An Examination of the Rehabilitation Process of Adult Male Offenders with a Mental Disorder

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Abstract

This thesis includes an examination of the rehabilitation process of adult male offenders with a mental disorder. More specifically, it examines the effectiveness of treatment, and the community rehabilitation of adult mentally disordered offenders (MDOs). In Chapter 1 a literature review following a systematic approach examined the effectiveness of cognitive-behavioural interventions with adult MDOs in inpatient settings. Results revealed such interventions have the potential to improve: problem solving ability, social-cognitive skills, social adjustment, hostile and aggressive behaviour, and awareness of illness, ultimately bringing about a reduction of antisocial thinking and behaviour. The review findings were considered in relation to study quality and methodological limitations and recommendations for future research were discussed. In Chapter 2, an empirical research study gathered qualitative information of the experiences of adult male MDOs under Section 37/41 of the Mental Health Act (1983) who had been given a conditional discharge into the community. Results offered preliminary indications of influential factors at the individual level for the process of MDOs reintegration into the community. Recommendations for future research were discussed along with the clinical implications of the findings. A case study is presented in Chapter 3, evaluating the effectiveness of a cognitive-behavioural intervention with an adult male offender suffering anxiety and depression serving a sentence at HMP Cardiff. This case study demonstrated the importance of individual assessment and formulation in developing appropriate and effective interventions to meet client needs and highlighted the need to address prisoners' mental health before they are released into the community. Future directions were considered with regards to working with offenders in prison settings. In Chapter 4 a critique of the CRIME-PICS-II (Frude, Honess & Maguire, 1994) offered a review of the tool in terms of its development, purpose, use, relevance to intervention planning and assessment, scientific and psychometric properties and its ease of use and accessibility. Further, it considered the tools applicability to forensic and clinical settings before exploring some of the limitations associated with its use. The implications of the thesis findings are finally considered in terms of existing limitations, clinical implications and future research.

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Introduction

The overall aim of this thesis is to examine the rehabilitation process of adult male offenders with a mental disorder. More specifically, it examines the effectiveness of the treatment and community rehabilitation of adult male mentally disordered offenders (MDOs). In addition, the thesis attempts to highlight how assessment and formulation can aid in the development of successful individualised interventions, whilst critiquing a psychometric tool that enables an evaluation of change following treatment. This introduction aims to introduce readers to this thesis by way of definitions of the concepts and ideas later discussed.

Defining Rehabilitation

Whilst the practices and ideas associated with the rehabilitation of offenders have a long history, as a concept, 'rehabilitation' is difficult to define. When different theorists, practitioners and writers refer to rehabilitation, they are often not talking about exactly the same thing, which may be in part due to the fact it can be understood as both a set or practices or a process, or as a general goal or objective (Rotman, 1990). Attempts to define 'rehabilitation' are difficult due to the number of related terms such as 'resettlement', 'reform', 'reintegration' and 're-entry'. However, it is clear that all these terms share the common prefix of 're', which implies a return to a preceding condition. Recently the use of the term 'rehabilitation' has also remained debatable due to the introduction of terms such as 'desistance' (Ward & Maruna, 2007). Nevertheless, the concept of rehabilitation alludes to the process of helping an individual to restore former positions in society or readapt to new positions. Throughout this thesis, rehabilitation will be discussed in terms of reintegration into society; the term rehabilitation will also be used to refer to the general process of behaviour change and symbolic process of change that allows for an individual to be reinstated with the community following a period of incarceration.

Offender Rehabilitation

The rehabilitation of offenders has caused much controversy and contest over the years; centring on the subject of punishment versus rehabilitation, with much debate

over whether rehabilitation actually 'works' (Becker, 1963). However, it has become increasingly clear – as research suggests – that treating and rehabilitating offenders does reduce reoffending, as opposed to just incarcerating them (Andrews & Bonta, 1998). Such evidence has lead to significant shifts in the rehabilitation approach, with less of a focus on punishment to an endeavour to rehabilitate offenders (Gendreau, 1996). It is now assumed that targeting the distinct patterns of psychological and social factors that cause offending behaviour will decrease offending rates.

The current models of offender rehabilitation have been influenced by the work of correctional researchers in regards to 'what works' (Gendreau, 1996; Andrews & Bonta, 1998; McGuire, 2002). Such work has emphasised the consideration of risk, need and responsivity in the successful rehabilitation of offenders, and has been supported by empirical research (Andrews & Bonta, 1998). Taken individually, the risk principle states individuals differ in their levels of risk, due to variations in their predisposition to commit crimes. As such, higher risk offenders require more intensive intervention than lower risk offenders, where treatment should be stratified according to the level of risk posed by the individual. The need principle stipulates that effective and ethical treatment should target the offender's individual dynamic risk factors or criminogenic needs that are related to his or her offending. Finally, the responsivity principle emphasises the need for treatment interventions to match the learning style, motivation and cultural identity of an offender, so that treatment may be successfully absorbed and behavioural changes made accordingly. The emphasis here has been largely on the use of structured cognitive-behavioural approaches in treatment (McGuire, 1996).

Whilst the risk and need principle have been researched widely, the responsivity principle appears to be much neglected in the international literature (Birgden, 2004). In addition, certain aspects of the risk and need principles have been challenged by theorists and researchers in recent years for their focus on reducing dynamic risk factors as opposed to broadening the scope to take into account the promotion of human goods or goals (Maruna, 2001). In general, it would appear that responsivity has been overlooked, both in terms of internal responsivity and external responsivity (Gendreau & Andrews, 1990). In terms of internal responsivity, this includes a focus on an individual's various barriers to participation in treatment, including among

others learning style, age, motivation and culture. With regards to external responsivity, it is evident that the active, participatory and engaging style of treatment delivery is of equal importance to internal responsivity, despite the fact this is sometimes overlooked (Gornik, 2002). A focus on external responsivity should acknowledge both the staff characteristics and setting characteristics that may influence successful rehabilitation (Kennedy, 2001). For example, in terms of staff characteristics, appropriate role modelling and the importance of a therapeutic alliance warrant much attention; when considering setting characteristics, the delivery of programmes in prison and community services also have different outcomes (Birgden, 2004).

The Rehabilitation of Mentally Disordered Offenders

In any consideration of the treatment and rehabilitation of offenders, the treatment of adult male MDOs needs to be addressed. Not only is this due to the fact MDOs are a population of continuing public concern and interest, but also due to the fact that research to date involves a poor amount of outcome research on the rehabilitation of MDOs, which is complicated by the heterogeneous nature of this population and their treatment needs. In terms of the continuing public concern and interest in relation to MDOs, this is of course in reference to literature surrounding the relationship between mental disorder and offending, which has long been a subject of vigorous debate (Gregory, 2004). Instead of considering that only a small number of MDOs pose a serious risk of offending, there is a tendency for all mentally disordered individuals to be regarded by society as high risk. However, as Blackburn (2004) notes, whilst *"there is little disagreement that the mental health needs of offenders are a challenge for rehabilitation, there is less agreement on whether mental disorder is a risk factor for criminal or harmful behaviour"* (p.289).

There exists a sufficient body of research employing widely varying methodologies to sustain some broad conclusions about the correlations between different forms of mental disorder and a range of offending behaviours. Studies investigating the link have highlighted that individuals suffering from mental disorders are more often convicted for crimes than the general population (Walsh, Buchanan & Fahy, 2002), but findings have not been universally supported (Mullen, 2006). Mullen (2006)

suggests the most common link between mental disorder and crime is thought to be mediated through active symptoms such as hallucinations and delusions, however, again, findings have not been universally supported (Swanson, Swartz, Van Dorn, Elbogen, Wagner, Rosenheck, Stroup, McEvoy & Lieberman, 2006). Due to the significant methodological challenges faced by researchers in this field, the nature of the association between mental disorder and offending remains unclear (Stuart, 2003). For example, violence has been difficult to measure directly, with researchers often relying on official documentation or uncorroborated self-reports, and samples are not always representative, often focusing on individuals who have been hospitalised. In addition, study designs have not always controlled for co-morbid substance abuse or eliminated individuals with a prior history of violence, thereby weakening any causal arguments that might be made (Wessley, 1993). Furthermore, associations between the presence of mental disorders and criminal offences do not reflect causal connections; however they do raise the question of the nature of the relationship between having a mental disorder and being more likely to offend. McInerney and Minne (2004) suggest that *"mentally disordered offenders have special problems; their offending places them apart from other psychiatric patients and major mental disorder separates them from most offenders"* (p.43). Current literature highlights a move towards an acceptance that the excess violence found in association with mental disorders is not a result of the disorder itself, but of factors such as coexisting substance misuse, personality vulnerabilities, and social dislocation (Mullen, 2006). Therefore, practitioners should always pay attention to mental disorder as a potential risk factor, especially when combined with substance abuse or antisocial thinking and behaviour.

MDOs by definition are mentally disordered individuals who commit crimes. In the UK, the Crown Prosecution Service uses the term 'mentally disordered offender' to describe a person who has a disorder or disability of the mind and is suspected of committing or has committed a criminal offence, however, the legal terms and definitions vary from one country to another. The term 'mentally disordered offender' designates legal recognition of a disorder, or adequate severity to permit interventions outside those of the usual criminal justice process (Halleck, 1987). In Britain such individuals are dealt with by hospital orders under the Mental Health Act (MHA 1983; 2007). Regardless of their legal status, and how they are labelled, MDOs present

multiple challenges to the clinicians and psychologists charged with their care. MDOs have treatment needs that are related to their offence characteristics, however, in spite of this heterogeneity, many forensic institutions adopt evidence-based treatments for MDOs that are validated on other populations (Hodel & West 2003; Hoffman & Kluttig, 2006), leaving forensic psychologists unsure about which treatments are appropriate for MDOs (Rice & Harris, 1997). In addition, although it is not possible to state for certain that mental disorder is a dynamic risk factor for offending; there is an assumption that mental disorder also affects treatment responsivity, which will therefore need to be addressed in the delivery of interventions with this client group (Andrews, 1995). It is clear that the population of MDOs is not homogenous with respect to the nature of their mental disorders; any population of MDOs will present each with their own distinct challenges and features, which is further complicated by the high levels of co-morbid difficulties evidenced in this population (Blackburn, 2002). MDOs may present for treatment with an array of concerns, including substance abuse histories, psychiatric diagnoses, unique offense characteristics, and high risk behaviour (Rice & Harris, 1997), with such clinical complexity inevitably serving to impact on likely therapeutic intervention and outcome (Linehan, 1993). For MDOs, lack of engagement in treatment does not necessarily mean lack of motivation to change (McMurran, 2002). This is highlighted by the fact that for some, treatment options may be limited to, for example, group work. In these instances, clients may display a resistance to some aspect of the *method* of treatment despite otherwise being motivated to change. In addition, MDOs with complex disorders may display different motivation for different aspects of their problems (DiClemente, 1999). The stages of change model (Prochaska & DiClemente,1986) is best used to conceptualise this, as the model acknowledges that individuals with multiple problems, such as is seen in MDOs, can be at different stages for each problem. For MDOs in particular, this point may be particularly important where a client is unable to acknowledge either their offence or mental disorder. For example, when considering MDOs who commit serious crimes within the context of a delusional belief system, attempts to challenge such beliefs may undermine the individual's rationalisation of the offence which may meet resistance as they begin to comprehend the seriousness of their behaviour.

Since MDOs are a complex population, the challenge is clear —forensic clinicians must consider the disorder, criminal offence, and setting of treatment—to identify

effective treatment interventions tailored to the idiosyncratic needs of MDO populations to address their heterogeneous needs. This requires the identification of subgroups of patients with distinctive characteristics and treatment needs and the development of specific combinations of treatments and services adapted to each (Hodgins, 2001). In summary, the forensic mental health services (FMHS) which attempt to rehabilitate MDOs face several challenges, including the previously mentioned debate of treatment versus punishment, together with recovery versus criminal rehabilitation (Lindqvist & Skipworth, 2000). Additionally, the community rehabilitation of MDOs remains largely neglected in the current literature.

Aims of Thesis:

This thesis argues that rehabilitation is a notion which implies change, the process of which may include, therapeutic interventions, environmental and behaviour changes, as well as self-directed efforts of individuals supported by significant others. This thesis is specifically interested in the rehabilitation of adult male MDOs, both in the inpatient setting and community setting. The thesis will attempt to address what types of changes are required for successful rehabilitation and how these can be achieved, whilst considering the context of change. The overall aim of this thesis is therefore to provide the professionals involved in the supervision of adult male MDOs with an evidence-base which may inform and improve the services they provide, both at the inpatient, and community level. With this is mind, the thesis is structured into four main Chapters which contribute to the overall aims of the thesis.

Chapter 1 presents a systematic review of cognitive-behavioural interventions with adult male MDOs in inpatient settings. Cognitive-behavioural interventions were chosen as a focus due to research demonstrating the efficacy of such interventions in providing offenders with interpersonal and cognitive skills (McGuire, 1995). The aim of this Chapter was to determine if psychological interventions based on cognitive-behavioural principles are effective with adult male MDO populations in inpatient settings. Results are analysed in terms of the integrity, delivery and effectiveness of interventions. The studies included are considered in terms of the duration and frequency of the intervention, the assessments used and the statistical analysis reported. Methodological considerations are also noted. The systematic review

findings are considered in relation to study quality and methodological limitations. Recommendations for future research are discussed along with the treatment implications of the findings.

Chapter 2 presents an empirical research study examining the experiences of adult male MDOs under Section 37/41 of the MHA (1983) who have been given a conditional discharge into the community from an inpatient FMHS. The purpose of this study was to employ a narrative life story interview technique (McAdams, 1993) to identify any common themes in MDOs journeys through the forensic mental health system, which may be used to inform professionals working with MDOs of what impacts on a successful reintegration into the community following a conditional discharge. Thematic Analysis of the data was used to generate main themes, and results offer preliminary indications of influential factors at the individual level for the process of MDOs reintegration into the community. Recommendations for future research are discussed along with the clinical implications of the findings.

Chapter 3 provides a case study which evaluates the effectiveness of a cognitive-behavioural intervention with a male offender suffering anxiety and depression serving a sentence in HMP Cardiff. This case study demonstrates the importance of individual assessment and formulation in developing appropriate and effective interventions to meet client needs and highlights the need to address prisoner's mental health before they are released into the community. The outcome of this case study is discussed in relation to the intervention setting, client characteristics and assessment issues. Future directions are considered with regards to working with offenders in prison settings.

Chapter 4 presents a critique of the CRIME-PICS-II (Frude, Honess & Maguire, 1994). The critique offers a review of the tool in terms of its development, purpose and use, its relevance to intervention planning and assessment, its scientific and psychometric properties – including reliability and validity - and its ease of use and accessibility. Further, it considers the tools applicability to forensic and clinical settings before exploring some of the limitations associated with its use. The implications of the thesis findings are finally considered in terms of existing limitations, clinical implications and future research.

Chapter 1: Systematic Review

A Literature Review Following a Systematic Approach: An Analysis of Integrity, Delivery and Effectiveness of Cognitive-Behavioural Interventions with Adult Male Mentally Disordered Offenders in Inpatient Settings

Abstract

This systematic review aimed to determine if psychological interventions based on cognitive-behavioural principles are effective with adult male mentally disordered offender (MDO) populations in inpatient settings. Relevant publications were sourced via 3 electronic bibliographic databases (PsychINFO, MEDLINE and EMBASE), hand search of journals, expert contact, reference lists of relevant previous reviews, and grey literature. Studies identified were subject to pre-defined inclusion/exclusion criteria, and the quality of all included studies was systematically examined, the findings of which were appraised. Data was extracted using a standard data extraction sheet. Database searches generated a total of 3370 hits. Of these studies, 3312 irrelevant studies were excluded, 4 were unobtainable dissertation abstracts, and 33 were duplicates removed. Of the remaining 21 studies from the database search, 15 did not meet the inclusion criteria and were removed. A further 34 were identified from reference lists, hand searching of journals, and expert contact. Of these 34 studies, 21 were replications of already retrieved studies, and 9 did not meet the inclusion criteria. Of the remaining 10 studies 9 met the quality assessment criteria and were included in the review. All nine studies were of male MDO participants in forensic hospitals or secure settings and reported findings to support the positive effects of delivered interventions that are based upon cognitive-behavioural principles. Studies were considered in terms of the duration and frequency of the intervention, the assessments used and the statistical analysis reported. Methodological considerations were also noted. Results revealed interventions based on cognitive-behavioural principles have the potential to improve: problem solving ability, social-cognitive skills, social adjustment, hostile and aggressive behaviour, and awareness of illness, ultimately bringing about a reduction of antisocial thinking and behaviour. The reviews findings were considered in relation to study quality and methodological limitations. Recommendations for future research are discussed.

Introduction

In the search for 'what works' in the rehabilitation of offenders, research has revealed new knowledge and understanding about factors decreasing recidivism (Blackburn, 2004). Such research has demonstrated the effectiveness of psychological interventions that provide offenders with interpersonal and cognitive skills in reducing recidivism, which, by and large, have been based on cognitive-behavioural therapy (CBT: McGuire, 1995). However, the research available to date involves a poor amount of outcome research on the rehabilitation of adult male mentally disordered offenders (MDOs). In addition, what does exist does not yet permit empirically-based generalisations about treatment effectiveness (Hodgins, 2000); despite the fact there now exist psychological interventions that are now integral – if uneven – features of forensic services (Blackburn, 1996). Evaluations of effectiveness through trials simply reveals what can, but not what will happen in the real world, nevertheless, indications of what can be effective under usual conditions are important for practitioners (Heilbrun & Peters, 2000).

CBT is a blanket term used for both cognitive and behavioural interventions (Steiman & Dobson, 2002). In terms of the aetiology, maintenance and treatment of mental illness, these interventions share an understanding that cognitions play a central role. There are two basic approaches that CBT uses in bringing about change within an individual, the first is restructuring of cognitive events and the second is social and interpersonal skills training. The former has its roots in cognitive therapy, the latter in behavioural, and jointly they form the fundamental platform of CBT. The two approaches are built on two pathways of reinforcement: strengthening behaviour due to the positive consequence of behaviour and strengthening the thoughts that lead to positive behaviours. In the treatment of adult male MDOs, CBT is widely used, and has been used for a wide variety of offender dysfunctions (Renwick, Black, Ramm & Novaco, 1997). According to CBT, MDOs have learned unacceptable behaviours and have failed to develop important cognitive skills; hence among the techniques used by CBT are social skills training, pro-social modelling with positive reinforcement and problem solving training. For MDOs there appears to be a specific amalgamation of both cognitive and behavioural principles used in CBT. The cognitive principles include improving cognitive skills and disputing distorted beliefs, and the behavioural

principles focus on social learning theory and reinforcement. Many of the CBT programmes delivered to MDOs offer specific individually tailored approaches; however the fundamental principles of CBT appear to be practiced by most. Overall, CBT provides MDOs with tangible and effective tools to address the multiple layers of dysfunction that must be ameliorated in order to rehabilitate these individuals and prevent recidivism (Hodel & West, 2003).

Appraisal of Previous Reviews:

Preliminary searches for previous reviews, and meta-analyses identified three reviews which have identified CBT as a particularly effective intervention for reducing the recidivism of adult and juvenile offenders (Pearson, Lipton, Cleland, & Yee, 2002; Wilson, Bouffard, & MacKenzie, 2005; Lipsey, Landenberger and Wilson, 2007). In a meta-analysis, Pearson et al (2002) examined sixty-nine research studies covering both cognitive-behavioural and behavioural programmes and Wilson et al (2005) examined twenty studies of group-oriented cognitive-behavioural programmes for offenders. Both reviews concluded that CBT was very effective in reducing recidivism. Lipsey et al (2007) also reviewed fifty-eight studies and reached the same conclusions. However, these three previous reviews did not include CBT programmes run in inpatient mental health settings for MDOs.

When searching for previous reviews examining MDO groups, five additional reviews were identified. These reviews focussed on interventions for learning disabled sex offenders (Ashman & Duggan, 2002), men who physically abuse their female partner (Smedslund, Dalsbo, Steiro, Winsvold, & Clench-Aas, 2007), people with both severe mental illness and substance misuse (Cleary, Hunt, Matheson, Siegfried & Walter, 2008), antisocial personality disorder (Gibbon, Duggan, Stoffers, Huband, Völlm, Ferriter, & Lieb, 2010) and general, sexual and substance abusing offenders (Dowden, Antonowicz & Andrews, 2003). Despite the fact these previous reviews present strong indications of the efficacy of CBT for offenders, they encompassed substantial diversity within the range of outcome variables, offender types, variations in what was counted as CBT and quality of study design.

However, in 2006, Duncan, Nicol, Ager and Dalgleish presented the first systematic review of structured group interventions with MDOs. Their aim was to evaluate the efficacy and effectiveness of all structured group interventions with MDOs (but not specifically those based upon cognitive-behavioural principles) through a systematic review of evidence. Twenty studies were retrieved for the purpose of the review, which included studies both with and without control groups, and studies including both men and women. These features, however, present limitations when generalising findings. Without a control group it is difficult to know what may have occurred in the absence of the intervention; it is also correspondingly difficult to be sure changes in the outcome of interest are truly due to the intervention, and not some other factor (Petticrew & Roberts, 2006). It has also been suggested that the criminogenic needs (and therefore effective interventions) of women may differ to those of males (Lart, Pantazis, Pemberton, Turner & Almeida, 2008), and despite the existence of only small differences in the prevalence of mental health problems between women and men, the types of illnesses and disorders and the stages of life at which they are most likely to be diagnosed differ (Astbury, 2001). Women's offending behaviour also displays a different pattern in comparison to the offending of men (Harper, Man, Taylor & Niven, 2005). Despite these limitations, their review confirmed the existence of useful research into structured group therapy interventions with MDOs, but also indicated a need to develop such studies, and conduct high-quality rigorous research in this area.

Aims and Objectives:

MDOs have treatment needs that are related to their offence characteristics, however, in spite of this heterogeneity, many forensic institutions adopt evidence-based treatments for MDOs that are validated on other populations (Hodel et al, 2003; Hoffman & Kluttig, 2006), leaving forensic psychologists unsure about which treatments are appropriate for MDOs (Rice & Harris, 1997). The present review therefore aims to expand the current knowledge on the effectiveness of cognitive-behavioural interventions with MDOs by way of presenting an up-dated review of the literature. More importantly, this review will utilise a systematic approach to identify and appraise studies, with the aim of exploring how effective cognitive-behavioural interventions are with adult male MDOs in an inpatient setting, as CBT has emerged

as the predominant psychological method of treating mental illness and socially problematic behaviours (Royal College of General Practitioners, 2008).

To specifically address what was not considered in the review by Duncan et al (2006), studies included will be those carried out with male forensic inpatients, to explore how effective such interventions are with adult male MDOs in an inpatient setting and to provide forensic clinicians working in these fields with an understanding of what is available. Given the time constraints, only studies in the English language will be included in this review and those published after 1980. In order to focus the review on generic CBT interventions for MDOs the effectiveness of CBT interventions with the following groups will not be included: learning disabled sex offenders, domestic abuse, substance misuse, antisocial personality disorder, and general sexual and substance abusing offenders, as including these groups would make the review too diverse. In addition, the previous reviews and meta-analyses mentioned have already systematically reviewed the evidence available in this area with these subgroups of MDOs, where findings are considered to be up-to-date. Generic CBT interventions were chosen as a focus given the interest in the population studied in inpatient units for the purpose of this review, with the aim of reviewing interventions that can be delivered to this client group which do not target specific offence or disorder related aspects. In terms of the characteristics of the studies reviewed, this review will only consider studies employing a randomised controlled trail (experimental), controlled trial (quasi-experimental) or cohort design. Only studies with a control group will be reviewed. This review will also only examine studies with male MDOs between the ages of eighteen and sixty-five; due to complications in psychiatric classification below the age of eighteen (e.g. 'conduct disorder') and the fact those over sixty-five are treated differently under the Mental Health Act (MHA: 1983; 2007). This review therefore aims to examine whether further research into this area has indeed been carried out since the review by Duncan et al (2006).

Objective: To determine if psychological interventions based on cognitive-behavioural principles are effective with adult male MDO populations in inpatient settings.

Method

Search Strategy:

The author chose to limit the search to references published from 1980 onwards due to limited resources in the searching stage. Relevant publications were sourced using the following techniques:

1. *Gateways*:
    a. All of the Cochrane Library was searched for existing reviews on 09.08.2011.
    b. The Database of Abstracts of Reviews of Effects (DARE) was searched for existing reviews on 09.08.2011.
    c. The Campbell Collaboration was searched for existing reviews on 09.08.2011.

2. *Key Meta-analyses and Reviews*
    a. The reference lists of the studies identified from the Gateways search were hand searched and considered based on the inclusion/exclusion criteria for the review.

3. *Electronic Bibliographic Databases:*
    a. Three databases were independently searched by one researcher. These included:
        i. PsychINFO: searched on 19.08.2011. Dates searched between: 1980 to August Week 3 2011
        ii. MEDLINE: searched on 19.08.2011. Dates searched between: 1980 to August Week 2 2011
        iii. EMBASE: searched on 19.08.2011. Dates searched between: 1980 to 2011 Week 33

4. *Hand Search of Journals*
    a. The journals that produced the most relevant papers were Criminal Behaviour and Mental Health, and The Journal of Forensic Psychiatry

and Psychology. These key journals were identified and hand searched from 1980 onwards on 23.08.2011, both to ensure inclusion of relevant studies and to cross-check the reliability of the computerised searches.

5. *Expert Contact*
    a. Professor Mary McMurran (Institute of Mental Health, University of Nottingham) was contacted as an expert in the field, and was able to identify and suggest relevant studies.

6. *Reference Checking*
    a. The reference lists of all selected studies were searched to identify additional research.

7. *Grey Literature:*
    a. The System for Information on Grey Literature in Europe Archive (SIGLE) was searched on 24.08.2011. SIGLE covers pure and applied science and technology, economics, other social sciences and humanities. The database covers from 1980 until March 2005.

Search Terms:

The search syntax used for the individual database search can be found in Appendix 1. The following search terms were applied to all databases and modified to meet with the specific requirements of each database. These were controlled and predefined for a narrower search, fewer hits and specificity:

(mental* ill*) OR (mental* disorder*) OR (mental* disease) OR (schizophren*) OR (psycho*) AND (offend*) OR (criminal*) OR (perpetrator*) OR (forensic*) AND (treatment outcome*) OR (cognitive behavio*) OR (cognitive therap*) OR (cognitive behavio* therap*) OR (cognitive behavio* treatment*)

Inclusion/Exclusion Criteria:

All references identified through the electronic bibliographic databases were imported directly into EndNote Web, a web-based service which allowed for a database to be built containing all references found. All the studies were assessed by the author for inclusion based on the pre-defined inclusion/exclusion criteria, using a form devised prior to commencing the review (See Appendix 2). The inclusion/exclusion criteria are documented below:

- ***Population***: Mentally disordered offender males aged between 18 and 65.
- ***Intervention***: Psychological intervention based on cognitive-behavioural principles.
- ***Comparator***: Control Group.
- ***Outcome***: Primary outcomes: Behavioural, Affective or Cognitive. Secondary Outcomes: Suicide or suicide attempts, sudden and unexpected death by other causes, leaving treatment early, lost to follow up.
- ***Study Design***: Random control trials (experimental studies), controlled trials (quasi-experimental studies) or cohort studies.
- ***Language***: English only.
- ***Exclusion***: Unpublished studies, and narrative, editorials, commentaries or other types of opinion papers.

Quality assessment:

After excluding publications that did not meet the inclusion criteria, the quality of each remaining study was assessed on the basis of a checklist piloted prior to the review. A different quality assessment checklist was used for each study type. The quality assessment checklist for experimental studies can be found in Appendix 3, and the quality assessment checklist for observational studies can be found in Appendix 4. The author assessed all studies, and a secondary independent reviewer assessed 20% to ensure consistency in the assessment of quality. Any differences between the quality ratings were discussed and decided upon by consensus. Each study was considered using the following categories: Sampling Bias, Selection Bias,

Performance Bias, Measurement/Detection Bias and Attrition Bias. A scoring system was applied to each item as follows: U = Unknown, 0 = Inadequate, 1 = Partial, 2 = Adequate. The overall score for study quality was determined by adding the scores for each item. In addition, the clarity of reporting was determined by counting the number of 'unknown' items, where insufficient information was available to rate the item. A high count indicates poor reporting. The total number of 'unknown' items was subtracted from the quality score, in order to determine the total quality assessment score:

- Quality Score – N° of Unknown = Total Quality Score.

Data extraction:

For the remaining studies that passed the quality assessment, rendering them included in the study, data was extracted using a pre-determined data extraction form (See Appendix 5). Where information was reported but details were sparse or unclear, information was recorded as 'not known' as unfortunately contact with researchers was not feasible within the time-frame for this review. The quality assessment score was noted on the data extraction form, along with the number of unclear or unanswered questions for each study.

Results

Description of studies:

Figure 1 shows that database searches generated a total of 3370 hits. Of these studies, 3312 irrelevant studies were excluded, 4 were unobtainable dissertation abstracts, and 33 were duplicates removed. Of the remaining 21 studies from the database search, 15 did not meet the inclusion criteria and were removed *(no control group (n=11), no results reported (n=2), females included (n=1), no description of intervention (n=1)).* A further 34 were identified from reference lists, hand searching of journals, and expert contact. Of these 34 studies, 21 were replications of already retrieved studies, and 9 did not meet the inclusion criteria *(no control group (n=5), females included (n=2), no description of intervention (n=1), wrong population of interest (n=1)).* Of the remaining 10 studies (6 from the database search and 4 from reference searching), 9 met the quality assessment criteria and were included in the review. Figure 1 displays the search results and the process of study selection.

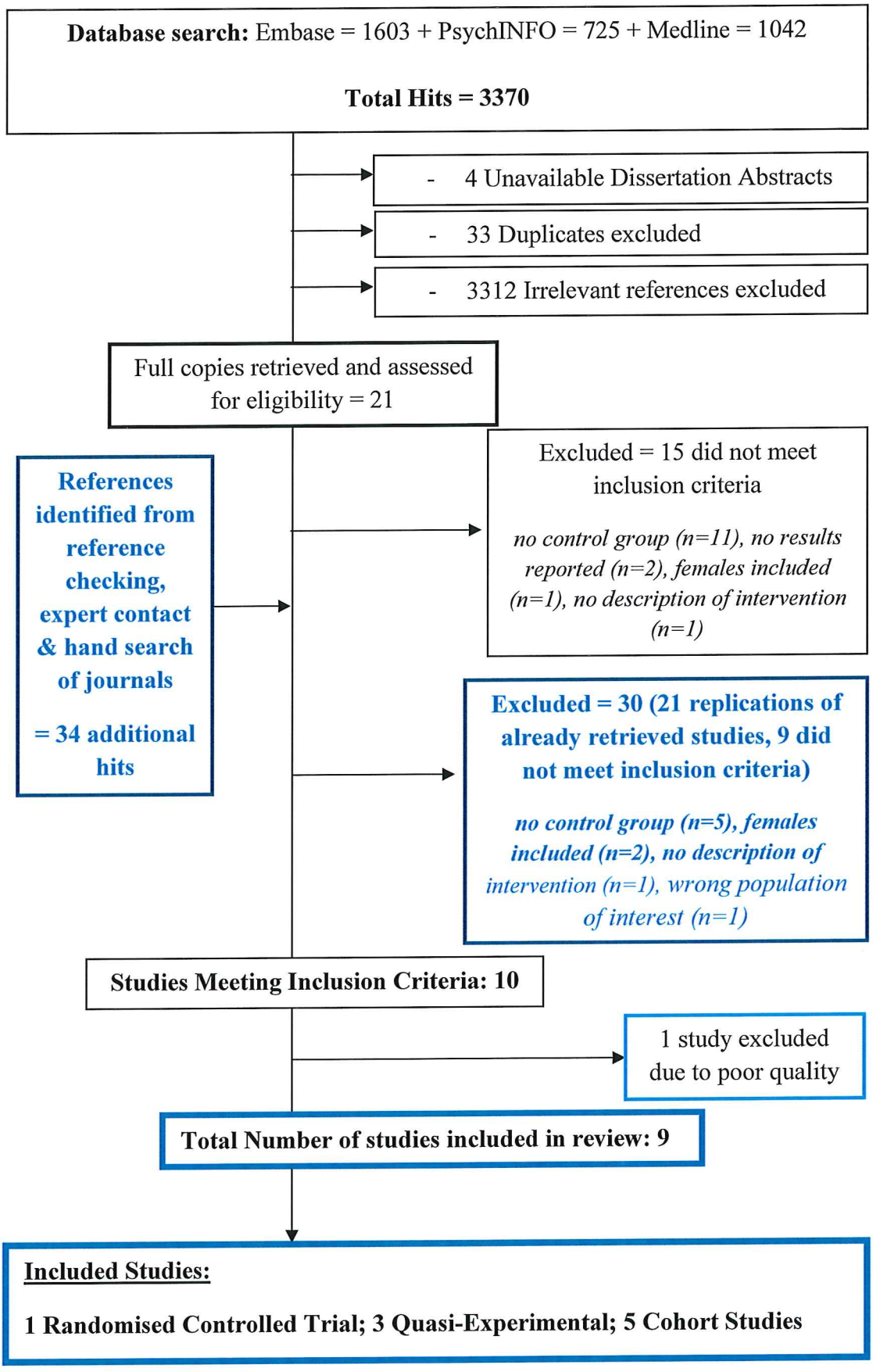


Figure 1: Selection Process

Characteristics of Included Studies

Nine studies are included that matched the inclusion criteria and passed the quality assessment. All included studies were of adult male MDO participants in forensic hospitals or secure settings. Two of these studies were conducted in British Medium Secure Hospitals and one was conducted in both a British Medium Secure Hospital and a British High Secure Hospital. The remaining six studies were conducted in The Netherlands (n=2), Finland (n=1), Canada (n=2) or Scotland (n=1), all of which were unclear regarding the level of security at the location where their study was undertaken, but did state their facilities were forensic hospitals/settings providing inpatient care for MDOs.

The methods employed by the included studies involved 4 experimental designs (3 quasi-experimental; 1 randomised controlled trail) and 5 observational cohort designs. Overall, the average sample size for all the included studies was 39.7 with the number of participants ranging from 15 to 84. The 4 experimental studies had a mean sample size of 45 (range 32-84) whilst the 5 cohort studies had a mean sample size of 35.6 (range 15-76).

All 9 studies were found to support the positive effects of delivered interventions that were based upon cognitive-behavioural principles. Several papers reported similar interventions which allowed for the following categories to be created from the retrieved papers:

- Problem-Solving Skills Training: *5 studies* (Jones & McColl, 1991; Clarke, Cullen, Walwyn & Fahy, 2010; Cullen, Clarke, Kuipers, Hodgins, Dean & Fahy, 2011; Donnelly & Scott, 1999; Young, Chick, & Gudjonsson, 2010).

- Anger and Aggression Management: *2 studies* (Stermac, 1986; Hornsveld, Nijman & Kraaimaat, 2008)

- Psychoeducational: *2 studies (*Aho-Mustonen, Miettinen, Koivisto, Timonen & Raty, 2008; Hornsveld & Nijman, 2005).

Ethical approval was only explicitly stated in 4 of the studies included in the review (Clarke et al, 2010; Cullen et al, 2011; Aho-Mustonen et al, 2008; Hornsveld et al, 2008).

Descriptive Data Synthesis

Experimental Studies

Of the 4 experimental studies, 1 examined the use of an 'Anger and Aggression Management Programme', and 3 involved 'Problem-Solving Skills Training'. Table 1 documents a summary of the 4 experimental studies included in the review.

Problem-Solving Skills Training:

Two studies examined the effectiveness of the 'Reasoning & Rehabilitation' (R&R) Programme with MDO patients. Clarke et al (2010) utilised a quasi-experimental design to compare the psychosocial function of those attending the 'R&R' programme (n=18) with that of a control group receiving treatment as usual (n=17) at 2 Medium Secure Units (MSU) in the UK. Cullen et al (2011) utilised a Randomised Controlled Trial (RCT) design to compare improvements in social-cognitive skills and thinking styles of those attending the 'R&R' programme (n=40) with that of a control group receiving treatment as usual (n=40) across 6 MSU's in the UK. The study by Jones et al (1991) utilised a quasi-experimental design to compare the performance of those attending an 'Interactional Life Skills Programme' (n=12) with that of a control group receiving conventional inpatient group psychotherapy (n=12) at the Forensic Inpatient Service of the Clarke Institute of Psychiatry, Canada.

