients as a result of staff attempting to deliver messages from both the *caregiver* and *agent of security* positions. Grace et al. (2020) and Fish (2016) also reported lack of clarity in the messages given by staff and in turn received by patients within LD secure services.

Extrinsic compliance and perceived choice

Coerced compliance with medical interventions is richly evidenced within forensic settings (Völlm & Nedopil, 2016). Few studies have studied the concept of coerced engagement with psychological interventions. In their study within an FMH service Simms-Sawyer et al. (2020) reported that patients were acutely aware of coercive pressures to engage with psychology. Participants in this study described *external motivation* driven by an association between psychology and discharge. This was a key factor influencing willingness to attend psychology. This type of association may be considered informal coercion. In their GT of adapting dialectical behaviour therapy within a forensic LD setting Browne et al. (2019) also reported patients being motivated to engage in psychology as a result of extrinsic compliance. The model presented here is considered to build on that of Browne et al. (2019) by proposing a process by which this extrinsic compliance may come about.

Unique to this study is the consideration of the concept of *choice without a choice* whereby patients maintain a perception of choice despite believing that discharge is conditional on attendance at psychology. The description that patients do not necessarily label the consequences attached to engagement as coercive, or perceive this as unjust or impinging on autonomy, contrasts with previous research (Simms-Sawyers et al., 2020). This suggests a possible difference between the way the offer of psychology may be received by PWLD and those without a LD within this setting. Staff participants spoke about the significance of patients' experiences of *living with a LD* on their perception of choice and coercive pressures. This included experiences of oppression, stigmatisation, dependence on others and limited power over their lives, experiences well documented in existing research in relation to PWLD (Scior & Werner, 2015). Wilson (1992) reported that past experiences of lacking control over a situation may foster passivity and disempowerment for PWLD, suggesting a relationship to the concept of "learned helplessness" described by Seligman

(1975, pp. 534). The author considers the use of this term problematic, partly in that it unfairly locates the ‘problem’ within the individuals who have been oppressed.

Participants described a possible influence of cognitive and communication difficulties which may make it hard for patients to either understand or express nuanced or conflicting messages. This highlights a difficulty in the language used by the systems/professionals and how this is understood by patients. This resonates with the concept of ideological power, an invisible form of power which through the control of language, meaning and agendas certain beliefs may be created (Johnstone & Boyle, 2018). Where those who hold the most power, staff and decision-makers, view psychology as valuable and essential for patients, a narrative of engagement being assumed and a given may influence how the offer of psychological input is perceived by PWLD within the system.

Methodological quality and limitations

Although theoretical sufficiency appeared to have been met, a significant limitation of the study was that theoretical sampling of participants was not possible and an abbreviated version of grounded theory methodology was used (Willig, 2008).

The model presented is based on the experiences and understanding of a small group of participants from one male low secure LD service. Those who chose to participate in the study may have held specific views on psychology and how it is offered, indicating a possible sample bias. For example, although not a requirement, all patients who participated had engaged with psychology. Patient participants, some of whom had since moved to the step-down unit, were required to recall information about the offer of psychology and how this was experienced. Recollection may have been influenced by current thoughts and feelings about psychology. Reliance on retrospective memory, which can provide challenges for PWLD, may have also influenced answers (Leven et al., 2008). Being initially approached about the research by a psychologist in the service may have influenced willingness to participate or what patients felt able to say about psychology; likely further impacted by my role as a trainee clinical psychologist with a clear association with the profession.

My own preconceptions likely guided interviews and the interpretation of data. The use of a bracketing interview, reflective diary, memoing and supervision aimed to hold this in mind. The included positioning statement invites the reader to interpret the study with the lens of the researcher in mind. Due to time limitations respondent validation was not possible, therefore it was not possible to test how the final model resonated with participants. With the aim of constructivist GT to provide theoretical insights rather than an objective truth, it is suggested that the presented model poses hypotheses to be tested. Common to qualitative research, the study did not aim to provide generalisable results but provide questions to be explored through further research.

Clinical implications

In presenting a model highlighting factors associated with willingness to attend psychology, this study adds to emerging literature and understanding regarding factors impacting PWLD's readiness to engage with psychological interventions within secure services. The study suggests a primary role of coercive pressure motivating patients' willingness to attend psychology within a low secure LD service. Holding in mind that the theory was developed based on people without a LD, Ryan and Deci's (2000) Self-Determination Theory (SDT) proposes that engagement or desire for change that is externally motivated in this way is unlikely to be maintained once the external motivation desists. It may be valuable for clinicians working with PWLD in low secure settings to consider the impact of this type of motivation on engagement and maintenance of change. For example, Motivational interviewing, aiming to increase intrinsic motivation, has been linked with improved therapy outcomes in non-LD forensic settings (Miller & Rollnick, 2002; McMurran, 2009). The apparent negative relationship between the perceived *challenges of psychology* and *willingness* *to attend*, highlights the benefits of working to alleviate patients' concerns regarding the consequences of speaking to professionals about offending histories.

Gaining informed consent without undue influence is an ethical requirement for psychologists (BPS, 2017). Potential issues regarding informed consent within forensic settings are well documented and considered in professional codes of conduct for staff working in these settings (BPS, 2017). The presented model indicates a particularly complex situation for patients within a LD low secure service regarding perception of choice and autonomy concerning engagement in psychology. Participants described perceived choice regarding engagement with psychology which may mask simultaneously held awareness of coercive pressure to engage, which patients may not identify as coercive. This has significant clinical implications for staff seeking to gain informed consent. When seeking informed consent from PWLD in this context, it may be important for clinicians to ask about choice and external motivators separately. A number of staff participants spoke about the potential for coercive power and how they tried to alleviate this. Fewer staff discussed the possible influence of inter-relational or ideological power. Staff across all disciplines working with PWLD within forensic settings should be supported to consider the different types of power that may be influencing patients' choices. If patients report coercive pressures to engage with psychology but do not view these as coercive, clinicians need to think carefully about how this is explored in order to empower patients to make fully informed choices regarding engagement.

Participants described an inherent coercive structure within the low secure LD setting, amplified by paternalistic attitudes towards PWLD. Although there is value in staff considering ways of navigating the challenges this poses when supporting individuals in their care, this study argues there is a need to work at a broader level. Consideration of how to deliver person-centred approaches to supporting PWLD who have offended should be a priority for legal and healthcare systems and forensic services for PWLD. An increased understanding of the needs and wishes of PWLD who access these services, particularly in regard to strategies for managing risk and increasing wellbeing, should be used to develop services aiming to engage patients through empowerment and intrinsic motivation. NHS England (n.d.) highlights the value of working closely with PWLD to consider difficulties and solutions for service design and development.

Research implications

In proposing a model of the process by which psychology is offered, and resulting willingness to engage, this study did not extend to consider the resultant engagement with psychology, including the quality of the therapeutic engagement or outcomes. Additional research exploring this with patients and practitioner psychologists in LD services across levels of security would be valuable.

Participants indicated that external motivation was often a key factor influencing willingness to engage with psychology, with intrinsic motivation being less established. As discussed, intrinsic motivation is generally understood to be associated with increased active engagement and improved therapeutic outcomes (Hettema et al., 2005). Investigation into the applicability of theories of motivation such as Ryan and Deci's (2000) SDT when working with PWLD is indicated. With limited research evidence in LD offender populations, research exploring the utility of motivational work prior to offering offender treatment programs or interventions may be helpful (Panting et al., 2018).

Motivation and perception of autonomy and choice are not static experiences. Future studies may explore the temporal process regarding how patients' perceptions of choice and factors contributing to willingness to engage with psychology may change over time. In vivo data gathering with PWLD at varying stages of admission or engagement with psychology could support this whilst circumnavigating issues of retrospective questioning.

The constructed model indicates the importance of social context on the perception of choice and experience of coercive pressure. As discussed, the sample in this study was small with limited diversity amongst patient participants in regards to gender, ethnicity and level of learning disability. It is widely acknowledged that certain groups in society are more likely to experience stigma, oppression and discrimination. More research should be encouraged to explore how these factors may relate to patients' experience of choice and autonomy in relation to engagement with interventions within forensic placements.

Co-produced research in this area may enable patient participants to feel more empowered to express their views and experiences regarding psychology, supporting understanding of PWLD's experiences. Increased involvement of PWLD in research on this topic would reduce reliance on professional's interpretations of patient's experiences, increasing the validity of findings.

Conclusions

This study provides a model of understanding how staff within a low secure LD service attempt to engage patients in psychological assessment and intervention, and how this is experienced by patients. As the first study to look at this it provides a novel contribution to existing research. The study highlights how having a LD may lead to experiences within coercive systems that may be different to those without a LD. Clinical implications and suggestions for future research are indicated.

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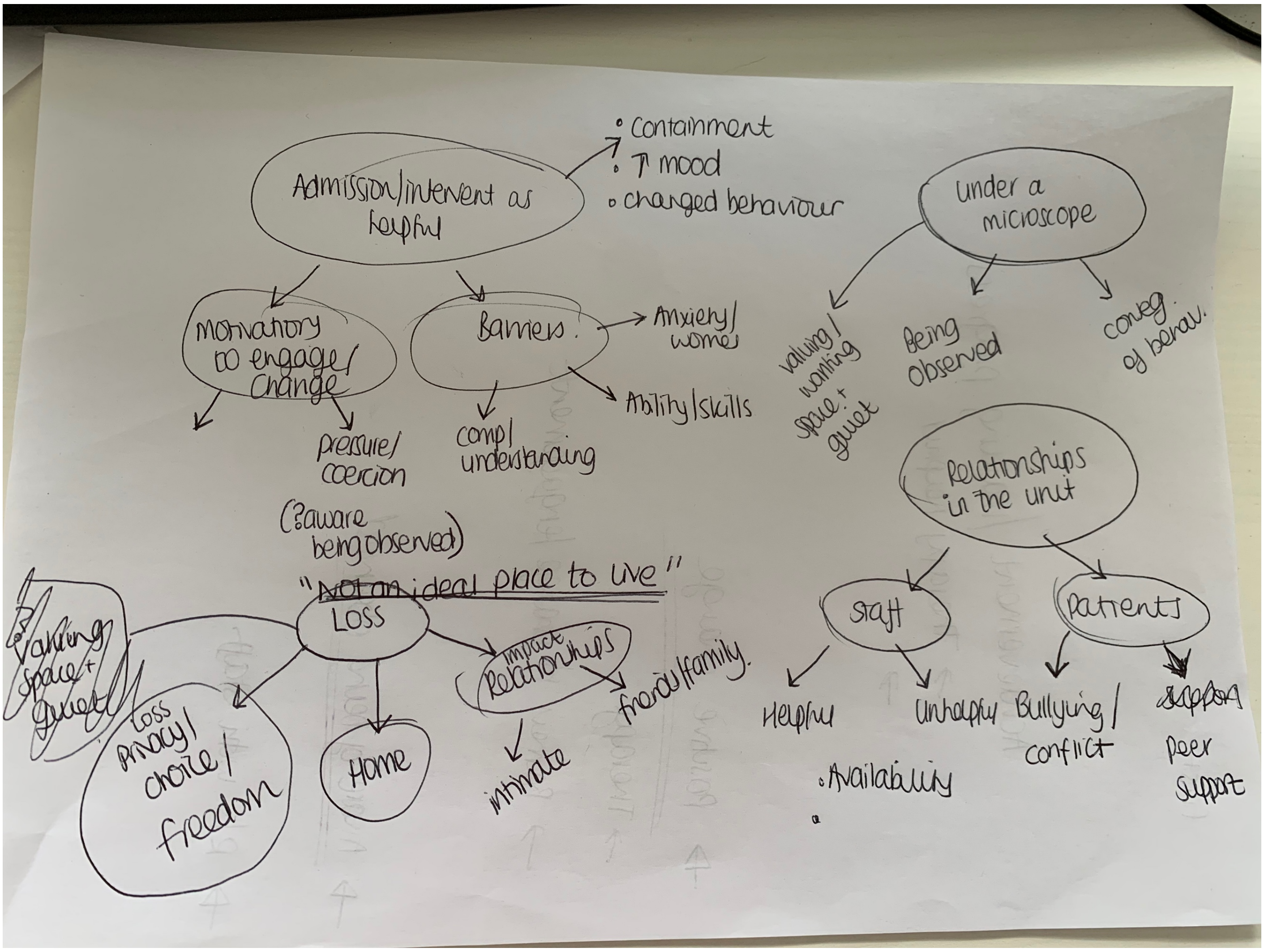
Appendices

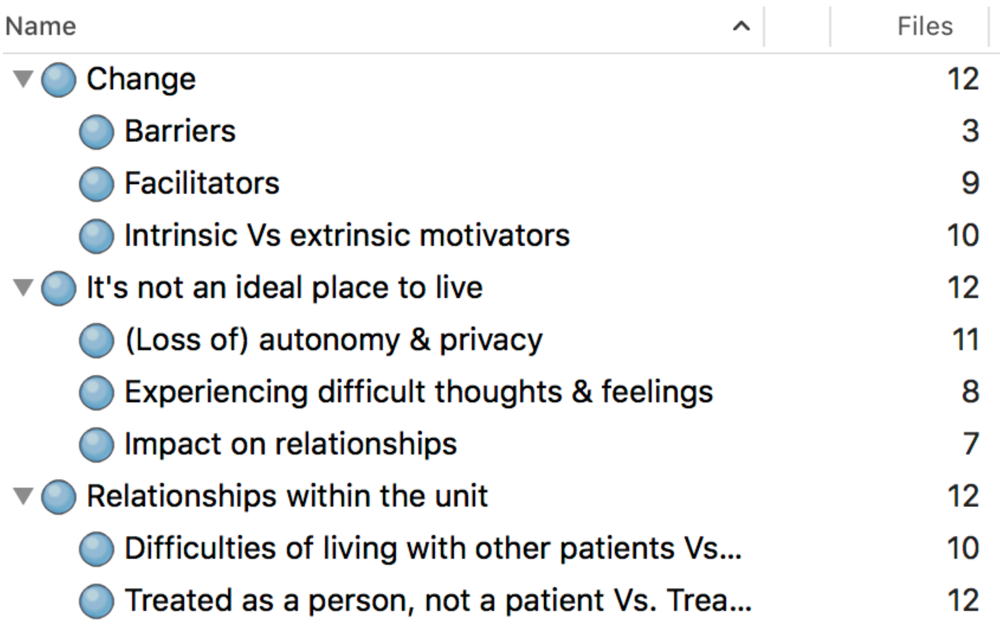
Appendix I – CASP Qualitative studies checklist

This has been removed from the electronic copy.