Anger and Aggression Management:

Stermac (1986) utilised a quasi-experimental design to compare the efficacy of short-term cognitive-behavioural 'Anger Control Therapy' with participants attending the programme (n=20) in comparison with a control group receiving psycho-educational treatment (n=20). This study was carried out at the Metropolitan Toronto Forensic Service, Canada.

Duration and delivery of intervention

The duration and frequency of interventions varied. Cullen et al (2011) delivered 36 sessions, lasting 2 hours each, Clarke et al (2010) delivered 54 sessions, lasting approximately 2 hours each and Stermac (1986) delivered 6 sessions, lasting 1 hour each. Jones et al (1991) did not state how long their sessions lasted; only noting that there were a total of six sessions. The frequency of the programmes also varied

between weekly sessions (Cullen et al, 2011) and twice-weekly sessions (Stermac, 1986; Jones et al, 1991), with only Clarke et al (2010) not including this information in their study.

In terms of treatment delivery, Clarke et al (2010) reported treatment was delivered by a multi-disciplinary team trained by the R&R programme developer (Professor Robert Ross) with assistance from the Cognitive Centre Foundation. Facilitators adhered closely to manual guidelines ensuring that session content and delivery style matched that described by programme developers. Sessions were videotaped and reviewed by the Cognitive Centre Foundation to monitor treatment integrity, and supervision was provided by the first author after every R&R session. Cullen et al (2011) reported R&R treatment groups were led by staff who had received training from programme developers. Treatment fidelity was monitored through the trial by a clinical psychologist with extensive experience of delivering R&R. Treatment sessions were recorded and a number of randomly selected sessions were assessed using an objective rating scale provided by the Cognitive Centre Foundation (UK). Formal feedback was provided to the facilitator to ensure that therapists adhered to the treatment manual. Both Jones et al (1991) and Stermac (1986) were less clear in the delivery and integrity of their treatment programmes. Stermac (1986) simply stated that their programme was presented by a staff psychologist and a psychology graduate student, whilst Jones et al (1991) made no reference to the delivery of the group, other than that it was developed and implemented in the Forensic Inpatient Service of the Clarke Institute of Psychiatry.

Assessments

Across the studies a total of 15 self-report measures were used, along with 1 visual motor task. Three self-report standardised measures were used by Clarke et al (2010), Cullen et al (2011) used 5 standardised self-report measures and Stermac (1986) used 2 standardised self-report measures and a visual motor task – a non-language test of mental ability. Jones et al (1991) reported the use of 1 standardised self-report measure, and 4 non-standardised self-report assessments. On average studies used 3.75 self-report measures (range 2-5), and no studies collected any observational data.

Statistical Analysis

Problem-Solving Skills Training:

Cullen et al (2011) utilised the Social Problem Inventory – Revised Short Form (SPSI-R:S), The Crime Pics II, The Novaco Anger Scale (NAS), The Revised Blame Attribution Inventory (BIA-R) and the Interpersonal Reactivity Index (IRI) in their study. At the end of treatment, Cullen et al (2011) reported participants in the R&R group showed statistically significant changes on the Crime Pics II 'anticipation of reoffending' subscale ($p=0.04$) and total SPSI-R:S score ($p=0.04$). In contrast, the control group did not demonstrate statistically significant changes on any of the subscales of the Crime Pics II or the SPSI-R:S. There were no significant differences found within or between groups on the NAS, the BIA-R or the IRI at the end of treatment. Measurements were also taken 12 months post treatment, when at this point, the R&R group demonstrated significant, small to moderate improvements on the SPSI-R:S 'impulsive/carelessness style' subscale ($p=0.05$) and 'avoidant style' subscales ($p=0.03$). The control group demonstrated statistically significant improvements on the 'anticipation of reoffending' scale of the Crime Pics II ($p=0.04$). Once again there were no significant differences found within or between groups on the NAS, the BIA-R or the IRI at 12 months post treatment. However, within group tests indicated that the R&R groups did not significantly worsen, neither did the control group significantly improve. These findings suggest that booster sessions may be necessary to help reinforce the principles of treatment and maintain improvements.

Clarke et al (2010) also utilised the SPSI-R:S and the Crime Pics II in their study, as well as using the Coping Responses Inventory (CRI). When examining the results of the CRI scale, significant differences were found between groups after treatment on the 'emotional discharge' ($p<0.01$) and 'approach summary index' ($p<0.01$) subscales. In contrast to Cullen et al (2011) they did not find any significant changes on the Crime Pics II 'anticipation of reoffending' subscale, but did report significant differences between groups on the 'general attitude towards offending' subscale. They also reported that on all Crime Pics II scales, the R&R group obtained lower scores (indicating fewer pro-criminal attitudes and problems) than the control group after treatment. Results were similar to those found by Cullen et al (2011) for the SPSI-R:S. The authors also reported a significant difference between groups after treatment on

the SPSI-R:S total score ($p<0.01$). In general, at the end of treatment the participants in the R&R group scored higher on SPSI-R:S adaptive scales and lower on maladaptive scales than the control group, with significant differences ($p<0.05$) on the scale. Relative to controls, the R&R group also obtained higher scores on all CRI approach coping scales and lower scores on three of the avoidant scales. After applying stringent Bonferonni corrections, only group differences on the total SPSI-R:S score ($p=0.002$), CRI Emotional Discharge scale ($p=0.001$) and CRI Approach Summary Index ($p=0.001$) remained significant.

Jones et al (1991) collected measurements for: (1) the desire to participate in other primary groups, (2) the ability to take on groups, (3) the ability to take on positively valued or pro-social roles and (4) affective response to group participation. They also used the Fundamental Interpersonal Relations Orientation Behavioural Scale (FIRO-B). Jones et al (1991) reported that desire to participate in social groups for both groups increased significantly ($p=.001$) over the duration of the study. With regard to positively valued roles, individuals in the experimental group took on significantly more roles that they valued socially ($p=.001$), and a significant difference was found with the extent to which subjects positively valued the roles they took on ($p=.01$). Scores on the FIRO-B showed no significant time effect ($p= .09$), no group effect ($p= .09$) and no interaction effect ($p= .68$). There were no significant differences with regard to affective response to group participant.

Anger and Aggression Management:

The study by Stermac (1986) utilised the Novaco Provocation Inventory (NPI), the Coping Strategies Inventory (CSI) and The Porteus Mazes-Vineland Revision (PM-VR). Analysis of the NPI showed subjective levels of anger decreased following anger control treatment. Experimental group subjects reported significantly decreased levels of anger following the programme ($p<.001$), relative to control group subjects. Analysis of the CSI revealed subjects demonstrated more use of cognitive restructuring strategies ($p<.05$) and less use of self-denigration strategies ($p<.01$) than controls following treatment. Analysis of the PM-VR revealed both groups decreased their impulsivity following treatment ($p<.002$).

Table 1: Overview of Experimental Studies

Title, Author(s), Year, Country, Quality Score	Participants & Controls	Intervention	Measured Used Pre and Post	Findings
A quasi-experimental pilot study of the Reasoning and Rehabilitation programme with mentally disordered offenders Clarke, Cullen, Walwyn & Fahy (2010). UK *Design – Q-E* **QS: 34/42**	Participants: n = 15 male DSM-IV defined major mental disorder (schizophrenia; schizoaffective disorder & bipolar disorder) *Location:* 2x MSUs Controls: n=17 Matched Received: TAU	Reasoning and Rehabilitation (R&R) Programme 36 sessions x 2 hours long	The Social Problem Inventory – Revised Short Form (SPSI-R:S) The Coping Responses Inventory (CRI) The Crime Pics II	End of treatment: The R&R group scored higher on SPSI-R:S adaptive scales and lower on maladaptive scales than the control group, with significant differences ($p<0.05$) on the scale. On all Crime Pics II scales, the R& R group obtained lower scores than the control group. Significant differences were found between groups after treatment on the 'emotional discharge' ($p=0.01$) and 'approach summary index' ($p=0.01$) subscales of the CRI. After applying stringent Bonferonni corrections only group differences on the total SPSI-R:S score ($p=0.002$), CRI Emotional Discharge scale ($p=0.001$) and CRI Approach Summary Index ($p=0.001$) remained significant.

A multi-site randomized controlled trial of a cognitive skills programme for male mentally disordered offenders: social-cognitive outcomes Cullen, Clarke, Kuipers, Hodgins, Dean & Fahy (2011). UK *Design - RCT* **QS: 33/42**	Participants: n = 44 male DSM-IV or ICD-10 defined psychotic disorder (schizophrenia & co-morbid diagnosis of Antisocial Personality Disorder) *Location:* 6x MSUs Controls: n = 40 Matched Received: TAU	Reasoning and Rehabilitation (R&R) Programme 36 sessions x 2 hours long	The Social Problem Inventory – Revised Short Form (SPSI-R:S) The Crime Pics II The Novaco Anger Scale (NAS) The Revised Blame Attribution Inventory Interpersonal Reactivity Index	End of treatment: The R&R group showed statistically significant changes on the Crime Pics II anticipation of reoffending subscale ($p=0.04$) and total SPSI-R:S score ($p=0.04$). In contrast the control group did not demonstrate statistically significant changes on any of the subscales. 12 months post treatment: The R&R group demonstrated significant, small to moderate improvements on the SPSI-R:S impulsive/carelessness style subscale ($p=0.05$) and avoidant style subscales ($p=0.03$).
Anger Control Treatment for Forensic Patients Stermac (1986). Canada *Design – Q-E* **QS: 25/42**	Participants: n = 20 male DSM-IV defined mental disorder (modal diagnosis of Antisocial Personality Disorder) *Location*: Toronto Forensic Inpatient Service Controls: n = 20 matched Received:	Anger Control Therapy 6 sessions x 1 hour long	Novaco Provocation Inventory (NPI) The Coping Strategies Inventory (CSI) The Porteus Mazes-Vineland Revision (PM-VR)	End of treatment:. Experimental group subjects reported significantly decreased levels of anger following participation in the programme ($p<.001$), relative to control group subjects. Analysis of the CSI revealed subjects demonstrated more use of cognitive restructuring strategies ($p<.05$) and less use of self-denigration strategies ($p<.01$) than controls following treatment. Analysis of the PM-VR revealed both groups decreased their

	8 x 1 hour psycho-educational treatment			impulsivity following treatment (p<.002).
Development and evaluation of an interactional life skills group for offenders Jones & McColl (1991) Canada *Design – Q-E* **QS: 29/42**	Participants: n= 12 male DSM defined mental disorder (not psychotic, or mentally retarded). *Location*: Toronto Forensic Inpatient Service Controls: n=12 matched Received: conventional psycho-therapy in an inpatient group	Interactional Life Skills Group 6 sessions	Desire to participate in other primary groups*: measured by a single item assessing interest in involvement in leisure groups* Fundamental Interpersonal Relations Orientation Behavioural Scale (FIRO-B) Ability to take on groups: *measured by a single item assessing the number of social roles the individual perceived he occupies in the community* Ability to take on positively valued or pro-social roles: *measured by a single item assessing the number of social roles the individual perceived he occupies in the community* Affective response to group participation: *measured using a serious of 24 dichotomous adjectives.*	End of treatment: Desire to participate in social groups for both groups increased significantly (p=.001), but there was no significant difference in desire for inclusion between groups (p=.68). With regard to positively valued roles, individuals in the experimental group took on more roles that they valued socially (p=.01). A significant difference was found with the extent to which subjects positively valued the roles they took on (p=.01).

KEY: TAU is treatment as usual, RCT = randomized controlled trial, Q-E = Quasi-Experimental, QS = Quality Assessment Score, MSU = Medium Secure Unit

Observational Studies

Of the 5 observational studies, 1 examined the use of an 'Anger and Aggression Management Programme', 2 involved 'Problem-Solving Skills Training', and 2 were 'Psychoeducational'. All the observational studies utilised a cohort design. Table 2 documents a summary of the 5 cohort studies included in the review.

Problem-Solving Skills Training

Donnelly et al (1999) compared changes in self-control, problem solving abilities, self-esteem, social comparison and locus of control of those attending an 'R&R' programme (n=11) with that of a control group (n=10) receiving treatment as usual at a State Hospital in Scotland. Young et al (2010) aimed to identify any changes in participants attending an 'R&R2M' programme (a modified version of R&R for MDOs) (n=22) in comparison with a control group (n=12) of waiting list controls, in 1 MSU and one High Secure Unit (HSU) in the UK.

Anger and Aggression Management

Hornsveld et al (2008) evaluated the reductions in hostility and aggressive behaviour amongst participants attending 'Aggression Control Therapy' (n=38) compared with a control group (n=38) receiving treatment as usual, at 6 forensic psychiatric institutions in The Netherlands.

Psychoeducational

Aho-Mustonen et al (2008) examined the outcomes of effectiveness of a 'Psychoeducational Group' run for participants (n=7) in comparison with a control group (n=8) receiving treatment as usual, in a forensic hospital in Finland. Hornsveld et al (2005) also evaluated a Psychoeducational group called the 'Psychotic Disorders Treatment Programme', which was administered to participants (n=16) and compared with a control group (n=16) receiving treatment as usual, in a forensic psychiatric hospital in The Netherlands.

Duration and delivery of intervention

The duration and frequency of interventions varied. Aho-Mustonen et al (2008) delivered 8 sessions, lasting between 44-60 minutes, Donnelly et al (1999) delivered

54, 2 hour sessions, and Hornsveld et al (2005) delivered 64 sessions, each lasting for 90 minutes. Hornsveld et al (2008) delivered 15, 90 minute sessions along with 3 follow-up sessions each lasting 90 minutes, and Young et al (2010) also delivered 16 sessions of 90 minutes accompanied by 16 'PAL' sessions lasting for 20-30 minutes. The frequency of the programmes also varied between weekly sessions (Aho-Mustonen et al, 2008) and twice-weekly sessions (Donnelly et al, 1999). Hornsveld et al (2008) carried out their sessions weekly, and their follow up sessions five-weekly. Hornsveld et al (2005) and Young et al (2010) did not include this information in their study.

In terms of treatment delivery, Hornsveld et al (2008) stated most of the trainers delivering the 'Aggression Control Therapy' (ACT) in their study were psychologists with several years of experience in the assessment and treatment of forensic psychiatric patients. The other trainers had less experience but were following a post-masters course in Health Psychology and were supervised by the first author when delivering ACT. Young et al (2010) noted the R&R2M group run in their study was facilitated by three trained facilitators working in nursing, psychology and/or occupational therapy disciplines. Programme integrity was ensured through the random observation of group sessions by one of the programme authors who sat in and cross-checked delivery of the programme against the manual and provided feedback at the end of the observed sessions. Donnelly et al (1999) stated the nursing staff and occupational therapy staff who delivered the R&R programme in their study had received formal training in the skills necessary for the presentation. Hornsveld et al (2005) did not document any information on this topic, and Aho-Mustonen et al (2008) simply said 'Psychoeducational Group' sessions were conducted by two psychologists.

Assessments

Two studies collected data for experimental groups, but not for controls; Hornsveld et al (2005) administered 2 self-report measures to the experimental group only, and Hornsveld et al (2008) carried out 6 self-report measures with the experimental group only. For the purpose of summarising the measurements tools used across studies, these tools are not included in any summaries but are documented in Table 2.

Across the studies a total of 11 self-report measures were used, along with a total of 4 observational measures. Five standardised self-report measures were used by Donnelly et al (1999) and Aho-Mustonen et al (2008) used 1 standardised self-report measure and 2 non-standardised self-report measures. Hornsveld et al (2005) reported the use of 2 observation scales, and Hornsveld et al (2008) reported the use of 1 observational scale. Young et al (2010) was the only study to report the use of both observational measures (n=1) and standardised self-report measures (n=3). On average, studies used 1.5 self-report measures (range 0-5), and 3 studies collected observational data. Only 1 study collected observational and self-report data.

Statistical Analysis

Problem-Solving Skills Training

Donnelly et al (1999) used The Rosenzweig Picture-Frustration (P-F) Study; The Means-End Problem Solving Procedure (MEPS), the Culture-Free Self-Esteem Inventory, Second Edition (CFSEI-II), the Social Comparison Scale (SCS) and The Norwicki-Strickland Internal/External Scale (N-SIES). At the end of treatment there was a significant difference between the pre and post means on the Rosenzweig P-F measure ($p<.05$) and the MEPS ($p<.05$) within the R&R group, however there were no significant differences between groups. There were no significant differences within or between groups on the CFSEI-II, SCS or N-SIES.

The study by Young et al (2010) utilised The Maudsley Violence Questionnaire (MVQ), The Ways of Coping Scale (WOCS), The Social Problem-Solving Inventory Revised-Short Version (SPSI-R:S) and the Disruptive Behaviour and Social Problem Scale (DBSP) – a staff rated observational measure. No significant differences were found between before and after measures on any of the measures for the waiting list controls. There were significant improvements found after R&R2M treatment for the experimental group on the MVQ measure ($p<.01$) and significant improvements on informant-rated behaviour DBSP effect sizes ($p<.05$). Compared to Donnelly et al (1999) this study did not find any improvements on a (different) problem solving measure - there were no significant differences found between before and after scores on the WOCS or SPSI-R:S. However, results cannot be easily compared to Donnelly et al's (1999) findings which utilised the R&R2M, as it is a much shorter version than the R&R used by Young et al (2010).

Anger and Aggression Management

Despite administering 6 self-report measures with experimental groups pre and post treatment, Hornsveld et al (2008) only collected data for both experimental and control groups on The Observation Scale for Aggressive Behaviour (OSAB) (A staff rated observational measure). Therefore these are the only results analysed for the purpose of this review. Results suggested that groups who received Aggression Control Therapy (ACT) diminished aggressive behaviour but did not change socially competent behaviour. The ACT group had significantly lower scores on the OSAB subscale Aggressive Behaviour at the follow up evaluation than the pre-treatment evaluation ($p<0.05$), whereas no such difference was noticed for the control group. Both groups had significantly lower scores on the OSAB subscale Social Behaviour at the follow up evaluation ($p<0.01$).

Psychoeducational

Aho-Mustonen et al (2008) administered a Knowledge of Schizophrenia Questionnaire (adapted from The Knowledge About Schizophrenia Questionnaire: KASQ), an Awareness of illness and attitudes towards psychiatric treatment and medication questionnaire (developed by the authors) and the Beck Depression Inventory (BDI). At the end of treatment, the intervention group showed improved knowledge about schizophrenia ($p=0.02$) and the change in mean scores between the groups was statistically significant ($p<0.01$). Intervention group members showed improved awareness of their illness after the intervention ($p=0.03$) and the change in scores between groups was statistically significant ($p=0.04$). The change scores concerning attitudes towards psychiatric treatment between the groups was statistically significant ($p=0.23$). The change in medication attitude scores between groups ($p=0.12$) and within the intervention group ($p=0.06$) was also statistically significant. The change in depression scores on the BDI between groups was not significant ($p=0.40$), however the change within the intervention group was significant ($p=0.17$).

Despite administering the The Positive and Negative Syndrome Scale (PANSS) and the Questionnaire for Interpersonal Behaviour (SIG) with the experimental group pre and post-intervention, the only measures with data collected for both the experimental and control group in the Hornsveld et al (2005) study were The Rehabilitation

Evaluation Hall And Barker (REHAB) (a staff rated observational measure) and the MI Observation Scale (MIOS; a staff rated observational measure). Therefore the REHAB and the MIOS are the only results analysed for the purpose of this review. At the end of treatment the REHAB score of patients who completed the programme changed very little and the scores of the controls showed practically identical development. However, participants in the programme group scored significantly better on the 'social skills' subscale of the MIOS ($p<0.05$), and displayed a significant difference in 'negative coping behaviour' ($p<0.05$) compared to controls.

Table 2: Overview of Observational Cohort Studies

Title, Author(s), Year, Country, Quality Score	Participants	Intervention	Measured Used Pre and Post	Findings
Group psychoeducation for forensic and dangerous non-forensic long-term patients with schizophrenia Aho-Mustonen, Miettinen, Koivisto, Timonen & Raty (2008). Finland **QS= 21/36**	Participants: n = 7 male DSM-IV defined mental disorder (primary diagnosis of schizophrenia with co morbid diagnoses of personality disorder) *Location:* Niuvanniemi Forensic Hospital Controls: n = 8 Matched Received: TAU	Psychoeducati-onal Group 8 sessions x 45-60 minutes long	Knowledge of Schizophrenia (adapted from The Knowledge About Schizophrenia Questionnaire: KASQ) Awareness of illness and attitudes towards psychiatric treatment and medication: *questionnaire developed by authors* Beck Depression Inventory	End of Treatment: The intervention group showed improved knowledge about schizophrenia after the intervention ($p=0.02$) and the change in mean scores between the groups was statistically significant ($p<0.01$). Intervention group members showed improved awareness of their illness after the intervention ($p=0.03$) and the change in scores between groups was statistically significant ($p=0.04$). The change scores concerning attitudes towards psychiatric treatment between the groups was statistically significant ($p=0.23$). The change in medication attitude scores between groups ($p=0.12$) and within the intervention group ($p=0.06$) was also statistically significant. The change in depression scores between groups was not significant ($p=0.40$), however the change within the intervention group was significant ($p=0.17$).

Evaluation of an Offending Behaviour Programme with a Mentally Disordered Population. Donnelly & Scott (1999). UK **QS= 24/36**	Participants: n = 11 male DSM-IV defined mental disorder (Schizophrenia and co morbid personality disorder) *Location:* State Hospital Controls: n = 10 matched Received: TAU	Reasoning and Rehabilitation (R&R) Programme 54 sessions x 2 hours long	The Rosenzweig Picture-Frustration (P-F) Study The Means-End Problem Solving Procedure (MEPS) The Culture-Free Self-Esteem Inventory, Second Edition (CFSEI-II) The Social Comparison Scale The Norwicki-Strickland Internal/External Scale	End of Treatment: There was a significant difference between the pre and post means on the Rosenzweig P-F measure ($p<.05$) and the MEPS ($p<.05$) within the R&R group, however there were no significant differences between groups. There were no significant differences within or between groups on measures of self-esteem, social comparison or locus of control.
Aggression Control Therapy for violent psychiatric patients: First results. Hornsveld, Nijman & Kraaimaat (2008) The Netherlands **QS= 22/36**	Participants: n = 38 male DSM-IV defined mental disorder (psychotic disorder and Antisocial Personality disorder) *Location:* 6x forensic psychiatric institutions Controls: n = 38 matched Received: TAU	Aggression Control Therapy (ACT) 15 x 90 minute sessions and 3 x 90 minute follow up meetings.	The Observation Scale for Aggressive Behaviour (OSAB) (Staff rated) *Only used with experimental group:* *The NEO Five-Factor Inventory; The Zelf-Analyse Vragenlijst (Dutch version of the Speilberger State-Trait Anger Scale); The Attibutie Vrangenlijst (Hostility Measure); The Agressie Vragenlijst (Aggression Questionnaire); The Novaco Anger Scale and The Inventarisatielijst Omgaan met Andern (Measuring social anxiety and social skills)*	End of treatment: The ACT group had significantly lower scores on the OSAB subscale Aggressive Behaviour at the follow up evaluation than the pre-treatment evaluation (p,0.05) whereas no such difference was noticed for the control group. Both groups had significantly lower scores on the OSAB subscale Social Behaviour at the follow up evaluation ($p<0.01$).

Evaluation of a cognitive-behavioural program for chronically psychotic forensic inpatients. Hornsveld & Nijman (2005). The Netherlands **QS= 19/36**	Participants: n = 16 male DSM-IV defined mental disorder (schizophrenia & co morbid personality disorder) *Location:* Forensic Psychiatric Hospital Controls: n = 16 matched Received: TAU	'Psychotic Disorders' Treatment Programme 64 sessions x 90 minutes long	The Rehabilitation Evaluation Hall And Barker (REHAB) (Staff rated) The MI Observation Scale (Staff rated) *Only used with experimental group:* *The Positive and Negative Syndrome Scale (PANSS) and Questionnaire for Interpersonal Behaviour (SIG).*	End of treatment: Participants in the programme group scored significantly better the 'social skills' subscale of the MI Observation scale ($p<0.05$), and displayed a significant difference in 'negative coping behaviour' ($p<0.05$) compared to controls.
A preliminary evaluation of reasoning and rehabilitation 2 in mentally disordered offenders (R&R2M) across two secure forensic settings in the United Kingdom. Young, Chick, & Gudjonsson (2010). UK **QS= 24/36**	Participants: n = 22 male Clinical diagnosis of serious mental illness (excluding learning disability & acute psychosis) *Location:* *1 MSU & 1 HSU* Controls: n = 12 (11 HSU) Received: waiting list controls	Reasoning and Rehabilitation 2 (R&R2M) Programme 16 sessions x 90 minutes long + 16 x 20-30 minute 'PAL' sessions	Maudsley Violence Questionnaire (MVQ) Ways of Coping Scale (WOCS) Social Problem-Solving Inventory Revised-Short Version (SPSI-R:S) Disruptive Behaviour and Social Problem Scale (DBSP) (staff rated)	End of treatment: Significant improvements found after R&R2M treatment for the experimental group on the MVQ measure ($p<.01$) and significant improvements on informant-rated behaviour DBSP effect sizes ($p<.05$). There were no significant differences found between before and after scores on the WOCS or SPSI-R:S. No significant differences were found between before and after measures on any of the measures for the waiting list controls.

KEY: TAU is treatment as usual, QS = Quality Assessment Score, MSU = Medium Secure Unit, HSU = High Secure Unit

Quality of Included Studies

The quality assessment scores for experimental studies can be found in Table 3, and for observational studies can be found in Table 4. Studies have been organised into overall study quality. All studies were quality assessed using two separate quality assessments, which can be found in Appendix 3 and Appendix 4. A high score on each section indicates good study quality, and a lack of bias in that area. Overall, 6 studies scored between 50-70% on overall study quality (Jones et al, 1991; Stermac, 1986; Young et al, 2010; Hornsveld et al, 2008; Aho-Mustonen et al, 2008; Hornsveld et al, 2005) and 3 studies scored between 70-80% (Clarke et al, 2010; Cullen et al, 2011; Donnelly et al, 1999).

A total of 6 studies scored over 100% on sampling bias, meaning in these studies, participants were adequately described, their control groups were matched and their sample was thought to be representative of male MDO patients in forensic settings (Clarke et al 2010; Cullen et al, 2011; Stermac, 1986; Hornsveld et al, 2008; Aho-Mustonen et al, 2008; Donnelly et al, 1999). The remaining 3 studies scored between 80-100% for reasons such as partial description of participants, and unmatched control groups. For example, in the study by Young et al (2010) almost all of their control group were from high secure settings, in comparison with the experimental group who were from medium security, Hornsveld et al (2008) also reported a significant difference in age between the groups, and a trend in the control group of more frequent sentencing for homicidal behaviour. Despite this, all studies scored over 80% which suggests a low possibility of sampling bias.

Only one study scored 100% on selection bias (Cullen et al, 2011), in which their assignment of patients to the intervention was randomised, the randomisation scheme was described well and was appropriate, and the study procedure was concealed to the person recruiting and allocating participants. This would suggest their study was not subject to selection bias. This was also the only study to provide details of their randomisation scheme. Five studies scored 50% on selection bias, for reasons such as not providing appropriate details, being unclear whether the study procedure was concealed to the person recruiting and allocating participants and only providing partial details of the randomisation process (Donnelly et al, 1999; Hornsveld et al, 2005; Aho-Mustonen et al, 2008; Clarke et al, 2010, Stermac, 1986). Selection bias

appeared to present a major issue for three studies who scored 0% on selection bias (Jones et al, 1991; Young et al, 2010; Hornsveld et al, 2008). This would suggest sampling bias may have occurred in these studies. For example, in the study by Young et al (2010) participants were referred by their clinical team and participation was voluntary. This selection bias may be explained due to the observational nature of the studies by Hornsveld et al (2008) and Young et al (2010). However, this does not provide an explanation for the experimental study by Jones et al (1991), who did not include sufficient information regarding their randomisation process, despite saying it was carried out.

All studies scored above 50% on performance bias, with only one study scoring 100% (Jones et al, 1991). In the Jones et al (1991) study, all groups received the intervention they were supposed to, the interventions were consistent, the assessor was blind to the hypothesis and participants were blind to outcome measures. Subjects were also blind to the purpose of the study and the rater was blind to subject identity and group designation. All the remaining studies received lower scores for various reasons, for example, it was often unclear whether the outcome assessment was blind to participants in the studies and whether the assessor was blind to the hypothesis in the studies. These scores suggest that apart from Jones et al (1991) the studies included may have been subject to some levels of performance bias. In general there was a lack of reporting regarding blinding of participants and assessors. Whether interventions were consistent within each group was also generally explicitly unreported, which will be discussed further on in the review.

All studies received scores of above 75% on detection bias, with four studies scoring 100% (Clarke et al, 2010; Cullen et al, 2011; Stermac, 1986; Donnelly et al, 1999; Young et al, 2010). In these studies every participant was assessed in the same way at baseline and follow up, they used standardised measurements, and used measurements that were comparable to those used in other similar studies. However, in the remaining 4 studies, lower scores were obtained for reasons such as partial reporting of follow up and the use of non-standardised measurements. For example, follow up was not complete by Hornsveld et al (2005) and Jones et al (1991) used four non-standardised measures. These results suggest partial reporting of follow-up and non-standardised measurement were common limitations across studies, which will be discussed in further detail later on. On attrition bias, all studies scored between 50-90%. In

general, studies were not always clear regarding their statistical attempts to deal with missing data, and did not always report drop-outs and reasons for drop outs. Only seven studies referred to drop-out rates with only six providing reasons for drop-outs. Across the board, there was also a general lack of reporting of all clinically important outcomes. These findings suggest most studies were subject to attrition bias, the implications of which are discussed further on in this review.

Table 3: Quality Assessment Ratings of Experimental Studies

Study	Sampling Bias	Selection Bias	Performance Bias	Measurement / Detection Bias	Attrition Bias	Total Quality Score
A quasi-experimental pilot study of the Reasoning and Rehabilitation programme with mentally disordered offenders Clarke, Cullen, Walwyn & Fahy (2010).	8/8	3/6	6/8 1U	8/8	10/12	35/42 -1U **=34**
A multi-site randomized controlled trial of a cognitive skills programme for male mentally disordered offenders: social-cognitive outcomes Cullen, Clarke, Kuipers, Hodgins, Dean & Fahy (2011).	8/8	6/6	4/8 2U	8/8	10/12 1U	36/42 -3U **=33**
Development and evaluation of an interactional life skills group for offenders Jones & McColl (1991)	7/8	0/6	8/8	6/8	9/12 1U	30/42 -1U **=29**
Anger Control Treatment for Forensic Patients Stermac (1986).	8/8	3/6 1U	4/8 2U	8/8	6/12 1U	29/42 -1U **=25**

Key: U=Unclear

Table 4: Quality Assessment Ratings of Observational Studies

Study	Sampling Bias	Selection Bias	Performance Bias	Measurement / Detection Bias	Attrition Bias	Total Quality Score
Evaluation of an Offending Behaviour Programme with a Mentally Disordered Population. Donnelly & Scott (1999).	6/6	2/4 1U	4/8 2U	8/8	7/10	27/36 -3U **=24**
A preliminary evaluation of reasoning and rehabilitation 2 in mentally disordered offenders (R&R2M) across two secure forensic settings in the United Kingdom. Young, Chick, Gudjonsson (2010).	5/6	0/4	4/8 1U	8/8	8/10	25/36 -1U **=24**
Aggression Control Therapy for violent psychiatric patients: First results. Hornsveld, Nijman & Kraaimaat (2008)	6/6	0/4 1U	4/8 2U	7/8	8/10	25/36 -3U **=22**
Group psychoeducation for forensic and dangerous non-forensic long-term patients with schizophrenia Aho-Mustonen, Miettinen, Koivisto, Timonen & Raty (2008).	6/6	2/4 1U	4/8 2U	6/8	7/10 1U	25/36 -4U **=21**
Evaluation of a cognitive-behavioural program for chronically psychotic forensic inpatients. Hornsveld & Nijman (2005).	5/6	2/4 1U	4/8 2U	6/8	5/10	21/36 -3U **=19**

Key: U=Unclear

Methodological Considerations

Interventions Used:

All 9 studies included in this review were found to support the positive effects of delivered interventions that were based upon cognitive-behavioural principles. As previously noted, several papers reported similar interventions; which allowed categories to be created from the retrieved papers. Five studies fell into the *'Problem-Solving Skills Training'* category, these included 3 studies reporting the use of the 'R&R' programme (Clarke et al, 2010; Cullen et al, 2011; Donnelly et al, 1999), 1 study examining an 'Interactional Life Skills Group' (Jones et al, 1991) and 1 study examining the 'R&R2M' (Young et al, 2010). Two studies fell into the *'Anger and Aggression Management'* category; including 1 study of 'Anger Control Treatment' (Stermac, 1986) and 1 study of 'Aggression Control Therapy' (Hornsveld et al, 2008). The remaining 2 studies fell into the *'Psychoeducational'* category, 1 study evaluated the use of a 'Psychoeducational Group' (Aho-Mustonen et al, 2008) and 1 study evaluated the 'Psychotic Disorders Treatment Programme' (Hornsveld et al, 2005). A table can be found in Appendix 6, which documents and provides descriptions of the different programmes used by the studies included in this review.

Assessments used:

Across all the studies included in this review, thirty assessments were used. These included self-report measures, observational methods, standardised and non-standardised assessments. Most studies, with the exception of 2, used self-report measures, with an average of 2.8 self-report measures used in each study (range 0-5). Only three studies included observational measures, (Hornsveld et al 2008; Hornsveld et al 2005; Young et al 2010) of which all were cohort studies. The only measurement tools used in more than one study were The Social Problem Solving Inventory-Revised: Short Form (SPSI-R:S) (n= 3 studies), The Crime Pics II (n= 2 studies) and The Novaco Anger Scale (NAS) (n= 2 studies). Quantitative meta-analysis was not possible, due to the lack of comparable data.

Discussion

This systematic review aimed to determine if psychological interventions based on cognitive-behavioural principles are effective with adult male MDO populations in inpatient settings. All of the nine studies reviewed were found to support the positive effects of delivered interventions that are based upon cognitive-behavioural principles. As previously mentioned, as several papers reported similar interventions, this allowed for a separation of studies into three categories based on the content of the intervention: Problem-Solving Skills Training, Anger and Aggression Management and Psychoeducational.

Of the five studies employing problem-solving skills training, three of these involved the delivery of the R&R programme. Clarke et al (2001) found that individuals who completed the programme showed improved problem solving ability and increased coping responses. Cullen et al (2011) also reported that among male MDOs, R&R participation was associated with improvements in social-cognitive skills, some of which were maintained for up to twelve months post treatment. Donnelly et al (1999) found that despite self-esteem and locus of control not being significantly affected by cognitive skills training, the R&R programme was successful in bringing about an improvement in problem solving abilities and social adjustment. Taken together, these studies suggest R&R can be successfully delivered in MSU's and participation is associated with improved psychosocial function. An application of the R&R2M was also included (Young et al, 2010), where findings suggested the programme was successful in bringing about a positive change in the reduction of antisocial thinking and behaviour. Other problem-solving skills training programmes included an Interactional Life Skills Program (Jones et al, 1991), in which participants were shown to take on significantly more roles than the control group, and valued the roles they occupied to a greater extent than did the controls, suggesting having learned pro-social behaviours participants will become better integrated into socially conforming groups and their tendency toward criminal behaviour should diminish.

Of the two studies employing anger and aggression management, one study supported the use of Aggression Control Therapy (Hornsveld et al 2008) in the reduction of hostility and aggressive behaviour, but reported no influence on social anxiety or social skills - which could indicate that in such programmes a greater emphasis should

be placed on teaching approaching skills and normalising inadequate limit setting skills. However, the other study employing the use of Aggression Control Treatment (Stermac, 1986), found subjects reported significantly lower levels of anger than did control subjects as well as reporting a greater use of cognitive restructuring strategies and less use of self-denigration strategies. The overall results of these studies support the efficacy of cognitive-behavioural treatment for anger control with forensic patients.

Of the remaining two studies, Aho-Mustonen et al (2008) evaluated the effectiveness of group Psychoeducation, and concluded that severely ill patients were able to gain improved knowledge and awareness of their illness. Hornsveld et al (2005) also employed Psychoeducational methods and found significant improvements in social skills and negative coping behaviour, as well as trends in the desired direction in positive coping behaviour and negative psychotic symptoms. Results of these Psychoeducation studies are encouraging, due to the fact awareness and understanding of illness is considered an imperative facet of insight, with a lack of insight being considered as a common problem in relapse prevention (Birchwood, Spencer & McGovern, 2000).