Appendix II – Example of theme development process

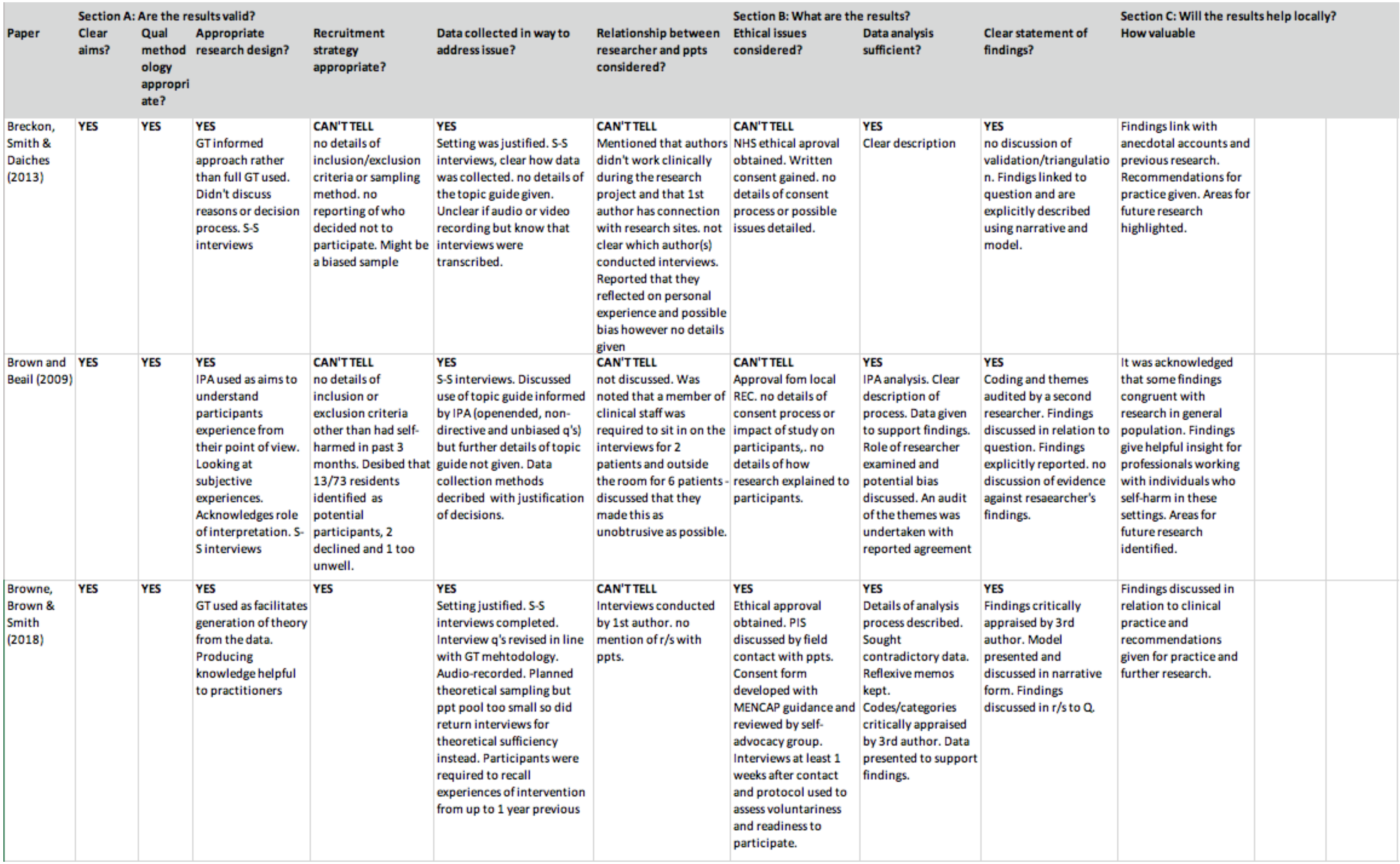


Appendix III – Theme development in Nvivo 12 software



Name	Files
Change	12
Barriers	3
Facilitators	9
Intrinsic Vs extrinsic motivators	10
It's not an ideal place to live	12
(Loss of) autonomy & privacy	11
Experiencing difficult thoughts & feelings	8
Impact on relationships	7
Relationships within the unit	12
Difficulties of living with other patients Vs...	10
Treated as a person, not a patient Vs. Trea...	12

Appendix IV - Detailed CASP table



Paper	Section A: Are the results valid?						Section B: What are the results?			Section C: Will the results help locally?		
	Clear aims?	Qual methodology appropriate?	Appropriate research design?	Recruitment strategy appropriate?	Data collected in way to address issue?	Relationship between researcher and ppts considered?	Ethical issues considered?	Data analysis sufficient?	Clear statement of findings?	How valuable		
Breckon, Smith & Daiches (2013)	**YES**	**YES**	**YES** GT informed approach rather than full GT used. Didn't discuss reasons or decision process. S-S interviews	**CAN'T TELL** no details of inclusion/exclusion criteria or sampling method. no reporting of who decided not to participate. Might be a biased sample	**YES** Setting was justified. S-S interviews, clear how data was collected. no details of the topic guide given. Unclear if audio or video recording but know that interviews were transcribed.	**CAN'T TELL** Mentioned that authors didn't work clinically during the research project and that 1st author has connection with research sites. not clear which author(s) conducted interviews. Reported that they reflected on personal experience and possible bias however no details given	**CAN'T TELL** NHS ethical aproval obtained. Written consent gained. no details of consent process or possible issues detailed.	**YES** Clear description	**YES** no discussion of validation/triangulation. Findigs linked to question and are explicitly described using narrative and model.	Findings link with anecdotal accounts and previous research. Recommendations for practice given. Areas for future research highlighted.		
Brown and Beail (2009)	**YES**	**YES**	**YES** IPA used as aims to understand participants experience from their point of view. Looking at subjective experiences. Acknowledges role of interpretation. S-S interviews	**CAN'T TELL** no details of inclusion or exclusion criteria other than had self-harmed in past 3 months. Desibed that 13/73 residents identified as potential participants, 2 declined and 1 too unwell.	**YES** S-S interviews. Discussed use of topic guide informed by IPA (openended, non-directive and unbiased q's) but further details of topic guide not given. Data collection methods decribed with justification of decisions.	**CAN'T TELL** not discussed. Was noted that a member of clinical staff was required to sit in on the interviews for 2 patients and outside the room for 6 patients - discussed that they made this as unobtrusive as possible.	**CAN'T TELL** Approval fom local REC. no details of consent process or impact of study on participants,. no details of how research explained to participants.	**YES** IPA analysis. Clear description of process. Data given to support findings. Role of researcher examined and potential bias discussed. An audit of the themes was undertaken with reported agreement	**YES** Coding and themes audited by a second researcher. Findings discussed in relation to question. Findings explicitly reported. no discussion of evidence against resaearcher's findings.	It was acknowledged that some findings congruent with research in general population. Findings give helpful insight for professionals working with individuals who self-harm in these settings. Areas for future research identified.		
Browne, Brown & Smith (2018)	**YES**	**YES**	**YES** GT used as facilitates generation of theory from the data. Producing knowledge helpful to practitioners	**YES**	**YES** Setting justified. S-S interviews completed. Interview q's revised in line with GT mehtodology. Audio-recorded. Planned theoretical sampling but ppt pool too small so did return interviews for theoretical sufficiency instead. Participants were required to recall experiences of intervention from up to 1 year previous	**CAN'T TELL** Interviews conducted by 1st author. no mention of r/s with ppts.	**YES** Ethical approval obtained. PIS discussed by field contact with ppts. Consent form developed with MENCAP guidance and reviewed by self-advocacy group. Interviews at least 1 weeks after contact and protocol used to assess voluntariness and readiness to participate.	**YES** Details of analysis process described. Sought contradictory data. Reflexive memos kept. Codes/categories critically appraised by 3rd author. Data presented to support findings.	**YES** Findings critically appraised by 3rd author. Model presented and discussed in narrative form. Findings discussed in r/s to Q.	Findings discussed in relation to clinical practice and recommendations given for practice and further research.		

Paper	Clear aims?	Qual methodology appropriate?	Appropriate research design?	Recruitment strategy appropriate?	Data collected in way to address issue?	Relationship between researcher and ppts considered?	Ethical issues considered?	Data analysis sufficient?	Clear statement of findings?	How valuable		
Burns & Lampraki (2016)	**YES**	**YES**	**YES** Focus groups and thematic analysis. Justified decision for method used.	**CAN'T TELL** Inclusion and exclusion criteria given. not detailed how ppts were approached or selected or why other patients didn't participate.	**YES** Setting justified, Focus groups with S-S interviews using an interview schedule. Audio recording of interviews. Saturation of data not discussed.	**CAN'T TELL** no details given	**YES** Ethical approval obtained and process and considerations when gaining informed consent discussed. no info given regarding impact of participation on ppts.	**CAN'T TELL** Thematic analysis used. Process of coding and development of themes not discussed. 2 researchers coded independently then came together to agree themes. Example data presented but reason for selection from original data not given.	**YES** 3 themes reported and discussed. Findings discussed in relation to research question. More than one analyst.	Discussed findings in context of previous research and theory. Implications for practice discusses. Areas of future research highlighted.		
Fish (2018)	**YES**	**YES**	**YES** Ethnographic approach. Observations and interviews used. Resons for choice of methods discussed in relation to the Q. Thematic analysis.	**YES** Discussed that wards at the research site were allocated by manager. All ppts observed were inivited to participate (?opportunisitc, self-selecting sample). Number of ppts who declined was given but not reasons.	**YES** Clear description of process from observation through to development of inteview schedule. Justification of methods given and sturation of data discussed.	**YES** Relationship between researcher and participants discussed including considerations around development of trust. Discussed motivation for research.	**YES** Ethical approval given. Discussed process of gaining consent and pertinent issues.	**CAN'T TELL** Thematic analysis used but not description of the process of coding and theme development. not explained why presented data was chosen. Consideration of own bias in interpretation and analysis not discussed	**YES** Discussed findings and how these fit with previous research. Credibility of findings not discussed. Limited discussion of evidence for/against arguments.	Findings discussed in relation to current literature and clinical practice/policy. Recommendations made for service provision and gaps in research are highlighted.		

Paper	Clear aims?	Qual methodology appropriate?	Appropriate research design?	Recruitment strategy appropriate?	Data collected in way to address issue?	Relationship between researcher and ppts considered?	Ethical issues considered?	Data analysis sufficient?	Clear statement of findings?	How valuable		
Greenhill & Withers (2017)			S-S interviews and critical discourse analysis. Reason for design chosen discussed and compared with alternative options.	Inclusion and exclusion criteria given. MDT made decisions on suitable participants based on risk and researcher not privy to these conversations. Reasons for non-participation and drop out discussed.	Setting was justified. It was clear how data was collected. S-S interviews with topic guide. Development of the topic guide was discussed. This was developed Interviews were recorded. Saturation of data not discussed.	Discussed potential for participants to feel pressure to engage in research and measures taken to minimise this. Interviewers influence on interview questions considered. Involvement in recruitment discussed - particpants selected by MDT decisions, not researcher.	Ethical approval gained. Consent gained with consideration of capacity. Confidentiality and issues around confidentiality considered. Recruitment completed by clinical staff so that researcher was not privy to patient details used for eligibility decision making. Considered potential for ppts to perceive pressure to participate.	Detailed description of analysis and reasons for chosen method of analysis given. Guidlines followed and referenced. Credibility checks performed by 2nd author. Researcher considered influences of own position.		relation to existing theory and reasearch. Clinical implications and recommendations discussed. Areas of research need highlighted.		
Harker-Longton & Fish (2002)	**YES**	**YES**	**YES** Phenomological approach. Longitudinal design. S-S interviews. Inductive thematic analysis. Justification for research approach given. Alternatives not considered.	**CAN'T TELL** Assumed opportunisitc sample. no details given of why ppt selected or whether other potential participants were approached.	**YES** S-S interviews. Interviews recorded or written dependent on ppt's wishes. Conduction of interviews and development of interview schedule discussed. Saturation of data not discussed.	**NO** Relationship considered and discussed but only in relation to certain elements. It was highlighted that they had pre-existing carer-patient relationship and that this may have facilitated openess in interviews. Potential issues were not considered e.g. impact of this on the Q choice or influence of researcher bias.	**NO** It was felt that this was not sufficient to warrant a 'yes'. A number of ethical issues were considered and discussed but details of formal consent processes were lacking. There was no mention of written consent or ethical approval for the study having been sought/granted.	**CAN'T TELL** Inductive thematic analysis. Process of analysis described. Data presented to support the process. no discussion of critical analysis of researcher's role. This was felt to be important given the nature of the design and the relationship with ppt.	Themes presented and discussed. Credibility of findings considered - credibility checks by 2nd author. Findings discussed in relation to research question. Quotes used to accompany themes.	The research has value as a rich account of one person's perspective. Application of findings is limited due to this. Further research suggested. Researcher also comments on the involvement of the ppt in the research process and suggests that this may encourage further co-production with people with LD.		

Paper	Clear aims?	Qual methodology appropriate?	Appropriate research design?	Recruitment strategy appropriate?	Data collected in way to address issue?	Relationship between researcher and ppts considered?	Ethical issues considered?	Data analysis sufficient?	Clear statement of findings?	How valuable		
Heppell & Rose (2021)	**YES**	**YES**	**YES** S-S interviews, Thematic analysis., design and methods described clearly and justified.	**YES** Purposive sampling to max. homogeneity of sample. Inclusion/exclusion criteria described. Recruitment procedure clear. Those who did not participate were acknowledged.	**YES** S-S interviews using a topic guide. Topic guide was described. Interviews were recorded and transcribed.	**YES** Researcher considered their role and outlined steps taken to minimise influence. Acknowledged potential impact of characteristics of researcher and impact of staff present during interviews.	**YES** Ethics approval gained. Clear description of issues of consent and confirdentiality and measures taken to ensure informed consent.	**YES** Inductive T.A. Process clearly described. Researcher considered role and possible influence. Data was reported to support the results.	**YES** Use of thematic map and narrative description of themes. Traingulation of findings. Findings were related back to original research question.	Research highlights information that may be important in informing service provision. Results were related to relevant policy and guidance. no discussion of future research.		
Tallentire et al. (2020)	**YES**	**YES**	**YES** Quali participatory approach. Narrative analysis. Justifcation for design/method choices given.	**YES** Inclusion and exclusion criteria listed. All who met eligibility within that service were invited to participate.	**YES** Setting was justified. S-S interviews and written info used. Description of prompts used and flexibility of interview schedule. The interview prompt sheet was provided in the appendix.	**YES** Role and experience of researcher discussed. Importance of reflexivity regarding own narrative discussed. Reflective journal used.	**YES** Ethics approval gained. Ethical issues discussed particualryl around confidentiality. Consent discussed.	**YES** 3 stage analysis described. Acknowledgement of how contradictory data was taken into account. Researcher critically evaluated own role.	**YES** Group story reported in illustrtaion and narrative. Credibility of findings discussed - repondent validation and multiple analysts. Findings discussed in relation to original research question.	Researcher discusses how findings link with other literature. Recommendations made for service provision. Further research suggested. Valuable example of participatory research.		
Thompson & Johnson (2017)	**YES**	**YES**	**YES** Qual. S-S interviews. IPA. Reseacrh design choice discussed and justified.	**YES** All women who attended the therapy were inivted to particpate and all consented. Purposive sampling. no inclusion/exclusion riteria detailed - all ppts invited who attended the group	**YES** S-S interview. Clear description of how interviews carried out and why. Audio-recorded	**YES** Researchers work clinically at research site but not core staff. Acknowledged potential for bias and used member checking to promote study rigour. Did not discuss risk of participant's response being influenced by relationship.	**YES** Ethical approval gained and consent discussed. Confidentially not explicitly discussed and this seems important considering staff members were conducting the interviews.	**YES** IPA process discussed as was reason for choosing the data presented as exemplars of themes. Member checking used.	**YES** Findings clearly reported. Member checking of themes used. Findings discussed in r/s to research Q.	Researchers discuss results in relation to setting up a DBT group within a service. A table of recommendations is provided which would be valuable to other services looking to set a group up. no recommendations for further research were made.		

Paper	Clear aims?	Qual methodology appropriate?	Appropriate research design?	Recruitment strategy appropriate?	Data collected in way to address issue?	Relationship between researcher and ppts considered?	Ethical issues considered?	Data analysis sufficient?	Clear statement of findings?	How valuable		
Williams, Thrift & Rose (2018)	**YES**	**YES**	**YES** Qual, S-S interviews, IPA used. Choice of design discussed	**YES** Ppts selected by clinical team who considered impact of the interviews. This is important to consider but does it increase potential for biased selection?	**YES** Setting justified. S-s interviews used with a topic guide. Topic guide was explained. Interviews audio-recorded.	**YES** Researcher independent to the hospital. Researcher considered their own role and potential bias.	**YES** Ethical approval gained. Consideration of impact of interviews on participants was considered. Consent processes described including use of Arscott interview to aid assessment of informed consent.	**YES** IPA process described and data presented to support findings. Researcher's influence discussed. S/V and IPA support group used to explore alternative perspectives.	**YES** Results reported clearly. Credibility and validity discussed. IT was highlighted that the interpretations of data were subjective and influenced by the researcher. Findings discussed in r/s to the Q.	Results contribute to debate around service provision. Results link back to policy and government/NHS initiatives for this SU group. Limitations in transferability discussed. Discussion of use of IPA with this client group discussed which would be informative for future research.		
Wood et al. (2008)	**YES**	**YES**	**YES** Qual s-s interviews, content analysis	**CAN'T TELL** no inclusion/exclusion criteria listed. It is assumed that all SU at the research site were invited to participate but this is not explicit. 2 SU's reported to have chosen not to take part.	**YES** S-S interview. Setting justified. Development of interview topic guide was from results of a SU survey asking what was important to include. Interviews audio-recorded.	**YES** Considered in r/s to the interview topic guide development and minimised by using SU surveys.	**CAN'T TELL** Ethical approval gained. 3rd party apporached SUs to invite to participate to reducde felt obligation. Consent process is not clearly described. Reported that confidentiality maintained but it wasn't discussed how this impacted by staff members conducting the interviews.	**NO** Set out to do IPA but following analysis realised this had not been done sufficiently and analysis fitted more with content analysis. Process of analysis not described. Researcher's influence on interpretation was discussed.	**YES** Findings were reported in r/s to the research Q. Multiple analysts used. Credibility of results discussed.	Findings discussed in relation to previous research and service provision. Recommendations made related to research site only. More could have been done to consider broader application of findings and/or gaps in research.		

Appendix V – Example quotes for themes

"It's not an ideal place to live"	Loss of autonomy and privacy	"They don't come to your house do they and sit and watch you? I've no privacy and that's difficult. It's frustrating for me, you wouldn't like it. I've had to lock myself in somewhere before now, because everywhere I go there's staff." (Harker-Longton &Fish, 2002, p.145) "I'm not a kid or a baby. I'm not an animal either but I'm in this cage " (Harker-Longton &Fish, 2002, p.146) "I was really annoyed cos they said I can go home and then they changed their mind " (Brown &Beail, 2009, p.507) "you don't get freedom … I wished I could leave here (hospital)" (Williams et al., 2018, p.137) "you can dress up, be whoever you want to be, where like you know in here [where he lives] you can't, you just have to dress normal.. .cos of how other people react" (Tallentire et al., 2020, p.22).
	Impact on relationships	If you're stuck in these places you can't, you can't hold down a relationship" (Grace et al., 2020, p.8) "When you're in hospital, you're in hospital for quite a long time (1) erm (1) and they expect you to (1) not have sex. (2) Conversation would be "ain't gonna stop us." Er, because we've still got needs." (Grace et al., 2020, p.8) "The girls and guys in here are like family because at the end of the day half of us haven't got that connection with family. We don't really see them, so the only people we've got are the staff and each other" (Burns & Lampraki, 2016, p.79)
	Experiencing difficult thoughts and feelings	"No. I was really scared I actually peed myself through being frightened. I wet myself!" (Fish, 2018, p.143) I think that because people get stressed in this kind of place there should be more staff trained to help with stress management (Burns & Lampraki, 2016, p.79) "like being in a thick fog…like being in a dark tunnel and no way out, can't see a light, all me thoughts are negative', 'like….I want to di" (Brown &Beail, 2009, p.508)
Relationships within the unit	Difficulties with living with other patients Vs. Peer support	"Because [name] she'd been whacking me all night, calling my family names. I got angry with her, my first time when I came, I didn't do nothing to her. I was nervous, upset, I went to seclusion room with [two staff members]" (Fish, 2018, p.144) "I stopped going because people ridiculed me and were name-calling, saying things like 'Faggot', 'Nonce' and 'you're in there with all the other Nonces' ... because it's in...[place] they can all see who goes in which makes it worse" (Tallentire et al., 2020, p.21). "I saw others struggling too so didn't feel as bad" (Browne et al. 2019, p.799) "we were all in it together" (Browne et al. 2019, p.799)

	Treated as a person, not a patient Vs Treated as a patient, not a person	My case manager will leave the paperwork until everybody's gone to bed if she's doing nights, or she'll take a break from doing her paperwork and come and sit with us. It's being able to approach them and being able to discuss things without being judged" (Burns & Lampraki, 2016, p.79) "Cause at my old place the staff just left me to struggle. But since I've been here, I've had help from the staff and [.. .] Cause I told one of the staff, cause I went home last week and I said to them I wouldn't mind like one of the support off one of the staff just to ask me if I'm alright after from my home visit and there was plenty of staff round." (Heppell & Rose, 2021, p.89) "they treat you like a human being. They don't treat you like a patient. They talk to you like a human being [.. .] And other placements I been to, it's we're staff, you're patient. Do you know what I mean?" (Heppell & Rose, 2021, p.89) "I'd just had enough of being treated by the staff like a nobody. Like a patient – I'm not a patient, I'm a person" (Brown &Beail, 2009, p.507)
Change	Facilitators	"A psychologist.Talk about past things. [long pause] That helps." (Harker-Longton & Fish, 2002, p.146) "It felt good, thought I wouldn't be able to do it but I'm actually learning and doing well using it for the first time ever" (Browne et al. 2019, p.799) "Some staff sit and listen to you, they help to try and solve your problems with you, and they try to support you" (Burns & Lampraki, 2016, p.79) "They've helped me a lot, a real lot. I just want to do DBT all again when it stops, cos it helps me a lot" (Thompson &Johnson, 2017, p.4)
	Intrinsic Vs extrinsic motivators	"'I need to get all my bad stuff off my head, open up. . .. I've got this opportunity to make a better life for myself and that's what I'm here to do''. (Breckon et al., 2013, p.1414) ''. . .say like the staff and that says that patient's doing well, he's listening to staff, he's doing well, I think we'll give him ground hall leave and it makes him feel good''. (Breckon et al., 2013, p.1411) "No, I didn't need to change. Thought I had no choice though to get out" (Browne et al., 2019, p.796) "they tell you…they'll know demonstrating behavioural change: you're using skills because you won't behave as bad…You've got not be aggressive at all to make progress" (Browne et al., 2019, p.796)

	Barriers	“I think because we've got learning disabilities we find it hard to understand things as well as other people” (Browne et al., 2019, p.797) “our homework it doesn’t give you clear information on what you want to do, what to do on the homework, just tells you what to do and I just don’t understand it.” (Thomspon & Johnson, 2017, p.6) “I'd get stressed, mind would go blank so I'd end up going to my room…then I'd be worrying or angry about doing it wrong and end up self-harming or kicking off so I'd lose my trips out anyway. Staff would ask why I didn't use my skills and inside I was like I tried but I couldn't!...I just stopped trying them skills and stayed in my room” (Browne et al., 2019, p.797)

Appendix VI – Clinical governance presentation

This has been removed from the electronic copy.

Appendix VII – Staff information sheet

Canterbury
Christ Church
University

Information about the research

A grounded theory of coercion to engage with psychology within a low secure forensic learning disability service (IRAS ID 272727).

Hello. My name is Grace Johnstone and I am a Trainee Clinical Psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide whether to take part, it is important that you understand why the research is being done and what it would involve for you. Please feel free to talk to others about the study if you wish.

Any reference to 'we' in this document means Canterbury Christ Church University and not [redacted]

- **Part 1 tells you the purpose of this study and what will happen to you if you take part.**
- **Part 2 gives you more detailed information about the conduct of the study.**

Part 1

What is the purpose of the study?

Within some secure services patients report experiencing pressure to engage in psychology. This may be thought of as perceived coercion. Coercion is likely to be on a continuum, including perceived friendly persuasion at one end and perceived threat of sanctions at the other (Simms-Sawyers 2018). The aim of this study is to further our understanding of perceived coercion to engage in psychology within a low secure forensic learning disability service. In particular, to explore staff and patient views and experiences regarding this. The project aims add to the development of theory regarding this phenomenon.

Why have I been invited?

All clinical staff working at the [redacted] have been invited to participate in the research.

Do I have to take part?

It is up to you to decide whether to join the study. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw at any time up to 4 weeks following the research interview, without giving a reason. After this point, information will have been anonymised and it will not be possible to remove it from the data set.

What will happen to me if I take part?

You will be asked to participate in an interview with the researcher. The interview would take no more than 1 hour and would be audio recorded. The interview will ask you about your views and experiences of this topic in relation to the low secure forensic learning disabilities setting. The interview would happen at your place of work or over video call.

What are the possible disadvantages and risks of taking part?

It is understood that it may be a difficult topic to talk about and there is a chance that you may feel distressed when discussing this. You would be encouraged to take a break or ask for the interview to be stopped should this be the case. You may also use your existing supervision arrangements to discuss the research.

What are the possible benefits of taking part?

We cannot promise the study will help you or others but the information we get from this study may help clinical staff working in these settings. It may improve the treatment of patients in low secure learning disability services. It will also add to the evidence base in this field.

What if there is a problem?
Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will information from or about me from taking part in the study be kept confidential?
Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. Information will be kept safe and secure by the researcher. There are some rare situations in which information would have to be shared with others. The details are included in Part 2.

This completes part 1.
If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2 of the information sheet

What will happen if I don't want to carry on with the study?
You would be free to withdraw your consent to participate in the study up to 4 weeks following the research interview. You would not be required to give a reason for withdrawing from the study.