Limitations and Future Directions:

This systematic review attempted to employ a comparatively inclusive search strategy in an effort to identify all pertinent publications within the field. Nevertheless, as is foreseeable, this review was susceptible to a number of publication biases. Time constraints prevented contact with authors for further information and all publications being restricted to English language only. Limited resources also prevented unpublished literature from being retrieved. Consequently, this will have limited the number of studies considered in this review and introduced a degree of publication bias. During the study selection stage, a large amount of studies were retrieved that did not include a control group, but otherwise would have been considered appropriate. Whilst it was considered that the presence of a control group would eliminate alternative explanations of experimental results, a lot of relevant studies were excluded from the review for not fulfilling this criteria. This highlights the fact most studies examining this area of research do not include a control group, which is something that should be considered in future studies, as without a control group, it is

difficult to know what may have occurred in the absence of the intervention and it is also correspondingly difficult to be sure that changes in the outcome of interest is truly due to the intervention, and not some other factor (Petticrew et al, 2006).

Other limitations included the method of outcome measures used across the studies, which is a significant problem for research in this area. However, the research carried out to date leads to some ideas for future solutions. Researchers used a varied selection of outcome measures in the studies reviewed, which makes comparisons difficult and less accurate; there were also discrepancies across studies in relation to the number of psychometrics administered and their similarities which can make comparison tenuous. Studies included in this review used twenty-six different assessments between them to measure the effectiveness and efficacy of the interventions employed. These included self-report measures, observational methods, standardised and non-standardised assessments. The questionnaires and measures used by the included studies suffer due to problems such as social desirability and response bias (Bloom, Fischer & Orme, 1995). Self-reports are limited not only by what a client is willing to tell you, but also by what they are able to tell you. Like all self-report questionnaires, the way the assessment is dispensed and administered may also affect the final results. For example, social expectations have been shown to elicit different responses if a patient is asked to fill in a form in front of other people in a clinical environment, compared to administration via a postal survey (Bowling, 2005). Most importantly, the extent to which improvements on questionnaire measures are relevant to behavioural change remains unclear. Therefore, future agreement regarding the most sensitive and appropriate measures would permit comparable data to be collected and would allow for quantitative analysis in such studies.

In forensic mental health research there are also important ethical issues to consider given the restricted freedoms of patients in secure environments. This often places a high degree of responsibility on researchers, who must endeavour to address rigour, ethical issues and transparently in their research. The extent to which these issues were considered in these studies varied. For instance, ethical approval was only explicitly stated in four of the studies included in the review, and details surrounding drop-outs and drop-out rates were vague across the board, with only six studies referring to drop-out rates and providing reasons, one study not reporting reasons for drop-outs and one study reporting no drop-outs. In all, most of the studies included in

this review reported high drop-out rates. In the instances where studies did report reasons for drop-out, there was little mention to improving drop-out rates. In future intervention studies, such evaluations should aim to explore whether improving therapeutic alliance, motivational interviewing and developing a modulised programme help to reduce drop-out from cognitive skills programmes in MDOs. The desire to participate in a group may also be influenced by impression management, which has been found to be related to a lower rate of general and violent offending (Mills & Kroner, 2006). Separate from impression management, Gudjonnson, Young and Yates (2007) have developed measures to address problems with motivation among patients in secure unit settings which could be used to identify and addresses motivational problems prior to the commencements of therapy. Given that schizophrenia is associated with moderate to large cognitive impairments (Mesholam-Gately, Giuliano, Goff, Farone & Seidman, 2009) breaking a programme down into shorter modular components may help to improve retention in this population.

Unlike previous systematic reviews (Duncan et al, 2006) this review also reported findings in relation to treatment delivery and integrity, which revealed significant inconsistencies regarding the quality (and reporting) of treatment delivery and programme integrity. Treatment integrity refers to the degree to which an intervention was implemented as prescribed by the study protocol. The rationale for assessing this in systematic reviews is taken from the assumption that effectiveness is directly associated to the fidelity with which an intervention is implemented (Rychetnik, Frommer, Hawe & Shiell, 2002). Two of the studies did not report any details regarding delivery of treatment, three studies stated sessions were delivered by psychologists and trainees and one study stated sessions were delivered by nursing and occupational therapy staff. Only three studies made reference to monitoring of treatment integrity and fidelity. These findings highlight a number of methodological issues and suggest assessing the implementation of treatment programmes should also be considered when interpreting findings. In terms of future studies, programme features should include monitoring of programme implementation, screening of prospective delivers, ongoing training and supervision, to name a few.

A further methodological flaw, which limits the generalisation of findings, includes the length of treatment delivery, and the circumstances control groups were subject to – which differed across studies. Session length ranged significantly between six one-

hour sessions and fifty-four two-hour sessions. There were also unexplained discrepancies between studies in delivery length of the same programme, for example, Donnelly et al (1999) delivered their R&R programme for fifty-four two-hour sessions, whilst other studies delivering the same intervention lasted for thirty-six one-hour sessions. In terms of the type of treatment controls received, this also differed, and was not always clearly reported. For instance, some studies reported 'treatment as usual' would include no intervention, and others reported 'treatment as usual' included elements of psychotherapy and non-verbal therapy (Hornsveld et al, 2005), or psychoeducational treatment of comparable length (Stermac 1986). In these instances, it is also important to acknowledge the effects of psychiatric institutionalisation that may or may not affect control groups. Therefore control groups in these settings as sources of comparable data may not always be reliable.

Each of the reviewed studies in this systematic review was open to varying degrees of bias. However, such issues are difficult to avoid, given the small patient groups accessible for research, and the staffing and resources available, which can consequently make large studies and blinding of treatment conditions difficult. Despite these limitations, and acknowledging the fact not all methodological problems can be solved, all studies should clearly articulate any methodological flaws, particularly when a resolution cannot be found. One of the central findings of this review was the similarities in the limitations of the studies reviewed, hence caution should be paid when attempting to generalise results to the population of MDOs. It is also important to acknowledge the findings of this systematic review may not be applicable when considering female or adolescent male forensic populations, thus limiting generalisability. Nevertheless, the review attempted to provide a systematic evaluation of the available evidence in relation to the cognitive-behavioural treatment of male MDOs, which has hopefully provided a valuable insight into which interventions are effective in inpatient settings with this client group.

Treatment Implications:

In terms of treatment implications, the results of the studies provide several promising conclusions. In summary, it would appear interventions employing problem-solving skills training are related to improved problem solving ability, increased coping responses, social adjustment, and a reduction in antisocial thinking and behaviour.

These findings suggest having learned pro-social behaviours participants will become better integrated into socially conforming groups and their tendency toward criminal behaviour should diminish, which are no doubt crucial findings in the field of 'what works' with adult male MDOs. Aggression and anger management interventions also display positive results in terms of a reduction in hostility and aggressive behaviour, and despite being different in their content, psychoeducational interventions are also successful in bringing about a change in awareness of illness. This is particularly encouraging as awareness of illness is an important aspect of insight, and a lack of insight is considered a common problem in relapse prevention (Birchwood, Spencer & McGovern, 2000). Taken together, these studies report interventions based on cognitive-behavioural principles, and whilst their results differed due to methodology, they present encouraging findings. Any interventions with MDOs, with the ultimate aim of reducing recidivism, should therefore pay attention to the effectiveness of cognitive-behavioural interventions in this field of practice.

Conclusions and Recommendations:

This systematic review has described and evaluated nine studies of cognitive-behavioural interventions with adult male MDOs in forensic inpatient settings with varying degrees of security. All of the studies were based on cognitive-behavioural approaches to interventions, and all reported successful outcomes. The frequency of publications in this area since the review by Duncan et al (2006) indicates significant practice developments within the field. This review retrieved and reviewed three of the studies included in Duncan's review, with the addition of six new studies – five of which were published after Donnelly et al's (2006) review, and one published before their review. However, the developments were reflected by the style of the papers included, which in some cases were not purposefully developed research studies, but a reporting of clinical practice. Whilst, such research is recommended and necessary in the early stage of research surrounding MDOs, perhaps the point has arrived to develop further methodologically rigorous explorations in the area of cognitive-behavioural interventions with MDOs. However, future studies should take into account the methodological limitations that have been discussed. Recommendations for future research are that studies should attempt to include comparison groups, and ensure follow up is complete, with attention paid to the treatment control groups receive. Ethical aspects of any study must always be transparent in any publication,

and adhered to strictly. Clear statistical outcomes should always be provided, including statistical significance, and studies ought to attempt to include validated and standardised measurements. Future studies should also endeavour to include more behavioural measures of assessment, and carry out long-term follow-up assessments, and where a validated and manualised programme is being delivered, any deviation from standard protocols should be clearly documented.

To conclude, this review has highlighted that structured psychological interventions based on cognitive behavioural principles should be considered as a key component in the rehabilitation of adult male MDOs[1]. As identified in this Chapter, interventions aimed at providing MDOs with certain skills may allow for a better reintegration into the community upon release. If effective inpatient treatment is seen as the first step in the rehabilitation process of MDOs, then the second step should examine how in order to succeed in the community MDOs need to be able to put into practice these skills learnt. Chapter 2 will now present an empirical study examining the narrative life story interviews of adult male MDOs who have been conditionally discharged from forensic mental health services into the community in order to examine what impacts on a successful reintegration into the community.

[1]This systematic review was presented via a poster presentation at the BPS Division of Forensic Psychology 21st Annual Conference 2012 (See Appendix 7 for poster)

Chapter 2: Empirical Research Study

Post-Discharge Narrative Life Story Interviews with Conditionally Discharged Adult Male Mental Health Patients: An Empirical Study

Abstract

Little is known of adult male mentally disordered offenders (MDOs) experiences of the conditional discharge and reintegration process, despite the fact qualitative research on the lives of ex-offenders has highlighted the need to recognise the subjective changes as well as the social changes that may help offenders reintegrate into the community (LeBel, Burnett, Maruna & Bushway, 2008). This study used an opportunity sampling method to gather qualitative information of the experiences of adult male MDOs under Section 37/41 of the MHA (1983) who had been given a conditional discharge into the community. Using an exploratory, qualitative design utilising a narrative life story interview method of data collection (McAdams, 1993), nine MDOs were recruited and interviewed. Results offered preliminary indications of influential factors at the individual level for the process of MDOs reintegration into the community. Thematic analysis (TA) generated four main themes, including the significance of initial negative experiences in secure settings, the importance of managing support networks, the importance of threats to identity and the significance of autonomy. An explanation of the importance of each theme, along with supporting research and the clinical implications of the findings are discussed. The themes elicited should be considered as important when considering the difficult journey MDOs make through forensic mental health services, and may be used to inform professionals working with MDOs of what impacts on a successful reintegration into the community following a conditional discharge. Recommendations for future research are discussed along with the clinical implications of the findings.

Introduction

As was highlighted in Chapter 1, research available to date involves a poor amount of outcome research on the rehabilitation of adult male offenders with a mental disorder, in particular, there has been relatively little research into the community reintegration of patients discharged from forensic secure settings (Maden, Rutter, McClintock, Friendship & Gunn, 1999), with research tending to focus more predominantly on admissions to inpatient care (Brown, Lloyd & Donnovan, 2001). This paucity of research is of particular concern, as such information could potentially help guide the interventions patients receive before they are released into the community. In particular information about the reintegration process after release from forensic mental health services (FMHS) could indicate which patients need particular types of supervision or support. When considering mentally disordered offenders (MDOs), research examining the accounts of those who have been released from FMHS into the community may possibly begin to identify some of the complex processes involved in moving towards and maintaining reintegration into the community. The implication for practitioners would therefore be that the rehabilitation process, which creates the context for building and sustaining a momentum for change, takes basic skills development beyond the formal interventions as seen in Chapter 1, to provide ongoing support and opportunities, to embed learning in the real non-offending life of the individual. In a sense, the notion of rehabilitation and reintegration needs to be a thread that runs through the whole process of work with MDOs.

Mentally Disordered Offenders

According to the Mental Health Act (MHA; 2007) the term 'mental disorder' refers to *"any disorder of disability of the mind"*. Throughout this Chapter, the term 'mentally disordered offender' (MDO) will therefore be used to refer to a heterogeneous population, crossing the full spectrum of personality disorders, psychiatric diagnoses and criminal offences (Rice & Harris, 1997). Given that MDOs typically have complex needs, including substance misuse, trauma, mental health management, criminogenic needs, poor life and social skills and affective and cognitive deficits, they require a long-term, co-ordinated, collaborative multidisciplinary approach (Muller-Isberner & Hodgins, 200). To enable successful reintegration into the

community post-release from a secure environment, effective treatment with MDOs is that which monitors behaviour, and controls symptoms, along with focusing efforts to achieve the changes required (Farrow, Kelly & Wilkinson, 2007).

The current legal and policy frameworks result in MDOs being defined by two of modern society's most powerful professions: medicine and law (Webb, 1999). When a MDO is given a hospital order (Section 37) under the Mental Health Act (MHA; 1983), an order restricting discharge may also be made under Section 41 (MHA, 1983); thus a Hospital Order with an accompanying Restriction Order is recorded as Section 37/41. Consequently, service-users subject to Section 37/41 (MHA, 1983) are defined by both their mental disorder and their crime. The restriction order places the responsibility for discharge, transfers and leave from hospital onto the Secretary of State, and the only other body with the power to discharge is a Mental Health Review Tribunal (MHRT). When a patient is conditionally discharged from a hospital, conditions may vary, but they will typically be required to reside at a specified place of residence, to attend out-patient appointments, take prescribed medication and to meet on a regular basis with their social supervisor. If a patient neglects to meet their conditions of discharge, the Secretary of State has the authority to recall them back to hospital. For the purpose of this Chapter, the terms 'forensic mental health service' 'secure unit' and 'secure hospital' will be used interchangeably to refer to services which provide secure inpatient care, which may be of low, medium or high security.

The presumption of limited autonomy that goes hand in hand with this framework can result in service-users' views not being heard (Dixon, 2010). It is important that practitioners are aware of the particular environmental challenges faced by MDOs subject to Section 41 (MHA, 1983) when moving between legal, hospital and community settings. For these MDOs in particular, it is important to provide information about successful reintegration to help guide the interventions that patients receive before they are granted conditional discharge into the community. Information about factors which foster or accelerate reintegration would be important in informing the interventions these individuals receive prior to and post release (Farrington, 2007). In particular, information about the reintegration process after release could indicate which patients need particular types of supervision or support.

The Rehabilitation of Mentally Disordered Offenders

It has been argued that the rehabilitation of MDOs ought to be concerned with providing individuals with the values and capabilities to live personally meaningful and pro-social lives. However, this depends on the attainment of correct knowledge of the physical and social world, development of a rigorous understanding of their own standards and values, the capacity to follow their own personal goals in specific environments, and being able to employ the resources they need to overcome everyday obstacles in the pursuit of those goals (Ward & Marshall, 2007). In the design of treatment programmes which aim to equip offenders with external and internal conditions necessary to implement a successful life plan, and subsequent rehabilitation plan, strength-based approaches, such as the Good Lives Model (GLM; Ward, 2002) place particular emphasis on the utilisation of offenders' primary values or desired goods in their design. In this respect, the GLM, offers a rehabilitation approach based on ways of living that are constructed around core values and desired goods, with a prosocial means of attaining these values and goods in an effort to pursue better lives (Maruna, 2001). Thus, according to the GLM, access to social supports, opportunities and alternative ways of living help to ensure offenders develop the competences to successfully reintegrate into society. Theories other than the GLM also emphasise the role of social support (Laub & Sampson, 2001; Giordano, Cernkovich & Rudoph, 2002), suggesting an offender's post-release environment can thus supply a kind of scaffolding that makes possible the construction of significant life changes.

The potentially pro-social features of the environment have been referred to as catalysts, change agents, turning points or even hooks for change (Laub & Sampson, 2001; Maruna, 2001; Giordano et al, 2002), however, there is no systematic agreement as to how individuals encounter such opportunities. Giordano et al (2002) propose these structural changes are insufficient to explain desistance from crime, and their cognitive transformation theory places emphasis on the person as an individual mediator in creating change in his life, rather than simply reacting to structural events. In terms of the rehabilitation process, Giordano et al (2002) propose that treatment programmes can only assist to the extent that they offer a specific 'cognitive blueprint' as to precisely how one goes about changing oneself, as individuals

themselves must discard old habits, attend to new possibilities and begin the process of constructing a different way of life.

The Service-User Perspective

It has been said that criminal justice practitioners often adopt paternalistic rehabilitation approaches, operating under the assumptions that they are better equipped to consider and evaluate offenders' needs than the offenders themselves, and offenders are somewhat irrational and unaware of their own conditions (Gideon, 2010). Possibly due to ethical difficulties encountered and social exclusion in secure settings (Coffey, 2006) research on service-user[2] views is scarce. However, in order to improve quality of life and better determine health needs, it is imperative that health services emphasise service-user perspectives (Sullivan, 2003). For example, the New Zealand Mental Health Commission (2000) interviewed three forensic mental health service users and family members to gather qualitative accounts of what hindered and aided recovery during participants' journeys through forensic services. During these interviews several themes emerged in terms of hindrances to recovery, which included relations with professionals, the institutional tension between sanctuary and confinement, and cultural insensitivity. In terms of aids to recovery, participants suggested appropriate timing of interventions, talking openly and finding spiritual/personal support and support of respectful professionals who instil hope. Following a review of the literature Coffey (2006) suggested *"we still know relatively little of the experience and perspectives of people who use forensic mental health services and may judge available findings as unreliable"* (p.73). The lack of current research certainly upholds this statement; there seems to be a greater necessity to hear from service-users themselves than has until now been the case.

Qualitative Research

The proposal that rehabilitation involves changes in an individual's personal outlook and thinking is among one of the oldest ideas in correction research. However, it is surprising that offender accounts are underrepresented in the published literature. It

[2] Service-user is a term frequently used to describe people who a diagnosed with a (usually long-term) mental health problem and are receiving or using services (Harper & Thompson, 2012)

may be, at a simplistic level that this is because it is assumed that such accounts will be a falsification of an individual's thoughts, feelings or behaviour, in order to minimise what has happened or what is still being considered. In recent years, there has been an emergence of qualitative literature based on analysis of text or interviews produced by the offender, which is distinct from more commonly published quantitative research. Such qualitative methods are particularly helpful for developing new lines of inquiry or conceptual categories, as they can offer a window to the mechanisms/processes that are more complicated to elucidate by means of traditional quantitative procedures (Abbott, 1992).

There are only a few studies examining the views of MDOs who have experienced a conditional discharge. Davies, Godin, Heyman, Reynold and Shaw (2008) carried out a four year qualitative study at an English Medium Secure Unit. The authors interviewed both staff and service-users, and suggested that service-users are often aware that in order to be released they need to convince professionals that their high-risk status is no longer valid. This theme was also echoed in research by Godin and Davies (2006), where, during interviews, the service-users subject to secure provisions in their study commonly stated they had to *'play the game'* (p.44). Coffey (2012) interviewed service-users from two forensic mental health services in the UK, asking them to speak about their experiences of discharge. Analysis of the transcripts in their study focused on service-user accounts of community return and the action-oriented nature of their talk, to examine what was being said, what it worked to accomplish and how this was achieved. This involved examining what speakers prioritised in their talk. Coffey's (2012) research suggested that service-users acquiesce to professional views in order to achieve discharge, where service-users often felt compelled to accept conditions proposed at their MHRT but that their perspective on these conditions changed once they had achieved discharge.

Using semi-structured questionnaires in an interview setting, Riordan, Smith and Humphreys (2002) asked service-users to focus on the positive and negative things about community supervision. The authors suggested participants valued the present (and guarantee of longer-term) support they received to re-enter the community, however, negative feelings were expressed towards coercive features of supervision, where participants felt it disallowed them privacy and personal autonomy. They also

reported that for some participants, the worst aspect of their community supervision was being required to have injections of psychiatric medication. A qualitative study by Dell and Grounds (1995) interviewed service-users with their social supervisors present. Their results suggested that the threat of recall to hospital was a continuous concern, where service-users complained of the subjective nature of such decisions. In addition, they disliked having to attend outpatient meetings at the hospital in which they had been previously detained.

All of the aforementioned studies employed various means of qualitative data collection, and most were not transparent in their reporting of the exact methods used during the interview and analysis stages. However, worth noting is the fact service-users were often interviewed in the presence of members of staff, and in the cases where they were not, their responses to interview questions were later compared with those of staff to produce results. To conclude, research in this area is sparse, yet the limited evidence available suggests concern and a need to explore this further, as an understanding of how MDOs experience the conditional discharge process can help to foster practice that is sensitive to service-users' needs in this area. This will now be discussed in terms of the importance of narrative methodology in this area of research.

Narrative Methods

One approach to gathering qualitative information on the conditional discharge and reintegration experience is narrative research methodology, which makes it possible to empirically examine the cognitive mediators between environmental influences and individual behaviour that make such a process possible. This is largely due to the fact that the use of narrative data reminds us of the bearing subjective and multifaceted experience has on offending. According to Bruner (1990), narratives are stories of past life experience and sets of expectations about future experiences which serve to both guide the actions of individuals and shape their experiences and lives. Bruner (1987) argues that we eventually *"become the autobiographical narratives by which we tell about our lives"* (Bruner, 1987, p.15). Narrative interviews can therefore offer a perspective on the means through which individuals signify that changes in life direction have been accomplished (Giordano et al, 2002). During narrative interviews, individuals draw from discursive resources to create a sense of what really matters to

them (Harré & Gillet, 1994). Narrative methodology can consequently be seen to offer a means by which individuals are able to arrive at an understanding of the self as evolving from experience and actions, both in relation to common themes or plots and as located in a cultural matrix of beliefs, meaning and practices.

Over the past decade, narrative approaches to psychological enquiry have impacted many forms of psychological research, gaining ascendance in psychology and sociology (Presser, 2009). Personality psychologists chart relationships between life stories, personality traits and psychological well-being (Bauer, McAdams & Sakaeda, 2005), cognitive scientists study the nature and course of autobiographical memory and its role in identity development (Thomsen & Bernsten, 2008) and developmental psychologists examine the origins of story comprehension and storytelling in childhood (Fivish & Haden, 2003). Cultural psychologists also describe how individuals appropriate and negotiate society's master narratives in the making of self (Hammack, 2008), whilst social psychologist explore how selves are narrated and performed in particular situations and social contexts (McLean, Papipathi & Pals, 2007). In addition, clinical and counselling psychologists cast an empirical eye on psychotherapy as a major avenue for life-story transformation (Alder, Skaline & McAdams, 2008) and psychological scientists have developed a range of new methodologies for collecting and analysing life-narrative data (King, 2003). In summary, interpretations of narratives are noteworthy to social scientists as people act based on their perception of things that concern them (Thomas & Thomas, 1972).

Narrative Life Story Interviews

A narrative is occasionally referred to as a life history or life story, but should not be considered as a report on one's entire life story so far, as narrative draws selectively upon lived experiences. In addition, the concept of story is used figuratively and does not mean individuals literally generate an imagined persona and then set about becoming that person - the circumstances and events of people's lives are real and function as constraints in the construction of a narrative. In the same way answers to an attitudes survey serve to represent an individual's beliefs, the stories individuals tell social researchers about themselves are believed to hold the outlines of their internalised self-narratives (McAdams, 1993). For psychologists, narrative cultivates

personal identity, or the sense of being one person over time and across circumstances (McAdams, 1999). Shaw (1930) suggests that the life story provides a window into the circumstances and events of one's life as well as the individual's perspective.

While a variety of methods have been proposed for accessing narrative life stories (Denzin, 1989), the majority involve rigorous, semi-structured interviews in field settings. In particular, McAdams (1993) has developed an interview protocol that he has employed in research into personal myths. He recommends that the interview protocol is seen as a tool, used to prompt further explorations in dialogues, encouraging adaptations to his protocol. His interview contains a 'life-chapter' format, which provides the storyteller with an organising narrative framework and invites more communication than other sorts of interviews. His interview protocol has since been adapted and effectively used by other researchers in the field (Maruna, Porter & Carvalho, 2004). The transcribed life story documents produced in narrative research provide estimated indicators of the internal self-story that the individual actually lives by. If qualitative data derived from narrative life story interviews can help uncover underlying social processes of stability and change, such qualitative data would be especially useful when considering MDOs who have been conditionally discharged into the community, as the experience of reintegration probably does not have the same meaning for everyone. Such narrative transcripts derived from narrative life story interviews could therefore be systematically compared for cross-case similarities and differences in themes, with the hope of furthering knowledge into what impacts on a successful reintegration into the community, in the rehabilitation process of MDOs.

Summary

Little is known of adult male MDOs experiences of the conditional discharge and community reintegration process, despite the fact qualitative research on the lives of ex-offenders has highlighted the need to recognise the subjective changes as well as the social changes that may help offenders reintegrate into the community (LeBel, Burnett, Maruna & Bushway, 2008). The process of reintegration into the community depends on the attainment of resources and capabilities that will enable an MDO to successfully rehabilitate in their post-release environment. However, what is not

currently known are what these capabilities and resources specifically are, and what are valued by MDOs. As such, a vital area of future research is to establish which social arrangements and events conduce to successful reintegration. Consequently, the purpose of this study was to examine the perspectives of adult male MDOs in regard to their experience of the conditional discharge process, and their reintegration into their community.

Study Aims

This study aims to gather qualitative information of the experiences of adult male MDOs under Section 37/41 of the MHA (1983) who have been given a conditional discharge into the community from an inpatient FMHS. The purpose of this study is to employ a narrative life story interview technique (McAdams, 1993) to identify any common themes in MDOs journeys through the FMHS, which may be used to inform professionals working with MDOs of what impacts on a successful reintegration into the community following a conditional discharge.

Method

Participants

Study Configuration and Participant Sample:

This study was carried out in a single-centre, namely Whitchurch Hospital, in the department of the Low Secure and Community Forensic Mental Health Team (CFMHT). The study aimed to recruit patients who were sectioned under Part 3, Section 37/41 of the Mental Health Act (1983), who had been given a conditional discharge into the community from a secure service and were still under the care of the CFMHT. During the recruitment stage of this study, there were 32 clients known to the CFMHT, who were sectioned under Part 3, Section 37/41 of the Mental Health Act (1983).

Participant recruitment was carried out by CFMHT staff, to ensure participants did not feel pressured to take part in the study. The study was introduced verbally to CFMHT staff during a routine staff meeting at Whitchurch Hospital. During this meeting all members of staff were given a Study Advertisement *(*Appendix 8*)* and a Participant Information Sheet (PIS; Appendix 9*)* to consider. In the PIS, the interviewer was described as a student and the study was described as a research project, being carried out for the purpose of an academic course and qualification. The Study Advertisement included a brief description of the study, and the inclusion and exclusion criteria, so that staff were aware of the participants required for the research. For the purpose of this study the inclusion and criteria were as follows:

Inclusion Criteria:

- Male
- Over the age of 18
- Has the ability to give Informed Consent
- Has at least one previous conviction for a criminal offence.
- Diagnosed with a mental disorder as specified by mental health legislation (Mental Health Act (MHA) 1983: 2007).

- Previously sectioned under Part 3, Section 37 (Hospital Order) of the Mental Health Act (1983) and consequently admitted to either a: Low; Medium; or High Secure Unit.
- Previously conditionally discharged at some point during their care (Under Section 41 of the MHA).
- Still under the care of the multidisciplinary team or
    - Living independently or supported in the community
    - A current inpatient due to: An informal admission, admission under a Civil Section or recall through the Ministry of Justice under Section 37/41 of the MHA.

Exclusion Criteria:

- Prisoners and those under a probation order from the courts
- Currently Sectioned under Section 47, Section 48, or Section 49 of the MHA.
- Unable to understand and speak English
- Currently displaying any significant cognitive impairment that would render them unable to concentrate during the study interview
- The interview is thought to cause them distress
- Others consider their risk level too high to be interviewed in a 1:1 setting

Of the 32 patients known to the CFMHT, 9 accepted the invitation and consented to take part in the study. All 9 participants were referred to the study by a CFMHT member. The researcher was not informed of any potential participants the team had approached, and if any potential participants declined to take part in the study no further action was taken. It is not known how many participants were approached to take part, how many were considered unsuitable or how many declined.

Sample Size

The sample size for this study was determined using evidence-based recommendations from Guest, Bunce and Johnson (2006). Following an experiment of data saturation, Guest et al (2006) systematically documented their degree of data saturation over the course of thematic analysis of sixty interview transcripts. In their study, following the

analysis of all sixty interviews 94% of high frequency codes were identified within the first six interviews and 97% were identified after twelve (p.73). Guest et al (2006) suggest that for most research studies in which the aim is to understand common perceptions and experiences among a group of relatively homogeneous individuals, a sample of six interviews may be sufficient to enable the development of meaningful themes and useful interpretations. Considering these guidelines, a sample of 6 participants was considered necessary for the study, however, a potential size of 12 was aimed for, to allow for recruitment problems and dropouts. Restrictions in relation to recruitment procedures and available (and willing) participants meant that 9 interviews were completed.

Participant Characteristics

Participants for this study were mentally disordered adult male offenders under Section 37/41 of the Mental Health Act (MHA: 1983). All participants had previously been given a conditional discharge from a FMHS where they were an inpatient and were currently open to the CFMHT at Whitchurch Hospital. Participants were 9 men, with a mean age of 41.44 (SD = 7.09), recruited using a method of Opportunity Sampling (Coolican, 2004). Time known to services was also recorded, which ranged from 7 to 26 years, with a mean time of 17.88 years (SD = 5.73). The demographic and clinical characteristics of the participants employed in this study are summarised in Table 5.

Table 5: Participant Clinical and Demographic Characteristics

Participant	Age	Ethnicity	DSM-IV diagnoses	*Time known to services
1	44	White British	Paranoid Schizophrenia	16 years
2	40	White British	Schizophrenia	13 years
3	39	White British	Paranoid Schizophrenia	20 years
4	27	White British	Paranoid Schizophrenia	7 years
5	35	White British	Paranoid Schizophrenia	15 years
6	49	Asian-British	Schizophrenia & PTSD	26 years
7	48	White British	Schizoaffective Disorder	20 years
8	44	Black British	Bipolar Affective Disorder	22 years
9	47	White British	Paranoid Schizophrenia	22 years

**From the first point of contact with mental health services, including all periods of time spent in hospital and in the community*

Design

Given the research aims, this study required an approach that would enable depth and richness of data generation (Blackie, 2000); therefore an exploratory, qualitative design utilising a narrative life story interview method of data collection was used. Semi-structured interviews are common when an interviewer has only one opportunity to interview a participant (Bernard, 2000).

Procedure

Recruitment

As previously noted, CFMHT members identified potential participants, approached them with information about the study and offered them the chance to read the PIS. If participants were considering taking part in the study or wanted more information, verbal consent was obtained to then discuss their participation with the researcher. On first contact with each potential research participant the researcher was introduced as a research student. During this meeting it was explained that entry into the study was

entirely voluntary and treatment and care would not be affected by their decision. It was also explained that they could withdraw at any time. For participants who wished to take part, the researcher arranged a convenient time and date to meet to take part in the study. This second meeting with the researcher occurred at a minimum of 24 hours after participants had read the PIS with the researcher and had any questions answered. The interviewer did not have any previous or subsequent clinical contact with participants; therefore the relationship with all participants was as a research interviewer only.

Study Regimen

Following the recruitment process, where a participant had verbally agreed to take part in the study, a room was booked, at a convenient time for the participant to attend. The study was carried out in a private room in the CFMHT department of Whitchurch Hospital, during office hours, to ensure the safety of participants and the researcher. An onsite supervisor was available to contact at all times if needed.

1. Participants met the researcher at the time and place negotiated to begin the study, where they were again shown the PIS provided with the opportunity to ask any questions. Participants were then asked to give informed consent by reading and signing the Consent Form *(*Appendix 10*)*.
2. Once informed consent had been collected the participant took part in the narrative life story interview (Appendix 11) which was conducted by the researcher and designed for the purpose of the study. The participant was asked questions contained in the interview schedule which was recorded using a Dictaphone.
3. After the participant had completed the interview they were fully debriefed and reminded they were free to withdraw from the study at any time.
4. Participants were asked to provide their contact details if they wished to receive a summary of the study results. It was explained to them that these results would be sent to them in the post.
5. Before they left the premises, participants were given a photocopy of their consent form to take away with them and the PIS which contained the researchers contact details.

6. Following the interview, one copy of the consent form was filed in the participants' inpatient file notes, and one was filed and kept by the researcher. The participant's responsible clinician was also informed via a letter (Appendix 12) that the patient had taken part in the study.

At a later stage, demographic data was collected by the researcher from hard copy file notes which held all patient information. The researcher held an honorary contract with the Cardiff and Vale University Local Health Board, which allowed her access to patient files and information with respect of the confidential nature of personal information and an understanding of the importance of maintaining confidentiality. This information was recorded after the participant had completed the interview and had consented to this information being shared. This demographic data was entered into Microsoft Office Excel 2007 and saved on a private password protected computer.

Materials

A Dictaphone was used to record each participant, which recorded the study from the start to the debriefing. In addition, a hard copy version of the interview schedule was brought to the interview.

The Interview Schedule

A semi-structured narrative life story interview was used to gather data for the study. The interview schedule was developed using interview protocol guidelines developed by McAdams (1993), who suggests the life chapters' organisation of his interview protocol provides the interviewee with an organising narrative framework. McAdams (1993) encourages adaptations and supplements to his interview protocol, and advocates that his interview protocol is seen as a tool that is open to experimentation with to regards the format. The interview protocol was therefore refined and adapted to form the interview used in the study. This was discussed with, and supervised by, the academic supervisor for the study. The narrative life story interview contained open-ended questions, asking participants to begin by thinking about their lives as if it were a book. The researcher clearly specified that they were interested in three

particular chapters which were a) the time before they came into contact with mental health services; b) the time spent in services and c) the time spent in the community post-conditional discharge. Participants were also asked to identify significant people and key events in their lives. Towards the end of the interview participants were asked to discuss a future script, and highlight current stresses and problems. The interviewed ended with a discussion regarding personal ideology.

The researcher did not set the interview length; rather it was set by how long each participant was willing to discuss their recovery process. When appropriate, interviewees were urged to elaborate on their comments. Researcher bias was considered when interviewing participants, asking questions and discussing topics, so not to influence the tone of conversation (Bryman, 2008). Interviews were conducted between November 2011 and March 2012.

Source Documents and Storage

Source documents for this study included the consent forms, the Microsoft Office Excel 2007 database containing demographic information, tape recordings and transcripts. All of which were kept in on a password protected computer in a private and secure office in the CFMHT department in Whitchurch Hospital. Consent forms were kept in a locked cabinet in the same office. Upon transcribing the interviews, tape recordings were anonymised and also stored securely in the same office. Confidentiality was maintained throughout and all identifiable participant information from the interviews provided such as names, dates, places and criminal activity was removed from the transcripts. Every participant who took part in the research was provided with a unique participation number – the only identifier used for identifying all data collected for the purpose of the study. This was present on the transcripts and in the Microsoft Office Excel 2007 database. The researcher kept a separate record of the participant's name, date of birth, local hospital number or NHS number, and Participant Study Number, to permit identification of all participants enrolled in the study for the purpose of collecting demographic data. This list was kept separate from all other study data and on a password protected computer in a private and secure office in the CFMHT department in Whitchurch Hospital and was destroyed once participants had been sent a summary of the research (Appendix 13).

Data Analysis

Thematic Analysis

Thematic Analysis (TA: Braun & Clarke, 2006) was used in this study. TA is a method for identifying, analysing and reporting patterns of themes within data (Braun & Clarke, 2006). Through its theoretical freedom, TA provides a flexible and useful research tool, which can potentially provide a rich and detailed, yet complex account of data (Boyatzis, 1998). Themes or patterns within data can be identified in one of two primary ways in TA; in an inductive or 'bottom up' way, or in a theoretical or deducting 'top down' way (Braun & Clarke, 2006). For the purpose of this research, an inductive or 'bottom up' approach was used to ensure the themes identified were strongly linked to the data (Patton, 1990). In this approach, the themes are not driven by the researcher's theoretical interest in the area or topic, neither is the data fitted into a pre-existing coding frame or the researcher's analytic preconceptions. See Table 6 for an example of a passage of coded text, as coded in the study.