If you requested to withdraw after the 4 weeks following the research interview has passed it may not be possible to identify and withdraw the information you had already provided.

What if there is a problem?

Concerns and Complaints
If you have a concern about any aspect of this study, you should ask to speak to me or xxxx (Senior Clinical Psychologist and Research Supervisor) and we will do our best to address your concerns.

You can contact me by leaving a message on the 24-hour voicemail phone number 01227 927070. Please leave a contact number and say that the message is for me [Grace Johnstone] and I will get back to you as soon as possible.

If you remain dissatisfied and wish to complain formally, you can do this by contacting Dr Fergal Jones, Clinical Psychology Programme Research Director, Salomons Institute for Applied Psychology fergaljones@canterbury.ac.uk

Will information from or about me from taking part in the study be kept confidential?

- We will need to use information from you for this research project. We will keep all information about you safe and secure.
- Information will be collected via interview and a demographics information form. This would include your gender, age, job title and years qualified and in role at the xxx (this will be a range, rather than specific years to maintain anonymity).
- Information will be stored securely on an encrypted memory stick and in a locked cabinet.
- Information will be anonymised through the use of coding and/or pseudonyms.
- Information will be used for the purpose of the current study.
- Data will be kept for 10 years by the researcher and the university after which it will be disposed of securely.

- The researcher's supervisors ([redacted]) may have access to the information collected post-anonymisation.
- The only time when I would be obliged to pass on information from you to a third party or to the supervisors prior to anonymisation would be if, as a result of something you told me, I were to become concerned about your safety, the safety of someone else, or you told me something that warrants a safeguarding concern. In this instance I would discuss the information with Dr xxx who would follow this up as appropriate.
- All information which is collected from or about you during the course of the research will be kept strictly confidential, and any information about you which leaves the hospital will be stored on an encrypted memory stick.
- Research and Ethics Committee approval has been gained for the study (IRAS number 272727).

The 'How your information will be used' document tells you more about how your data will be used.

What will happen to the results of the research study?
Participants often want to know results of a study they have been in.

- You will be able to read the completed project following its completion (expected to take around 2 years).
- You will be offered the opportunity for feedback from the research.
- The research project will be submitted to Salomons Institute for Applied Psychology as part of a doctoral qualification. It is planned that the completed report will also be submitted for publication in a relevant journal.
- Anonymised quotes from your interviews may be used in published reports. You would not be identified in any report/publication.

Who is sponsoring and funding the research?
The study is being completed as part of a doctoral qualification and is funded by Canterbury Christ Church University.

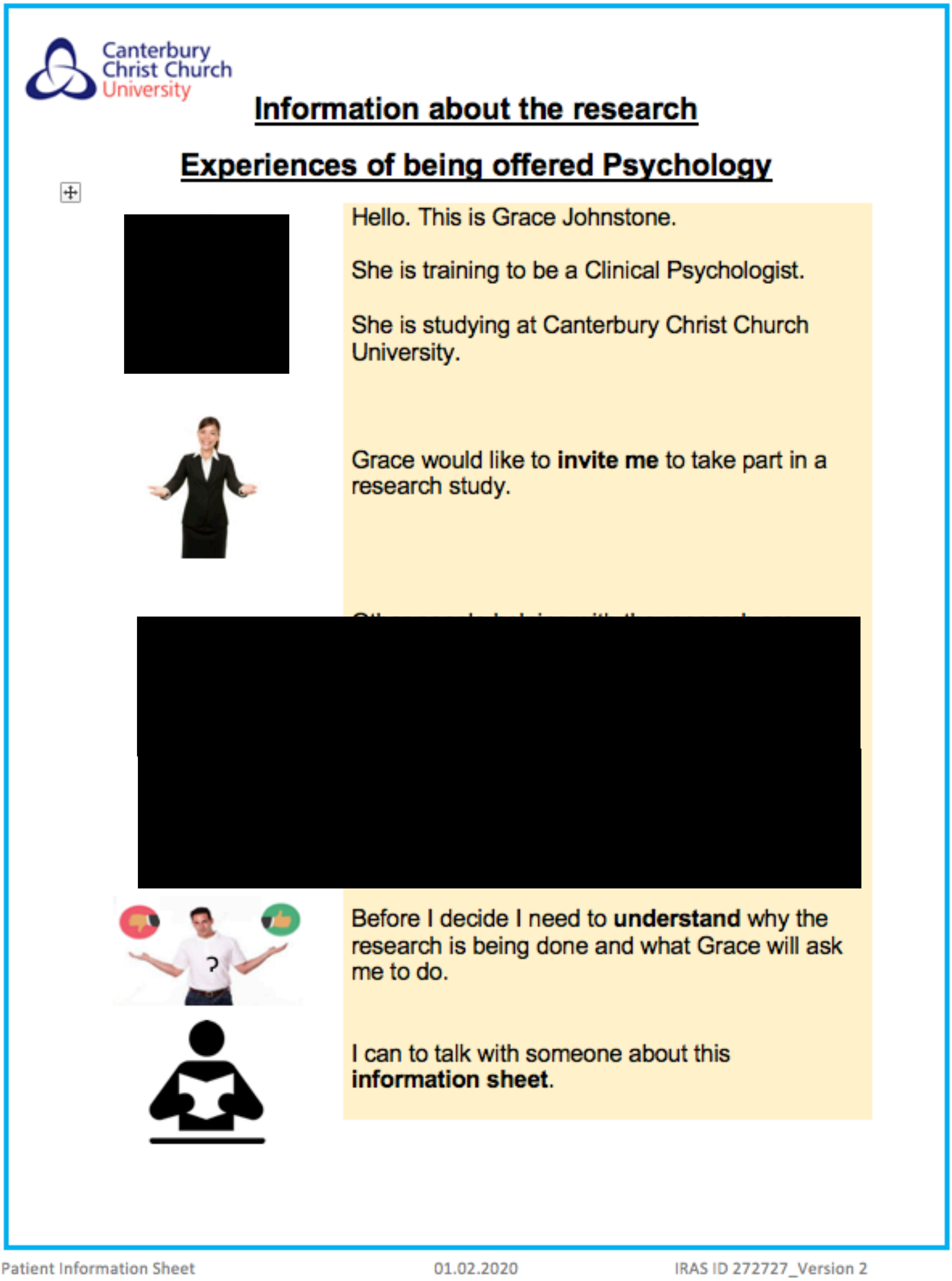
Who has reviewed the study?
All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been checked and approved by [redacted]

Further information and contact details

If more people than needed express an interest in participating in the research then participants will be chosen at random. You will be informed whether you have or have not been selected.

If you would like to speak to me and find out more about the study of have questions about it answered, you can email me on g.johnstone108@canterbury.ac.uk or leave a message for me on a 24-hour voicemail phone line at 01227 927070. Please say that the message is for me [Grace Johnstone] and leave a contact number so that I can get back to you.
If you are dissatisfied with the study or have any concerns during the course of the study please contact Dr Fergal Jones, Clinical Psychology Programme Research Director, Salomons Institute for Applied Psychology fergaljones@canterbury.ac.uk.

Appendix VIII – Patient information sheet



Information about the research

Experiences of being offered Psychology

[redacted]

Hello. This is Grace Johnstone.

She is training to be a Clinical Psychologist.

She is studying at Canterbury Christ Church University.

Grace would like to **invite me** to take part in a research study.

[redacted]

Before I decide I need to **understand** why the research is being done and what Grace will ask me to do.

I can to talk with someone about this **information sheet**.

Patient Information Sheet 01.02.2020 IRAS ID 272727_Version 2

Why is the study being completed?

In some hospitals, some patients feel pressure to attend psychology. Other people don't feel pressure to attend psychology.

Grace is **interested to hear my views** and experiences of **being offered psychology** at the [redacted]

The research is organised and paid for by Canterbury Christ Church University. Grace is doing the research as it is part her training.

Why have I been invited?

[redacted]

Who has reviewed the study?

[redacted]

Do I have to take part?

I **do not have to** take part.

If I agree to take part, Grace will ask me to sign a **consent form**. That means that I agree to take part in the study. We wil [redacted] all to go through this together. It might take up to 1 hour. I can have breaks.

If I change my mind I can ask not to be a part of the study.

I have four weeks after my interview to tell Grace I have changed my mind about taking part.

After 4 weeks it might not be possible to remove my information.

I do not have to say why I have changed my mind. No one would think badly of me.

If I do not want to take part it will not affect my care.

What will happen to me if I take part?

Grace will meet with me to ask me about my experiences of being offered psychology.

We will **meet at** [redacted] **or over videocall** again at a time that suits me. It will take around 1 hour. I can take breaks.

The **conversation will be recorded** using a Dictaphone. Dictaphones record sound but not pictures.

What could be bad about taking part?

Some of the questions in the interview might be hard to talk about. I do not have to answer every question.

If I get upset when I am being interviewed the **researcher will support me**. I can stop or have a break at any time.

I can talk to staff after the interview if I need more support.

What could be good about taking part?

I will **not get a reward** for taking part.

The **information I give might help future patients**. The hospital might change the things that have not helped me. They might do more of the things that have helped.

I will be asked if I would like to hear about the research when it is finished.

The researchers hope that I will feel good about taking part in the research.

Will anyone know I have taken part?

My multi-disciplinary team (MDT) and my psychiatrist (RC) will know that I am taking part.

This is so that I can talk to them if I have any concerns.

A member of the research te [redacted] will also talk to my MDT to make sure that they think it is okay for me to do the interview. Grace will keep what I say **private**. My MDT Will not know what I say.

I can tell people that I have taken part, if I want to!

If I tell Grace anything that she thinks puts me or others at risk she will need to tell a member of staff. Grace will discuss this with me before telling a member of staff.

What will happen to what I say?

Where it says **'they'** it means **Canterbury Christ Church University,** [redacted]

Information about me will be kept safe (in a locked drawer or on a password protected memory stick.)

Only the research team will be able to see my information.

They will need to use my information for this research project. This information will include my age, gender, ethnicity, length of stay in hospital, diagnoses and Mental Health section. Grace will use this information to do the research. They will keep all information about me safe and secure.

They will keep what I say for 10 years. After that they will delete all of the information.

The things I say might be included in reports or presentations about the research. **No one will know that it was me.**

They hope to let other people know what they find. They will do this by writing a paper which could be **printed** or be put on the **internet**. They can send me a summary of the results if I want.

The 'How your information will be used' page tells me more about how my data will be used.

What if there is a problem?

If I am **unhappy** about [redacted] **can speak to Grace or** [redacted] Centre and they will do their best to answer my questions.

If I want to speak to someone at the university or **make a formal complaint** I can write to:
Fergal Jones Research Director
Salomons Centre for Applied Psychology, 1 Meadow Road, Tunbridge Wells, Kent TN1 2YG.

[redacted]

I can also contact my local Independent Mental Health Advocate. They can tell me about my legal rights and raise concerns on my behalf.. There is information on the ward about how to contact an advocate. Or I can ask a member of staff to help me.

I can ask a member of staff to help me contact the above people.

What next?

I do not have to take part in this study. It will not affect my care or treatment in any way.

If I have any **questions** or worries about the study I can tell the staff that I would like to **speak to Grace** and they will let me know.

Thank you for reading this information sheet and thinking about taking part in this research!

Take time to think about taking part in the research.

If you are interested in taking part in the research please give this to a membe [redacted] e. If you want to take part you will need to do this

If more people than we need offer to take part we will choose people randomly. We will let you know if you have or have not been selected.

If you are interested in taking part in the research please write your name below:

Name: ____

Appendix IX – Email to staff

Subject: Invitation to participate in research project

Hello,

My name is Grace Johnstone and I am a Trainee Clinical Psychologist at Canterbury Christ Church University.

I would like to invite you to take part in a research study that is being conducted at the [redacted]. All clinical staff working at the [redacted] have been invited to participate in the research.

This project was presented at a clinical governance meeting at the [redacted] and NHS Research and Ethics Committee approval has been gained.

I have attached the information sheet and consent form for your information.

Please read the attached information and decide whether you would be interested in participating. **If you would like to participate please reply to g.johnstone108@canterbury.ac.uk or speak directly to myself or [redacted].** Please reply by [date 7 days from email sent].

Inclusion criteria:

1) Over 18 years old
2) Currently working at the [redacted]

Exclusion criteria:

1) Involved in the research project (other than as a participant).
3) The only person in the team to hold your role/title meaning that confidentiality may be compromised.

Yours sincerely,

Grace Johnstone
Trainee Clinical Psychologist
Researcher

Attached:

- ☐ *Staff Information Sheet*
- ☐ *Staff Consent Form*
- ☐ *How your information will be used*

Appendix X - Interview guide for patients

interview guide for patients

Thank you for agreeing to talk to me.

- Go through information sheet
- Consent form
- Arscott questionnaire

I am asking people about their experiences of being offered psychology at the XXX.

I am interested to hear your views about being offered psychology at the XXXX.

Let me know if you would like to stop the interview at any time. You don't have to answer any questions that you don't want to.

Going to start recording

Offer of psychology

- Have you been offered psychology whilst at XXX? Did you attend? (If no skip to orange Q's)

- How was psychology offered to you? (Who, when, where, how, what)

- How did you feel when you were offered psychology? (prompt emotions) Why?

    - Did you have any worries? Did you discuss them with anyone?

- Did the psychologist help you understand how psychology could help you? How? (information, questions)

- Did you understand that you could decide not to go to psychology?

Engagement in psychology

- What made you decide to attend psychology sessions?
    - Did you make up your own mind? If so, tell me more about this.
    - Did other people or something else influence your decision, if so how?

- Could you describe the reason(s) why you thought you needed, or did not need psychological treatment?

- How keen were you to attend psychology? / How much did you want to go to psychology?
- Can you tell me about the type of psychology work you have done? (Groups? Individual?)
- Describe what CHOICE you had over the type of psychological treatment you wanted?
- Describe your choice about what you wanted to speak about during your sessions?
- Did your feelings about psychology change over time?
- Did your motivation to do psychology go up or down? Why? What changed it?
- Did you benefit from psychology? How? (Symptom improvements, coping strategies, reflections on offence, functional improvements, if the participant had no benefits- can they suggest the reasons for this?)
- What was the psychologist like? (positive and negative qualities? How did they affect engagement?)
- What do you think the psychologist's role or job was? (in your treatment)
- How did your psychologist involve you in your treatment?
  - Did you agree goals together?
  - How did you have control over the time and location of your session? (1:1)
  - How much choice did you have over the discussion topic?
  - How much control did you have over choosing which psychologist? /in groups, as well
- How easy did it feel to talk to your psychologist? How easy to be honest about what you thought?
- What type of feelings or thoughts did you have during psychology(psychological assessment and treatment)?
  - Can you tell me about anything that made you feel worse or better about your situation?
  - Can you tell be about anything that was difficult or upsetting, how was this managed during psychology sessions?
- Tell me about a time when you felt you could honestly tell the psychologist about your different opinions or problems and how did the psychologist respond to this during your psychology session?

- If this didn't happen, suggest why? (e.g. can you describe a time when you felt - pressured to agree, why did you feel pressured to agree- what did you fear the consequences were if you didn't agree?

How would you describe your overall satisfaction (how happy?) with your experience of psychological assessment or treatment?

<u>If didn't engage –</u>

Could you describe the reason(s) why you thought did not need OR want psychological treatment? (still feel the same?)

Would anything have made you feel differently? (asked in a different way, different therapy available, information given)

What did you think would happen if you went to psychology?

What did you think would happen if you said no? What did happen?

- Restriction on leave or ward privileges?
- Negative reviews at ward round, CPA or tribunal meetings?
- Delayed Discharge?
- Did you experience any pressure from staff? If so, what type of pressure did you experience?

In some hospitals, some patients feel pressure to attend psychology. Other people don't feel pressure to attend psychology.

(**Explain pressure/coercion -** feeling like you should, or have to. Might include thinking that you will be rewarded for doing it or that something would happen if you don't do it)

Did you ever feel pressured to go to psychology? Can you tell me about that?

- Did you think anything good would happen? Why? (Did anyone tell you anything good would happen?)

- Describe what types of reward you thought you would receive (e.g. leave, discharge)? What made you think that?

- Did you think anything bad would happen if you didn't go? What? Why?

- How did this make you feel?

- How did these feelings of being pressured change over time? Would you go again?

[If person indicates perceived coercion to engage]

- Did this stay the same after starting psychology work?
- Did it change in any way, if so why?
- What do you think about patients feeling X [use their words] to engage with psychology?
- Are there any benefits?
- Are there any costs/problems with it?

Is there anything else about your experience of psychology that you would like to tell me about?

I have now stopped recording

End interview

Debrief process

Appendix XI - Interview guide for staff

Interview guide for staff

Thank you for agreeing to speak with me.

- Go through information sheet
- Go through consent form and complete
- Demographics form
- Any questions?

Within some secure services patients report experiencing pressure to engage in psychology. This may be thought of as perceived coercion. Coercion is likely to be on a continuum, including perceived friendly persuasion at one end and perceived threat of sanctions at the other.

The aim of this study is to further our understanding of perceived coercion to engage in psychology within a low secure forensic learning disability service. Keen to hear staff and patient views.

I will ask you questions about your experiences and views, I will ask broader questions about experiences first but will also be asking about coercion or pressure to engage in psychology.

Let me know if you would like to stop at any time for a break or if you want to end the interview.

I am now going to start recording

Can you say anything about why you agreed to be a part of the research?

Role and views about the service

- Can you tell me about your role at the XXX?
- Why would a patient come here?
- What is the aim of the service?

Offering Psychology

- Can you tell me about the type of psychological assessments and interventions that are offered at the [XXX] Centre?
- Why might someone be offered psychology input? Who decides they should be offered?
- What is your involvement in decision making about who should be offered? Or process of offering psychology?
- How would someone normally be offered psychology? (Who offers it to them? How? When? Where?)

Decision to attend

- Can you describe the process of patients consenting to engage with psychology?
- How do patients respond when offered psychology?
- What do you think might influence a patients' decision to attend psychological assessment/treatment?
  Do they make up their own mind?
  Do other people influence their decision, if so how?
- What opportunity do patients have to discuss their decision whether or not to engage with staff?
- Can you describe the reasons patients may feel that they need psychological assessment/treatment?
- Can you describe the reasons patients may feel that they do not need psychological assessment/treatment before starting?
- What happens if patients decide not to engage in psychology?

[Coercion is likely to be on a continuum, including perceived friendly persuasion at one end and perceived threat of sanctions at the other. **Discuss concept of coercion to engage in psychology – define and give clear examples]**

- Are you ever aware of patients feeling coerced or pressured to engage with psychology?
  Can you describe what you are aware of?
  What makes you think that this is the case?
  How do you become aware of this?
- What are your thoughts about what might make patients feel pressured or coerced to engage with psychology?
  What are your thoughts regarding this?
- Can you describe any benefits of patients feeling coerced to engage with psychology?
- Can you describe any challenges/negative consequences of patients feeling coerced to engage with psychology?

Ask about what the impact having an LD may or may not have on this?

Experience of psychology

- For those that do attend, how do you think they find it?
- Challenges?
- Benefits?

Questions for psychologists:

- Does [this] affect the therapeutic relationship with them?
- Any impact on therapeutic process/outcome?
- Any changes to the way you work if you feel a patient has perceived coercion to engage in psychology?

Is there anything else about your experience of working as a XXX with patients in this setting regarding patient's engagement with or experience of being offered psychology that you would like to tell me about?

Is there anything that you hadn't thought about before that came up in the interview?

What, if anything, was the most important thing we thought about today?

I am now going to end recording

The interview is now complete. Thank you for your participation.
Do you have any questions or comments to make?
If you have any issues to raise or further questions, you think of later, please contact me.

Just a reminder that you are free to discuss your participation with your line manager should you wish, although this is *not* a requirement. You are also welcome to approach a member of the psychology team, as well as senior members of staff (Team Leaders, Ward manager, Service Lead) for support should you wish.

Appendix XII – REC favourable opinion

This has been removed from the electronic copy.

Appendix XIII – HRA Approval

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Appendix XIV – Trust R&D letter of access

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Appendix XV – Trust Green Light to start study

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Appendix XVI – Thomas and Stenfert Kroese questionnaire (2005)

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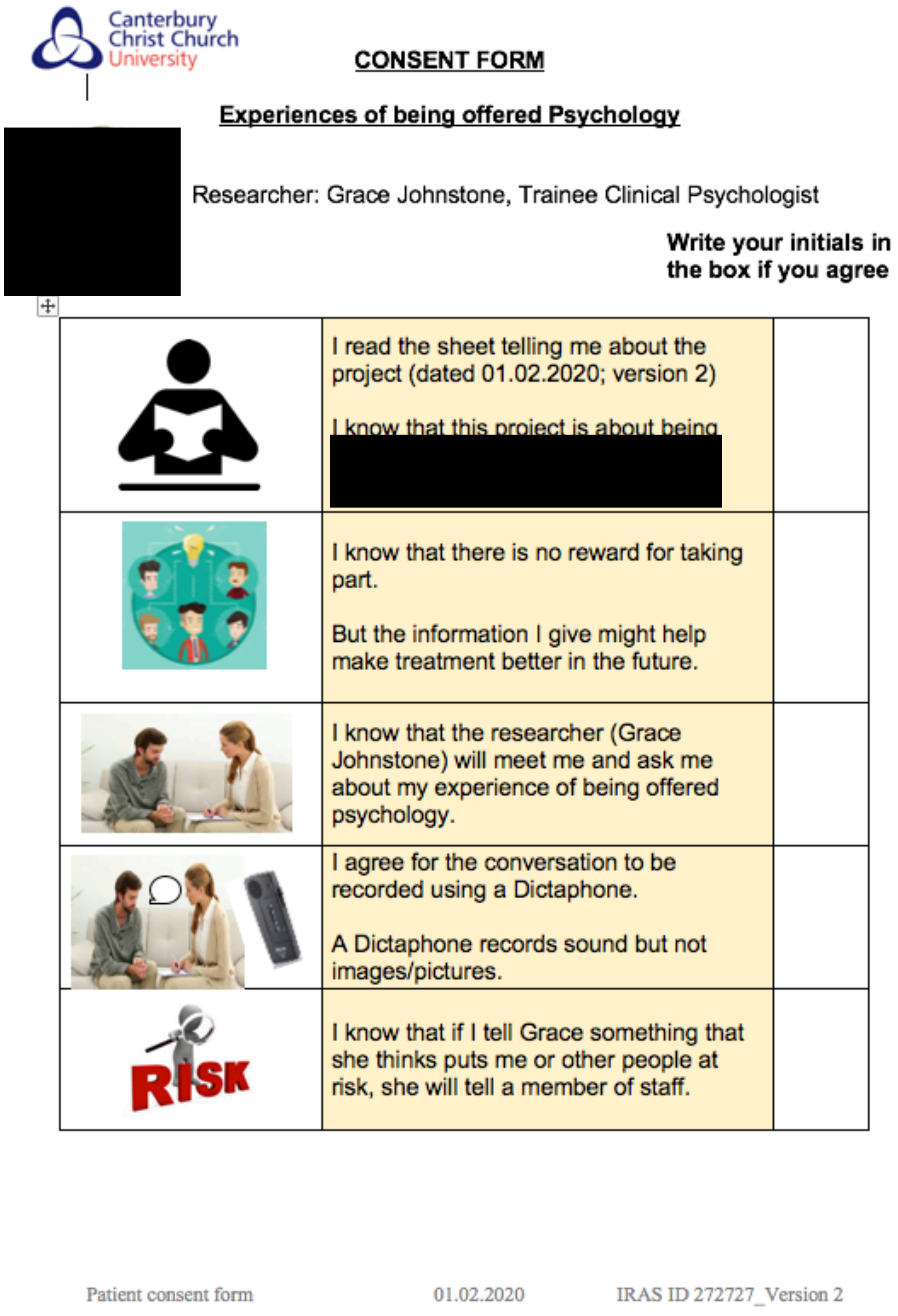
Appendix XVII – Patient consent form



Canterbury Christ Church University

CONSENT FORM

Experiences of being offered Psychology

[redacted]

Researcher: Grace Johnstone, Trainee Clinical Psychologist

Write your initials in the box if you agree

	I read the sheet telling me about the project (dated 01.02.2020; version 2) I know that this project is about being [redacted]	
	I know that there is no reward for taking part. But the information I give might help make treatment better in the future.	
	I know that the researcher (Grace Johnstone) will meet me and ask me about my experience of being offered psychology.	
	I agree for the conversation to be recorded using a Dictaphone. A Dictaphone records sound but not images/pictures.	
	I know that if I tell Grace something that she thinks puts me or other people at risk, she will tell a member of staff.	

Patient consent form 01.02.2020 IRAS ID 272727_Version 2

	The information from the research will be stored on a password protected memory stick or in a locked drawer. Only Grace and her supervisors [redacted] [redacted]ill have access to it.	
	I know that my name, date of birth and the name of the hospital will not be used in the report. Some information about me will be used, but it will be anonymised. This means that no one will be able to tell the information is about me. Things that I say might be used in reports or presentations about the research. No one will be able to tell it is me.	
	I can tell Grace o[redacted] I change my mind. I have four weeks after my interview to tell someone if I have changed my mind. This will not affect my care or treatment.	
	I know that after 4 weeks the researchers will not be able to remove my details from the research because they will not be able to tell which ones are mine. My name would not be on the details.	
	I have had time to think about if I want to take part in the project and let Grace use my information.	

	I have been able to ask any questions. These questions have been answered.	
	I know that taking part is my choice.	
	I know that if I decide to take part my multi-disciplinary team (MDT) and psychiatrist (RC) will be told that I am taking part.	
	I can see the results and the finished report if I want to. This might take a while.	