Table 6: Coding Example

"Just that no matter what I do[1] I can't seem to get well enough. Being in a place like this you're mixing with the wrong crowd[2]. And you've got patients on this ward who aren't well, when you're trying to get better...they don't seem to realise[3], they just see you as a danger[4] when you're back and forth like this."	talking about decisions being made for him	[1]AUTONOMY - LOSS
	talking about the stigmatising effects of being in hospital	[2]STIGMA –HOSPITAL
	believes no one really cares about him	[3]NO ONE CARES
	talking about the stigma of being a mental health patient	[4]STIGMA - ILLNESS

Analysis of Transcripts:

Table 7 describes the stages of TA (Braun & Clarke, 2006)., which were followed when analysing the transcripts.

Table 7: Phases of Thematic Analysis

Phase	Description of the Process
1. Familiarising yourself with your data	Transcribing data, reading and re-reading the data, noting down initial ideas
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collecting data relevant to each code
3. Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme
4. Reviewing themes	Checking if the themes work in relation to the coded extracts (level 1) and the entire data set (level 2), generating a thematic 'map' of analysis
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme and the overall story the analysis tells, generating clear definitions and names for each theme
6. Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research questions and literature, producing a scholarly report of the analysis

Following the criteria suggested by Braun and Clarke (2006), during phase 1 (*familiarising yourself with the data*) the entire data set was transcribed by the researcher and read and re-read to ensure familiarity. Analysing the data involved considering the whole interview as one continuous excerpt of text, this was to ensure the data collection questions (from the interview schedule) were not used as potential themes and where instead, themes could be identified across the entire dataset, to examine the pattern of responses.

During phase 2 (*generating initial codes*), descriptive coding (Wolcott, 1994) was used to code the data. Descriptive coding summarises in a word or short phrase the basic topic of a passage of qualitative data. To clarify, Tesch (1990) differentiates that "it is important that these [codes] are identifications of the *topic*, not abbreviations of the *content*" (p.119). This method categorises data at a basic level to provide the

researcher with an organisational grasp of the study, and has been recommended for use in TA (Saldana, 2009). Using the descriptive coding method, a coding frame was created to classify, understand and examine the data. The coding frame is a conceptual tool used to guide the TA and documents all the codes found in the data set. In a coding frame the code name appears in the first column, a definition of what should be classified within this code in the second column, and an example of material that should be coded within this code in the third column (Joffe , 2012). According to Joffe (2012) once codes have been developed, refined and clearly described in the coding frame, the researcher should determine its validity, by subjecting 10-20% of the data to checking by a second independent rater unfamiliar with the study. Therefore, 3 of the transcripts were passed to an independent researcher along with the developed coding scheme. In the instance of inconsistency, the relevant code was more carefully described and operationalised via discussion between the two researchers. After the coding scheme had been checked for validity, the final coding frame contained 58 codes (Appendix 14).

Utilising the coding frame, themes were searched for in phase 3 (*searching for themes*) of the TA process and codes were collated into potential themes. Following the development of an initial thematic map, during phase 4 (*reviewing themes*) emerging themes were reviewed to check they worked in relation to the coded extracts and entire data set. Once this was completed, during phase 5 (*defining and naming themes*) an analysis refining the specifics of each theme allowed for the generation of clear definitions and names for each theme, and the production of a final thematic map. The quality of TA was enhanced as a result of reference to a '15-Point Checklist of Criteria for Good Thematic Analysis' (Appendix 15) as suggested by Braun & Clarke (2006).

The final stages of TA were conducted by the researcher. Whilst it is acknowledged that a hybrid of approaches concerning validity checks were used, it was considered useful to gain a validity check at the coding stage to increase the transparency of the coding frame so the researcher, when using it, would consistently apply the same code to the same excerpt. However, by the theme identification stage it was considered that the researcher was more familiar with the entire data set, and therefore more able to

make a valid interpretation of results. This position draws upon recent emphasis of the critical role of the researcher as an 'instrument' in the research process (Pyett, 2003).

Ethical Considerations

Participants were reminded that they did not have to discuss anything they did not feel comfortable with and they could refuse to answer any questions. They were informed that their mental health team or the research team could provide support if they found the interview upsetting or need extra support. All contact details were provided to the participants. It was not expected that the results of this study would have any direct implications or outcomes towards the care the participants received, as participants were informed of in the PIC. Participants were informed they were welcome to receive a copy of the study results; where participation in the study would remain anonymous.

Anonymity & Confidentiality

Individual participant medical or personal information obtained as a result of this study was considered confidential and disclosure to third parties was prohibited. Participant confidentiality was further ensured by utilising identification code numbers to correspond to data in the computer files. The researcher followed the British Psychological Society's Code of Ethics and Conduct (2009) and was prepared to restrict breaches of confidentiality to those exceptional circumstances under which there appears sufficient evidence to raise serious concern about: the safety of participants; the safety of other persons who may be endangered by the participant's behaviour; and the health, welfare or safety of children or vulnerable adults. During the course of the study interview process this was not necessary.

Informed Consent and Participant Withdrawal

The process for obtaining participant informed consent was in accordance with the Research Ethics Committee guidance, and Good Clinical Practice (GCP). The researcher and the participant both signed and dated the Consent Form before the participant took part in the study. The researcher explained the details of the study,

answered any questions and provided a PIS, ensuring the participant had sufficient time to consider participating or not. Participants were made aware that their decision regarding participation in the study was entirely voluntary. Participants were informed that they could be withdrawn from the study either at their own request, or at the discretion of the researcher, their responsible clinician or a member of their clinical team. The participants were made aware that this would not affect their future care. Participants were made aware (via the PIS and consent form) that should they withdraw the data collected to date could not be erased and might still be used in the final analysis. None of the participants who took part in the study withdrew.

Supervision

Throughout the duration of the study (preparation, data collection, analysis and write up) the researcher received monthly supervision from an academic supervisor and weekly supervision from the placement supervisor employed at the site of data collection. Extra supervision was sought where necessary from both supervisors.

Ethics Committee and Regulatory Approvals

Ethical approval for this study was received from the University of Nottingham (Appendix 16), the Research Ethics Committee (REC; Appendix 17), and the respective National Health Service (NHS) Research & Development (R&D) department (Appendix 18). Coordinating ethical approval from the REC and NHS R&D proved challenging, as both committees requested further clarification and subsequent changes to study documents. These clarifications were in relation to: inclusion and exclusion criteria of participants, recruitment procedures, safeguards for researcher, and simplification of the PIS. After both committees were satisfied with the amended study documents ethical approval was granted.

Results

Participants

Nine participants were recruited to the study; information about them is presented in Table 8. As Table 8 shows, despite all the participants having received a conditional discharge from an secure setting at some point during their care, two of the participants had been recalled to the low secure rehabilitation ward at Whitchurch Hospital at the time of interviewing. The remaining 7 participants were either living independently in the community (n=1) or living in 24-hour (n=5) or 12-hour (n=1) supported community accommodation. The length of interviews varied substantially: the shortest was 14 minutes, and the longest was 1 hour and 28 minutes. Interview length, along with further participant information, is presented in Table 8.

Table 8: Participant Information

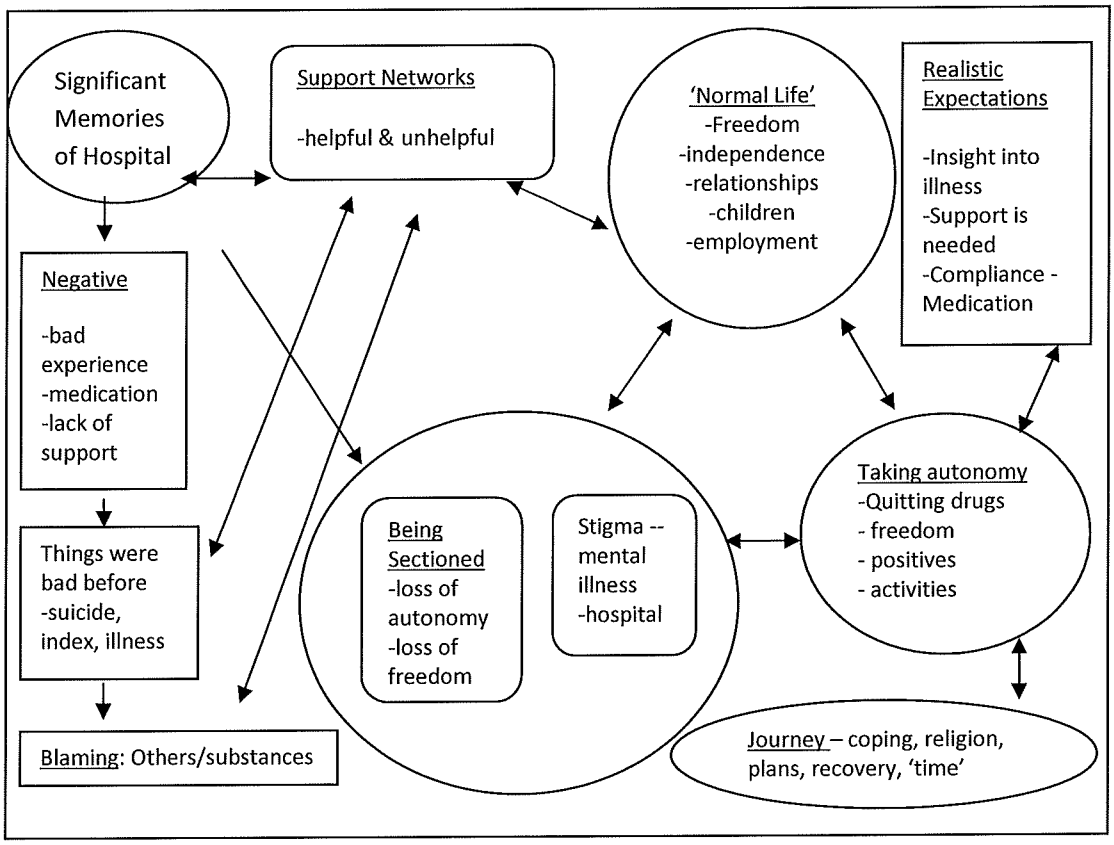
Participant	Age	Index offence	Current place of residence	Interview Length
1	44	Arson	NHS Low-Secure	1 hr 28 min
2	40	Arson	Independent accommodation	1 hr15 min
3	39	Assault & Attempted Kidnap	24 hour SCA	35 min
4	27	Criminal Damage & Possession of a bladed article	12 hour SCA	18 min
5	35	Possession of a fire arms x2	24 hour SCA	42 min
6	49	Abduction & Sexual assault of a minor	24 hour SCA	1 hr 6 min
7	48	Possession of an imitation firearm	24 hour SCA	1 hr 9 min
8	44	Sexual assault & false imprisonment	24 hour SCA	14 min
9	47	Arson	NHS Low-Secure	29 min

**Key: SCA = Supported Community Accommodation*

Thematic Map

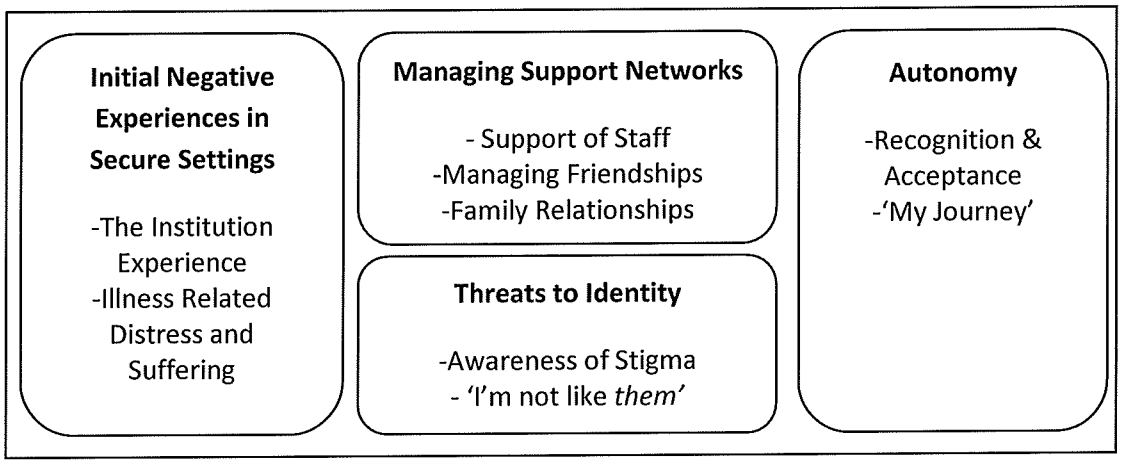
As previously mentioned, the final coding frame contained 58 codes (Appendix 14) which were collated into an initial thematic map seen below in Figure 2.

Figure 2: Initial Thematic Map



These themes were reviewed and checked against coded extracts and then clearly defined themes were produced in a final thematic map (Figure 3). This approach resulted in a hierarchical thematic framework, in which higher order themes represented more general or over-arching topics or issues and sub-themes reflected variation, or reasons for subcomponents of these.

Figure 3: Final Thematic Map



These major themes will now be described and illustrated with quotes, with additional illustrative quotes provided in Appendix 18. The themes reported by participants were generally congruent: differences in perspectives are reported where found.

Theme 1: Initial Negative Experiences in Secure Settings

Subtheme 1: The Institution Experience

Between them, participants had experienced being in prisons, NHS medium- and low-secure services, high secure special hospitals, and private provision:

> "I've been in prisons, in and out since then, hospitals the works" [P6]

Throughout the interviews, participants attempted to establish how and why the initial experience of using forensic services had significantly impacted upon their recovery. Results revealed some institutions, treatment regimes and professionals could be recognised as being better than others, and the variety of institutions referred to were recognised to have both negative and positive features which served to differentiate some from others. In general however, it appeared to be the negative descriptions of hospital which were most prominent in the initial descriptions of care.

Participants generally started their discussions of institutional care by reference to their time spent in prisons. Participants spoke of this as if it was a starting point for

subsequent difficulties. Many believed transfer to hospital was not warranted at the time, and prison incarceration should have been the end of their 'intervention'. Other participants spoke about how if they had been provided treatment whilst in prison for their mental health problems they may not have entered the forensic mental health service:

> "...if I could have been treated in prison and released, umm, I think I could have taken care of myself..." [P1]

Participants frequently referred to the fact that whilst in prison there was a reassuringly clearly defined time limit to ones incarceration, where one simply had to 'do time' to become released:

> "...it's not the same as with prison, you do your 4 and half months and they let you go..." [P2]

One participant went as far as stating that he would have been better off committing what he considered a 'worse' crime, where he would have subsequently served a longer sentence but would have been released earlier compared with detention under the mental health act:

> "...all I keep thinking to myself is I might as well have been a murderer, I would have been better off killing someone, going to prison, serving a sentence, then so many years and I'm out." [P9]

Nevertheless, prison was acknowledged to be a 'disturbing' establishment, particularly by those who had experienced both prison and secure units. Participants often used the prison environment as a comparison to the more positive aspects of hospital settings:

> "...it didn't seem that bad, you know I took it on the chin, I thought it's not an ideal situation, but it's not as bad as prison really I've been in worse places..." [P2]

In addition, participants' transfer to hospital settings was even considered in a positive light, with one participant acknowledging that prison did nothing to aid his recovery:

> "...I saw it as part of my development basically; I wouldn't have got anywhere if I'd stayed in that single cell in prison..." [P3]

The process of adapting to the hospital environment was likened to adapting to other institutions. Participants often made reference to their initial experiences and memories of coming into hospital. For some, these incidents ranged back over twenty years, suggesting the significance of these memories on their lasting impressions of the institutional experience:

> "... I was manhandled onto the ward, and out into a cell, I'll never forget this...I remember thinking I'll never get out and I was going to be stuck there for eternity... I was in there curled up in a ball on the floor, I didn't have any clothes on, they'd taken them from me...I thought I was being experimented on or something..." [P7]

In particular, participants recalled the environmental constraints of hospital, including the locked door of the ward, lack of privacy and strict regimes; one participant described this as 'absolute hell':

> "... it was absolute hell...umm...the ward was terrifying, claustrophobic, I couldn't go out...couldn't see anyone...umm... it was just absolute hell..." [P1]

At earlier stages in their contact with FMHS, participants described unpleasant, restrictive physical environments. It was during these times that participants recalled the difficulties faced in relation to having limited autonomy over daily routines, which was challenging and experienced as infantilising. In terms of the hospital regimes, participants discussed how they felt they had to 'prove themselves' in order to 'get out', which often went hand-in-hand with a worry about how they were perceived in terms of adherence. Participants reported feeling under continual pressure to perform in therapy sessions, groups, and ward rounds. They felt they were being judged by their performance and their future progress to release depended on this.

> "...You could only get on certain paroles, in the garden...Constantly having to prove myself all the time so I could eventually get out of there. I was worried that at one time they would send me somewhere else because I wasn't [progressing] at the proper rate..." [P7]

For the majority of participants, adhering to the routines on the wards was particularly difficult. Participants felt they were left alone on the wards for periods of time without activities to engage in. Furthermore the demands and judgements of the regime were not always seen as fair or helpful:

> "...you're more or less cooped up on the ward all day, 24/7, just stuck in the day room. Which I think is a little bit, it can be boring you know, I can understand why people get a little bit frustrated and end up, I don't know, having a pop at the staff or one of the other patients, because if it's boring, you know what I mean....you're stuck on the wards all day long, and it's a long day 8 till 10...you're stuck there with nothing to do..." [P2]

Among some of the most frequently and significant recalled difficult initial memories of hospital were those of being made to speak to people and losing freedom:

> "I think speaking to people was even more difficult than having your freedom taken away from you. Umm, having to talk to people on a daily basis was the most difficult part of being there..." [P3]

The staff group referred to most commonly when recalling time in hospital were nursing staff. Participants made particular reference to how staff reactions and interactions significantly impacted upon their initial memories in hospital. In discussion about specific unpleasant events they had experienced, participants often considered where blame should be allocated. In so doing they frequently apportioned blame to staff:

> "... I became very very paranoid... I heard the person who made the allegation was someone who worked in the hospital... I thought, oh the people who are meant to be helping me are lying about me..." [P7]

Despite acknowledging that their behaviour could at times be challenging for staff to manage, participants discussed how the behaviour of staff was challenging at times, in particular, suggestions were made that staff should be more understanding to patients' situations. Participants also made reference to the fact that staff are paid to 'help', but do not really have a genuine interest:

> "...Nah, no one really wants to help you, they're just told to. And even the ones who are supposed to help you can never really be bothered when you really need their help..." [P9]

Every participant in the study made reference to losing their freedom on admission to hospital. This appeared to be the most noteworthy aspect of being institutionalised, which participants seemed concerned with emphasising:

> "...having your freedom taken away from you...the most difficult part of being there..." [P3]

The reference to freedom was spoken about in two major contexts, one being in relation to the environmental constraints and the other in terms of the Section 37/41 (MHA: 1983). In terms of environmental constraints, participants recalled not being able to engage in the 'normal' activities one would normally take for granted:

> "...at the end of the day you're locked up in a secure place, and if you want to get out you can't simply open the door and take a walk down to the shop because you're not allowed to." [P2]

Participants also made reference to their loss of freedom, in the light of their Section, and what having 'a section' meant to them; one participant described their section as "like having a death sentence", where coming off their section would mean they would be classified as a "free person". In relation to this loss of freedom, participants also reported being very much aware that decisions were being made on their behalf, decisions that they were not always happy with:

> "...Well as far as I see it, it doesn't matter what my plans are. I don't know what I'm supposed to do to get out, and I mean, well I don't know why I'm even here, so how would I know how to get out! I don't have a say, and no one tells me anything about what's going on..." [P9]

This was discussed even further by some participants, to the extent that this loss of freedom and subsequent loss of autonomy, left them feeling worried and out of control of their own destiny:

> ...I didn't know what was happening at the time...I was worried that...if I didn't prove myself, that I would end up somewhere, that is an unpleasant feeling, worried I'd end up there for years and years..." [P7]

Lastly, participants expressed concern about major side effects of psychiatric drugs and their questionable therapeutic value. Most of the participants had experienced significant negative side effects of various medications, and were keen to offer lengthy descriptions of how the 'early days' of medication were bad:

> "... I was on haloperidol, which was, which made me so depressed for the first time in my life, I'd never been depressed before, but when I went on this I remember I couldn't see properly or move my limbs properly, I had very negative thoughts, I remember looking at my life and thinking what have I done in my life to deserve this. I remember walking through the hospital in a daze really, I remember hugging the wall, I couldn't walk straight at the time, I had to cling to the walls, and I couldn't speak because I was heavily drugged..." [P7]

Consequently, most participants described how they felt they were now more or less fully compliant with medication because their previous experiences had taught them reducing or stopping medication led to hospital admissions.

Subtheme 2: Illness Related Distress & Suffering

For the participants in this study, having a 'mental disorder' was viewed within the context of illness. Throughout the interviews participants' appeared to seek a degree of closeness to psychiatric discourse when describing their illness and symptoms, with

some participants openly proclaiming themselves to be 'paranoid'. Moreover, some participants explained themselves and their illness in terms of the concepts and ideas that appeared to originate from mental health care discourse:

> "... I did have symptoms of schizophrenia, I was paranoid all the time...I was very ... didn't know what was happening to me, umm, but I umm, was hearing voices and really paranoid...I was pulling my hair out you know, I was crazy" [P1]

Severity of mental illness was described in terms of length of time in hospital, initial disorientation when first admitted and changes to the person's personality. In terms of disorientation when first admitted, this was discussed in reference to changes that a participant had undergone following admission:

> "... I mean years ago when I was first in hospital I used to hear voices and stuff, and would talk to them. And as I was in hospital more you know, it started to go away...I felt ok I had no problems, I wasn't paranoid I wasn't seeing things, I wasn't hearing voices, I was ok, it was brilliant." [P5]

Participants also emphasised severity by talking about the effect on physical health, how life-threatening the problems had been and how suicide was one way of coping with the mental health problems. For some participants, having attempted suicide indicated the severity of mental health problems:

> "...I said to myself I can't go on like this anymore like, you know, the voices were attacking me, and I thought the only way of dealing with the situation was to kill myself, so I um....I lit a gas canister and....umm.....my house was quite burnt..." [P1]

Participants reported alternative explanations for psychotic symptoms which most frequently included substance misuse:

> "... I don't know whether I had that many symptoms of schizophrenia umm at this...can't really...really recall whether I was hearing voices or anything like that, umm, but, but with drugs it's hard to say you know..."[P1]

> "To tell you the truth I'm not mentally ill, it's just cannabis..." [P6]

One participant offered, by way of lengthy description, an account suggesting he was drugged and consequently became ill:

> "... I just became deluded, manic, psychotic, whatever you call it, virtually overnight, it does make me think whether I was drugged, it's a possibility I suppose..." [P7]

Participants were not asked directly about their offending history, or index offence, however, some did make reference to this during the interview. At the times when offending behaviour was discussed, this was most often during conversations regarding their mental illness:

> "...that's what made me do that index offence... I didn't know what I was doing I was off my head at the time, if I was alright I wouldn't have done it." [P5]

In general, participants acknowledged that mental health issues were present and that medical intervention was consequently warranted. Participants seemed to be aware of a need for help as their symptoms became uncontrollable and resulted in crisis:

> "... I had a replica fire arm...and I was waving people on just to lead them to safety... But I understand I frightened people, it wasn't my intention to frighten people, I was only trying to wave them on to safety, because I thought they weren't safe. And they got very very scared, understandably... I just put the gun in the air and waved it around, and it really frightened them you know I didn't think it would but it did... I know what I did was frightening, but I didn't intend on frightening anyone." [P7]

Theme 2: Managing Support Networks

Subtheme 1: Support of Staff

One of the most significant support networks described by participants as having a considerable effect on their recovery and rehabilitation process, were staff groups. Participants spoke a great deal about how the interpersonal encounters and relationships with nurses and other professionals assisted or impaired their progress towards recovery:

"...the staff were really helpful. If it wasn't for them I don't know where I'd be really..." [P3]

Progress towards recovery was characterised by the value of friendships with staff, beliefs about how staff viewed mental health patients, and the staff group as a controlling force to be negotiated with. Participants made particular reference to the fact that staff were aware of the difficulties faced by mental health patients, which made participants feel more comfortable around them than other members of the public:

"...umm...I suppose the understanding that the staff have, you know I suppose the staff have seen it all before you know...if you are ill you can do things, and umm, other people around you are fully aware that you have a mental illness... suppose that's helpful..." [P1]

Along with such comments, came references to feeling safe in hospital, which was often a direct consequence of having caring staff around. Participants recalled the positive benefits of having caring staff around them who would 'look out' for them, and look after them:

"... after all what I've said about hating the place here, the first thing that I thought of, the only place that I would be safe and be cared for was here..." [P1]

Throughout the interview, staff were discussed as a group; however diversity within this group was noticeable. The differences between staff members seemed to include a diversity of interests and backgrounds, where participants commonly spoke about staff they felt they could relate to, due to differing interpersonal styles:

"...you could sit down with a member of staff and have a game of chess, or you could sit down with them and talk about your favourite music, or play a board game, or you know, just engage in sort of chit chat, like have you read this book, this and that, you can have a conversation about the weather, but they were always friendly and polite , you know, that's what I liked about the staff there..." [P2]

Communicating with staff was described as a positive experience by participants during the times they were feeling well, however, when they were not feeling well, participants described this as a more difficult task:

> "...I've been pretty much alone now for most of my adult life, and it's difficult for me to talk to people and communicate with people...and that was difficult for me..." [P3]

When reflecting on hospitalisation, the most frequently discussed staff group were nursing staff and also specifically consultant psychiatrists. Participants briefly referred to occupational therapists and psychologists; however it appeared that the staff group for these participants when discussing hospital care mainly consisted of nurses and psychiatrists. Nevertheless, individual work on a one-to-one basis with a psychologist was also discussed, where the work started in hospital appeared to have a positive impact upon current functioning:

> "...I also had therapy sessions with a psychologist, she was brilliant...psychology, in some ways it helped, you know, because when I came out of hospital, I did suffer quite badly with stress...I think it was thanks to some of those psychology sessions that I was able to recognise when I was becoming unwell and too stressed..." [P2]

All participants who mentioned input from psychologists described how therapeutic work impacted their progress; this was generally viewed as a valuable part of their recovery. Descriptions of the therapeutic process uncovered features that facilitated participants' recovery, these included: working through of past experiences whilst being allowed time to arrive at a place where they were able to make use of therapy. In addition to the 'listening ear' of a psychologist, there was a significant emphasis on the fact that being in hospital meant participants had someone to talk to about the elements of their illness. As well these illness-related conversations, participants also valued having someone to talk to about 'everyday life'. One participant made reference to the fact it was important for him to have someone in his life to talk to other than family. In general, staff exhibiting respectful, positive professional attitudes and behaviour, were perceived as being therapeutically competent:

> "...they treat you with respect which is nice...you would call the staff by their first name." [P2]

This participant felt treatment adherence was more tolerable and beneficial in the company of staff he believed were therapeutically proficient. Staff were considered to be non-therapeutic when they were perceived as being unhelpful, failed to take participants' perspectives into account and prescribed medication that made them feel unwell. For most participants the positive experience of relationships with staff was more often with the staff they encountered in community settings, which seemed to be due to the fact that these relationships were more frequently longer-term, and were most likely to be experienced on a one-to-one basis:

> "... I see the staff as friends you see...I like the staff they're really understanding and friendly, they're a good group really..." [P7]

In particular, participants valued the structure that supported community accommodation and care provided, which was again, discussed in the context of staff support:

> "I went to a supported a project, rather than straight out on my own, so I felt that there was some support there...I didn't feel rushed, or pushed out or anything like that. I felt there was enough there after I'd been discharged for me to actually have a real chance at getting out and staying out kind of thing..." [P2]

However there was always a concern that this help and support could disappear, where participants appeared to have become over-reliant and dependent on the support from community staff:

> "...I do worry that if I end up, when I get into the community again, will I have enough input from the staff here or clinical teams or will I become ill again?..." [P7]

At later points during their journey through forensic services, in particular when negotiating their way through re-integration with the community, participants who felt

certain of staff availability reported feeling encouraged to be more open with staff, where support provided strength and confidence to try new tasks and challenges:

> "...in the past I wouldn't have been able to, if I'd been younger, I wouldn't have been able to complete this part of my life, I wouldn't have been accepting of it...The support I'm having at the moment is helping me, it's giving me a shoulder to cry on if you like, to talk about my problems if you like, but it does help..." [P3]

In summary, professionals who were respectful, and worked effectively and collaboratively with participants appeared to make reintegration achievable. Community teams offering this approach were particularly valued, and generally talked about in a more positive and encouraging light than any other staff group. In general, participants felt that they could accept their illness, and the fact that they could be at risk because of it, whilst expressing a desire to be cared for by professionals demonstrating communicative competence.

Subtheme 2: Managing Friendships

Participants in the study made reference to the importance of maintaining and developing friendships throughout their journey through FMHS and whilst in the community. Prior to hospitalisation, friendships were discussed in terms of their supportive nature, but were also discussed in the past context, where friendships had deteriorated due to mental illness onset:

> "... I had a breakdown not long after that, I felt they were slipping away from me, I got left behind and all that... I had lost touch with my friends because they had all moved on, but for me I was in the same place." [P8]

For this participant, he felt his friends had moved on, and due to his mental illness he was no longer seen as part of the 'group'. Many other participants also described retreating from their social networks as a response to their symptoms. In the instances where participants had established social networks prior to hospitalisation, these were often disrupted by a period of illness. Although some participants had experiences of unhelpful responses to their mental illness, other participants reported being

encouraged to seek help by their immediate social networks; one participant in particular described how friends could see his illness before he was aware of it himself:

> "... one day, round a friend's house, I said there's someone in the attic listening to us, and umm, he said, nah man you're just schizophrenic...and I was like what? He was just like yea, yea you've got a mental illness, all the drugs you've been doing you've got a mental illness, and that was the first time I'd really thought about it..." [P1]

There was a general consensus amongst participants that having a strong social network was an important component to their rehabilitation and reintegration into the community. Participants often made comments reflecting the supportive nature of current friendships, particularly those in which the friend in question understood and supported the individual:

> "My mate... His brother committed suicide, so he's used to looking after someone with a mental health problem, like me... he's been there for me, comes to appointments and things like that. If I need to call him, or talk to him he's there and listens, so he's been very important. He was there when I was in Hospital, came to visit, brought me in things and that, and he's still there now." [P8]

For one participant in particular, friendship was a very important part of his recovery. Not only did he make reference to the fact that the 'best time' he had in life was when he was around friends, he stated that he had since lost these friends and held a strong desire for new friends:

> "... what I really want to do is make new friends...because I've got no friends really you see... I also want to get a girlfriend..." [P5]

The mention of a 'girlfriend' or indeed any other sexual relationship was rare throughout the interviews with all participants. Participants were not asked about sexual relationships directly, nevertheless, considering all participants were single males, the absence of such relationships throughout their narratives could be considered as somewhat unexpected. In addition, the mention of children was also rare, with only one participant talking about his desire for children:

"...I wish I'd had kids, or wish I could have kids, I, umm, I haven't given up on that yet, even though I'm 44, there's life in the old dog yet..." [P1]

Subtheme 3: Family Relationships

A recurring theme throughout the reintegration process of the participants' in this study was that of support from family. Participants whose family had continued to be supportive explained how their family's practical and emotional support had aided their progress not only whilst in hospital, but also whilst in the community:

"My mum, major part of my life. Always there, she'd come in every week to see me rain, sleet or snow, she's been a diamond, my rock like, she's wicked..." [P4]

In some circumstances family members were responsible for the patient's admission to hospital:

"My father and my brother brought me in...Because I was having that breakdown, they thought I needed help, they saw that I wasn't myself and wasn't well." [P8]

Whilst in hospital, many participants said that they had missed their family, but had kept in touch with them. Progress and development often necessitated continuous adjustment on the part of the patient and their families; participants frequently discussed how the negotiation of changing situations and environment could be difficult, where family relationships could destabilise patients. Within this theme, one particular occurrence, that of death in the family, was also something participants wished to stress the significance of in terms of their recovery. For some, they felt the death of family members was something that destabilised them in the first instance:

"Thing is after my girlfriend died in 1991, I didn't care what happened to me...well I just fell apart...that was a downward spiral and I became irresponsible and not caring what happened, because there was no one to care for really... that's when everything started to change for me, because I was just left on my own... that's what sort of really opened the gates to depression and criminal behaviour and that sort of thing." [P7]

For this same participant, death in the family also led to relapses in his mental illness:

> "...I relapsed, my father died a couple of years ago and I relapsed a bit then, I became depressed, paranoid, psychotic, not for long, just a couple of months." [P7]

Participants felt losing family whilst they were in hospital was one of the most difficult experiences, mainly due to the guilt they experienced in terms of not being there for their family, and not having the right support to cope with the loss:

> "I've lost two brothers and a sister, and they all died within 6 months. This was difficult because I wasn't there for them, and didn't really have anyone to talk to about it." [P6]

In terms of changing family dynamics, participants also discussed how their hospital admission and mental illness had changed their family relationships:

> "... I wasn't speaking to my family really, I'd go up there and not really say anything really, and umm, wasn't really communicating with anybody at all, I was very isolated..... I didn't speak to them when I first went in... But after I moved to the other ward, I'd speak to them on the phone every day basically." [P3]

For one participant, his admission to hospital had significant repercussions for his family dynamics, as it led him to contact his sister for support, an individual he had not been in contact with before. Most participants had supportive family and believed that their support had been invaluable. Conversely, the few who had little family support described their situation as more difficult because of this:

> "... I've got no family and no friends. I've got a family but they're not supportive, same as friends, I thought I had friends but I haven't." [P9]

This participant in particular stated he had no support network, and through the interview suggested that this lack of support and interest had led to his current recall. In terms of remaining successful in the community, this support network from family was discussed often, where participants attributed their recovery to the support of family, and made particular indication that this was even more encouraging considering what they 'had put' their family through:

"... I think my parents have seen a difference, I'm more outgoing with them, able to make jokes, you know, just we're closer now as a family. I've put them through a lot in my life, and I think the family ties are very close now." [P3]

Theme 3: Threats to Identity

Subtheme 1: Awareness of Stigma

A number of participants expressed the view that stigma was the greatest disability they had had to deal with. Most participants reported fears about mental health services, negative reactions to mental illness from others, and fears about the social consequences of mental health service involvement. Participants felt that becoming a mental health patient (although the term service-user is in common usage, participants described the process as becoming a patient), had caused them to lose a previously credible identity, and to become someone whose voice no longer counts. One participant began the interview stating that he was going to 'tell the truth', in an attempt to ensure I would value his following narrative, whilst emphasising 'I wouldn't lie to you'. This in itself may highlight the perceived lack of 'credibility' this participant felt.

Some participant's views of themselves as a mental health patient included stereotypical behaviour, such as acting in a 'strange' way, where they attempted to distance themselves from their perceived stigmatising diagnostic label. One participant in particular made direct reference to his loss of identity when becoming a mental health patient:

"...when I was brought in...above the door is 'newid' ward, and I read it as 'new id', n-e-w-id... and it was like a flip, a flip from the mental illness I had before, to being well, and, and like umm, building myself up to who I was before I got mentally ill, before I got mentally ill..." [P2]

For most participants, the stigmatising effect of their mental illness began when they were sectioned, which was an experience that 'changed everything'. Participants

typically thought that others did not realise what being a mental health patient actually meant and expressed significant worry about being perceived as a 'danger':

> "...I think it's a bit of a stigma as well, it makes you feel like a dangerous, umm, a dangerous lunatic is not a nice way of putting it, but it makes me feel like a criminal which I'm not...I don't see myself as a criminal...it was difficult to be able to shake of the feeling of guilt about myself..." [P7]

The feelings of guilt expressed by this participant where also echoed by others. One participant discussed how he had made 'stupid mistakes' in his life, expressing despair at the fact his life had become 'all about mental illness'.