If you agree to take part in the research you should sign here:

Name of Participant: ______________________

Date: __________________

Signature: _____________________

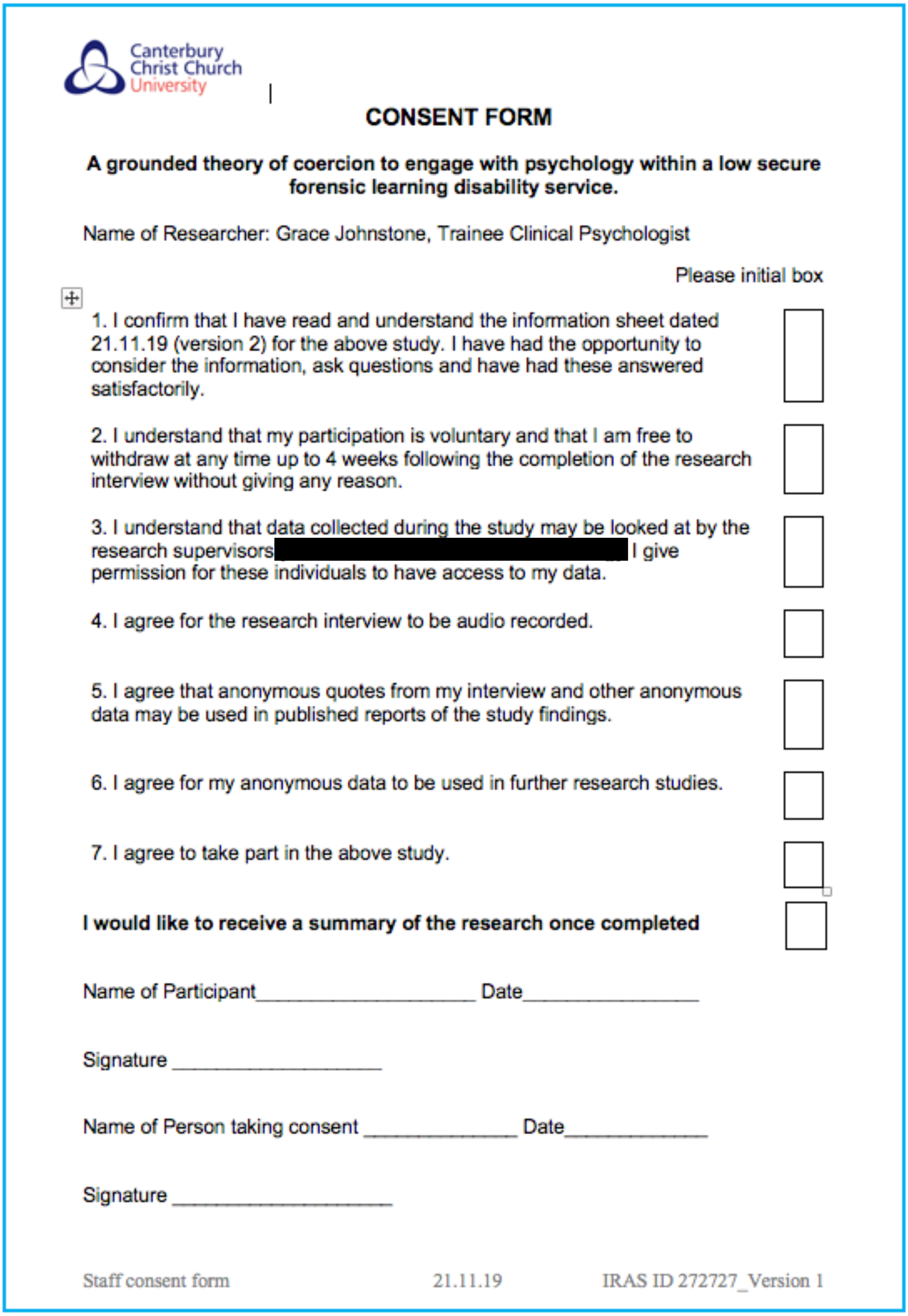
If you would like to be sent a summary of the research when it is finished tick here: ☐

For the researcher to complete:

Name of Person taking consent: _______________

Date: ______________ Signature: ______________________

Appendix XVIII – Staff consent form



Canterbury Christ Church University

CONSENT FORM

A grounded theory of coercion to engage with psychology within a low secure forensic learning disability service.

Name of Researcher: Grace Johnstone, Trainee Clinical Psychologist

Please initial box

1. I confirm that I have read and understand the information sheet dated 21.11.19 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time up to 4 weeks following the completion of the research interview without giving any reason. ☐
3. I understand that data collected during the study may be looked at by the research supervisors [redacted] I give permission for these individuals to have access to my data. ☐
4. I agree for the research interview to be audio recorded. ☐
5. I agree that anonymous quotes from my interview and other anonymous data may be used in published reports of the study findings. ☐
6. I agree for my anonymous data to be used in further research studies. ☐
7. I agree to take part in the above study. ☐

I would like to receive a summary of the research once completed ☐

Name of Participant_____________________ Date_________________

Signature ____________________

Name of Person taking consent ______________ Date_____________

Signature _____________________

Staff consent form 21.11.19 IRAS ID 272727_Version 1

Appendix XIX – Visual prompt sheet

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Appendix XX – Coding example

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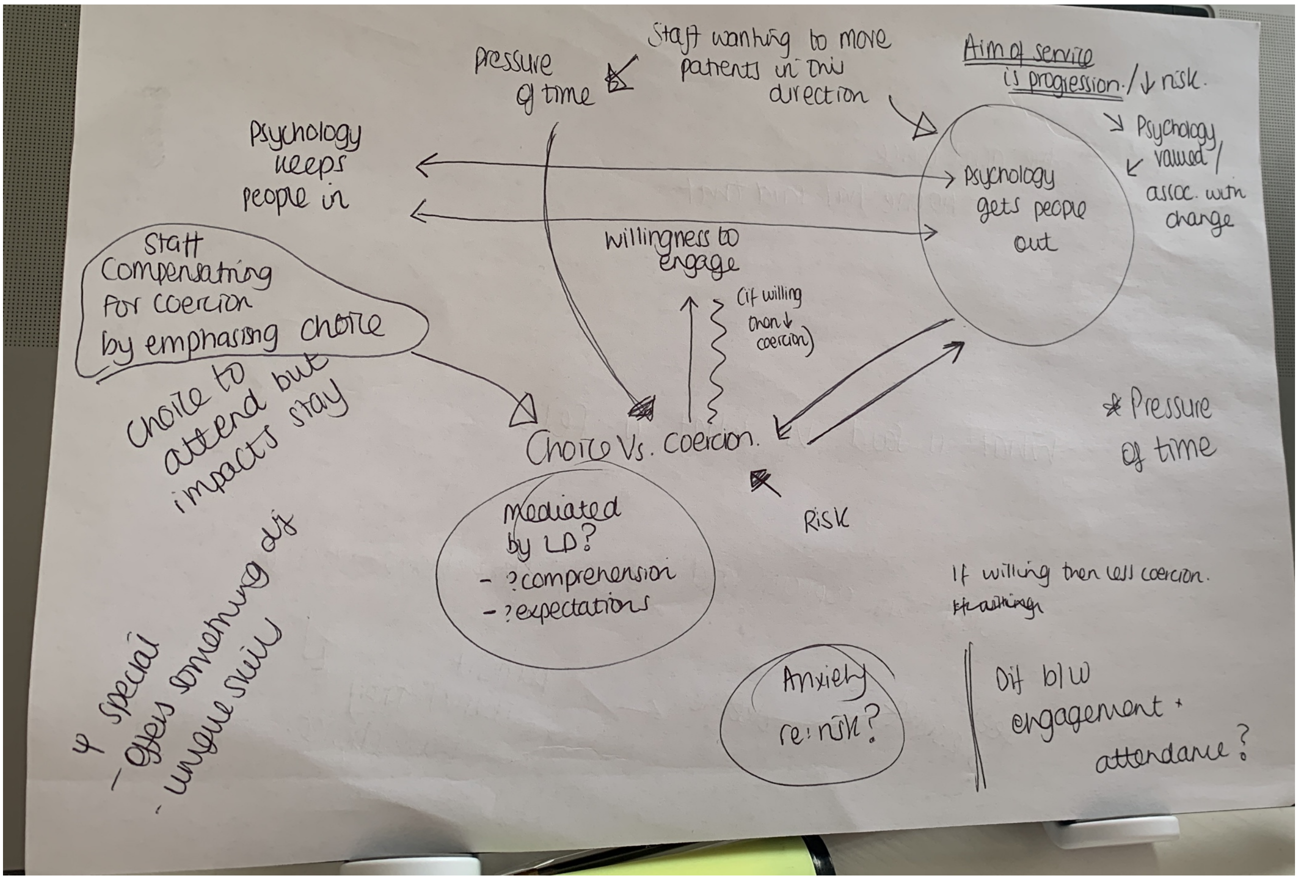
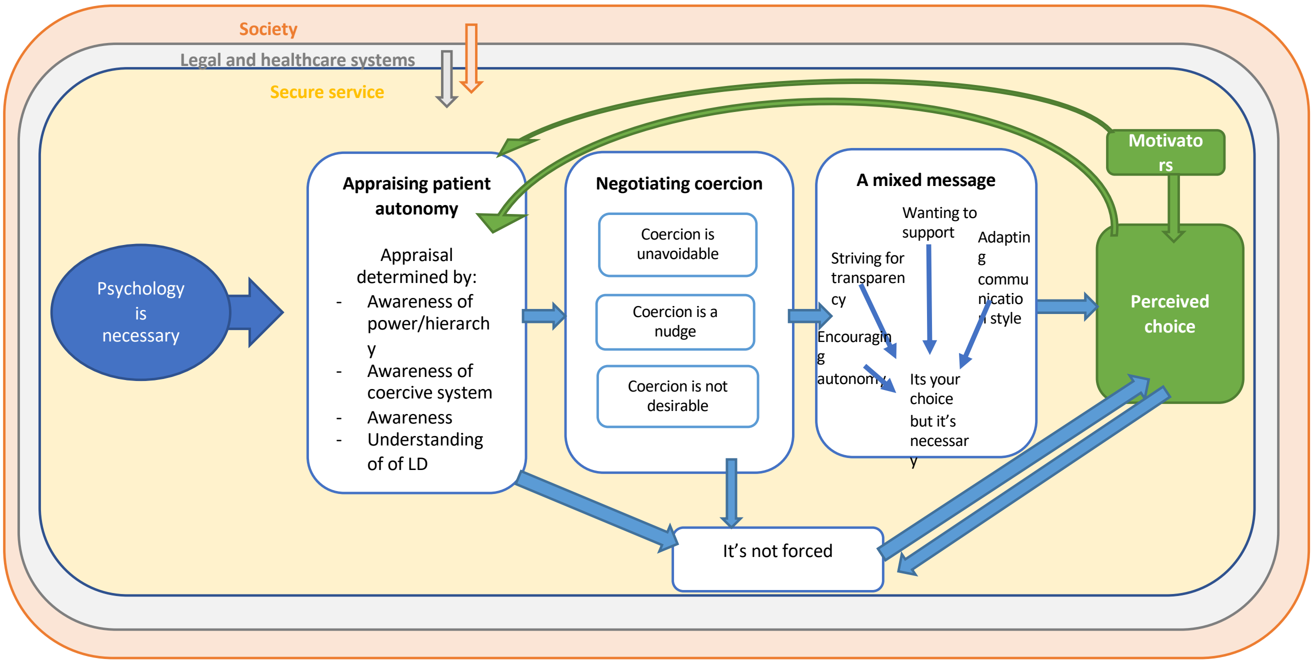
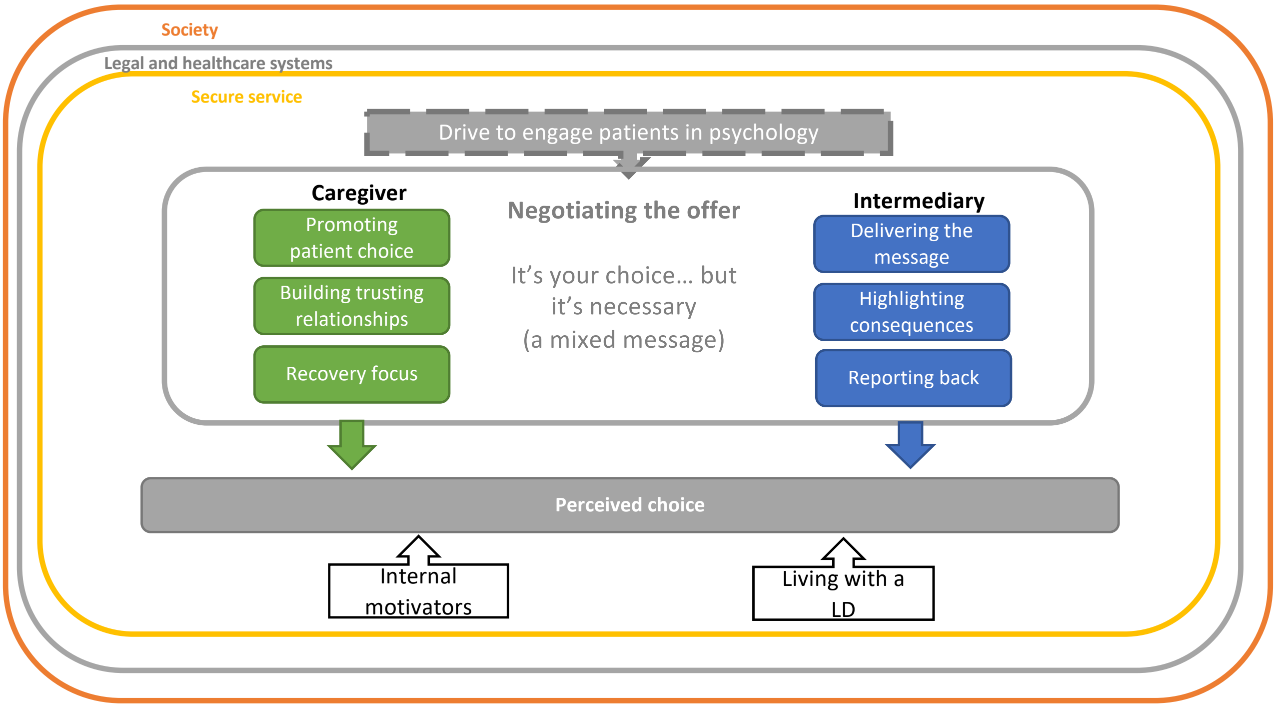
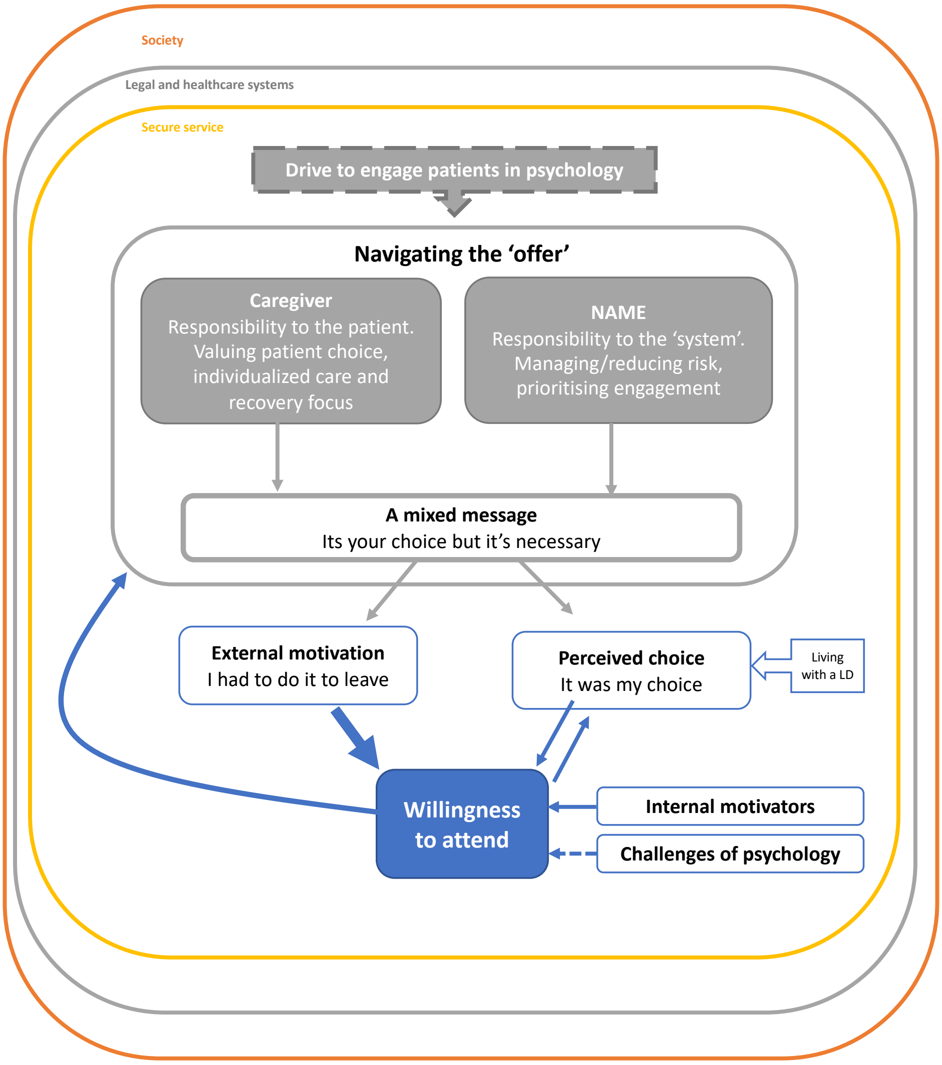
Appendix XXI – Development of model through diagrams