The main consequence of 'becoming a patient' appeared to be a loss of autonomy and feeling coerced. This could mean many things, but most important in this theme was how others now made decisions about their lives. Participants explained how staff would make decisions on their behalf, where the consequence of becoming a patient meant that individual views were not taken into account. Participants felt this was due to the way patients are seen by staff, believing that the label of being a 'mentally disordered offender' evoked both expectations amongst staff that patients would react in a deviant manner:

> "... people might think people in psychiatric hospitals don't care, oh they'll take a knife they'll go out and stab someone for no reason, but you don't, you are aware of the fact you're ill..." [P2]

Participants commonly acknowledged the diagnostic labels that had been given to them, but occasionally this was done reluctantly. It also appeared that diagnostic labels, in some instances, operated to usefully explain and excuse their conduct in the past that they now regretted. This was often referred to when patients discussed wanting to come off their section, in the attempt to regain what they considered a credible identity:

> "...I need to come off my section... I really want that as a finalisation of my past, just, you know, I had a mental illness once, once upon a time...and just move on from there, leave it all behind." [P1]

Despite acknowledging and accepting diagnostic labels, participants were also acutely aware of how such labels of mental illness served to discredit them, both inside and outside of institutional care.

> "...The stigma of mental health, that's got to change...the media are so so, umm sensational, in their, in...they want people to have a history of mental illness, you know when someone kills someone or something like that the first thing they say is oh they had a history of mental illness, and I mean that's got to stop, cos that's bad, and it makes us feel terrible you know." [P1]

Though participants regularly spoke about their diagnoses, they appeared less eager to divulge facts about the offences they had committed, possibly demonstrating the greater stigma of criminal deviance. Whether in reference to the stigma of mental illness or criminal deviance, for participants, this stigma operated within and outside of mental health services. All participants expressed experiencing being made to feel apart or different because of their mental illness, and appeared very much aware of a stigma that was coupled with being thought of as mentally ill. A few participants spoke about particular incidents where they felt they had been subject to discriminatory treatment in the community, where they perceived that their mental illness meant a devalued social status that served to greatly affect their capability to instigate and develop social contacts:

> "...I'm thinking about a job as well, but people wouldn't really want me, because of where I've come from and what I am, when they find out I'm a patient and what I've done they probably won't want me...that could be a problem I suppose." [P5]

As this participant highlights, while the FMHS these patients had been through had endeavored to help them develop skills, for example, by providing inpatients with vocational courses etc, participants found it difficult to gain employment as they considered their past history and current 37/41 status meant they would not be accepted by society. In addition to the stigma in relation to employment etc, participants also spoke about feeling vulnerable in society in general:

> "...sick people... a lot of a people they take advantage of things like that...see a weakness there and use that weakness there to play their own gain...I just let my guard down... I got taken advantage of, and umm...I umm...when I was beaten and burgled..." [P1]

Here, this participant discusses how letting other people know he was a mental health patient had significant repercussions, when his house was burgled during one of his hospital appointments.

Subtheme 2: 'I'm not like them'

Given the strength of the dominant discourse about people labelled as having mental health problems being stigmatised, participants frequently made attempts to distance themselves from other mental health patients, representing 'others' in terms of negative and undesirable characteristics.

> "...there are people who have done some really horrific things..." [P2]

These sorts of discussions seemed to allow participants to detach themselves from the 'bad' patients in order to portray themselves in a positive light. Other patients were commonly described as 'not good people' who had done 'terrible things'. It was common, for example, for participants to describe other patients on the wards as being a barrier to progression:

> "...you've got patients on this ward who aren't well... I mean how do you get better, you can't get back out if you're mixing with the wrong crowds." [P9]

This participant felt the patients on the ward were directly responsible for his lack of progress and recovery during his hospital stay, and he was not the only participant to note the fact that having people around you who were unwell meant it was uncomfortable and difficult to stay out of conflicts. The notion of 'mixing with the wrong crowds' also seemed to have a significant effect for other participants during their stay in hospital. As well as describing other inpatients in terms of symptoms, participants talked of their behaviours, where words used to describe the behaviour of

other inpatients included 'frightening' and 'disturbing'. One participant found other inpatients behaviour particularly threatening:

> "...There was a guy...went into detail about how he held her down and did it, and that's disturbing, you know, being on a ward with people like that which can be disturbing... but when people do that and then they brag about it, they go into detail about it, you know, it's disturbing, and then there's no remorse, it's like oh well so what, it's not important, but that's such a serious thing... it is quite frightening listening to that kind of thing, so that I found difficult..." [P2]

Participants' acceptance of becoming an inpatient was therefore particularly difficult for them to come to terms with. Throughout this theme there appeared attempts to remain a unique individual with strong statements made about other groups. Acceptance of being a mental health patient who had committed a criminal offence was usually discussed in terms of comparison of self with other patients, basing one's view of the self on others' behaviour. One participant stressed throughout the interview 'I'm not a bad guy', and others referred to a group of patients he was in hospital with as 'quite a crew'. In particular, participants discussed the uncertainly of their own identity following admission to hospital:

> "Umm, I felt like I was a criminal when I was there, because I was with lots of people who had done awful things, murders and rapists and all that sort of thing... I started questioning myself as to whether I was a criminal, I was evil or whether I was dangerous to the public." [P7]

Only one participant in the study valued his relationships with other patients, recalling their support and helpful guidance during his stay in hospital. However, for the majority of participants, other patients were generally seen as 'untrustworthy' sources of information who should be avoided, and individuals who made the hospital experience difficult in terms of barriers to recovery and threats to their own identity.

Theme 4: Autonomy

Subtheme 1: Recognition and Acceptance

Despite facing considerable challenges during the process of reintegrating back into the community, participants appeared to feel largely hopeful about the future and the ability to manage large levels of responsibility for their own mental illness. The major step for most participants appeared to be recognising that they have a mental illness which still has a significant impact on their daily functioning:

> "... I'm still recovering from that really... I am better, but I'm still recovering, I would class myself as still recovering... I wouldn't say I'm 100% normal, but maybe 90% normal." [P3]

In addition to acknowledging mental illness, participants also discussed an appreciation of medication, varying from broad comments that medication had been helpful, to descriptions of medication reducing certain symptoms and thus assisting progress. Participants reported generally that medication 'works'; one participant in particular made reference to the fact that one would be 'stupid' not to take it. For certain participants, their belief that they had a mental illness increased following the perception that medication had reduced symptoms. For some participants, making sense of such experiences and perceiving them as part of mental illness impacted upon their self-understanding:

> "... I realise there are certain things that I need to do, like taking my medication because I know I suffer from a mental illness, and that keeps my mental state stable. And obviously stopping taking my medication has caused me problems in the past, so yea, that's quite important, but I see that as something necessary." [P2]

The awareness of mental illness and the need for medication also went hand-in-hand with awareness that recovery was an ongoing process. With this process went adherence. Participants often expressed the value of adherence, and spoke about how they felt positive about doing 'what they tell me to do to get better'. One participant spoke about the importance of adherence with staff and regimes, and how he believed

severing ties with support from staff and services had not only been a mistake he had made, but one that others make too:

> "... I think the big mistake, that I made, and that a lot of boys make, is cutting off ties with the hospital...umm, because, navigating my way through, and umm, when you have that conditional discharge and you move on and then maybe supported accommodation...but when you get to your flat, it's a different world you know, instead of what you've been living for a long time..." [P2]

This participant appeared to be talking about the concept of responsibility, which was often described as a necessary component of progress. Whilst adopting increasing responsibilities was seen as important, it was also acknowledged that these can also function as a risk factor, in terms of taking a 'backwards step'. One participant spoke about how the adaptations to the hospital environment, with its restrictions of freedom, meant that he experienced uncertainties and anxieties when he was released into the community:

> "Well, it was like I got that space in the hospital when I'm there constantly, and now I've got space, and loads of time to do everything. So it was hard to know how to fill my time and get used to being out." [P4]

Adapting to the environmental changes from hospital to community accommodation appeared to be a continual process for participants, which occurred over time, and at points included unmet expectations and/or a continuing need for staff support. However, in general, as participants progressed through services they experienced 'increasing freedom' and 'peaceful environments'. Experiencing more control over daily routines was described to increase patient autonomy and wellbeing and facilitated further progress forward:

> "...I was having overnights...so it was giving me a taste of freedom then, and it was, and nourishment for my soul really, when I was able to be free again... it's great to be able to just go out, go on a bike, or catch a bus somewhere...it's the freedom..." [P3]

Over time, many of the participants appeared to have developed their understanding of past behaviours/offences and of emotions and management strategies. Participants

increasing self-understanding appeared to encourage greater self direction. Participants often provided descriptions of reaching a place where they wanted things to be different, and suggested various contributing factors, such as being symptom free and having something to aim for:

> "...I kind of see it like a process, you know, one thing at a time. You know my first thing is to get through university and finish my degree, then start thinking about what I want to do in the future... I'm trying to be positive..." [P2]

For a number of the participants, religious beliefs were also important to their self-understanding and sense of purpose, and played an important part in their recovery and rehabilitation, by providing a sense of support from a greater entity:

> "...Well I do believe that there's got to be something, because what's the point in living, like and dying and there's just nothing. I'd like to believe that there is something you know. I've got faith, but you know, a lot have things have happened in my life, so I'm a bit shook, so yea, I hope so! I do believe there's gotta be something." [P4]

Much like this participant, others also stated that they had started praying whilst in hospital, and their beliefs had provided them support and encouragement to carry on with life. One participant said he had had his prayers answered, and found spiritual comfort from God, which made him believe there was someone else looking after him other than staff and family.

Subtheme 2: My Journey

Throughout the interviews there was a significant emphasis of being on 'a journey' through both FMHS and life in general. As the participants discussed how they began to take assertive action, employing their power of choice in regard to their treatment for example, this appeared to influence the growth of self-direction.

> "I asked them like, what do I have to do to change to get out...and I went to a tribunal then, and I got it, I was pretty chuffed." [P5]

As patients discussed their life journey, there appeared to be a shift from feeling hopeless towards looking forward and developing a focus in life. There were a variety of elements which seemed to contribute to this changed outlook. These included overcoming the experience of having a mental illness and becoming a mental health patient, accepting their circumstances, peer and staff support, experiencing increased responsibilities and working towards/focusing upon something. Despite the fact some participants anticipated stigma, over time some participants were able to develop confidence, which often resulted from achieving qualifications or engaging in new activities:

> "...I feel like I've gown, I've changed I've developed, you know, some of the things, umm, I feel that there's a future now. It's not all doom and gloom, there's something to look forward to." [P2]

Some participants spoke about the progress they had made, which included time spent in FMHS. This heightened confidence, along with receiving positive regard from staff, were two factors which seemed to increase a participants' self worth:

> "I felt vindicated as well... I felt like it was an end result at the end of all of that you know, I felt like I was making progress. It didn't feel like they were saying off you go then, leave hospital you've done your time, it felt like I'd made progress, and it was progress, it was like a step forward, they felt and I felt like I was making progress, so I felt good about it..." [P2]

Participants also appeared to find a way to work with their past, rather than deny it, where personal histories were essentially rewritten or corrected for the sake of psychological continuity. For these participants, the past did not go away; rather it was reconstructed, and salvaged to serve as a marker for 'how far I've come'. It appeared that though these reinterpretations, participants were able to understand their past, whilst rationalising the decision to engage positively in their community:

> "Yea, I see it as a process, you know, no one's going to wave a magic wand and make all your troubles go away, yes I've got a bit of a past, I know that, and it's good to know..." [P2]

This participant was not alone in describing his life journey as a process. Many described how they 'had to get on' with certain things, acknowledging 'blips' along the way. This participant in particular felt he had to live each day with what it brings:

> "...Take each day as it comes, wake up, and if it's a good day good, but if it's bad it's bad. You never know what's around the corner; try to live each day as it unfolds." [P4]

The feelings of hope towards the future for the participants in this study was evident throughout the interviews, where hope - for the purpose of the interview - appeared to be in relation to an individual's overall perception and confidence that personal goals could be achieved. There was much discussion around wanting things to be better, and hoping for changes. In addition, participants often spoke about specific goals and plans for the future. These included learning to drive, volunteering, attending college, but generally encompassed the theme of 'moving on'. However, whilst discussing their current hopes and plans, it was evident for some participants that they still had worries and concerns that they anticipated could impact their rehabilitation, for example, one participant discussed how he had difficulties shopping in supermarkets and 'things like that'.

In general participants had an optimistic outlook regarding their future, some felt their lives were good already, and others considered that that they would and could only get better:

> "...you've got to be sensible about it, it doesn't happen overnight, but you can make progress and you can get through it. You know there is light at the end of the tunnel, it's not all doom and gloom, you've got to have a bit of a positive outlook..." [P2]

On a final note, many of the participants maintained a notably optimistic sense of control over their future, and strong internal beliefs in regard to their own self-worth. For some participants, making their own decisions in life regarding their care and direction were of utmost importance, for example, participants discussed wanting certain members of staff to care for them, and wanting to be in certain environments. This in particular, was in reference to certain supported community accommodation,

where participants voiced that they had wanted a chance to 'have a prolonged period of being well'. In addition to making their own decisions in life, many participants spoke about how they had taken control of their own lives, and helped themselves to recover:

> "...I've got to give myself a pat on the back, you know, I've gotten into...university and I've worked hard, umm so I don't see anything wrong with saying I've helped myself to remain successful, because at the end of the day, the staff can't do everything for me... some of it has to come from me. So I had to make the effort...and sometimes it's hard, and sometimes it means I've got to sacrifice things..." [P2]

Discussion

This study aimed to gather qualitative information of the experiences of adult MDOs under Section 37/41 of the MHA (1983) who have been conditionally discharged into the community from an inpatient mental health setting. This study employed a narrative life story interview technique (McAdams, 1993) to identify any common themes in MDOs journeys through the forensic mental health system (FMHS), which may be used to inform professionals working with MDOs of what impacts on a successful reintegration into the community following a conditional discharge. Results offer preliminary indications of influential factors at the individual level for the process of MDOs reintegration into the community. Thematic analysis (TA) generated four main themes, including the significance of initial negative experiences in secure settings, the importance of managing support networks, the importance of threats to identity and the significance of autonomy. Within these four main themes, sub-themes were also discovered. Similarities in participants' experiences were more outstanding than differences. An explanation of the importance of each theme, along with supporting research and the clinical implications of the findings follows.

In reference to the first theme, 'Initial Negative Experiences in Secure Settings', initial experiences and memories of being in prisons and FMHS and the care they received, had long-lasting effects on participants. This seemed to bear significant weight on their early recovery in such services. The attitudes participants held towards treatment and FMHS based on those initial experiences were determinants of subsequent treatment progress. Participants often expressed that they were unlikely, in the initial days of hospitalisation, to approach staff for help, particularly for emotional support. Such initial negative responses to hospitalisation are frequently the reactions that cause concern amid mental health professionals (Sayre, 2000). A study by Sayre (2000) examining the individual perceptions of psychotic inpatients suggested the respondents in their study perceived hospitalisation as a 'bewildering attack', which they dealt with by withdrawing from ward activities and openly defying the staff (p.78). As Hatfield and Lefley (1993) have noted, at least some of the behaviours seen in mental illness, such as withdrawal, are not symptoms of the illness itself but attempts to cope with the stressful situation in which individuals find themselves. Studies examining the ways in which patients use a variety of coping strategies to self-

regulate a psychotic experience have also highlighted a significant percentage of patients who do not accept a psychiatric diagnosis (DeSwann, 1990).

According to McLeod (2008), the medical model holds the position that an individual's explanation of their illness is simply a manifestation of their mental disorder. Such a clinical approach can be considered to strengthen the rejection of the individual reality and meaning of mental illness, hence patients often find that being in hospital neither helps them understand what has happened nor improves their capability to manage their lives more successfully (Hatfield & Lefley, 1993). This study contributes to awareness about initial attributions of mental illness and initial experiences of hospital by exploring this topic from the patients' viewpoint. An approach to understanding mental illness that turns the focus from labelling symptoms to the personal meaning of the illness experience presents potential for a more accurate understanding of clients (Healy, 1990). This approach requires a shift in thinking about the behaviour of mentally ill patients away from a focus on symptoms to consideration of the fact such behaviour may represent ways of coping with the stressful situation of having a mental illness. Results suggest mental health professionals should be aware that MDOs are often frightened and confused during hospitalisation, not only by the circumstances of being confined to a ward and the deprivations this brings, but also by the adverse nature of their mental illness. It is important that the initial experiences of prison and FMHS should be made less aversive and more helpful. To avoid long-term damage and lasting negative memories, it is important that on admission to services patients are treated with great care, for example, they should be given plenty of information about the services they are entering, and perhaps appointed a key-worker to acknowledge and assist with individual anxieties and build rapport to show that staff are approachable. Through the formation of an empathic connection that gives prominence to their subjective experience, patients may be assured that staff are on their side, potentially leading to the development of treatment plans that make sense to patients (Drake & Wallach, 1992). Most importantly, patients should also be offered the right type of treatment and management to reduce the likelihood of later readmission, as was noted by participants in this study.

The second theme revealed in this study, was that of the importance of 'Managing Support Networks', which appeared to be significant throughout an individual's journey through FMHS and in the community. The most commonly discussed support networks by participants were those of professional staff working with them. Specifically, the most significant interactions reported by participants were the day-to-day exchanges with staff, especially nurses. It is therefore in this milieu that staff can interact with patients in ways that show they are respected and valued, with the aim of building self-worth and hope. The study findings reveal the particular elements of patient-staff relationships that were considered helpful and that ought to be strived for when working in FMHS. These included transparency, equality, empowerment and trust. Results also highlighted the importance of clinicians being receptive to particular individual factors including a patient's current understanding about their mental health and degree of self-direction.

The therapeutic alliance is traditionally viewed as critical to prognosis (Stark, Lewandowski, & Buchkremer, 1992), and often considered as being accountable for most of the variance in treatment outcome research (Kanfer & Schefft, 1988). Positive relationships between MDOs and staff may impact favourably on criminal prognosis (Cooke, Ford, Thompson, Wharne, & Haines, 1994) however; detention and security are features of hospital services that present particular challenges for MDOs in developing a therapeutic alliance (McDougall, 1996). A recent study involving both male and female inpatients in three forensic services (low-, medium- and high-secure) offers results supporting the hypothesis that high levels of criticism and hostility are associated with negative clinical outcomes for patients with complex and enduring mental health problems (Moore, Yates, Mallindine, Ryan, Jackson, Chinnon, Kupiers & Hammond, 2002). Research by Tattan and Tarrier (2000), examining the relationships between patients and case managers, has also suggested that the absence of a positive relationship with staff is often associated with higher symptom and lower satisfaction ratings of patients. In summary, it appears that the development of a therapeutic alliance is of primary importance to the effectiveness of the rehabilitation of MDOs. Of course, therapeutic alliance is dependent on staff qualities and skills, such as those noted by participants in the study. Staff may help the patient develop an alliance through the formation of an empathic connection that gives prominence to the

subjective experiences of clients, which may help patients feel more assured that staff are 'on their side' (DiMatteo & DiNicola, 1982).

Family and friends were also important social networks that participants felt played a considerable part in their reintegration. It has been suggested that social networks can function either as potential providers of protection and support, or sources of stress (Wasylenki, James, Clark, Lewis, Goering, & Gillies, 1992). Where participants in this study had lost friendships due to their illness they often reported feeling lonely, or a sense of isolation. In these instances participants attempted to seek suitable replacements for lost attachments, where again staff played an important role. The results of this study are similar to those of Hall and Cheston (2002), who examined the use of a community drop-in centre for mental health patients. Most of the service-users interviewed in their research reported a reduction in social networks, and where social networks had been established these were often disrupted by periods of mental illness. Regarding future directions, the results of this study suggest that the social adjustment of conditionally discharged MDOs could be enhanced through two approaches. One approach may be to emphasise the building and maintenance of MDOs social support networks while they are still in FMHS by encouraging and enabling family and friends to correspond with and visit them. Where appropriate, the participation of family members in the planning of the conditional discharge process could also meet this objective. The second approach could involve developing community based, formal and informal support networks for conditionally discharged MDOs, which may provide encouragement, education, and assistance to family and friends to help them sustain support. The recovery approach to mental disorder (Repper & Perkins, 2003) supports the idea that family and other supporters are often crucial to recovery, and emphasises that they should be included in the recovery process wherever possible. As can be seen by the results of this study, participants did not recover in isolation.

The third theme identified in this study, 'Threats to Identity', captured the essence of what it meant for participants to be a 'mental health patient'. Participants in this study experienced stigma regarding their mental illness. Studies have shown that the mentally ill are one of the most stigmatised social groups (Kelly, Sautter, Tugrul & Weaver, 1990) and that they experience a significant loss of social status after

diagnosis (Cummings & Cummings, 1995). Jackson, Tudway, Giles and Smith (2009) explored the social identity of mental health inpatient service users, reporting similar findings to this study, namely that participants in their research also talked of a lack of understanding of mental health problems in society, believing physical health problems were taken more seriously.

It has been suggested that the experience of having a mental illness and subsequent hospitalisation triggers internalised harmful expectations that wear away self-confidence (Link, 1987). As Hooks and Levin (1986) note, some behaviour attributed to mental illness may be better understood from a social identity perspective, which emphasises the important effects that group membership can have on behaviour (Tajfel & Turner, 1979). An important aspect of self-definition is identification of oneself with other people who share common attributes (Ethier & Deaux, 1994). Participants in this study were not only acutely aware of the stigma attached to mental illness, but made notable attempts to distance themselves from the perceived negative aspects of mental health patients, thus positioning themselves away from such a social identity. The participants in this study commonly presented as being unwilling to identify with other service-users who displayed more acute experiences of mental illness than themselves, particularly if this behaviour bore a relation to the stereotypes imposed by society. This, along with the fact participants also reported feeling threatened and scared by other patients, suggests stigma and fear about mental illness exists in people with mental illness as in people without.

When considering the social identity of MDOs, both the negative stereotyping and the exclusion from valued social roles can have major implications. Identity – a sense of who one is – is essential for numerous reasons, the most significant of which is that it motivates and gives a direction for behaviour (Paternoster & Bushway, 2009). A person's actions can be seen as expressions of their self-identity, where people behave intentionally in ways that are consistent with who they think they are. Given that the self is reflexive and interpretive, this means that the same self that guides action is capable of change. As such, this study proposes that issues of self-concept and social identity must be considered in terms of the psychological needs of MDOs. By considering stigma as a significant issue in its own right, encouraging MDOs to separate their opinions of mental health patients from their own self-concept,

clinicians may help MDOs adapt to lives that may be adapted but not dominated by their illness. Findings also suggest that the stigma of mental illness should be tackled in society. Recent evidence suggests that this is presently underway, as Parliament are currently considering a Bill intended to reduce the stigma and negative perceptions associated with mental illness (Mental Health [Discrimination] [No.2] Bill [HC Bill 11]). The Bill, if passed, would repeal legislative provisions that can prevent people with mental health conditions from serving as Members of Parliament, members of devolved legislatures, jurors, or company directors.

The fourth and final theme identified in this study was 'Autonomy'. Within this theme, participants spoke about their journey through FMHS which was coupled with a recognition and acceptance that they had a mental illness, and subsequently required ongoing support for this. This theme highlighted that MDOs can suggest or set goals for responsible behaviour themselves, but this is only one step in a longer process, which must be strengthened through institutional and structural supports. It appeared in this study that some form of external, third-party affirmation or 'certification' was necessary for participants to maintain the difficult process of reintegration. Participants were aware of what was possible or not possible for them to achieve, moving towards their individual goals with the support of their social network. With this in mind, results suggest that participants' behaviour was not solely driven by agency, but influenced by social and cultural environment within which their reintegration took place.

Results suggest it is important to acknowledge an individual's beliefs about personal change and what is accomplishable; as such beliefs may also influence the likelihood of individual MDOs identifying need for treatment and subsequent engagement. In addition to beliefs about change, setting specific and realistic goals and identifying ways of attaining such goals also appeared significant in the rehabilitation process of participants. The literature on the working alliance emphasises agreement on goals and the existence of a bond of mutual respect and trust (Orlinsky, Grawe, & Parks, 1994). With this in mind, the rehabilitation process of MDOs should occur within a collaborative relationship that respects, seeks to discover and works with patients' experiences, perceptions and goals. Here strength-based approaches would be helpful, allowing the individual the right to set their own goals, draw their own conclusions

and make their own choices. In terms of clinical implications, it is therefore important that clinicians help MDOs set goals, whilst creating a therapeutic climate conducive to generating hopefulness in the patients regarding their prospects of effectively achieving these goals (Marshall, 1989).

In line with findings that *"hope is the catalyst"* of recovery processes (Anderson, Oades & Caputi, 2008, p.589), participants reported a shift from feeling hopeless towards feeling hopeful. Having something to aim for was central to this shift, which indicates that 'hope' for these participants comprised of a goal, a foreseeable pathway to the goal, and self-belief that the goal was accomplishable. Additionally, participants with the right 'subjective mindset' were competent in taking advantage of the 'good events' in life, and tended not to be discouraged by social disappointments, which may be a necessary condition for success after release from hospital. It has been suggested that the enhancement of hope is an important underlying factor that produces treatment gains (Frank, 1989). In order for MDOs to succeed in their goals and thereby successfully reintegrate, it is therefore necessary to enhance their sense of hope. Enhancing hope should not only involve the provision of the skills, beliefs, attitudes and values necessary to achieving their goals, but should also help identify the potential obstacles to their goals, so, when they arise, they will not seem so insurmountable.

Limitations

One limitation of this study is that the sample was small and hence may not be truly representative of a forensic population. Nonetheless, the cohort size of nine participants is a high proportion of the small population known to the CFMHT at the time of recruitment (9/32 – 28%). In terms of generalisability of findings, despite the relatively small sample size, the sample is considered to be representative of the community forensic population studied for the purpose of this research. In addition, small samples are advantageous in qualitative research. Wolcott (1994) asserts that a large sample size in qualitative research does not enhance the research, and indeed can do harm as it might prevent the depth and richness that working with smaller samples can allow.

The methodology used in this study is affected by the usual limitations of qualitative research. That is, the use of the interview method itself, and some of the limitations of the qualitative analysis method selected. Firstly, the views expressed by participants throughout the interviews illustrate rather than represent possible positions; however, Burgess (1966) maintains it is not the absolute truth about an event that concerns us, but the way in which individuals respond to that event. Firth and Gleeson (2012) propose that the interview method of data collection can be an intensive and intrusive experience for participants. In addition, in this study the social identity of the participants in may have been influenced by the research process itself. This includes the impact of the participant information sheet inviting people to take part in the study, the signing of consent forms, and the influence of the interviewer during the interview process. In this respect, the interview itself signified something about who they are. In addition, interviews are inevitably hampered by social desirability bias; it is possible that participants were hesitant to share some experiences and risk-related information due to fears of repercussions. Research interviews can also mirror therapeutic encounters because both provide space for people to talk about their experiences with someone who wants to listen, and require similar skills of listening and attending to participants responses (Tee & Lathlean, 2004). Participants in this study might have been intimidated by the interview situation, or reminded of therapeutic relationships, where they may have consequently adjusted their communication with the expectation of receiving knowledge, help and advice. Nevertheless, these issues did not appear to cause any problems for participants, as most participants were happy to talk at length, which may, among other factors, be due to the fact that participants were aware that confidentiality was protected.

Attention should also be paid to the interview schedule itself, which asked participants to think about their life as if it were a book, but then went on to ask questions that could have been answered within each chapter separately. As Young (1987) argues, one life event causes another, and it is that causality that is more essential than the chronological telling of the story. With this in mind the structure of the interview may have also influenced the final 'product', in that the order of a life story's event moves in a linear way through time, where a disruption of that order may modify the original semantic meaning of the story. Nevertheless, narratives told in an interview settings

have been suggested to be evidently more complete than those related elsewhere (Presser, 2004).

In terms of the TA of the data, whilst the method was chosen for its key features, it is not without some disadvantages. The flexibility of the method can also be a disadvantage, in that it makes developing explicit procedures for higher-phase analysis difficult, and can be difficult for the researcher when trying to decide which aspects of their data to focus on. Unlike many other qualitative methods, studies utilising TA tend not to reflect on the impact of the researcher's preconceived ideas, and presence on the data that emerge (Joffe, 2012). While this may be seen as problematic, the emphasis on being systematic and transparent regarding the analysis allows other researchers to trace the process whereby the results were reached, and if necessary, challenge them.

Implications for practice

Each of the barriers and facilitative factors for successful reintegration into the community elucidated within the current study has potential clinical implications for work with adult male MDOs. For example, during initial hospitalisation it is essential that staff working in FMHS settings are aware of the difficulties and stressors faced by MDOs and endeavour to form an empathic connection placing emphasis on the subjective experience of patients. In addition to this understanding, it appears essential that the development of a working therapeutic alliance is of primary importance to the effectiveness of the rehabilitation of MDOs, along with a collaborative relationship that respects and seeks to discover and work with the client's experience, expertise, perceptions and goals. The importance of family and social relationships also indicates that family-inclusive approaches might be fruitful at all stages of FMHS delivery. In terms of treatment, if, as this study suggests, MDOs partially shape their lives according to their values, then the emphasis on what is important to MDOs, in concurrence with the exploration for socially acceptable ways of realising these values, may well help this group reintegrate successfully in the community. Study findings support the use of strength-based approaches such as the Good Lives Model (Ward, 2002) which promote individual well-being. Such approaches should drive the rehabilitation work which aims to enable MDOs to meet needs via pro-social methods,

whilst accounting for individual skills, personality, social supports and goals (Ward & Marshall, 2007).

The narrative interview process itself may also be considered in terms of treatment implications, as the utility of life stories and personal narratives are increasingly being used in a wide range of disciplines and settings (Atkinson, 1998). Whether it is for research purposes on a particular topic or question, or to learn more about human lives and society in general, life stories serve as excellent means for understanding how people see their own experiences, their own lives and their interactions with others. For example, as seen in treatment programmes based on cognitive models, facilitators monitor and edit ex-offenders' stories, urging speakers to adopt certain discourses about why they offended and how they might avoid re-offending (Waldram, 2007). In short, for ex-offenders, telling ones story promises a new start even as it invites a new sort of surveillance. Narrative story telling in this sense can be considered as a vehicle for self-understanding and as such, an instigator to action. Narrative stories may possibly steer action quite literally, as Sternberg (2003; p.314) writes: 'People often create self-fulfilling prophecies as they try to make their stories come true'. A related point is that understanding the significance of helping offenders to successfully reintegrate into the community involves listening very carefully to what is of real importance to them.

Future Research

Research in this area could usefully proceed in multiple ways. The current findings provide an insight into the experiences of Section 37/41 (MHA, 1983) conditionally discharged adult male MDOs recruited from one CFMHT in South Wales. Before findings can be reliably applied to adult male MDOs in general, it will be important for future studies posing the same research questions to be conducted in different service settings and with diverse samples. Future research could investigate the experiences of sub-groups of MDOs for example, female offenders and those who have committed particular offences types (for example, sex offenders), who may be subject to increased exclusion and stigma in ways that influences their experiences of FMHS and their journey towards reintegration. Despite the fact this study was able to identify some factors that impede the progress of MDOs, the focus was upon

individuals who have successfully reintegrated into their community, indicating the patients who are 'stuck' at earlier points in the FMHS require further exploration.

In terms of the interview itself, it would be interesting for future research to involve using interviewers from different backgrounds in the data collection phase, possibly even service-users themselves. Traditionally, service-users have been the subjects of research carried out by others and have not had any part to play in the research process, far less an equal part. However, greater sincerity, openness, transparency and inclusion of service-users in the production of forensic mental health research might well help MDOs feel more positive about taking part in research. Future research might also involve implementing some of the aforementioned recommendations for improving the rehabilitation process, and evaluating the outcomes. For example, given that the findings signify the value of family relationships in the journey through forensic services, future research could also include family-member experiences.

Conclusion:

FMHS have been slow in comparison to other psychiatric specialities in terms of meeting the needs of their patients within the community (Alcock & White, 2009). It is hoped that the current study will begin to address the lack of research in this area, whilst stimulating further interest in the rehabilitation and reintegration of Section 37/41 (MHA, 1983) adult male MDOs. It is essential to note that the barriers and difficulties faced by MDOs can foster understanding of the factors that influence adherence and engagement in community treatments and subsequent successful integration. The themes elicited throughout the interview and analysis process should be considered as important when considering the difficult journey MDOs make through FMHS, and may even be considered to serve as organising processes which help to galvanise changes.

Chapter 3: Case Study

An Evaluation of a Cognitive-Behavioural Treatment Approach with a Male Offender Suffering Anxiety and Depression: A Case Study

Abstract

This case study considers the effectiveness of a prison-based intervention with a 31 year old male offender suffering anxiety and depression, serving a 72 month sentence for robbery, violence and criminal damage. Initial assessment demonstrated the client presented with symptoms suggestive of subjective anxiety and depression in relation to his ability to successfully reintegrate into the community post-release from prison and maintain employment so he would not return to his 'cycle' of offending. Additionally, he displayed features suggestive of difficulties with the expression of anger and interpersonal problem solving skills. Formulation revealed the client would benefit from an intervention based on cognitive-behavioural principles to address his thinking and behaviour associated with offending. An intervention was designed to address interpersonal problem solving, cognitive style, social perspective taking and critical reasoning. Following the intervention, the client completed a battery of post-intervention assessment. Results from post-intervention assessments suggested the clients self-reported levels of anxiety and depression had decreased to a minimal level, and he displayed a clear and appropriate understanding of his offending behaviour and the consequences of further involvement with crime. It would appear the intervention addressed some of the client's immediate needs, at least in the short-term, however long-term treatment success is not possible to establish at this stage. The outcome of this case study is discussed in relation to the intervention setting, client characteristics and assessment issues. Future directions are considered with regards to working with offenders in prison settings.

Introduction

Client Introduction:

For the purpose of this case study and to protect the individual's anonymity, the client will be referred to as Mr N. Mr N is a 31 year old male who received a 72 month custodial sentence for robbery, violence and criminal damage. He served half of this sentence before being released, however he was recalled to prison for not meeting his licence requirements and was serving the remainder of his sentence during the intervention period. Mr N had previously served numerous prison sentences for offences of a similar nature, including theft, drug offences and handling of stolen goods. He presented with symptoms suggestive of subjective anxiety and depression, and problems with appropriate anger expression. These issues appeared to bear a direct influence on his offending behaviour and anticipation of future re-offending. The client appeared to lack the required interpersonal skills in order to successfully abstain from future offending. His criminal offence that had brought him into prison was robbery, violence and criminal damage, where he had attempted to gain money and material possessions to fund his lifestyle. He had no psychiatric history, and no previous contact with psychology services, however he had previously been prescribed and was currently taking anti-depressant medication.

Context & The Referral Procedure:

The client was serving a sentence at HMP Cardiff and was referred to the inreach team by a prison officer following Mr N's complaints of anxiety and stress. This referral was discussed in an inreach mental health team meeting, where he was referred for assessment. At the time, the trainee was on placement in the inreach team and was assigned as the individual who would assess Mr N following his referral. Following assessment, Mr N was considered an appropriate inreach referral, and the subsequent intervention was approved by the inreach team.

The Prison Population

The prison population in England and Wales grew by 66% between 1995 and 2009 (Ministry of Justice, 2009), with almost all of this increase taking place within the areas of those sentenced to immediate custody (78% of the increase) and those recalled for breaking conditions of their release (16% of the increase). In June 2012, statistics showed the current UK prison population in England and Wales had reached 86,048 (Ministry of Justice, 2012). In terms of the characteristics of the prison population, recent statistics revealed 43% of prisoners had a family member who had also been convicted of a criminal offence (Berman, 2012). Statistics also revealed 81% were unmarried prior to imprisonment and 25% were young fathers. Around 50% of sentenced male prisoners were excluded from school, and had no qualifications, with only two-thirds having numeracy skills at or below the level expected of an eleven year old, 50% having a reading ability and 82% with writing ability at or below this level. The same report revealed prisoners were more likely than other sectors of the community to be abusers of alcohol and illegal drugs, and two-thirds were unemployed in the four weeks before imprisonment. In addition to these findings, were statistics revealing around 70% of prisoners were said to be suffering from two or more mental disorders (Berman, 2012). Whilst many of these disorders may be present prior to prison admission, they may be further exacerbated by the stress of imprisonment. The stress of imprisonment may be caused by multiple factors, such as lack of privacy, overcrowding, isolation from social networks, violence, and uncertainty about future prospects. Whatever the case, this is important to highlight, as the increased risk of suicide in prisons - often related to depression – can be a manifestation of the cumulative effects of these factors (Paton & Borrill, 2004).

Given the characteristics of the offending population in prisons, and the problems they face before, during and after imprisonment on release into the community, there exists now, more than ever, a need to understand not only why people offend, but how this can be prevented. In the first instance, relevant theories of offending behaviour are

able to offer explanations of the occurrence of offending, allowing for successful treatment to be based upon their frameworks.