Society
Legal and healthcare systems
Secure service
Drive to engage patients in psychology
Caregiver
Promoting patient choice
Building trusting relationships
Recovery focus
Negotiating the offer
It's your choice… but it's necessary (a mixed message)
Intermediary
Delivering the message
Highlighting consequences
Reporting back
Perceived choice
Internal motivators
Living with a LD


Society
Legal and healthcare systems
Secure service
Drive to engage patients in psychology
Navigating the 'offer'
Caregiver
Responsibility to the patient. Valuing patient choice, individualized care and recovery focus
NAME
Responsibility to the 'system'. Managing/reducing risk, prioritising engagement
A mixed message
Its your choice but it's necessary
External motivation
I had to do it to leave
Perceived choice
It was my choice
Living with a LD
Willingness to attend
Internal motivators
Challenges of psychology

Appendix XXII – Example memos showing domain/category development

Negotiating the offer

2.5.22

The RC spoke about not wanting to give coercive messages to patient such as if you don't do this then you won't get this. They also discussed that this can be complicated in a system where patients have a right to know that their engagement in psychology might sway a tribunal or the MOJ. It's tricky when this message gets distilled to this most basic X=Y level as this may feel like coercion whereas the aim is to allow patients to make an informed decision. I noticed that a number of staff have spoken in this way about supporting patients to get out, it seems as though staff are the messengers of the coercive system, trying to help patients understand what is needed to be discharged.

26.5.22

I had a category called 'consequences of coercion' which suggested that it would come at the end of the process of psychology being offered and patients attending or not. I also had a category relating to staff processes that was labelled 'awareness of coercion’. This hasn't felt quite right though and did not feel like it was in keeping with what participants were describing. Looking back through the interviews, staff talk about the consequences more as a hypothetical awareness of what the consequences would be and described these as a motivator to try to avoid patients feeling pressured. Awareness of coercion makes it sound as though staff are passive in this process however what staff were describing were trying to work within an inherently coercive system in a non-coercive way. In order to navigate this staff try to offer as much choice as possible, telling patients it is their choice whether they attend. But they also feel a need to be transparent and clear with patients about the expectations of the system, that psychology can be helpful and that without psychology they may find it difficult to progress.

01.6.22

I have been noticing that staff describe 2 roles, the messenger of the system and the professional who wants to care for and support patients in a patient centred, empowering way. Some staff feel a pull to one role more than the other but a number of staff have described being stuck between both. This seems to be more when they hold more responsibility for patient risk and progression and when they are the one recommending or delivering the intervention.

Agent of security

11.6.22:

I am not sure 'messenger' of the system feels right? Staff weren't talking about just relaying messages, they were talking about their own clinical recommendations and responsibilities. Staff discuss that it is part of their role to reduce offending risk and keep others safe.

16.6.22

I still don't know what to call this concept that sits alongside the caregiver. I spoke about it in supervision today and we thought about the dual role of the care giver and the 'X'. We discussed that this other role is almost like the prison warden role but this didn't sit right with us or with the data from participants. Participants weren't describing a punitive, enforcing style I feel might be considered if the term prison officer is used. Participants were more talking about the duty to protect others and a responsibility to evidence doing this in a way perceived as convincing or acceptable by the system (e.g. tribunals seeing psychology as important for ensuring reduced risk).After some thought we considered that the ‘agent of security’ seems to capture what is being described.

Appendix XXIII – Tong et al.'s (2007) consolidated criteria for reporting qualitative research (COREQ).

This has been removed from the electronic copy.

Appendix XXIV – Main themes from bracketing interview

Bracketing interview

- main themes

I reflected on my previous experiences working in an inpatient MH unit. I encountered patients reporting feeling coerced to attend psychology on a very regular basis. I am aware that I am expecting patients to feel this way within my research setting. I considered that I might expect even more explicit coercion within a forensic setting.

I thought about my views on coercion. My experiences of patients being coerced have been that is has been very damaging for the therapetuic relationship. The work was often undoing the mistrust that seemed to result from feeling 'forced' to speak with a psychologist. I am aware that others feel that patients may benefit from some level of coercion if it ultimately helps them to access support.

I reflected on interviewing people about their experience of being offered psychology whilst also identifying as a trainee psychologist. I considered how this might make me feel and interpret what is said but also how it might make particpants feel.

I thought about conducting research with PWLD. I considered my experience of working with PWLD in the past and how some of those people may have found it difficult to make their needs and wishes known. I wondered how this is experienced within secure settings. I also thougtb about holding this in mind during recruitment and interviews.

I wondered about how controversial the topic of coercion is and how this might be perceived by professionals. I wondered how easy people might find this to think about. I also thought about how it might feel uncomfrtable as a researcher to ask about this.

Appendix XXV – Excerpts from reflective research diary

This has been removed from the electronic copy.

Appendix XXVI – Positioning statement

Completing the bracketing interview supported me to consider my beliefs about how psychology is offered within services for people who have been involuntarily admitted. This helped to develop my awareness of how my beliefs and assumptions may impact the interviews and following data analysis.

In my 30s at the time of completing the research project, I am a white British female living in the south of England. Upon completing my undergraduate degree in 2011 I worked in a number of different mental health services. I worked as a support worker in an independent hospital for people with learning disabilities detained under the Mental Health Act 1983 for assessment or treatment. I later worked as an Assistant Psychologist in a male inpatient mental health hospital, again working with individual detained under the Mental Health Act 1983. Many of the people I worked with in these settings did not want to be there and had very limited choice and freedom. As an Assistant Psychologist I had experiences of trying to engage patients in psychological assessment and/or interventions. Patients were often unwilling to attend psychology, often feeling that it would not be helpful, or having concerns about what it would involve. I observed differing responses to this within the staff team, with some staff tying engagement with 'privileges' such as leave and smoking breaks. It was a frequent occurrence that patients attended sessions I offered, citing that they had been told that they had to come by other members of the MDT, solicitors, tribunal panels, or family members. I experienced my therapeutic relationship with patients being impacted by experiences of perceived coercion. It often felt as though I was starting on a therapeutic back-foot with patients who felt angry about being in the room with me, or at best disinterested. I was always interested in how as a staff team we encouraged attendance and how we could do this in a way to support engagement, whilst also ensuring that patients were not being coerced to attend. Where patients demonstrated internal motivation to attend psychology, these sessions felt more helpful. I observed the emphasis placed on attending psychology within the service and was always interested in how this came about, and what engagement meant to staff members, particularly across disciplines other than psychology.

The research study was completed in partial fulfilment of a Doctorate in Clinical Psychology. In developing this study I hoped to develop an understanding of the processes by which psychology is offered to detained patients, particularly PWLD, for whom this process may be even less understood and potentially more complex.

Appendix XXVII – Journal of Intellectual Disabilities and Offending Behaviour author guidelines

Before you start

For queries relating to the status of your paper pre-decision, please contact the Editor or Journal Editorial Office. For queries post acceptance, please contact the Supplier Project Manager. These details can be found in the Editorial Team section.

Author responsibilities

Our goal is to provide you with a professional and courteous experience at each stage of the review and publication process. There are also some responsibilities that sit with you as the author. Our expectation is that you will:

Respond swiftly to any queries during the publication process.

Be accountable for all aspects of your work. This includes investigating and resolving any questions about accuracy or research integrity

Treat communications between you and the journal editor as confidential until an editorial decision has been made.

Read about our research ethics for authorship. These state that you must:

Include anyone who has made a substantial and meaningful contribution to the submission (anyone else involved in the paper should be listed in the acknowledgements).

Exclude anyone who hasn't contributed to the paper, or who has chosen not to be associated with the research.

If your article involves human participants, you must ensure you have considered whether or not you require ethical approval for your research, and include this information as part of your submission. Find out more about informed consent.

Research and publishing ethics

Our editors and employees work hard to ensure the content we publish is ethically sound. To help us achieve that goal, we closely follow the advice laid out in the guidelines and flowcharts on the COPE (Committee on Publication Ethics) website.

We have also developed our research and publishing ethics guidelines. If you haven't already read these, we urge you to do so – they will help you avoid the most common publishing ethics issues.

A few key points:

Any manuscript you submit to this journal should be original. That means it should not have been published before in its current, or similar, form. Exceptions to this rule are outlined in our pre-print and conference paper policies. If any substantial element of your paper has been previously published, you need to declare this to the journal editor upon submission. Please note, the journal editor may use Crossref Similarity Check to check on the originality of submissions received. This service compares submissions against a database of 49 million works from 800 scholarly publishers.

Your work should not have been submitted elsewhere and should not be under consideration by any other publication.

If you have a conflict of interest, you must declare it upon submission; this allows the editor to decide how they would like to proceed. Read about conflict of interest in our research and publishing ethics guidelines.

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Please take a few moments to read our guide to publishing permissions to ensure you have met all the requirements, so that we can process your submission without delay.

Open access submissions and information

All our journals currently offer two open access (OA) publishing paths; gold open access and green open access.

If you would like to, or are required to, make the branded publisher PDF (also known as the version of record) freely available immediately upon publication, you should select the gold open access route during the submission process.

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Appendix XXVIII – End of study form

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Appendix XXIX – Summary report for ethics panel

Dear Ethics Panel,

RE: Coercion to engage with psychology within a low secure learning disability setting

Final title: The offer of psychology within a low secure learning disability service: Choice without a choice. A grounded theory.

I am writing to inform you that the above study has now been completed and submitted to Canterbury Christ Church University in partial fulfilment of the requirements of the Doctorate in Clinical Psychology. The summary provides an overview of the research project and findings.

The study

Employing grounded theory methodology this study sought to understand the processes regarding offering psychology within a low secure learning disability setting, informed by the experiences of both patients and professionals. In particular the study sought to provide an understanding of coercion to engage with psychology within this setting. Five patients and six staff members, recruited from one low secure learning disability service in the south of England, participated in the research. A constructivist grounded theory methodology was used to develop a theory rooted in the experiences of those interviewed.

The model summary

Findings were constructed across four domains, including ten categories and four sub-categories, with three further sub-categories. The four domains were: ‘context of the offer’, ‘drive to engage patients in psychology’, ‘navigating making the offer’, ‘making sense of the offer'. Interactions between these are highlighted. A narrative description of the model and visual representation was provided.

Summary

This study aimed to develop a GT of the process by which psychology is offered to patients within a low secure LD service and resulting motivation to engage. The constructed model highlights four overarching domains: context of the offer, drive to engage patients in psychology, navigating making the offer and making sense of the offer. The model highlights staff experiences of trying to promote patient choice and individualised care within an inherently coercive system, that places high value on engagement in psychology in managing risk to others. Staff navigate this by reinforcing a message of choice to patients whilst at the same time making clear that engagement in psychology is valued by the system in order to be perceived as ready for discharge. In receiving this message patients hold a contradictory position of feeling that they have a choice whilst also experiencing engagement as the only option. Engagement as a currency by which to achieve discharge was a key motivator for patient's willingness to attend psychology. Within the constructed model, willingness to attend is also mediated by internal motivators and perceived challenges of attending psychology, with the former appearing to influence perceived choice regarding engagement.