Theories of Offending Behaviour:

Behavioural, cognitive and social learning theories came to be applied by criminologists during the 1980's as explanations for both the onset and maintenance of offending behaviour (McGuire, 2006). Behavioural theory, derived from the work of psychologists including Skinner, Pavlov and Watson emphasises how offending behaviour is influenced or shaped by external factors, specifically the person's environment. Behaviourism stresses the role of external, environmental factors in shaping offending behaviour; it attempts to explain behaviour in its social context, suggesting we learn to behave in particular ways via reinforcement – namely receiving rewards and disincentives. Cognitive theory derives from the work of another group of psychologists, among them Beck (1976), and emphasises the way our behaviour is influenced by our thoughts or thinking patterns, which are also known as cognitive processes. Cognitive theory sees offending behaviour as more than the product of environmental or external forces, and points to the ways in which behaviour is mediated by internal processes: beliefs, interpretations, thoughts, judgements and so on.

Social learning theory is a variant of behavioural theory which represents a bridge between ideas from the behavioural and cognitive traditions (McGuire, 2006). Research by Bandura (1974) showed that learning could take place in the absence of direct experience of rewards and punishments. His idea of observational learning (from family, peer and symbolic models) saw a departure from traditional behaviour theory, in that it implied a reliance on internal cognitive mechanisms. Researchers have also applied social learning theory to explain the intergenerational transmission of family aggression (Cappell & Heiner, 1990) and the patterning of violence among children observing violence in their families (Kalmuss, 1984), with research in this area confirming the importance of family factors as predicting offending behaviour. In reference to the intergenerational transmission of offending behaviour, there exist multiple explanations for why offending tends to be transmitted from one generation to the next, for example, there may be intergenerational continuities in exposure to

multiple risk factors (e.g. poverty), where the intergenerational transmission of offending is part of a larger cycle of deprivation and antisocial behaviour (West & Farrington, 1977). Farrington, Coid, Harnett, Joliffe, Soteriou, Turner and West (2006) also suggest having a convicted parent or sibling predicts an individual's own convictions, with each family member being independently important as predictors of future offending. It has also been observed that parental modelling and favourable attitudes to substance misuse are also interlinked, leading to greater likelihood of drug abuse in the subsequent adult, which might be reflected within the wider span of modelled pro-criminal behaviour (Hawkins & Catalano 1992). To summarise, a family history and parental attitudes which exhibit and condone anti-social and criminal behaviour appear to be risk factors in their own right, quite apart from parental skills and responses (Rutter, Giller & Hagell, 1998).

When discussing parental skills and resources, it is imperative to highlight how offending behaviour patterns are communicated from one generation to another, which can be discussed in reference to both social learning theory and attachment theory (Bowlby, 1969). Social learning theory (Bandura, 1979) posits that through the process of witnessing and experiencing violence, individuals behave in a violent manner akin to their parents through modelling, imitation, and reinforcement, which, in turn, creates susceptibility to engaging in violent behaviour (Corvo, 2006) via parental punishments and reinforcement and the models of behaviour that parents represent (Patterson, 1995). For example, children will tend to become delinquent if parents do not respond consistently to their antisocial behaviour and if parents behave in an antisocial manner. Attachment theory inspired by the work of Bowlby (1969), stipulates that insecure attachment styles in infancy set out expectations for all future close relationships, suggesting children who are not emotionally attached to warm, loving and law abiding parents will tend to become delinquent (Carlson & Stroufe, 1995). The mechanism through which this occurs is what Bowlby (1969) terms 'internal working models' – which are internal templates for relationships which develop as a consequence of earlier patterns of interactions between parents and their children. In summary, when considering family factors, bonding and warmth of social relationships with parents or carers have been identified as crucial protective factors for offending behaviour (Farrington 2002).

A cognitive model of offender rehabilitation was proposed by Ross and Fabiano in 1985, which was a variant of social learning theory and had a particular focus on what they termed 'cognitive skills'. In short, it was hypothesised that many offenders have cognitive deficits (rigid thinking styles, impulsive, unable to consider consequences of action). This model seemed to suggest that targeting these deficits, and building offenders cognitive skills could be a fruitful strategy for reducing their propensity to offend. And thus, the first of many programmes designed to specifically tackle offender behaviour was born – the Reasoning and Rehabilitation Programme (Ross, Fabiano & Ewles, 1988). Anyone who implements a programme or intervention with the aim of preventing a specific behaviour should assume, that the programme or intervention addresses some of the factors that cause the behaviour in question (Wikström, 2007). With this in mind, it is important to acknowledge that the previously discussed theories of offending behaviour underpin some of the more commonly used treatment programmes in the prison service.

Treatment in Prison:

There have been many developments over the years in the efforts to treat prisoners so they leave prison with a chance of being rehabilitated into a wider society and less likely to offend (Robinson & Crow, 2009). Such efforts include the development of treatment programmes intended to address particular issues and specific offenders in an area with what may be termed social rehabilitation, including training, social skills programmes and education, designed to prepare offenders for when they are released. The HM Prison Psychology Service functions to provide assessment and treatment of offending behaviour, and has established several offending behaviour programmes to cover areas such as sexual deviancy, anger management, poor social skills, drug and alcohol addiction and anger management (Towl, 2003). The development and use of such programmes suggests that much therapeutic activity can and does take place in prisons. Prison has now become less of a treatment in itself, and more of a place where treatment can occur, where, for those whose offences warrant imprisonment, prison may present an opportunity to re-assess and re-build their lives.

Research has suggested that in terms of specific treatment programmes available in prisons, the more successful offending behaviour programmes are those that focus on

cognitive skills training featuring a cognitive-behavioural approach (McGuire, 1996). In general, cognitive behavioural treatment involves structured learning experiences designed to change distorted or dysfunctional cognitive processes by teaching new cognitive skills. Arguably, such programmes are successful as they work to correct a number of cognitive deficits exhibited by offenders, including: self-control, cognitive style, interpersonal problem solving, social perspective taking, and moral and critical reasoning (Mahoney and Arnkoff, 1978). Cullen and Gendreau (2002) suggest all effective cognitive-behavioural programmes should attempt to assist offenders define problems that lead to offending behaviour, select goals, and generate and implement new prosocial solutions.

Cognitive-Behavioural Programmes

The two most widely adopted cognitive-behavioural programmes by the prison service are the Reasoning and Rehabilitation Programme (R&R: Ross et al, 1988) and the Enhanced Thinking Skills (ETS; Clark, 2000) programme. In 1992, the R&R was introduced to the prison system, and a modified version of the programme (Thinking Skills) was launched the following year. This modified version too underwent some modification, which became the ETS programme – a short group-based general offending behaviour programme. The ETS programme is one of the most widely delivered cognitive skills courses by HM Prison Service. It addresses thinking and behaviour associated with offending, focusing on six key areas: social perspective-taking; interpersonal problem solving; cognitive style; critical reasoning; self-control and moral values. The ETS programme follows the cognitive-behavioural approach, and is based on the principle that cognitive skills deficits are important factors in explaining offending behaviour, and such skills can be taught (Clarke, 2000). The ETS programme aims to boost offenders' cognitive skills through a sequenced series of structured exercises, whilst enhancing an offenders' ability to accomplish meaningful goals, ultimately aiming to reduce recidivism. To date, evaluation of the ETS programme has been predominantly based on adult male offenders within probation and prison services (Blud, Travers, Nugent, & Thornton, 2003). However, a recent study by Tapp, Fellowes, Wallis, Blud and Moore (2009) provided an evaluation of the ETS programme with mentally disordered offenders (MDOs). Their finding suggested that individuals who completed ETS were significantly more likely

than non-completers to endorse changes in thinking styles. The study demonstrated the significant impact of the course for MDOs with regards enhancement of their social problem solving skills and change in aspects of their thinking style. Additionally, there was a decline in the endorsement of aggressive solutions to social problems.

Summary

Literature suggests the more successful offending behaviour programmes are those that focus on cognitive skills training featuring a cognitive-behavioural approach (McGuire, 1996). Over the last decade however, developments have occurred in relation to programme approach, design and content, in terms of tailoring programmes to the needs of specific offenders. The 'responsivity' principle indicates interventions ought to be matched to, or take account of, the individual learning styles or abilities of offenders (Andrews, Bonta & Hodge, 1990). With this in mind, this case study aims to design and deliver an individualised cognitive-behavioural intervention, incorporating specific elements of the ETS programme in an endeavour to adhere to the principle of "responsivity". This individualised intervention programme was delivered to a convicted adult male offender serving a sentence in HM prison service, and was chosen in order to improve his interpersonal problem-solving skills.

Assessment

During the initial stages of assessment general information was gathered from two main sources:

1. Archival File Sources: an in-depth file search was carried out of all available documents available to the prison healthcare files.
2. Interview with the Client: This history taking interview was carried out before the intervention began. During this interview Mr N was able to provide informed consent for his participation in the case study (Appendix 20).

For the purpose of the case study, the interview content, along with gathered file information has been summarised below.

1. General Information

1.1 Client details

The Client Mr N is a 31 year old male who received a 72 month custodial sentence for robbery, violence and criminal damage. He served half of this sentence before being released, however he was recalled to prison for failing to meet his licence requirements and was serving the remainder of his sentence during the intervention period.

1.2 Family history

Mr N was born in Cardiff with his mother and father, and has three siblings. Mr N reports a good relationship with his sister and older brother, but not with his younger brother – who was also serving a prison sentence at the time of assessment (co-defendant in Mr N's index offence). At the age of 13 Mr N was placed in a children's home due to behaviour that his parents found unmanageable. It was this move that saw him introduced to substances, when he discovered that some of the other boys in the home, including his best friend at the time, were using them. Between the ages of 13 and 17 Mr N was moved between children's homes due to his behaviour and involvement with criminal activities. At the age of 17 Mr N received his first custodial sentence and has been in and out of prison since. In between prison sentences Mr N has lived with his mother.

Mr N's father was, as he described a 'prolific offender'. Mr N was brought up to believe that offending was an acceptable way of life, and looked up to his father as a role model. However, his mother had a differing opinion, which caused frequent problems in their family. As a result of the difference in opinions Mr N's mother and father were often fighting, and Mr N witnessed considerable domestic violence in the home. Their relationship ended when Mr N was aged 15, where his father left his mother for another woman. This put increasing pressure on family relationships, and his mother eventually moved to Spain to live. Mr N reports having a volatile relationship with his mother during his early years, but states this has now improved. Mr N was serving a prison sentence in 2006 when his father died, he found this experience difficult to cope with and sought bereavement counselling at the time.

1.3 Relationship history

Mr N reports having been in several short-term relationships with females, but these have never lasted more than a few months. He has never been married and has no children.

1.4 Educational and employment history

At the age of 12, Mr N started truanting from school, and was eventually expelled aged 13 for causing behavioural problems, leaving with no qualifications. In terms of employment, Mr N has had various temporary jobs, but has not managed to secure permanent employment for longer than 6 months. He believes this is because he does not take direction well, which causes problems in the workplace.

1.5 Psychological and social development:

Mr N reports problems in terms of his social development, where he does not feel comfortable in social situations where there are large groups of people. He describes negative thoughts about himself, and presents with relatively low self-esteem.

1.6 Medical and psychiatric history

Mr N describes intermittent periods of low mood and depression from the age of 15. He has previously been prescribed antidepressant medication, and was taking them during his current sentence. He also reports symptoms of anxiety and depression, and has previously had suicidal thoughts. Mr N reported previous visual hallucinations,

but believes this was down to substance use. Mr N states there is a history of mental illness in his family on his father's side; he believes his grandmother has a mental illness, and his uncle was suffering from mental health problems before he hanged himself.

1.7 Forensic history

Mr N has a forensic history dating back to when he was 15. Mr N himself had lost count of the number of prison sentences he had received, but did report he has been in and out of prison since the age of 17, serving numerous sentences of varying lengths. There have been no offences against the person, with previous convictions including similar offences of theft, criminal damage and robbery, as well as multiple acquisitive offences. However the most recent offence (index offence warranting prison sentence) appeared to have escalated in terms of violent behaviour. Details of the index offence include: Mr N, along with two co-defendants (one of which was his younger brother, and one other male of the same age), targeted a local restaurant twenty minutes after last orders, when a member of staff was still present and was counting the day's takings in the office. The offence was planned by Mr N and his co-defendants. Upon entering the restaurant, Mr N along with his two co-defendants, verbally threatened the member of staff to hand over approximately six thousand pounds in cash. The member of staff did not sustain any injuries, and there were no reports of any weapons being used. Mr N, along with his co-defendants then left the premises with the money, after causing significant damage to the property. Mr N was arrested later that month, after being found by the police in a stolen vehicle, he was subsequently charged with robbery, violence and criminal damage and sentenced to 72 months in custody. As previously mentioned, Mr N served half of this sentence before being released, however he was recalled to prison for failing to meet his licence requirements (not home within his curfew) and was serving the remainder of his sentence during the intervention period.

1.8 Substance Misuse

Mr N began smoking cannabis and drinking alcohol between the ages of 10 and 13. He said this is because *"it was there, everyone else was doing it, my dad used to smoke and sell it and I really wanted to be like him"*. He states he has also taken various prescription drugs such as Tamazepam, Valium and Nitrazapam. He also

reports having tried and used ecstasy and smoking crack cocaine for short periods of time. At the time of assessment, Mr N stated he had "*had enough*" of illegal substances and was "*keen to change*".

2. Psychometric Assessment:

In addition to the general information gathered from the file review and interview, Mr N was asked to complete one self-report psychometric assessment, three psychometric self-report measures and one self-report questionnaire. This was in order to guide formulation and provide pre- and post-measures to assess the intervention effectiveness. The aim of assessment was to highlight the areas that required immediate intervention so that goals could be set. The questionnaires and measures used suffer from the same problems as other self-report inventories, in that scores can be easily exaggerated or minimised by the person completing them and are highly desirable to impression management (Bloom, Fischer & Orme, 1995). These factors have been considered when interpreting results, and will be discussed later.

2.1 The Millon Clinical Multiaxial Inventory III (MCMI-III):

The Millon Clinical Multiaxial Inventory–III (MCMI- III; Millon, Millon, Davis & Grossman, 2006) is a 175-item True / False self- report measure of 10 clinical syndromes and 14 personality patterns for use with adults over the age of 18. It is one of the most commonly used assessment instruments for the assessment of personality disorders and major clinical syndromes.

Results: During the assessment stage, Mr N was asked to complete a MCMI-III. In terms of personality patterns, Mr N's profile was suggestive of an individual with clinically present (BR 75-84) Avoidant, Depressive, and Antisocial personality traits. Scores on the clinical syndromes were suggestive of an individual with the presence (BR 75-84) of Anxiety features. The MCMI-III profile of Mr N suggests an individual who wants to be involved and accepted by others but perceives themselves as socially inept and inadequate. He may be prone to feeling worthless, self-critical, discouraged, hopeless and immobile in solving life's problems. In relationships, he may be angry, pessimistic and resentful. In interpersonal relationships, he may be mistrustful, suspicious and guarded with others, but at other times may be gracious, charming and

friendly. Mr N may also show frequent impulsive acting out behaviour, ignoring the consequences. His levels of anxiety may also suggest an anxious, tense and apprehensive individual who is physiologically over-aroused.

The following questionnaires and psychometric measures were also used to aid formulation, but in addition, were completed with the intention of repeating these measures at a later date in order to evaluate the intervention's effectiveness. These measures were chosen as a focus for assessment at the time of referral given Mr N's presentation and self-reported difficulties.

2.2 The Anger Disorder Scale:

The Anger Disorder Scale (ADS: DiGiuseppe & Tafrate, 2002) is a 74-item inventory assessing five specific domains of emotional experiences; arousal, provocations, cognitions, motives, and behavioural expressions. This scale has shown good internal consistency and test-retest reliability and good convergent validity has been established through correlations with the Speilberger (1988) State Trait Anger Expression Inventory (STAXI) and the Buss and Perry (1992) Aggression Questionnaire (AQ).

Results: During the assessment stage Mr N was asked to complete an ADS. When reporting the results of the assessment only the scores that appeared in the moderate range (between the 90th and 94th percentiles) will be reported. When interpreting the ADS for Mr N, it appeared that he scored in the moderate range on the M (Brooding) scale; P (Relational Aggression) scale; Q (Passive Aggression) scale; B (Hurt/Social Rejection) scale; and I (Impulsivity) Scale. Results of the scaled scores on these scales are presented in Table 9. Mr N's score on the M scale suggests he does not express his anger outwardly, but rather holds anger in, which may account for his alternating periods of depression, suggesting the potential need for assertiveness training. His high score on the P scale suggests Mr N is likely to isolate those at whom he is angry with and speak negatively about them, where again assertiveness training may be of benefit. His scores on the Q scale may suggest Mr N has poor conflict resolution skills, where an intervention involving consequential thinking may help him recognise the long-term negative consequences of his interpersonal behaviour. His elevated scores on the B scale suggest Mr N may be sensitive to criticism and have many

interpersonal problems. Here, cognitive restructuring to develop different interpretations of negative or neutral responses by others may be a useful approach. Finally, Mr N's scores on the I scale reflect a concern about losing control when angry. Here, interventions building on impulse control skills may be of benefit.

Table 9: Pre-Intervention ADS Scores

Scale	Scaled Score
M (Brooding)	19
P (Relational Aggression)	5
Q (Passive Aggression)	16
B (Hurt/Social Rejection)	20
I (Impulsivity)	6

2.3 The CRIME-PICS-II

The CRIME-PICS II (Frude, Honess & Maguire, 1994) is a widely used, fully validated questionnaire for detecting and examining changes in offenders' attitudes to offending. The Welsh and English probation and prison services have adopted the tool for several years, where it has proved successful in evaluating the effectiveness of a wide variety of offender programmes (Frude et al, 1994). The CRIME-PICS II elicits information about criminal beliefs and attitudes about personal and social difficulties experienced by offenders, in the form of a 35-item self-report questionnaire.

Results During the assessment stage Mr N was asked to complete a CRIME-PICS-II, the results of which are presented in Table 10. Results show a high score on the G scale, which indicate Mr N believes offending is an acceptable way of life. His high score on the A scale indicates the acceptance of the likelihood of re-offending. Mr N's low score on the V scale indicate an acceptance that offending has adverse effects for victims. Mr N displayed a moderate score on the E scale, suggesting he acknowledges crime has benefits that outweigh costs, but only partially accepts crime is a useful way gaining excitement or of obtaining goods. Mr N's high score on the P scale indicate he perceives a high number of problem areas in his life.

Table 10: Pre-Intervention CRIME-PICS-II Scores

SCALE	Raw Score	Scaled Score
General attitude to offending (G)	55	9
Anticipation of reoffending (A)	21	9
Victim hurt denial (V)	3	0
Evaluation of crime as worthwhile (E)	12	5
Perception of current life problems (P)	50	9

2.4 The Becks Anxiety Inventory

The Becks Anxiety Inventory (BAI; Beck & Steer, 1993) is a 21-question multiple-choice self-report inventory that is used for measuring the severity of an individual's anxiety over the preceding week. The BAI was purposely intended to reduce the overlap between depression and anxiety scales by measuring anxiety symptoms shared minimally with those of depression.

Results: During the assessment stage Mr N was asked to complete a BAI. Results indicated that Mr N obtained scores that placed him within the moderate range for anxiety, with a total raw score of 19 (moderate range = 16-25). All of the elevated scores were on what are considered to be 'subjective' symptoms of anxiety, such as 'fear of the worst happening', 'scared' and 'fear of losing control'. The findings contribute to evidence that Mr N experiences subjective symptoms of anxiety and also contributes to the identification of problematic emotions that precipitate offending. Results were interpreted with caution due the availability of appropriate norms for the prison population.

2.5 The Beck Depression Inventory – Second Edition (BDI-II):

The BDI-II (Beck, Steer & Brown, 1996) is a 21-question multiple-choice self-report inventory, and is one of the most widely used instruments for measuring the severity of depression. The BDI-II can be separated into two subscales to determine the primary cause of a patient's depression: affective (e.g. mood) and 'somatic' (e.g. loss of appetite). The two subscales are moderately correlated at 0.57, suggesting the

physical and psychological aspects of depression are closely related (Steer, Ball, Ranieri & Beck, 1999).

Results: During the assessment stage Mr N was given a BDI-II to complete. On this assessment he scored 21, which put him in the moderate (moderate range = 20 – 28) range according to the test interpretation manual. He reported the highest scores on the affective subscales (past failure, pessimism, self-dislike, and worthlessness) suggesting affective causes of depression.

Formulation

Forensic CBT Case Formulation

For the purpose of this case study a cognitive-behavioural approach to formulation was used which addresses Mr N's predisposing, precipitating, and perpetuating factors which lead to the presenting issues. Protective factors will also be discussed. Figure 4 offers an illustrative diagram of the formulation

Predisposing Factors

During Mr N's childhood his father was in and out of prison, committing crimes that Mr N was fully aware of. Mr N states that he respected his father and looked up to as his offending provided material possessions for the family; in this respect it appears that Mr N learnt to behave antisocially through behaviour modelled by his father (Bandura, 1973). During Mr N's childhood there was no discipline at the family home and offending was encouraged. Mr N expressed a strong desire to please his father and on occasions where Mr N obtained material possessions through criminal behaviour he was praised by his father, offering positive reinforcement to encourage further antisocial behaviour. However, despite the fact this behaviour was encouraged by his father, his mother was not of the same opinion. Mr N reports witnessing domestic violence between his parents, which was often as a result of their differing opinions regarding what was acceptable. Social learning theory (Bandura, 1979) posits that through the process of witnessing and experiencing violence, individuals behave in a violent manner akin to their parents through modelling, imitation, and reinforcement, thus the witnessing of violence in the family home may have contributed to his poor negotiation skills, where violence was seen as an acceptable way of handling conflict (DiGiuseppe & Tafrate, 2002). Witnessing this violence made Mr N feel angry, sad and hurt, where he would isolate himself from the family in an attempt to hide his emotions. These early experiences of isolation left him brooding, leading to states of depression and feelings of loneliness. On the occasions when Mr N's father was absent due to prison sentences he reports that he was abandoned by his mother and left to do as he pleased. His time at school was strained due to the lack of a father figure at home, and anger towards the fact other children at school had money where he didn't.

In response he would steal to impress his peers. His behavioural problems at home and in school eventually led to his removal from the family home at the age of 13 and placement in care, as his mother found his behaviour too difficult to cope with. This rejection by his mother served as a negative reinforcement to his offending behaviour, which triggered his beliefs of incompetency and abandonment leaving him mistrustful of others (Millon et al, 2006) and sensitive to criticism (DiGuiseppe & Taffrate, 2002). Through his early experiences he developed poor problem solving strategies to deal with his emotions, leaving him avoidant in social situations and impulsive. Mr N was moved between multiple children's homes due to his behaviour, which resulted in him not having a stable home or relationship with peers or family throughout his early years. The end product of his early experience at home, in school and in care led him to develop maladaptive core beliefs, including beliefs that 'possessions mean status', 'criminal behaviour can be justified', 'I do not control my own destiny' and 'illegal substances alleviate bad feelings'. With regards his offending, Mr N possibly internalises the view that he is skilled at the crimes he commits (as they produce possessions and status) but incompetent at anything else. In this respect, offending is all he knows. This is supported by the fact his father and brother have been convicted of crimes, which research has suggested is linked to the prediction of an individual's own likelihood of future conviction (Farrington, et al (2006).

Precipitating Factors

As a result of his continuing antisocial behaviour Mr N spent most of his early life in and out of care homes and prisons. This continued shift in his accommodation resulted in Mr N not establishing any secure attachments to care givers and failing to bond with positive role models; this may suggest that his lack of attachment to warm, loving and law abiding parents may have led him to become delinquent (Carlson & Stroufe, 1995). In terms of secure relationships, Mr N has only ever been in 'relationships of convenience' to fulfil his own needs for accommodation and money, which is in keeping with attachment theory (Bowlby, 1969), which stipulates that insecure attachment styles in infancy set out expectations for all future close relationships. Mr N's early exposure and easy access to illicit substances in care homes encouraged experimentation from an early age. This combined with an increased lack of guidance as well as other risk factors including family discord and

negative peer influences prior to, and during time in prison has encouraged the use of illicit substances. This is based on social learning theory which suggests parental modelling and favourable attitudes to substance misuse lead to greater likelihood of drug abuse in the subsequent adult (Hawkins & Catalano 1992). Feelings of anger and low affect also appear to have contributed to the regular use of drugs to ameliorate such feelings temporarily. Mr N has also offended to fund drug habits, thereby initiating and maintaining a drug use and crime cycle. When Mr N's father passed away he started using heroin to cope with anxiety and depression. It was around this time he began to experience feelings of despair and thoughts that he would never accomplish anything significant and worthwhile in his life. These feelings of despair and anxiety regarding his future appear to have a significant impact on his functioning, where a lack of critical reasoning skills prevents him from solving his perceived life problems effectively to achieve a crime-free life.

Perpetuating Factors

Due to Mr N's antisocial criminal behaviour he spent most of his early adulthood in and out of prisons, witnessing violence and offending behaviour throughout. His family history and parental attitudes which exhibited and condoned anti-social and criminal behaviour appear to be risk factors in their own right (Rutter et al, 1998). His own experiences of using violence and crime have often proved to be an effective problem solving strategy since this behaviour has elicited desired outcomes for him. When faced with confrontation Mr N will often act aggressively as he lacks assertiveness skills. He also lacks the ability to think of the consequences of his actions, and as a result continues to offend. In addition, his physiological symptoms such as excitement and arousal as a result of adrenaline release following criminal involvement further reinforce his criminal behaviour. Mr N believes he does not have the interpersonal skills required to retain employment, due to his aggressive outbursts and lack of consequential thinking. His anger towards his inability to maintain any form of employment has led to impulsive behaviour in the attempt to regain control over his circumstances. With this comes the belief that offending to maintain personal resources is the only option to fund his lifestyle. Furthermore, Mr N states that it is easier for him to make money to survive by engaging in criminal activities, rather than staying in employment. Offending to achieve desired outcomes is likely to have

empowered him, giving him the feelings of control over situations and his life. Although this tactic has its advantages, it has also proved problematic in the sense that he has continued to elicit negative responses from authority figures thereby enhancing the view that he is incapable of positive interpersonal reactions. This is likely to have ingrained a maladaptive coping/problem style within Mr N, which hinders him from dealing effectively with unfavourable and anger provoking situations. In terms of social support, Mr N does not have any peers that he considers to be good role models. In terms of personal resources, Mr N does not have the skills to remain successfully out of trouble with the law, as he is not able to consider the longer-term effects; instead he focuses on short-term gains. This suggests a deficit in his consequential thinking and a problem of immediate gratification.

Protective Factors

It appears Mr N is motivated to change his offending behaviour and lifestyle and participate in work to address is offending behaviour. As well as his motivation, he also has the support of his sister and older brother, who will offer a support network to him upon release. In terms of substances, Mr N has stopped taking drugs and alcohol as they were making him feel paranoid. He does not have a desire to use again. Mr N also has the promise of employment when he leaves prison, which he is focusing on as a desired goal.

Presenting Issues

The main presenting problem for the client was his involvement in antisocial criminal behaviour. The pre-intervention assessments also indicated he was experiencing problems with subjective depression, affective anxiety, and anger – which he did not know how to express in an appropriate manner. He also reported that on release from prison he was worried about maintaining employment and becoming involved in peer groups which have a negative influence. He was worried that he would not have the skills required to function in the community in a pro-social manner that would keep him out of trouble with the law. He was concerned that altercations in future

employment would be inevitable, where he would return to his offending behaviour to support his lifestyle.

Issues for Treatment

The cycle of crime has become a way of life for Mr N which has impacted upon all other areas of his life including employment and relations with partners as well as general social functioning. Thus it would appear that in addressing Mr N's problem behaviours a more holistic approach is required, not only to address his offending behaviour, but to equip him with the necessary skills to make positive changes in all other areas in his life. These areas include interpersonal problem solving, cognitive style, social perspective taking and critical reasoning, which were considered as treatment needs in the planning of an intervention.

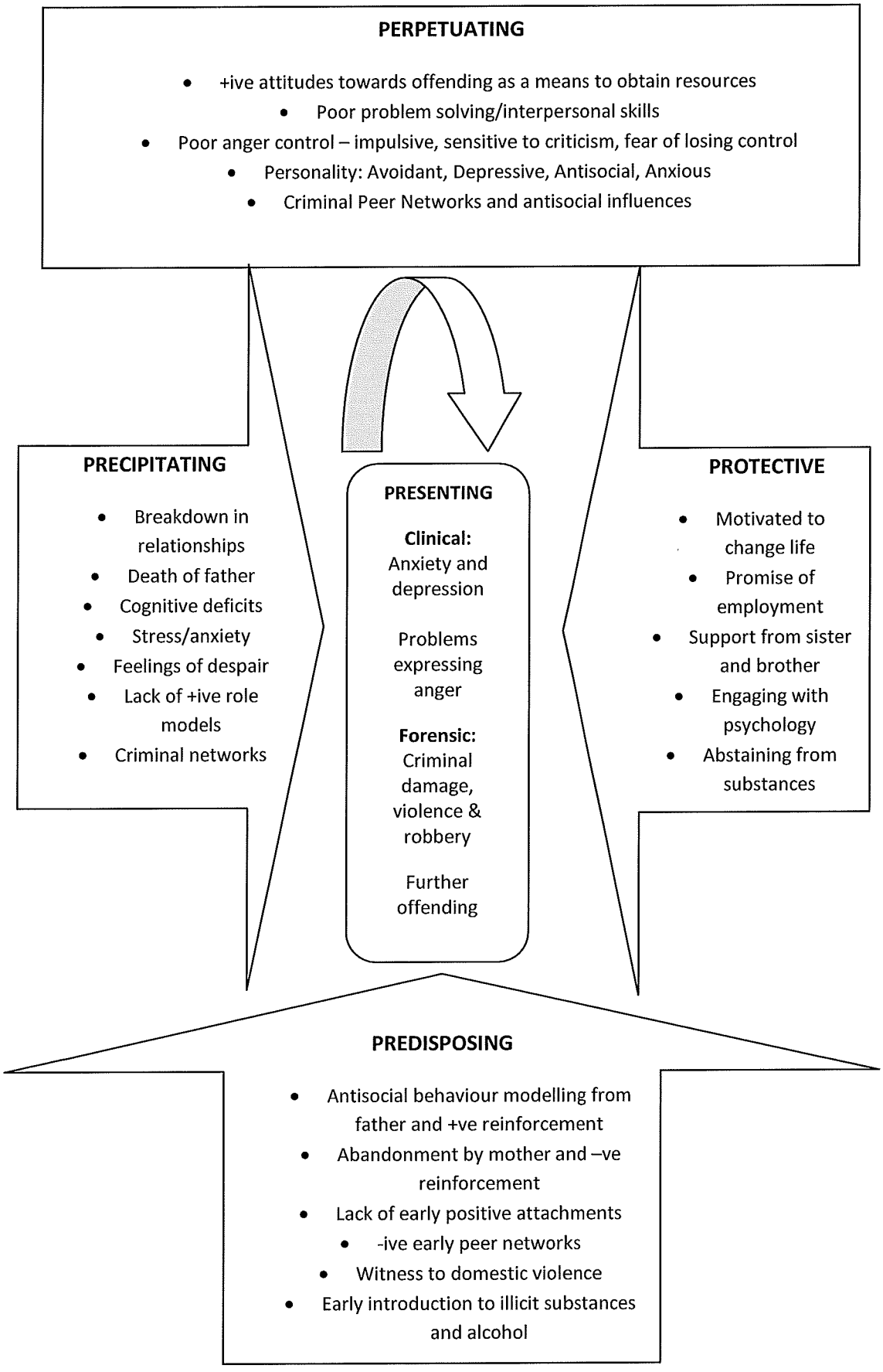


Figure 4: Case Formulation

Responsivity Issues:

For the purpose of delivering this intervention, responsivity issues were also considered. Responsivity factors can be termed as external and internal, and suggest treatment delivery should correspond with the learning style of the offender (Andrews & Bonta, 2003). In terms of the external responsivity factors, these are factors that exist outside of Mr N, but may impact on his ability to benefit from treatment. Staff who rate high on interpersonal sensitivity and awareness of social rules interact better with offenders, which suggests appropriate role-modelling should be used during the intervention sessions (Bonta, 1995). The intervention should also be delivered using an empathic, rewarding, directive, and non-confrontational approach (Marshall & Serran, 2004). In terms of internal responsivity factors, these are characteristics of the individual that impact on their ability to benefit from treatment interventions (Kennedy, 2000). For Mr N, his motivation to change would seem to indicate his recognition of a problem with his offending and an attempt to seek help to curtail his behaviour. This might indicate the likelihood of a good response to supervision, however it might also merely reflect his self-defeating traits. In terms of interpersonal responsivity factors, individuals with an anxious personality profile are more likely to have social skills deficits, difficulties relating to others, low self-esteem and are more inclined to have negative expectations regarding themselves and their behaviour (Lussier, Proulx &McKibben, 2001). As Mr N presents with such a profile, these issues should be considered as possible therapy interfering factors. Hence, a strength-based approach, concentrating on improving Mr N's ability to achieve higher-order goals in appropriate way, may offer a beneficial way of working with him.

Intervention

The assessment and formulation indicated that Mr N would benefit from an intervention to address interpersonal skills. The intervention was designed specifically to increase the client's interpersonal problem solving, cognitive style, social perspective taking and critical reasoning skills. The intervention was scheduled at regular time, once a week and each session lasted two hours, including a short break. The total number of sessions was limited to twelve sessions because the client was due to attend a Parole Board hearing shortly after the referral for individual work was made. The intervention was delivered on a one-to-one basis, working under the supervision of a clinical and forensic psychologist.

All of the sessions utilised a cognitive-behavioural approach, in order to teach Mr N effective social skills through a stage process. New skills and thinking were rehearsed in role-play situations, and Mr N was given feedback. Mr N was encouraged to practice the skills learnt in sessions outside of treatment and report back on his progress during subsequent sessions. Using cognitive-behaviour therapy techniques, Mr N was encouraged to examine the thoughts and contexts associated with negative emotions and to generate alternate ways of thinking. Cognitive restructuring techniques were used to challenge and neutralise intrusive cognitions sustaining depression and anxiety. Appropriate modelling and positive reinforcement was used. A summary of the individual intervention sessions can be found in Appendix 21.

Results

Engagement:

Between the period of November 2011 and March 2012 Mr N attended 12 weekly sessions. He displayed a positive attitude towards the sessions, and was enthusiastic throughout. He was committed to the homework assignments, completing them without fail. During the sessions he was open and honest and maintained a good sense of humour and affect throughout the intervention period. His commitment to address his offending behaviour remained consistent throughout the intervention period.

Therapeutic Process:

During the initial stages of the intervention there were some issues regarding Mr N's time management. He found it difficult to limit our sessions to the set times, and would often continue discussions on the way back to his cell. Initially this did not present too many problems, however, as time went on it became clear that he was unable to keep to the times set of the sessions which often meant issues were left unaddressed at the end of the session due to time limitations. Through the successful establishment of a therapeutic relationship, it became possible to address this issue with Mr N without causing upset. He was reminded throughout sessions that he should try to remain focused, and he appeared to feel more comfortable over time when interferences had to be made to keep him on track. These processes were made to feel less threatening by the fact we had developed a good working therapeutic alliance during the intervention period.

Progress in Treatment:

During the last session, Mr N was asked to discuss his own progress following the intervention. Mr N stated that he really enjoyed the sessions, and he believes he has learnt many skills, for example, he reported that he needs to stop and think before he does things, and think clearly about all the consequences of his actions. The following section highlights treatment effects that occurred over the intervention period. Clinically significant change is not possible to ascertain due to the difficulties

associated with the availability of appropriate norms. Thus, significant change is identified as a level of change recognised in terms of Mr N's presentation and reported problems during treatment, and his behaviour outside of treatment.

Follow Up Assessments:

1.1 The Anger Disorder Scale:

For the purpose of this case study, the results of the post-intervention scores on the ADS will be discussed in respect of the previously elevated scores in the pre-intervention assessment which are shown in Table 11. Following the intervention, none of Mr N's scores were in the moderate range, and all fell below the mild range (between the 75th and 89th percentiles). These scores suggest positive changes in Mr N's ability to manage his anger in social situations. Mr N displayed a notable decrease in his impulsivity, and became more confident in his ability to remain controlled. This was observed through his interactions with other prisoners on the wings during and after our sessions. The reduction on the M scale suggests Mr N was more able to express his anger verbally post-intervention, instead of internalising feelings of frustration. His response of the Q scale is most encouraging, suggesting a development of his conflict resolution skills, where he is now able to react to anger-provoking situations more assertively. Results may also be suggestive of an improvement of his negotiation skills and social perspective taking.

Table 11: Pre- and Post-Intervention ADS Scores

	Pre-Intervention (*November 2011*)	**Post-Intervention** (*March 2012*)
Scale	Scaled Score	Scaled Score
M (Brooding)	19	13
P (Relational Aggression)	5	3
Q (Passive Aggression)	16	6
B (Hurt/Social Rejection)	20	14
I (Impulsivity)	6	4

1.2 The CRIME-PICS-II

The results of Mr N's pre- and post-intervention scores on the CRIME-PICS II are in Table 12. The was a significant change on the G scale, where post-intervention scores suggested Mr N now believes that offending is not an acceptable way of life. Scores on the V scale remained the same. Mr N's lower score on the E scale indicated that Mr N now rejects the view that crime has benefits that outweigh costs. This could have been due to an increase in his consequential thinking. There was also a notable reduction on the P scale, suggesting Mr N did not perceive a great number of life problems in his life in comparison to pre-intervention scores. This result was most encouraging, as it may contribute to the alleviation of depressive and anxious feelings. The only scale which changed modestly was the A scale, which suggests Mr N had not completely resolved not to offend again.

Table 12: Pre- and Post-Intervention CRIME-PICS-II Scores

	Pre-Intervention (*November 2011*)		**Post-Intervention** (*March 2012*)	
Scale	Raw Score	Scaled Score	Raw Score	Scaled Score
General attitude to offending (G)	55	9	34	0
Anticipation of reoffending (A)	21	9	14	5
Victim hurt denial (V)	3	0	3	0
Evaluation of crime as worthwhile (E)	12	5	9	2
Perception of current life problems (P)	50	9	31	6

1.3 The Becks Anxiety Inventory

Following the intervention period Mr N was asked to complete the BAI. Results indicated that post-intervention he obtained scores that placed him within the minimal range for anxiety with a total raw score of 3 (minimal range = 0-7). This result shows a decrease in self-report feelings of anxiety, in comparison with his pre-intervention score of 19 (moderate range = 16-25). These were encouraging findings, which could indicate Mr N was feeling more positive about the future, and not anticipating too many difficulties in his post-release environment.

1.4 The Beck Depression Inventory – Second Edition (BDI-II):

Following the intervention period Mr N was asked to complete the BDI-II. Results indicated that post-intervention he obtained scores that placed him within the minimal range for depression with a total raw score of 5 (minimal range = 0 – 13). This result shows a decrease in self-report feelings of depression, in comparison with his pre-intervention score of 21 (moderate range = 20 – 28). These post-intervention scores are suggestive of a change in Mr N's levels of affective depression. These were again encouraging findings, which could indicate Mr N was feeling more positive about the future.

Communication with other professionals:

Contact with the Short Duration Programme (SDP)

During the intervention period, Mr N decided he would benefit from the SDP run by probation. He was encouraged to attend this programme and subsequently did so. The programme is based on a harm minimisation model and addresses substance misuse. Mr N's initiative to attend this group was praised, and contact was kept with the facilitator to monitor his progress and behaviour within the group. In general, positive reports were received weekly.

Contact with Probation:

Following the intervention period, Mr N's probation officer was contacted for an update on his progress. He stated that he was very impressed with Mr N's progress over the intervention period, and informed me that Mr N had been successful in his early parole release.

Areas Requiring Further Work:

Mr N engaged well in the intervention and positive results were evident through analysis of pre- and post-psychometric measures, communication with other professionals, and behaviour observations. However, the A scale on the CRIME-

PICS-II did not decrease as low as was hoped, suggesting Mr N had not completely resolved not to offend again. This result was unanticipated, as Mr N himself made direct comments to suggest that he felt more positive about the future and less inclined towards offending behaviour. This result therefore suggests not only the fact that he had not completely changed his attitude to offending, but also highlights the subjective nature of self-report psychometrics. Mr N may not have felt comfortable telling me directly that he still had doubts about his future, whereas through the assessment he was able to convey this. Nevertheless, this indicates an area for future treatment. A booster course may be necessary to recap the skills learnt, and positive encouragement to refrain from offending evidently needs to continue.

Next Steps:

Due to the nature of the referral (to the inreach team for mental health concerns), the intervention was not designed to specifically address Mr N's risk of future offending, from a risk assessment perspective. However, had the referral been from his probation officer for an intervention to address his risk of offending, work could have focused on the risk of future engagement in criminal offending, where the use of different psychometric measures and reports may have focused on risk. For example, use of the Historical-Clinical-Risk Management – 20 (HCR-20; Webster, Douglas, Eaves & Hart, 1997) may be a useful next step, in terms of determining his risk of reoffending. Tools such as the HCR-20 have been developed under the structured professional judgement approach, which combines risk predictors of clinical, actuarial and situational factors, using a guideline approach to decision making. Despite the fact that the HCR-20 does not allow for a definite prediction of violence, it does however give predictions based on the likelihood of violence, presented in terms of low, moderate or high. It is at an advantage to other risk assessment as it allows for dynamic factors, as well as static factors. The HCR-20 was not used in this case study, as information available on Mr N prior to the assessment was insufficient, and following the collection of the relevant information, a HCR-20 was not considered warranted, as all the information required for the formulation and already been presented in the relevant format (the forensic CBT case formulation). Nevertheless, future work could focus on completing a HCR-20 for Mr N that could inform his probation officer of the level of risk for reoffending that he poses. In addition,

behavioural reports from officers on the wings and other professionals in contact with Mr N may provide information that is not self-reported, to illustrate any behavioural changes within Mr N. Such behavioural reports could include prison system information regarding any adjudications whilst serving his sentence, or interactions with other prisoners and wing/educational/occupational prison staff that interact with Mr N on a daily basis. Whilst recommending a risk assessment would be the next steps for work with Mr N, it is also important to comment on his motivation and engagement with the intervention in light of this issue of risk assessment. Despite the fact the referral for work was not from his probation officer, and was not intended to influence his early parole or subsequent prison movement, Mr N may have anticipated that engaging with one-to-one work would provide him with an advantage when his parole board hearing commenced. On reflection, his willingness to engage may have been in connection with his parole board hearing, where he considered engagement with treatment a positive element that would foster his success in early release. Such an influence may have also affected his response on the self-report measures that he completed, where he may have over-reported positive results in order to convince others that he had 'changed'. This highlights the transparency of the measures used, and the fact that his responses on the psychometrics used – given that they are self-report measures – warrant attention in terms of his own desirability to 'perform' and 'appear to perform' well. With this in mind, Mr N may have taken advantage of the opportunity for input from the inreach team, where this was primarily to improve his perceived levels of compliance among other professionals involved in his case, for example, probation. This brings the focus back to the use of a future risk assessment, which would be recommended in future work, to allow for a measure that is not dependant on Mr N's self-report data.

Discussion

This case study was based on the assessment, formulation and intervention of a 31 year old Caucasian male offender suffering anxiety and depression. The individual was sentenced to custody following a robbery, violence and criminal damage offence for which he received a 72 month prison sentence. The main presenting problems were interpersonal problem solving skills. Assessment confirmed and contributed to this hypothesis in addition to identifying predisposing and perpetuating factors. Additionally, assessment and formulation identified possible responsivity factors that may impact on treatment and the therapeutic relationship. Formulation allowed for the development of a tailored intervention. Sessions addressing interpersonal problem solving aimed to provide Mr N with a problem solving strategy which could be applied in any situation. These sessions were designed to address areas such as impulsivity and consequential thinking. The sessions to address Mr N's cognitive style were designed to consider how his thinking and consequent emotions may hinder effective thinking, and assertiveness was considered. Sessions addressing social perspective taking involved a focus on the importance of listening to others and managing emotions in social situations. Sessions were also designed to enhance his critical reasoning skills through identification of irrational thinking with a focus on negotiation and responding skills. Post-intervention progress was observed on measures indicative of improvements in targeted deficits, including justification of offending behaviour, and aggressive social problem solving. Post-intervention scores also suggested an improvement in the client's depression, anxiety and levels of anger.

Practical Issues:

A conceptual and methodological issue to consider in this case study is how treatment performance outcome was measured. The questionnaires and measures used suffer from the same problems as other self-report inventories, as they are subject to problems such as social desirability and response bias and scores can be easily exaggerated or minimised by the person completing them (Bloom et al, 1995). Self-reports are limited not only by what a client is willing to say, but also by what they are able to tell you, for example, Mr N may have been uncomfortable with the measurement tools used. In addition, self-report questionnaire are also limited by what

the client is aware of. The way an instrument is administered can also affect the final score. For example, social expectations have been shown to elicit different responses if a patient is asked to fill out a form in front of other people in a clinical environment, compared to administration via a postal survey (Bowling, 2005). Particularly when considering the follow-up measures used, Mr N might have unwittingly reported more change than actually occurred to justify his investment in time, please others or influence feedback to other agencies such as probation. Four of the assessments administered in this case study contained no social desirability scales that alert respondents to those who are 'faking good' or 'faking bad', which is important to consider in respect of this case study, but also for future researchers in evaluating outcomes. In order to address these anticipated problems a motivational style was adopted throughout assessment and treatment in order to ensure Mr N was motivated to provide the most accurate information (McMurran & Ward, 2004).

Barlow and Hersen (1984) suggest the essence of successful practice is to help resolve client problems and to attain client objectives. Whilst this has been demonstrated, it should be mentioned that a case study design does not allow for systematic comparison between a non-intervention period. This may lead to a strong bias in favour of interpreting events in terms of how a theory predicts the events will turn out. A case study design can only provide clear information on changes in the problem between baseline and intervention; it appears to, but does not necessarily provide strong evidence about whether or not the intervention caused the observed change. In this instance, it would appear the intervention addressed some of Mr N's immediate needs, at least in the short-term, however long-term treatment success is not possible to establish at this stage. Nevertheless, case studies do employ flexible designs, capable of changing as new events occur in the clients' circumstances, including allowing new targets. They also provide additional flexibility in allowing you to make specific rational decisions about needed changes in an intervention plan. Furthermore, involving the client in setting goals and using these methods will most likely serve to enhance the quality of a therapeutic relationship, not distract from it.

The forensic placement that provided the context for this assessment and intervention process produced some problems with regard to resources available for the prison population. The academic nature of the case study and resources available allowed for

a reflection on whether certain aspects of the assessment would have been carried out differently. Treatment effectiveness should measure motivation, attitudes and compliance, therefore had this case study not been academic in nature, thus limiting time and resources, a battery of more extensive measures could have been used.

Reflection on Practice:

As a trainee on my forensic practice doctorate, the work carried out with Mr N provided me with many opportunities to develop professionally. The one-to-one assessment stage and intervention process provided me with greater confidence in working on a one-to-one basis with a client. I was also able to gain a better understanding and develop skills in evaluating assessment work in order to develop a formulation as the work progressed. The assessment work developed my understanding of how important it can be to individualise treatment according to the client's needs. In addition issues around modifying a treatment plan as different issues arise can be equally important. When talking with the client I became increasingly able to work jointly to develop a formulation, and this provided a more collaborative approach which I observed to be successful. The work provided me with a greater understanding of the process of building a successful therapeutic relationship and the importance of communicating boundaries and confidentiality issues. I gained an understanding and skill base of how to work with this client group and in particular the importance of working in an understanding and empathic manner in order to maintain or develop motivation.

Implications for Practice

As was discussed at the beginning of this case study, there have been many developments over the years in the efforts to treat prisoners so they leave prison with a chance of being rehabilitated into a wider society and less likely to offend (Robinson & Crow, 2009). The purpose of this case study was to highlight that effective treatment is important in prison settings as there are many prisoners who experience what can be considered as mental health problems (Birmingham, 2003). In this instance, the client in this case study was suffering from feelings of depression and anxiety in relation to his future prospects. However, it seems reasonable to suggest

that such feelings are most likely to be common amongst the prison population (Birmingham, 2003). In fact, it has been suggested that common mental health problems such as sleeping disorders, anxiety and depression are experienced by more than half of prisoners (Anthony & McFadyen, 2005). Individuals with severe and enduring mental health problems are the focus of the majority of mental health provision in prisons, and consequently prisoners with common mental health conditions often remain untreated. For these prisoners, they often return to their communities with the same problems they had prior to imprisonment, with prison exacerbating these problems through the experience of unnecessary distress (Brooker, Repper, Beverley, Ferriter & Brewer, 2002). Addressing the common mental health needs of prisoners has received more attention recently from both providers of prison healthcare and commissioners (DH & HMPS (2001). Problems such as anxiety and mood have become acknowledged to affect function in all aspects of an individual's life. It is only by addressing the common mental health problems of prisoners that they are more likely to rehabilitate into their communities successfully, achieving a better quality of life upon release. Promoting and supporting health behaviour change among prisoners should receive a much greater emphasis, where primary care in prisons should play a central part. Further research and more discussion should allow for a development of new approaches to prison health care and primary mental health care in prisons. However, it should be noted that in prison establishments in Wales, Part 1 of the Mental Health (Wales) Measure 2010 seeks to strengthen the role of primary care in delivering effective mental health care and treatment to prisoners in Wales. It is expected that the statutory duties on Local Health Boards and Local Authorities to provide these services will come into force in October 2012, which may drive the development of services for the most common mental health problems, where early identification of mental ill health is achievable, thus allowing for appropriate levels of intervention to be gauged.

Conclusion:

It seems reasonable in this case to conclude that short-term changes in interpersonal problem solving, cognitive style, social perspective taking and critical reasoning can be achieved with a cognitive-behavioural approach. However, it is only by further exploration of the treatment and evaluation of such offenders that practitioners will be

aware of effective intervention targets and ways of working with such offenders. Treatment in prison should be considered as an opportunity to re-assess and re-build the lives of offenders. It is acknowledged that much therapeutic activity can and does take place in custodial establishments, this is not denied; this case study simply highlights the need to address prisoners' mental health before they are released into the community and that cognitive-behavioural intervention style work is an effective form of psychological intervention.

Implications for Thesis

The empirical study in Chapter 2 revealed that most of the participants in the study had been in prison before they started their journeys through the forensic mental health system. Participants in the study expressed that they did not receive appropriate treatment in prison, believing their mental health deteriorated as a result. Some participants even believed that if they had been treated in prison they may not have entered the mental health system. The results from the study in Chapter 2 indicate the need to study the mental health of prisoners in closer detail, especially given that release from prison can cause anticipated feelings of hopelessness and anxiety as was illustrated in this case study (MacKenzie, & Goodstein, 1985). If such problems are not addressed in prison these may later be the cause of re-offending, or in some cases develop into more severe and enduring mental health problems, as was acknowledged by participants in the study in Chapter 2. In addition, given the evident problem of substance abuse among prisoners, and the acknowledged link between substance misuse and mental illness (Bennett & Holloway, 2009), prisoners as a population warrant more attention than they currently receive.

Chapter 4: Psychometric Critique

Critique of a Psychometric Assessment: The CRIME-PICS II

(Frude, Honess & Maguire, 1994)

Introduction

The CRIME-PICS II is a widely used, fully validated questionnaire for detecting and examining changes in offenders' attitudes to offending. The Welsh and English probation and prison services have adopted the tool for several years, where it has proved successful in evaluating the effectiveness of a wide variety of offender programmes (Frude et al, 1994). The CRIME-PICS II elicits information about criminal beliefs and attitudes about personal and social difficulties experienced by offenders, hence offering a standardised means of measuring change in these areas. In the systematic review in Chapter 1, the CRIME-PICS II was revealed as the most frequently used tool in assessing the effectiveness of the interventions included in the review. The case study in Chapter 3 also demonstrated its effectiveness in measuring individual change when used in one-to-one treatment interventions. Therefore, this Chapter will provide a critique of the CRIME-PICS II questionnaire, developed by Frude, Honess and Maguire (1994). For the purpose of this critique the CRIME-PICS II will be reviewed in terms of its development, purpose and use, its relevance to intervention planning and assessment, its scientific properties, and its ease of use and accessibility.

The CRIME-PICS II was first published by the M&A Research Group in 1994, the second edition was published in 1998 and the third in 2008. The authors of the CRIME-PICS II are members of the M&A Research Group, an independent Policy Research Group specialising in Criminal Justice Policy and crime. Professor Neil Frude and Professor Terry Honess are Chartered Psychologists and Professors of Psychology, both of whom have published widely in the areas of crime control and decision making. Professor Mike Maguire, a Professor of Criminology has also published widely in the areas of parole, prisons, policing and probation work. Members of the group have also developed instruments to measure impulsivity and aggression (Conflict Resolution, Impulsivity and Aggression Questionnaire; Honess, Maguire & Vanstone, 2001).

Evidenced based practice should always involve developing and employing interventions based on evaluating and monitoring outcomes. As part of this continuous review, the purpose of psychometric evaluation to assess the impact of treatment

programmes is of utmost relevance and importance. The effectiveness of offender intervention programmes has traditionally been considered on the basis of outcome measures such as reconviction rates, or of behavioural measures such as adherence levels. However, whilst reconviction rates are of public interest, and are relevant, they also have their disadvantages. Most importantly, their use in evaluation typically relies on knowing what reconviction rates would have been expected in the absence of any intervention (Healy, 2010). While reconviction and behavioural measures are relevant, alone they do not offer an adequate picture of the degree to which an intervention has produced a change in offenders. With its focus on attitude change, the CRIME-PICS II offers a useful additional tool for measuring and evaluating the impact of offender interventions, and as such has therefore been used to measure the impact of both non-accredited and accredited intervention programmes throughout the National Offender Management Service (NOMS).

Purpose of the CRIME-PICS II

Any data that provides insight into programme and offender performance helps identify who is successful and who is not, whilst also allowing for adjustments to interventions and programmes to be made (Latessa & Holsinger, 1998). Used alongside other measures, the CRIME-PICS II offers a 'before and after' evaluative measure of changes in offenders' thinking about victims and crime, which therefore offers an valuable indicator to assist in the evaluation of any intervention. The authors suggest changes in scores on the CRIME-PICS II offer an indication of a programme's likely impact on recidivism, as scores are said to be statistically correlated with chances of reconviction (Frude et al, 1994). Relevant research has indeed shown associations between changes in CRIME-PICS II scores and positive reconviction outcomes (Raynor, 1998). When used with individuals, the tool can also be utilised as a means of monitoring progress in detail, as well as offering a useful diagnostic instrument. It has the propensity to provide information about a client's attitudes and perceived problems, and, where appropriate, results can be usefully shared and discussed with clients on a case basis. It also allows for repeated administration, which allows for comparisons between a baseline measurement against which changes can be assessed. This repeated administration provides an indication of change on a number of key dimensions. CRIME-PICS II scores from

groups of offenders can also be aggregated to allow for comparisons between before and after interventions or between offender types. In addition, CRIME-PICS II scores offer data to establish offender profiles, which may help in the designation of particular offenders to specific programmes.

Population

The authors of the CRIME-PICS II do not specify an age range, gender or population for which the tool is to be used with. The original validation sample for the CRIME-PICS II came from the UK. This consisted of 422 offenders supervised by the Mid Glamorgan service between 1991 and 1993. The sample was almost exclusively male, and at a time when the Mid Glamorgan caseload was 99.5% white (Home Office, 1994). However, research has been demonstrated applying the CRIME-PICS II to both male and female populations, as well as adult male and juvenile offenders. One such study (Feasey, Williams, & Clarke, 2005) utilised the CRIME-PICS II with female offenders, and offenders in a Young Offenders Institution (participants under the age of twenty-one) as an evaluative measure of a victim awareness programme. Their results highlighted significant positive attitudinal changes with regard to the five psychometric features of CRIME-PICS II with all groups of prisoners, including adult and young and male and female prisoners. Holloway and Brookman, (2008) also utilised the CRIME-PICS II with female offenders within the assessment process, which offered them a way of measuring the progress of a crime reduction programme for women. However, when comparing the CRIME-PICS II results of Black and Asian offenders with the original sample, researchers demonstrated the Black and Asian sample obtained lower CRIME-PICS II scores on all scales than the original validation sample (Calverley, Cole, Kaur, Lewis, Raynor, Sadeghi, Smith, Vanstone & Wardak, 2004).

Nature of Content

The CRIME-PICS II is a self-report assessment, which was originally designed for administration to an individual; but can also be administered to groups of offenders. The 35 item structured questionnaire was designed to measure individuals' attitudes

towards offending on five distinct scales (Frude et al, 1994), however the assessment is split into four parts as follows:

- Part 1: The first part requires the client or assessor to complete a number of questions to summarise the client's demographic details. This part contains a number of items and may be modified to suit the purpose of the service administering the assessment. Here, the client's history of past offending and current status is summarised.

- Part 2: The second part is the 20-item CRIME-PICS II questionnaire completed by the client (*A full list of the items can be found in Appendix 22*). Here the client is presented with twenty statements, and is asked to indicate the degree to which they agree or disagree with each statement. The response options are "Strongly Agree", "Agree", "Neither Agree nor Disagree", "Disagree" and "Strongly Disagree". Answers are numerically coded and combined to create four scores; the main score ('G') represents a person's general attitude to offending at the time of completion, with other measures including a client's evaluation of crime as worthwhile ('E'), victim hurt denial ('V') and anticipation of re-offending ('A').

- Part 3: The third part is the Problems checklist, an inventory of 15 common life problem areas, completed by the client (*see Appendix 23*). In each case the client is asked whether each item represents "A big problem", "A problem", "A small problem", or "No problem" in their life at present. Answers to the problem inventory are numerically coded and combined to create a P scale measuring the individual's perceptions of their current problems.

- Part 4: The fourth part of the questionnaire consists of a summary page for scores on the dimensions G, A, V, E and P to be recorded, which is used by the assessor. The client's responses are translated into five scores, which collectively present a profile for the client. It is also possible to transform raw scores into scaled scores using the conversion table provided in the manual, which allows for the scores to be presented graphically on the chart provided.

Interpretation of results:

The scoring system for the CRIME-PICS II states that high scores on the five scales are indicative of attitudes which predispose individuals towards involvement in crime. In terms of the problems scale 'P', a higher score indicates an individual has many problems areas in their life. However, these scores are a snapshot of the client's attitudes and problems at the time of measurement, and a repeat administration of the measure later on can enable an assessor to identify change on any of the five scales. Between administrations, reductions in raw scores are to be interpreted as improvements in the client's attitudes to crime, or in the case of the 'P' scale, are indicative of reductions in the numbers of life problems the client is identifying. The individual problems indentified in the problems inventory can also allow for a quick scan of problematic issues in the clients current lifestyle, which as such, taken with other responses, can provide valuable diagnostic information, which may later form the basis for further examination and discussion. Table 13 displays the interpretation of scores from the CRIME-PICS II, taken from the manual.

Table 13: Interpretation of Scores on the CRIME-PICS II Scales:

G – General Attitude to Offending (17 items)	A low score on the G scale indicates the individual does not believe offending is an acceptable way of life.
A – Anticipation of Reoffending (6 items)	A low score on the A Scale indicates the individual has resolved not to offend again. This scale provides a direct assessment of the individual's acceptance of the likelihood of re-offending.
V – Victim Hurt Denial (3 items)	A low score on the V scale indicates the individual accepts that offending has adverse effects for victims, as this scale measures the degree to which the client rejects or accepts that their crime had adverse effects on a victim.
E – Evaluation of Crime as Worthwhile (4 items)	A low score on the E scale indicates the individual rejects the view that crime has benefits that outweigh costs, as this scale measures the degree to which the client accepts or rejects the view that crime is a useful way gaining excitement or of obtaining goods.
P – Perception of Current Life Problems (15 items)	A high score on the P scale indicates the individual perceives a high number of problem areas in their life.

Relevant Research

In the attempt to measure the impact of interventions, the CRIME-PICS II has been used in a number of studies, by administration before and after programs, which generally report improvement in scores rather than deteriorations (Raynor, 1998). It is beyond the scope of this critique to discuss its use in all studies; however its use in specific areas of research will be highlighted. In addition, a list of some studies which have utilised the CRIME-PICS II can be found in Appendix 24.

When examining the use of the CRIME-PICS II in evaluating the effects of offending behaviour programmes in prisons, two key studies were noted. In a randomised control trial evaluating the effectiveness of the Enhanced Thinking Skills (ETS) programme, it demonstrated significant levels of change in prisoners attending the programme (McDougall, Clarbour, Perry, & Bowles, 2009). It was also used in a reoffending study for propensity score matching, where results provided dynamic factors used in matching prisoners taking part in an ETS programme and a control group (Sadlier, 2010).

Research using the CRIME-PICS II is also evident in the area of probation, where individual services have utilised the tool in the evaluation of particular programmes. Examples of such use include a West Midlands probation centre study, showing reductions mainly in G, V and P scores (Davies 1995); a Merseyside probation centre project study , showing reductions in P scores (McGuire, Broomfield, Robinson & Rowson, 1992) and the Intensive Probation Centre in Cambridgeshire, where programme completing offenders showed reductions in G, V and E scores (Richards, 1996). However, with the exception of Davies (1995), these studies generally involved fairly small numbers and were not able to make comparisons between reconviction and changes in CRIME-PICS II scores.

In addition to its effective use with prisoners and those on probation, the CRIME-PICS II was recently used with mentally disordered offenders to evaluate the effectiveness of the Reasoning and Rehabilitation (R&R) Programme (Cullen, Clarke, Kuipers, Hodgins, Dean & Fahy, 2011; Clarke, Cullen, Walwyn & Fahy, 2010). At the end of treatment, Cullen et al (2011) reported participants attending R&R showed

statistically significant changes on the A scale, and whilst Clarke et al (2010) did not find any significant changes on this scale, they did report significant differences between groups on the 'G' subscale, with the R&R group obtaining lower scores after treatment on all CRIME-PICS II scales.

To summarise, the use of the CRIME-PICS II in studies to date yields informative results regarding offender profiles in different areas of supervision, as well as the impact of different supervision on attitudes and problems. In addition, studies have highlighted the relationship between attitudes and problems and recidivism, whilst simultaneously providing information regarding the effectiveness of the tool in the assessment and evaluation of offenders under different forms of supervision.

Directness and Relevance to Intervention Planning:

In terms of applying the CRIME-PICS II to Case Study designs, the tool may be used in direct intervention work with clients for initial screening to determine the presence of specific targets for intervention. The Problems checklist part of the CRIME-PICS II may assist in determining whether a client is in need of intervention in a particular area, and subsequently may allow for the selection of the most appropriate and effective intervention strategy. It can also be administered periodically throughout an intervention to determine the generality of change, including a determination of improvement or deterioration in unanticipated areas, so that any necessary modifications in the intervention plan can be undertaken.

Technical Evaluation

Appropriate Norms:

The original validation sample for the CRIME-PICS II came from the UK. This included 422 offenders supervised by the Mid Glamorgan service between 1991 and 1993. The sample was almost exclusively male, and at a time when the Mid Glamorgan caseload was 99.5% white (Home Office, 1994). Although the original sample was not weighted to improve its representativeness of offenders under supervision in general, the sample was selected to represent a wide range of areas, and

hence the characteristics of the validation sample were similar to those of probationers at the time (Frude et al, 1994).

Reliability: Internal Reliability

For a measurement to be useful it must be reliable, which can be established by examining whether the scores from the items that make up the CRIME-PICS II are correlated with each other in the predicted direction. A computed alpha coefficient represents the overall estimate of internal consistency for each scale, with an alpha value of .70 of above being generally advised to indicate good internal consistency (Field, 2005). Table 14 provides the alpha coefficients for each of the CRIME-PICS II scales as provided by the manual, and based on the original validation sample. As Table 14 shows, at least four of the five scales are reliable, with the E scale failing to meet the alpha criterion considered adequate. However, the authors state that the four items in the E scale do correlate significantly with each other, but scores should be treated with caution. This may be due to the fact that higher alpha values are usually more difficult to establish for short scales, due to the fact the alpha coefficient reflects the number of scale items as well as the inter-correlations within a scale (Field, 2005).

Table 14: Alpha Coefficients for CRIME-PICS II Scales:

SCALE		Alpha coefficient
General attitude to offending (17 items)	G	0.76
Anticipation of reoffending (6 items)	A	0.75
Victim hurt denial (3 items)	V	0.73
Evaluation of crime as worthwhile (4 items)	E	0.55
Perception of current life problems (15 items)	P	0.83

Reliability: Test-Retest Reliability and Test Sensitivity

A reliable measuring instrument should provide stable information, irrespective of who is administering it, or at what time or day a client completes it. The CRIME-PICS II aims to provide stable information, whilst also being sensitive to change in client's attitudes. Table 15 is based on a sample of clients provided by Frude et al (1994) who

had taken part in intervention programmes, with varying test-retest intervals. To meet the test-retest reliability criterion, all scales should display significant correlations between testing times when examining score changes as a result of interventions. The coefficients in Table 15 are not alpha coefficients, but are correlations, and as the table displays, the CRIME-PICS II meets the test-retest criterion, as all correlations are highly significant. In addition, each of the scales also demonstrated movements in the predicted direction, i.e. towards a more desirable attitude to offending.

Table 15: Correlations on the CRIME-PICS II Scales:

SCALE		Correlations
General attitude to offending (17 items)	G	0.63
Anticipation of reoffending (6 items)	A	0.58
Victim hurt denial (3 items)	V	0.59
Evaluation of crime as worthwhile (4 items)	E	0.56
Perception of current life problems (15 items)	P	0.55

Validity

There are various recognised means by which the validity of tests can be assessed. The CRIME-PICS II was developed following extensive consultations and testing with probation officers and is said to cover all of the essential common dimensions that emerge as relevant to attitudes to offending, thus it can be said to have good face validity and good content validity. In terms of predictive validity, the tools used in criminal justice services for assessment and evaluation purposes are expected to be of value if the changes they measure can be shown to be associated with reductions in reoffending. However, it should be acknowledged that the CRIME-PICS II was designed to offer a practical tool for measuring and assessing attitudes and problems likely to be connected with offending and not to predict reoffending. Despite this, Healy (2010) reports, that when used to predict desistance from crime, the CRIME-PICS II is a valuable measure. However, Raynor and Vanstone (1997) found the problem inventory, but not the attitudinal scale, predicted whether reconviction occurred within two years.

When examining concurrent validity, one would anticipate certain client groups to differ in terms of their scores on different scales. In an attempt to assess the validity of the scales, the authors investigated the relationship between the scales and the following: a) A composite risk-of-reoffending score, b) Number of previous convictions, c) Number of previous custodial sentences and d) Type of offence (Frude et al, 1994). The composite risk of re-offending (ROR) score used for this analysis was similar to scores used in many probation services within the United Kingdom, and considers the client's age, offence type, previous convictions, as well as a number of other factors. Results indicated a higher ROR score was positively correlated with the CRIME-PICS II scales, and those with higher ROR scores tended to have higher scores on the G, A and E scales. After banding clients into groups depending upon their number of previous convictions, and experience of a previous custodial sentence, differences in CRIME-PICS II scores between the groups were found to discriminate between them in a meaningful fashion. The group with the highest number of previous convictions had the highest scores on the A and G scales, whilst the group with the lowest scores displayed the opposite. Those who had not experienced a custodial sentence also had significantly lower A and G scores than those who had. When examining differences in offence types, offences were classified into three groups, including offences against the person, property offences and motor vehicle related offences, and differences in the scores between groups provided clear support for the validity of the scales.

With no studies to date having examined the construct validity of the CRIME-PICS II it is not possible to assess the convergent or discriminant validity of the measure. As the measure gains recognition, it is hoped that the research and evidence base pertaining to this will increase.

Ease of Use

Bloom, Fischer and Orme (1995) suggest questionnaires that take no more than five to fifteen minutes to complete are ideal, as they do not require too much energy to fill in. When considering the CRIME-PICS II, the tool is straightforward to administer and can be scored easily and quickly. According to the authors, administration and scoring usually takes no more than fifteen minutes, and the time is further reduced if the

scoring software is used. In sum, extensive use with offenders demonstrates that the CRIME-PICS II is user friendly and encourages interest among offenders, due to the fact it relies on offenders' responses rather than interviewers' judgements (Calverley et al, 2004).

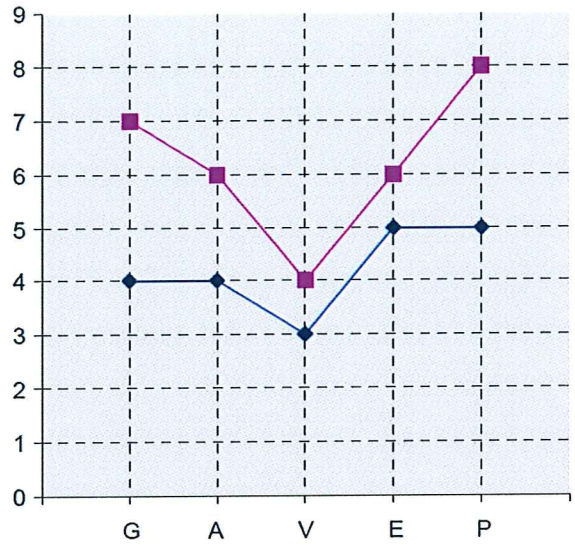
Scoring Procedures:

There are several methods of scoring the CRIME-PICS II. The CRIME-PICS II computer scoring programme allows for the test to be scored in under two minutes, whilst scoring the test by hand is also made easy by the use of acetates used as an overlay to score the various scales. It is also possible to transform raw scores into scaled scores using the conversion table provided in the manual, which allows for the scores to be presented graphically on the chart provided on the back page of the questionnaire.

Potential for Repeated Administration:

The CRIME-PICS can be administered a number of times to the same client, thus making it valuable in monitoring changes in terms of the clients general attitude to offending and in other variables measured by each of the scaled scores. Following a repeated administration, new scores can be entered on the score sheet, to allow for a difference in scores to be calculated. In these cases, a decreased score on any individual scale represents improvements in a client's attitude in this area, or on the P scale, a reduction in the number of perceived life problems. The difference in scores can also be illustrated graphically, as seen in Figure 5:

Figure 5: An Example of a Graphical Representation of Changed Scores on the CRIME-PICS-II



Practicality:

Aggregate data from the CRIME-PICS II can also provide a numerical index of the general effectiveness of a service, allowing professionals the means to demonstrate success in a standard way that is statistically meaningful and easily communicated. As well as providing a baseline measure for effects of interventions to be measured against, it also provides instant relevance for the work of professionals working with offenders. Not only are CRIME-PICS II scores useful when evaluating the impact of interventions on an individual basis, when considering groups of offenders, scores can also be aggregated to evaluate general patterns of change.

Accessibility

The CRIME-PICS II is not difficult to obtain, and can be easily purchased for a reasonable price from the authors. Unlike other questionnaires the CRIME-PICS II is not restricted to certain professionals, and is available without documentation of special training. The only instructions regarding administration include that if the CRIME- PICS II is to be used for official assessment and evaluation purposes, someone other than the individual generally responsible for an intervention with the client should administer it. These considerations make the CRIME-PICS II a readily accessible instrument, with minimal restraints.

Summary Evaluation

Alternative Assessments:

Alternative assessments to the CRIME-PICS II include the Measures of Criminal Attitudes and Associates (MCAA; Mills, Kroner & Hemmati, 2004), which has been found to show predictive validity for the outcomes of recidivism amongst offenders, with the MCAA significantly improving the prediction of violent recidivism. The Criminal Sentiments Scale (CSS; Gendreau, Grant, Leipciger, & Collins, 1979) is another self-report measure of criminal attitudes, which has been used with a number of forensic populations, and found to be predictive of recidivism (Andrews & Wormith, 1984). The Psychological Inventory of Criminal Thinking Styles (PICTS; Walters, 1995) can also be considered as alternative tool, due to the debate regarding whether it is what offenders think or how they think that it the key factor for recidivism (Simourd & Olver, 2002). Whereas the CRIME-PICS II measures attitude content, the PICTS measures criminal thinking styles, or attitude processes, thought to support criminal behaviour, and unlike the CRIME-PICS II, the PICTS has two validity scales.