These findings highlight that the experience of being offered psychology may be different for people with a learning disability within secure services, than for people without a learning disability. Implications for clinical practice and research were discussed. With particular consideration of the challenges of gaining informed consent and exploration of ways of increasing intrinsic motivation to engage with psychology.

Dissemination

A summary of research findings will be sent to all participants, with an accessible summary sent to patient participants. It is planned to present the research findings to staff at the recruitment site. It is planned to submit the study for publication in Journal of Intellectual Disabilities and Offending Behaviour.

If you have any questions please feel free to contact me.

Yours faithfully,

Grace Johnstone
Trainee Clinical Psychologist
Salomons Institute for Applied Psychology
Canterbury Christ Church University

Appendix XXX – Summary report for staff participants

End of study summary

Research title: A grounded theory of coercion to engage with psychology within a low secure forensic learning disability service (IRAS ID 272727).

Final title: The offer of psychology within a low secure learning disability service: Choice without a choice. A grounded theory.

Dear Participant,

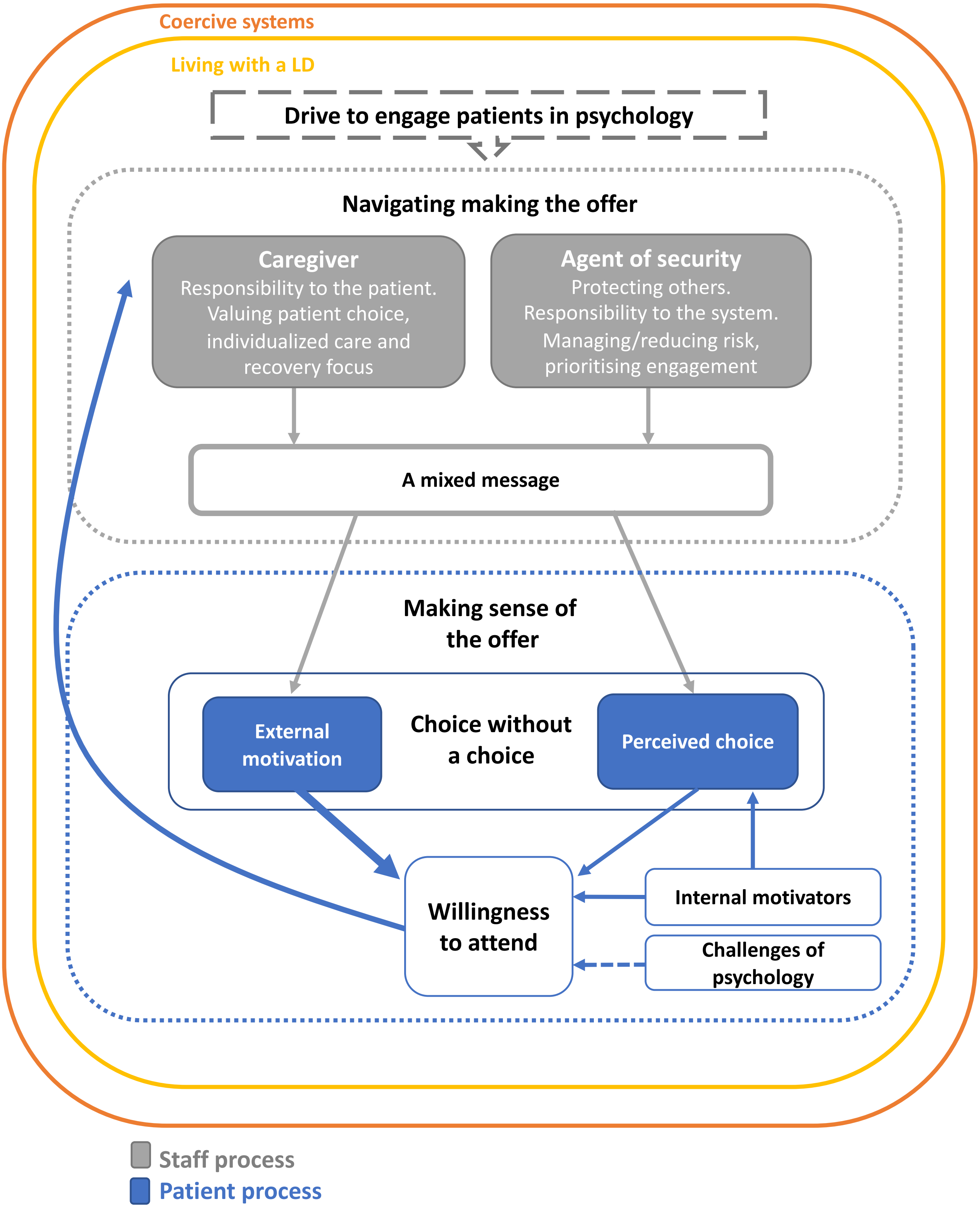
Thank you for taking part in this study. The research has now been completed and the following is a summary of the process of the study and findings.

The study:
Six staff and five patients from a low secure learning disability service in the south of England were interviewed. A grounded theory methodology was used to construct a theory grounded in the accounts of participants, considering themes that occurred across participant interviews. The developed theory is just one possible way of making sense of what emerged and how this can be used to understand the process of psychology being offered, and the offer being received, within the context.

The model summary:
This study aimed to develop a GT of the process by which psychology is offered to patients within a low secure LD service and resulting motivation to engage. The constructed model highlights four overarching domains: *context of the offer*, *drive to engage patients in psychology*, *navigating making the offer* and *making sense of the offer*. The model highlights staff experiences of trying to promote patient choice and individualised care within an inherently coercive system, that places high value on engagement in psychology in managing risk to others. Staff navigate this by reinforcing a message of choice to patients whilst at the same time making clear that engagement in psychology is valued by the system in order to be perceived as ready for discharge. In receiving this message patients hold a contradictory position of feeling that they have a choice whilst also experiencing engagement as the only option. Engagement as a currency by which to achieve discharge was a key motivator for patient's willingness to attend psychology. Within the constructed model, willingness to attend is also mediated by internal motivators and perceived challenges of attending psychology, with the former appearing to influence perceived choice regarding engagement.

The model is depicted and described overleaf.

Model diagram:



Model summary:

Context of the offer

Staff participants highlighted the importance of the broader context in which the attempt to engage PWLD within the low secure service takes place.

Coercive systems

The low secure service exists within multiple other systems including legal and health care systems and broader society. Staff participants described these systems as being built on paternalistic ideation, reinforcing ideas of hierarchy and power that likely influence many elements of both staff and patient choice and behaviour. Patients are detained involuntarily and experience a multitude of restrictions on freedom and choice.

Living with LD

Perceived by society and health and legal systems as people who require support and who may struggle to make independent choices, some staff participants described that PWLD have a pervasive experience of stigma, disempowerment and dependence on others. The label of LD and the experiences and characteristics associated with this were referred to as having an influence across the processes described by the model, these are highlighted throughout.

Drive to engage patients in psychology

Within this concept 'engaging' patients refers to encouraging attendance at psychology sessions or groups. Staff participants described psychological input as highly valued by the systems, service and staff working within it. Staff participants across disciplines were motivated to support patients to engage in psychological assessment and intervention.

Reducing risk

In working with offenders, understanding, managing and reducing risk were spoken about as key tasks of the service. Psychological assessment and intervention were seen as important in achieving this.

Psychology is helpful

Psychology is seen as helpful in supporting patients to develop understanding and learn skills that can improve quality of life. One participant described that psychology may be particularly valued within LD services where medication may be perceived as having less of a role.

Psychology is necessary

Staff described experiences of MHA tribunal panels and step-down services emphasising a need for patients to complete psychological assessment and intervention. Associated with its perceived helpfulness and role in risk management, psychology was described as a core intervention, with staff perceiving engagement in psychology as a necessary condition for patients to progress.

Navigating making the offer

The 'offer' of psychology covers the initial recommendation to patients, inviting them to psychology sessions and encouraging attendance. When navigating how to make this offer within the context described, staff indicated that their thoughts and actions were influenced by different motivations, responsibilities and aims. These were conceptualised in the model under two categories, *caregiver* and *agent of security*.

Caregiver

The *caregiver* category represents staff valuing individualised patient care, in which patient choice and autonomy is highly esteemed and strived for. Staff spoke about wanting to improve patients' quality of life and support them to achieve goals meaningful to them. All staff described being influenced by the concepts captured by the *caregiver* category. Staff described feeling strongly that patients should not feel forced or pressured to engage in psychology.

Agent of security

The *agent of security* category represents staff experiencing responsibility to the service, legal system and other stakeholders to manage risk and keep people safe. Staff described a pressure to engage patients in psychology as a way of evidencing reduced risk, with an aim to progress patients though the system. Staff felt a responsibility to relay information to patients regarding what is required by the system, although aware that this may in turn pressure patients to engage. The extent to which staff members described being influenced by the *agent of security* category appeared to be dependent on their role within the service. Staff who held clinical decision-making responsibility and were involved in delivery of interventions appeared to be more aligned with this category than others.
Where motivations were aligned with both the *caregiver* and the *agent of security* categories this was experienced as conflicting.

A mixed message

Staff described negotiating this dissonance by trying to find ways to fulfil both roles, often trying to compensate for possible pressure on patients to engage. This included being clear about the importance of psychology and associating engagement with psychology with increased likelihood of positive consequences such as Section 17 leave or discharge but also emphasising patient choice and power to choose whether or not to engage. The navigation of the *caregiver* and *agent of security* roles both within and between staff results in contrasting messages being delivered to patients regarding their engagement in psychology. Patients are given the message that engagement is their choice but that it is also likely to be necessary for, or speed up, discharge from the service. Staff participants reported that discharge was not made conditional on engagement with psychology but that patients are made aware of how psychology can help them progress and how lack of engagement may be viewed by tribunals and key professionals within the legal system.

Making sense of the offer

Choice without a choice

Patients described experiencing choice *(*constructed as *perceived choice)* regarding whether or not they attended psychology, but at the same time said they *had* to engage with psychology to be able to be discharged (constructed as *external motivation*). This experience was constructed within the model as *choice without a choice***.** The majority of patients did not express explicit awareness of this juxtaposition.

Perceived choice

Mirroring the messages given by staff, patients reported experiencing choice regarding whether or not they engaged with psychology. Where patients perceived choice regarding attending psychology, the recommendation from staff to attend was received more positively rather than as something to resist, influencing willingness to attend.

Understanding and expectations

Staff described experiences of patients not questioning their choice in the process, possibly not understanding influence of external factors on their decisions, or being aware of coercive pressure but not seeing this as impacting self-determination. Staff suggested that this may be impacted by comprehension and communication abilities of patients and past experiences of reduced autonomy.

External motivation

All patients described that attending psychology was necessary for them to progress from the service. Patients were aware that attendance at psychology is recorded by staff and fed back to the multidisciplinary team and during meetings. Some perceived negative consequences of not attending psychology, such as decision makers viewing this negatively. This message came from staff within the service, but also external staff such as solicitors, Care Programme Approach (CPA) meetings and tribunals, highlighting the influence of the wider systems in the process of engaging patients in psychology within this setting. External motivation was a significant factor driving patients' willingness to attend psychology, appearing to carry significant weight in comparison to other influencing factors, emphasised by the heavier line on the diagram. Although staff reported that when *navigating the offer* discharge was not presented as conditional on engagement, patient participants expressed that this was the message they received.

Willingness to attend

Patients described experiencing different levels of inclination to engage in psychology; however, the majority of patients reported that they felt willing to access psychology. Staff reported that patients largely respond positively when invited to or offered psychology, recalling experiences of patients requesting psychology or eagerly waiting for the psychologist to arrive on the ward. *Willingness to attend* psychology was described as influenced by *external motivation* and *perceived choice* but also by *internal motivators* and *challenges of psychology*.

Internal motivators

Wanting help

Internal motivators to attend psychology included patients wanting help to understand themselves, develop coping strategies and reduce risk of recidivism. Patients described seeing psychology sessions as a helpful space to talk about any difficulties. Presence of internal motivators that aligned with what was being offered or requested by staff appeared to be associated with increased *perceived choice* regarding attendance. With the contrast being described by one patient who reported no internal motivators to attend.

Social gain

Attending psychology was described as a social opportunity and a way to reduce boredom. Patients described positive regard for psychology staff. Staff reflected that they experience patients as seeking positive social relationships. One staff member proposed that this may be influenced by living with a LD and experiencing challenges forming relationships in other areas of life. Staff described observing a desire to have a relationship with staff as a motivator for patients' attendance at psychology.

Challenges of psychology

Participants described that the idea of psychology could be anxiety-provoking and that talking to a psychologist can feel hard. This was associated with presence of offending histories. Participants described possible experience of shame regarding discussing offending, or concern that disclosing information to a psychologist may lead to negative consequences. Difficulty engaging with the content or structure of the sessions was also described. These factors negatively impacted willingness to attend.

Due to the drive to engage patients in psychology, where patients are ambivalent or not willing to attend or engage with psychology staff described returning to the *navigating making the offer* stage. A continual process of staff trying to engage patients in psychology was portrayed. This entailed repeatedly offering psychology and reminding patients of the benefits and/or need for it.

What next:

The full research paper will be submitted in partial fulfilment of the requirements for a doctoral degree. Once assessed and approved, the paper will be prepared for submission to a peer reviewed journal for publication.

I would like to thank you very much for your time and contribution to this research project. Thank you for reading the summary. If you would like to send me feedback, please feel free to email me (gj108@canterbury.ac.uk).

Yours sincerely,

Grace Johnstone

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Appendix XXXI- Summary report for patient participants

Due to the time constraints of project, and the summary needing to be made accessible for participants with learning disabilities, the summary report for participants will be completed following submission of this Major Research Project. A copy of this can be made available at a later date if required.