Conclusion:

The 'What Works' research reveals that pro-criminal attitudes are among the strongest predictors of re-offending (Gendreau, Little, and Goggin 1996), and whilst as an evaluation tool it offers important information about beliefs, attitudes and problems, one would expect to see a more robust overall association with recidivism in a tool used for probation type work. Despite the fact the problem profile as a measure may perhaps create a stronger relationship with reoffending, current literature on the correlates of offending and criminogenic factors indicate a wider collection of issues than is at present covered by the CRIME-PICS II (Farrington, 1990). The relevant literature reviewed for the purpose of this critique on the use of the CRIME-PICS II suggests that while it is a valuable tool used in research, it is neither adequately correlated with risk of reoffending nor sufficiently inclusive in its coverage of risk factors to fill this gap alone as other meta analytic investigations (Andrews, 1995) and studies of the antecedents of offending (Farrington, 1990) point to other factors not addressed by the CRIME-PICS II. Among some of these not addressed are social

supports for offending, early influences on socialisation and educational difficulties. This suggests that the CRIME-PICS II should attempt to cover a wider array of offender characteristics, including the addition of 'static risk' factors that are based on age, gender and criminal history.

Implications for Practice:

The CRIME-PICS II suffers from the same problems as other self-report inventories, as they are subject to problems such as social desirability and response bias and scores can be easily exaggerated or minimised by the person completing them (Bloom et al, 1995). Self-reports are limited not only by what a client is willing to say, but also by what they are able to tell you. The way an instrument is administered can also affect the final score (Bowling, 2005). All these factors should be considered when interpreting the self-report data provided by the CRIME-PICS II. When considering the use of the CRIME-PICS II as a follow-up measure, individuals may unwittingly report more change than actually occurred to justify their investment in time. The CRIME-PICS II contains no social desirability scales that alert respondents to those who are 'faking good' or 'faking bad', which is important to consider in respect of its validity, but also for future researchers in evaluating outcomes. As was noted, the CRIME-PICS-II was utilised in the case study in Chapter 3. Given the limitations discussed in this Chapter, the usefulness of the tool in measuring attitude change over the course of a treatment intervention should therefore be interpreted with caution, particularly when considering the lack of social desirability scales, which was highlighted as a problem when evaluating change in the case study.

Discussion

The overall aim of this thesis was to examine the rehabilitation process of adult male offenders, with a specific focus on adult male mentally disordered offenders (MDOs). Chapter 1 of the thesis examined the inpatient treatment of adult male MDOs and Chapter 2 presented an empirical study examining the community reintegration process of adult male MDOs. The case study in Chapter 3 discussed the importance of individualised assessment and formulation prior to treatment planning, whilst highlighting the need to address the common mental health problems of prisoners. The critique in Chapter 4 also evaluated a psychometric tool that enables an evaluation of change following treatment, which can be utilised with both offenders and MDOs as was seen in the systematic review in Chapter 1. The overall findings of this thesis may be considered collectively or at the individual Chapter level, nevertheless, the finding discussed throughout may provide professionals involved in the supervision of offenders with an evidence-base which may inform and improve the services they provide, both at the inpatient, and community level.

In the introduction, the thesis argued that rehabilitation is a notion which implies change, which every Chapter has attempted to address. In Chapter 1, change was evaluated in terms of the success of inpatient interventions following cognitive-behavioural approaches with adult male MDOs in bringing about changes in targeted deficits thought to influence the recovery process. All of the studies in the review reported encouraging findings in relation to changes on outcome evaluations of the effectives of the programmes implemented. This suggests such psychological interventions based on cognitive-behavioural principles should be considered as a key component in the rehabilitation process of MDOs, as interventions aimed at providing MDOs with certain skills may allow for a better reintegration into the community upon release.

Chapter 2 went beyond the inpatient treatment setting; to examine what specific – individual level – changes made the community reintegration of adult male MDOs successful. Results in Chapter 2 offered preliminary indications of influential factors at the individual level for the process of MDOs reintegration into the community. Thematic analysis generated four main themes, including the significance of initial

negative experiences in secure settings, the importance of managing support networks, the importance of threats to identity and the significance of autonomy. The themes elicited should be considered as important when considering the difficult journey MDOs make through FMHS, and may be used to inform professionals working with MDOs of what impacts on a successful reintegration into the community following a conditional discharge, they may even be considered to serve as organising processes which help to galvanise changes.

Chapter 3 provided a case study to illustrate that change is sometimes necessary prior to release from prison settings. Initial assessment demonstrated the client in the case study presented with symptoms suggestive of anxiety and depression in relation to his ability to successfully reintegrate into the community post-release from prison and maintain employment so he would not return to his 'cycle' of offending. The client had acknowledged that he had to make changes to his lifestyle and thinking patterns in order to break his cycle of offending. The CRIME-PICS-II (Frude, Honess & Maguire, 1994), was one of the psychometric tools used to evaluate outcome change in the client's attitude towards offending which allowed for a measurement of outcome change following the intervention. The CRIME-PICS-II was further critiqued in Chapter 4, where the tool was found to be applicable to forensic and clinical settings as a means of measuring change in attitudes towards offending, as it can be administered a number of times to the same client, thus making it valuable in monitoring changes in terms of the clients general attitude to offending and in other variables measured by each of the scaled scores.

Limitations

Each Chapter of the thesis has individual limitations which are applicable to the differing styles of methods used to collect and analyse data. For example, the main limitations of Chapter 2 included the small sample size, and the methodology used, which included the limitations of the interview method and the qualitative analysis method selected. The case study in Chapter 3 also suffered from limitations, in relation to how treatment performance was measured, which was largely due to the academic nature of the case study in relation to resources available. Had this case study not been academic in nature, thus limiting time and resources, a battery of more

extensive measures could have been used. In Chapter 1, the main limitations in the systematic review include the degree of publication bias with regards to the studies selected, due to time and resource limitations during the searching stage. Other limitations included the varying method of outcome measures used across the studies, the differing length of treatment delivery and the details the control groups were subject to, which made comparisons difficult and less accurate. However, despite these limitations, and acknowledging the fact not all methodological problems can be solved, it is suggested that all studies evaluating treatment outcome should clearly articulate any methodological flaws, particularly when a resolution cannot be found.

Treatment Implications:

In terms of treatment implications, the results of the thesis provide several promising conclusions which may inform treatment. The review in Chapter 1, for example, presents encouraging findings that suggest any interventions with adult male MDOs, with the ultimate aim of reducing recidivism, should pay attention to the effectiveness of cognitive-behavioural interventions in this field of practice.

In Chapter 2 each of the barriers and facilitative factors for successful reintegration into the community elucidated within the study have potential clinical implications for work with adult male MDOs. As was highlighted in the introduction, the 'risk' component of rehabilitation suffers from a tendency to focus on risk reduction rather than positive ways of living. The results of the study in Chapter 2 suggest participants are often aware of this preoccupation with risk, and as a result experience a lack of attention paid to their personal identity and human needs (Ward & Stewart, 2003). It is essential that during initial hospitalisation staff working in forensic mental health settings are aware of such experience of MDOs, endeavouring to form an empathic connection which places emphasis on the subjective experience of patients with the aim of developing a working therapeutic alliance (Cooke et al, 1994). In terms of treatment, it is essential that therapists cultivate attitudes of respect and openness, accepting that MDOs have their own views about what is important to them (Stark et al, 1992). Enquiring about individual goals is a first step in designing a rehabilitation plan for MDOs, as such an approach may also help motivate individuals during the difficult process of the behaviour change expected following discharge from FMHS.

The results of this study also indicate that continuum of treatment and community supervision after discharge from hospital are critical factors in the rehabilitation and community reintegration of MDOs (Kaufman, 2000). Participants in the present study agreed that being supervised in the community after their conditional discharge was necessary for successful rehabilitation. The study revealed how both the availability of formal social support mechanisms and family and social relationships play a central role in the reintegration process (Repper & Perkins, 2003). With this in mind, continuous rehabilitation that fosters a continuum of treatment with community supervision and is family-inclusive is highly desirable and recommended.

Chapter 3 suggests that by addressing the common mental health problems of prisoners they are more likely to rehabilitate into their communities successfully, achieving a better quality of life upon release. Indeed, Woolf and Tumin (1991) emphasise the importance of rehabilitation in prison which is intended to prepare the individual for their eventual reintegration into the community post-release. It seems reasonable, in this instance, to conclude that short-term changes in interpersonal problem solving, cognitive style, social perspective taking and critical reasoning can be achieved with a cognitive-behavioural approach, as was demonstrated in Chapter 3. In terms of the clinical implications of the case study, prisoners as a population warrant more attention than they currently receive, in particular, promoting and supporting health behaviour change among prisoners should receive a much greater emphasis, where primary care in prisons should play a central part (MacKenzie & Goodstien, 1985). However this argument is set in a context where custody may be viewed by the public as essentially punishment and the current economic case for spending on treatment in prison is poorly articulated. Whilst forensic psychologists have a key role in examining the treatment efficacy of individual interventions in prisons, there is also a need for forensic psychologists to contribute to the wider public policy debate around the costs of offending versus the costs of psychological interventions.

Future Directions

When considering the future directions of research, future enquiry could proceed in multiple ways. When considering evaluation studies of treatment effectiveness, as

were reviewed in Chapter 1, an evaluation of the studies revealed significant inconsistencies regarding the quality (and reporting) of treatment delivery and programme integrity throughout. It is now essential to develop further methodologically rigorous explorations in the area of cognitive-behavioural interventions with MDOs. Recommendations for future research include that evaluation studies should attempt to include comparison groups, and ensure follow up is complete. Attention should also be paid to the treatment control groups receive. Ethical aspects of any study should always be transparent in any publication, and adhered to strictly. Clear statistical outcomes should always be provided and studies should attempt to include validated and standardised measurements, carrying out long-term follow-up assessments. When considering the future of research on the topic of MDOs who have been conditionally discharged, it is important for future studies to include diverse samples across different service settings, including subgroups of offenders, and those that are unsuccessful in their journey towards reintegration. Future research might also involve implementing some of the recommendations made in light of the clinical implications of findings, to evaluate the outcomes in terms of improving the rehabilitation process. It is only by further exploration of the treatment and evaluation of MDOs that practitioners will be aware of effective intervention targets and ways of working with such offenders. In Chapter 2, the participants employed discussed how structurally and theoretically there are strong parallels between psychiatric hospitals and prisons, with MDOs often beginning their journey through forensic mental health systems in prisons. With this in mind, it is therefore also important to focus on the extent to which prisons play a role in the overall rehabilitation process, which is largely due to prevalence of mental disorder in the prison population (Brooke, Taylor, Gunn & Maden, 1996).

Conclusion:

A continuing culture of interest among researchers and practitioners is the best way to progress in terms of rehabilitating adult male MDOs, which should take into account the views of those subject to rehabilitative practices, as was demonstrated in Chapter 2. This thesis acknowledges the limitations of the work presented, highlighting that it is essential to continue to investigate 'what works' with MDOs, with recognition of responsivity issues to investigate 'what works with whom?'

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Appendices

Appendix 1: Search Syntax from Electronic Searches

Notes: ** = unlimited truncation – this sign retrieves all possible suffix variations of the root word indicated; mp. = search as keyword; exp. = explodes search terms to include all sub-headings within the search strategy.*

Database: PsycINFO <1980 to August Week 3 2011>

1 exp Mental Disorders/ or mental* ill*.mp. (380180)
2 mental* ill*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures] (34769)
3 exp Psychosis/ or mental* disease*.mp. (82614)
4 mental* disease*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures] (2916)
5 mental* disorder*.mp. (86562)
6 mental* disorder*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures] (86562)
7 psycho*.mp. (876885)
8 psycho*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures] (876885)
9 schizophren*.mp. or exp Schizophrenia/ (89791)
10 schizophren*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures] (89791)
11 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 (1115612)
12 exp Criminal Behavior/ or exp Criminals/ or offend*.mp. or exp Perpetrators/ (43937)
13 offend*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures] (24786)
14 criminal*.mp. or exp Criminal Behavior/ (47589)
15 criminal*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures] (36199)
16 exp Perpetrators/ or perpetrator*.mp. (22212)
17 perpetrator*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures] (8670)
18 forensic*.mp. (12625)
19 forensic*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures] (12625)
20 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 (70590)
21 11 and 20 (32204)
22 cognitive behavio*.mp. (24435)
23 cognitive behavio*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures] (24435)
24 cognitive therap*.mp. or exp Cognitive Behavior Therapy/ (19580)
25 cognitive therap*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures] (12470)
26 exp Cognitive Behavior Therapy/ or exp Treatment Outcomes/ or treatment outcome*.mp. (36563)
27 treatment outcome*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures] (26251)
28 cognitive behavio* therap*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures] (13539)
29 cognitive behavio* treatment*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures] (3133)
30 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 (56986)
31 21 and 30 (1121)
32 limit 31 to (english language and yr="1980 -Current") (1042)
33 from 32 keep 1-1042 (1042)

Database: Ovid MEDLINE(R) <1980 to August Week 2 2011>

1 exp Mental Disorders/ or mental* ill*.mp. (838124)
2 mental* ill*.mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier] (25108)
3 exp Schizophrenia/ or exp Mental Disorders/ or mental* disease*.mp. (832014)
4 mental* disease*.mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier] (1864)
5 mental* disorder*.mp. or exp Psychotic Disorders/ (154564)
6 mental* disorder*.mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier] (124570)
7 psycho*.mp. (767943)
8 psycho*.mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier] (767943)
9 exp Schizophrenia/ or schizophren*.mp. (95870)
10 schizophren*.mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier] (95660)
11 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 (1343642)
12 offend*.mp. (9136)
13 offend*.mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier] (9136)
14 criminal*.mp. (17854)
15 criminal*.mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier] (17854)
16 perpetrator*.mp. (2664)
17 perpetrator*.mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier] (2664)
18 forensic*.mp. (43222)
19 forensic*.mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier] (43222)
20 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 (65586)
21 11 and 20 (21004)
22 cognitive behavio*.mp. (10472)
23 cognitive behavio*.mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier] (10472)
24 cognitive therap*.mp. or exp Cognitive Therapy/ (12564)
25 cognitive therap*.mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier] (12564)
26 cognitive behavio* therap*.mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier] (5151)
27 cognitive behavio* treatment*.mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier] (1136)
28 exp Treatment Outcome/ or treatment outcome*.mp. (517157)
29 treatment outcome*.mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier] (498454)
30 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 (529208)
31 21 and 30 (774)
32 limit 31 to english language (732)
33 limit 32 to yr="1980 -Current" (725)

Database: Embase <1980 to 2011 Week 33>

1 exp mental disease/ or exp schizophrenia/ or mental* ill*.mp. (1289889)
2 mental* ill*.mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword] (22692)
3 exp psychosis/ or mental* disease*.mp. (293848)
4 mental* disease*.mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword] (140932)
5 mental* disorder*.mp. (39813)
6 mental* disorder*.mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword] (39813)
7 psycho*.mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword] (994068)
8 psycho*.mp. (994068)
9 schizophren*.mp. (121393)
10 schizophren*.mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword] (121393)
11 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 (1851383)
12 offend*.mp. or exp offender/ (14908)
13 offend*.mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword] (14908)
14 criminal*.mp. or exp criminal behavior/ (21611)
15 criminal*.mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword] (21611)
16 exp offender/ or perpetrator*.mp. (8330)
17 perpetrator*.mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword] (3297)
18 12 or 13 or 14 or 15 or 16 or 17 (34640)
19 exp cognitive therapy/ or cognitive behavio*.mp. (29989)
20 cognitive behavio*.mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword] (15647)
21 cognitive therap*.mp. (24909)
22 cognitive therap*.mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword] (24909)
23 forensic*.mp. (60379)
24 forensic*.mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword] (60379)
25 18 or 23 or 24 (87606)
26 11 and 25 (39147)
27 exp treatment outcome/ or treatment outcome*.mp. (753571)
28 treatment outcome*.mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword] (532003)
29 cognitive behavio* therap*.mp. (8032)
30 cognitive behavio* therap*.mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword] (8032)
31 cognitive behavio* treatment*.mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword] (1756)
32 19 or 20 or 21 or 22 or 27 or 28 or 29 or 30 or 31 (775685)
33 26 and 32 (1702)
34 limit 33 to (english language and yr="1980 -Current") (1603)

Appendix 2: Exclusion/Inclusion Criteria

	Inclusion	Exclusion
Population	Male, aged over 18 and under 65 <u>Setting:</u> Mental Health/Psychiatric Inpatient Setting • **participants must be deemed to have presented offending behaviour** *Can include those in the General Psychiatric System who have not been charged or convicted of offences but nevertheless present offending/violent behaviour.* • **participants must be deemed to be mentally disordered*.** i) the diagnosis is in relation to either ICD or DSM criteria and is made using reliable validated research instruments OR ii) a differential diagnosis was made by medical practitioners/psychiatrists.	Females. Community and/or Probation Settings. Prison Settings Participants with organic brain diseases such as dementia or Alzheimer's Disease Participants with problems of substance abuse, personality disorder or learning disabilities in the absence of mental illness
Intervention	A structured psychological intervention based on cognitive behavioural principles*: (can be group-work or individual) **The treatment focuses on changing an individual's thoughts (cognitive patterns) in order to change behaviour and emotional state.*	An intervention targeted for: • Sex offenders • Domestic Violence • Learning Disabilities • Substance Abuse • Personality Disorders in the absence of mental illness
Comparator	Control Group	No control group
Outcome	***Primary outcomes :*** <u>Affective</u>: As measured by means of a standardised or non-standardised test. AND/OR: <u>Behavioural</u>: as measured by	No affective, behavioural or cognitive measures

	reconviction or caution (official records/administrative data/self report) or reduction in aggressive behaviour AND/OR: Cognitive: as measured by means of a standardised or non-standardised test. ***Secondary outcomes:*** Suicide or suicide attempts; Sudden and unexpected death by other causes; Leaving treatment early; Lost to follow up	
Study Design	Random control trials (experimental studies), controlled trials (quasi-experimental studies) or cohort studies.	Narrative, editorials, commentaries or other types of opinion papers. Non-published studies.
Language	English	Non-English

Appendix 3: Quality Assessment Checklist for Experimental Studies

Scoring Key: U = Unknown, 0 = Inadequate, 1 = Partial, 2 = Adequate	U	I	P	A

Sampling Bias

Are participants adequately described?
Are control groups matched?
Sample representative?
Controls representative?

Comments:

TOTAL /8

Selection Bias

Was the assignment of patients to the intervention randomised?
Was the randomisation scheme described and appropriate?
Study procedure concealed to the person who recruited and allocated participants?

Comments:

TOTAL /6

Performance Bias

Did all groups receive intervention they were supposed to?
Were the interventions consistent within each group?
Was the outcome assessment blind to all participants?
Was the assessor blind to the hypothesis?

Comments:

TOTAL /8

Measurement/Detection Bias

Was everyone assessed in the same way at baseline?
Was everyone assessed in the same way at follow up?
Were the measures used validated and standardised?
Were the assessment measures used comparable to those used in other similar studies?

Comments:

TOTAL /8

Attrition Bias

Were all of the patients who entered the trial properly accounted for at its conclusion?
Was follow up complete?
Were patients analysed in the groups to which they were randomised?
Are drop- out rates reported?
Were all clinically important outcomes considered?
Was there any statistical attempt to deal with missing data?

Comments:

TOTAL /12

Appendix 4: Quality Assessment Checklist for Observational Studies

Scoring Key: U = Unknown, 0 = Inadequate, 1 = Partial, 2 = Adequate	U	I	P	A

Sampling Bias

Is the cohort adequately described?
Are control groups matched?
Was the cohort representative of a defined population?

Comments:

TOTAL /6

Selection Bias

Study procedure concealed to the person who recruited & allocated participants?
Are groups similar at baseline? *(Age, diagnosis, location)*

Comments:

TOTAL /4

Performance Bias

Did all groups receive the intervention they were supposed to?
Were the interventions consistent within each group?
Was the outcome assessment blind to all participants?
Was the assessor blind to the hypothesis?

Comments:

TOTAL /8

Measurement/Detection Bias

Was everyone assessed in the same way at baseline?
Was everyone assessed in the same way at follow up?
Were the measures used validated and standardised?
Were the assessment measures used comparable to those used in other similar studies?

Comments:

TOTAL /8

Attrition Bias

Were all of the patients who entered the trial properly accounted for at its conclusion?
Was follow up complete?
Are drop- out rates reported?
Were all clinically important outcomes considered?
Was there any statistical attempt to deal with missing data?

Comments:

TOTAL /10

Appendix 5: Data Extraction Form

Name of Reviewer Extracting Data :	
Date of Data Extraction:	
Title of Paper:	
Author(s):	
Year, Source, Volume, Page(s)	
Country of Origin:	
Quality Assessment Score & N° of Unclear Answers:	

Re-verification of Study Eligibility:

		Yes	*No*	*Unclear*
Population:	*Setting: Mental Health (psychiatric inpatient)* *Participants: Male, MDOs aged between 18 - 65*			
Intervention:	*A structured psychological intervention based on cognitive-behavioural principles*			
Comparator:	*Control Group*			
Outcome:	*Affective, Behavioural or Cognitive Measures*			

Study Characteristics:

Aims/Objectives of the study:	
Study Design:	
Study Inclusion Criteria:	
Study Exclusion Criteria:	
Recruitment Procedures: (e.g. details of randomisation, blinding)	
Study Setting:	

Population:

Target Population:	
Participants Receiving Intervention: Age: Mental Health Diagnosis(es): Offending Characteristics: Total N° of Participants Approached:	

Total N° of Participants Enrolled: Total N° of Participants Completed:	

Comparator (Control Group):

Type of Control: (Tick)	No treatment Standard care Waiting list control Other:		
Control Group Matched?	Yes	No	Unclear
N° of controls: Details of control group:			

Intervention:

Name of Intervention:	
Type of Intervention:	
Details of Intervention: (What it included, content)	
Theoretical Basis of Intervention:	
Type of targeted behaviour: (Focus of intervention)	
How often and how long was it delivered for?	
Who was it delivered by?: (Level of training, profession)	
Sustainability (Any measures taken to ensure retention)	
Site of Delivery:	
Ethical Approval:	

Outcome/Outcome Measures

Measurement Used (name of tool or type of measurement):	Results Pre Intervention	Control Group Results	Results Post Intervention	Control Group Results
1)				
2)				
3)				
4)				
5)				
6)				

Summary of Results:

Length of time outcomes measured after initiation of the intervention	
Were tools validated and standardised?	
Any further post-intervention follow up assessments at a later date?	
Who carried out the measurement(s)?	
Secondary outcomes: *Suicide or suicide attempts, Sudden and unexpected death by other causes, Leaving treatment early (withdrawal), Lost to follow up. Any other outcomes?*	
Adverse Effects?	

Analysis

Statistical Techniques Used?	
Results of study analysis e.g. *Dichotomous:* odds ratio, risk ratio and confidence intervals, p-value *Continuous:* mean difference, confidence intervals	
How many participants included in final analysis? Drop-out rates and reasons for drop out:	

Appendix 6: Programmes Used in Studies Included

Programme	Description/Summary	N° of Studies
The Reasoning & Rehabilitation Programme	By targeting social-cognitive deficits and maladaptive thinking styles, incorporating skills-focused cognitive-behavioural approaches, offenders are encouraged to develop a repertoire of pro-social skills and behaviours as alternatives to criminal activities. The R&R programme, although essentially cognitive-behavioural, is a multi-modal programme which draws on cognitive theory for practice guidelines and appears to have a significant impact on offending behaviour. The programme covers 8 modules: Problem solving; Assertiveness skills; Social skills; Negotiation skills; Creative thinking; Emotion management; Values reasoning; Critical reasoning.	3
Anger Control Treatment	Intervention is based upon cognitive-behavioural and stress inoculation principles. Consists of cognitive and behavioural techniques through the problem situations provided by patients within the group. Each session has a specific focus for in-depth discussion, demonstration, or rehearsal. The contents of the sessions include: Identification and recognition of personal anger patters; Ellis's ABC of emotional arousal; Examination of personal assumptions and expectations; Identification of irrational ideas and Identification of differential strategies for various stressful situations. Techniques for anger modulation included self-instruction as both a preventative and coping strategy, assertiveness and relaxation training, cognitive reappraisal, thought stopping, and substitution and distraction techniques. Each session also contains a didactic component about the function and expression of anger.	1

Interactional Life Skills Group	Based on the premise that successful rehabilitation of offenders lies in reattaching them to more socialised others and reinforcing their commitment to work and conventional leisure pursuits. Having learned pro-social behaviours it is expected that participants will become better integrated into socially conforming groups and their tendency toward criminal behaviour should diminish. In terms of content, most of the sessions focus on the area of the self, with a secondary emphasis on leisure participation. Antisocial behaviours are identified by the use of inter-member feedback and opportunities for modifying these behavioural and experimenting with new and more socialised behavioural were provided. Pro-social behaviours are shaped by behavioural techniques practiced by the leader and imitated by the members. When interpersonal problems arise during the group, members are encouraged to cooperatively solve them by applying the strategies of problem solving. The group content involves: Modelling and reinforcement of pro-social behaviour and attitudes; Training in the use of cognitive problem-solving techniques, with applications to both concrete personal and abstract social problems; and the use of peer group reinforcements.	1
Psychoeducational Group	The group provides information about schizophrenia and its treatment and cognitive-behavioural elements are used to enhance patient's learning and coping. Participants are assigned homework between sessions. Topics covered in group sessions include: Orientation; Definition of schizophrenia and common symptoms; Diagnosis and aetiology of schizophrenia; Course of illness; Outcome of schizophrenia and warning signs of relapse; Causes of schizophrenia; The stress vulnerability model and the influence of stress; Substance abuse in schizophrenia; Antipsychotic medication; Psychosocial treatment of schizophrenia; Legal issues .	1
Aggression Control Therapy	ACT includes the modules: Anger management – recognising and managing feelings such as irritation, anger and rage; Social Skills – improving or extending relevant social skills; Moral Reasoning – becoming aware of current values and norms, and solving moral problems and Self Regulation – changing inadequate aspiration level,	1

	reinforcing oneself for attained results and making programmes for new behaviour. Participants receive a portfolio containing information brochures and homework assignments.	
The 'Psychotic Disorders' Treatment Programme	A cognitive-behavioural programme including: Psychoeducation Information on schizophrenia; Prospects for the future (grief processing); Stress management; Functional and skills training; Coping with psychotic symptoms; Social skills training; Domestic skills training; and Self-Care skills training.	1
The Reasoning and Rehabilitation 2 (R&R2)	The programme is unique in its inclusion of a module that focuses on cognitive impairments, for example, attention, memory and planning. The programme additionally incorporates a manualised 'coaching' paradigm whereby a member of staff meets with the patient between group sessions and helps them apply what they have learned in the sessions to their daily lives. The 'PAL' coaching role aims to help participants transfer skills learned in the group session to everyday activities. Course modules include: neurocognitive skills, interpersonal problem solving, emotional control, social skills and critical thinking.	1

Appendix 7: Systematic Review Poster Presented at BPS Division of Forensic Psychology 21st Annual Conference 2012

A Literature Review Following a Systematic Approach: Evaluating the Effectiveness of Cognitive-Behavioural Interventions with Mentally Disordered Offenders in Inpatient Settings

Suzannah Tyler, Shihning Chou & Nigel Hunt, Institute of Work, Health and Organisations, The University of Nottingham

1. Introduction

•Many forensic institutions adopt evidence-based treatments for mentally disordered offenders (MDO's) that are validated on other populations (Hoffman & Kluttig, 2006), often leaving forensic psychologists unsure as to which treatments are appropriate for MDO's (Rice & Harris, 1997).

•In the search for 'what works' with MDO's in reducing recidivism, research has demonstrated the efficacy of cognitive-behavioural psychological interventions (McGuire, 1995).

•Research to date does not yet permit empirically-based generalisations about treatment effectiveness (Hodgins, 2000) and involves a poor amount of outcome research with MDO's.

2. Aims & Objectives

•***Aims*** **:** To expand the current knowledge of the effectiveness of cognitive-behavioural interventions with forensic inpatients (MDO's), to provide clinicians working in these fields with an understanding of what is available and effective with these clients.

•***Objectives***: To determine if psychological interventions based on cognitive-behavioural principles are effective with male MDO populations in inpatient settings.

3. Source of literature

•Electronic databases (*Search terms are detailed in Box 1*):
- •OVID Medline (1948– 2nd week of August 2011)
- •OVID EMBASE (1980 – 2nd week of August 2011)
- •OVID PsychINFO (1806 – 3rd week of August 2011)

•Reference checking: existing systematic reviews and key studies

•Hand searching of key journals .

•Contact with experts

•Grey Literature

Box 1: Search Terms

(mental ill*) OR (mental* disorder*) OR (mental* disease) OR (schizophren*) OR (psycho*) AND (offend*) OR (criminal*) OR (perpetrator*) OR (forensic*) AND (treatment outcome*) OR (cognitive behavio*) OR (cognitive therap*) OR (cognitive behavio* therap*) OR (cognitive behavio* treatment*)*

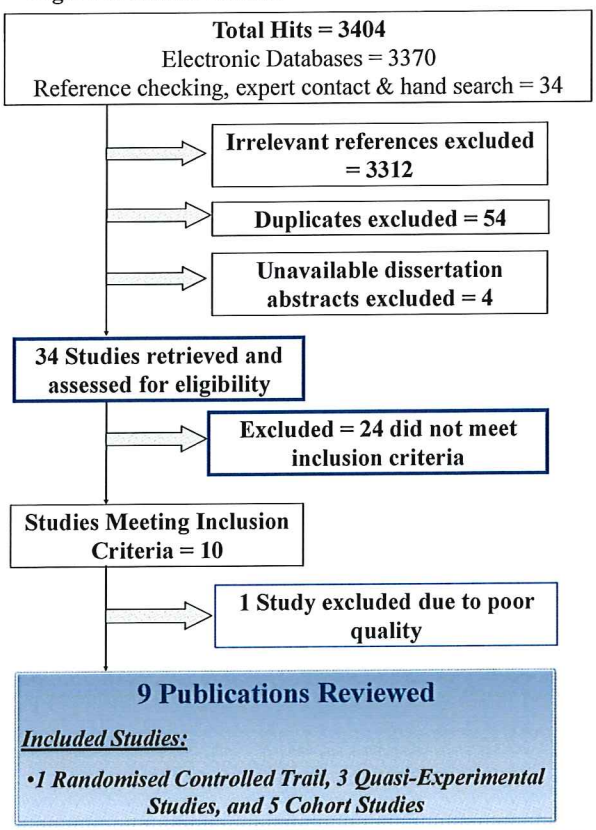
4. Inclusion criteria

To be included in the review, studies were required to meet the following criteria:

Population:	MDO's males aged between 18 and 65
Intervention:	Cognitive-Behavioural Psychological Intervention
Comparator:	Control Group
Outcome:	Primary Outcomes: Behavioural, Affective, Cognitive
Study type:	Experimental, Quasi-Experimental, Observational
Language:	English Only
Exclusion:	Narratives, editorials, commentaries

5. Search Results

Figure 1: Search Results



6. Results

•All 9 included studies were found to support the positive effects of the delivered interventions based upon cognitive-behavioural principles.

•Interventions based on cognitive-behavioural principles have the potential to improve: problem solving ability, social-cognitive skills, social adjustment, hostile and aggressive behaviour, and awareness of illness – ultimately bringing about a reduction of antisocial thinking and behaviour.

7. Conclusions & Recommendations for Future Research

•*Conclusions:* Structured psychological interventions based on cognitive-behavioural principles should be considered as a key component in the rehabilitation of MDO's.

• *Recommendations for future research:* Based on the findings, future studies evaluating the effectiveness of structured psychological interventions with MDO's should attempt to:

- Include control groups; ensure follow up is complete; report clear statistical outcomes - including statistical significance; adhere to ethical aspects; include validated and standardised measurements; carry out long-term follow-up assessments and clearly document any deviation from manualised programmes.

Select References

•Hodgins, S. (2000). Offenders with major mental disorders. In C. Hollin. (Ed.). *Handbook of Offender Assessment and Treatment*. (pp.433-415). Chichester: Wiley.
•Hoffman, K., & Kluttig, T. (2006). Psychoanalytic and group-analytic perspectives in forensic psychotherapy. *Group Analysis, 39, 9-23.*
•McGuire, J. (1995). *What Works: Reducing Offending: Guidelines from Research and Practice.* Chichester: Wiley.
•Rice, M.E., & Harris, G.T. (1997). The treatment of mentally disordered offenders. *Psychology, Public Policy and Law, 3, 126-183.*

Appendix 8: Study Advertisement

NLSI Study Advertisement: Final Version 2.0: 09-08-2011

Post Discharge Narrative Life Story Interviews with Conditionally Discharged Mental Health Patients

To: The Low Secure and Community & Forensic Mental Health Team

A study sponsored by the University of Nottingham is interested in discussing the conditional discharge experience with individuals who have been given a conditional discharge into the community following an inpatient stay in a secure setting. The study will be run at Whitchurch Hospital by Suzannah Tyler (Trainee Forensic Psychologist) and supervised by Mary McMurran (Nottingham University). The study will begin on March 2011 and will end on November 2011. For the purpose of this study we are looking to recruit participants matching the inclusion criteria listed below:

Inclusion Criteria:

- *Male*
- *Over the age of 18*
- *Has at least one previous conviction for a criminal offence.*
- *Diagnosed with a mental disorder as specified by mental health legislation (Mental Health Act (MHA) 1983: 2007). (This definition will allow for the inclusion of participants with a mental illness, personality disorder or both to be included in the study).*
- *Previously sectioned under Part 3, Section 37 (Hospital Order) of the Mental Health Act (1983) and consequently admitted to either a: Low; Medium; or High Secure Unit.*
- *Previously conditionally discharged at some point during their care (Under Section 41 of the MHA).*
- *Still under the care of the multidisciplinary team (If they are not, they are not likely to be contacted as staff will be unaware of their current circumstances).*
- *Individual is either:*
    - *In the community living independently;*
    - ***OR** in a supported accommodation;*
    - ***OR** a current inpatient due to:*
        - *An informal admission*
        - ***OR***
        - *An admission under a Civil Section (Section 2, 3, 5.2, 5.4) as instructed by the Multi-Disciplinary Team*
        - ***OR** recall through the Ministry of Justice under Section 37/41 of the MHA.*
- *Has the ability to give Informed Consent*

Exclusion Criteria:

- *Prisoners and those under a probation order from the courts*
- *Currently Sectioned under one of the following of the MHA:*
    - *Section 47 (Sentenced prisoners,*
    - ***OR***
    - *Section 48 (Those on remand and those convicted but awaiting sentence),*
    - ***OR***
    - *Section 49 (Restriction) as this would render them a prisoner.*
- *Unable to understand and speak English*
- *Currently displaying any significant cognitive impairment that would render them unable to concentrate during the study interview (eg: side effects of medication, active psychotic illness, under the influence of drugs or alcohol)*
- *The interview is thought to cause them distress*
- *Others consider their risk level too high to be interviewed in a 1:1 setting*

The research team would greatly appreciate your help in referring participants to the study. If you know of any patients under your care that may be interested in participating and match the study inclusion criteria please contact Suzannah for further details. For any other enquires please also contact Suzannah.

Many Thanks for your time, Suzannah Tyler, Co-Investigator

Telephone: 02920336096/ E-mail: suzannah.tyler@wales.nhs.uk

Appendix 9: Participant Information Sheet

Participant Information Sheet: Final Version 3.0 31-08-2011

Short Study Title: Narrative Life Story Interviews

Name of Researchers: Mary McMurran (Chief Investigator) and Suzannah Tyler (Co-Investigator)

This is a student research project, being carried out for the purpose of an academic course and qualification by Suzannah Tyler – a student of Nottingham University.

We would like to invite you to take part in a student research project that has been organised by the University of Nottingham. This research is being carried out as a part of an academic course and qualification by the student Suzannah Tyler. It is not part of your treatment plan.

Before you decide, it is important that you understand why the research is being done and what it would involve for you. Please read this information sheet carefully. Talk to other people about the study if you wish, and ask us if there is anything that is not clear. Please take your time to decide whether or not you want to take part. Reading this information sheet should take about 20 minutes.

What is the purpose of the study?

The purpose of this study is to gather information about engagement with services, and for the student Suzannah Tyler to investigate an area of research for an academic course at the University of Nottingham. During the study researchers are hoping to interview individuals who have been previously given a conditional discharge from mental health services into the community. We would like to find out how these individuals are able to live in the community successfully, or in less successful cases, what went wrong. We are interested in the events that led to an admission to hospital, and to the conditional discharge. We are also interested in the individuals time spent in the community, and would like to talk about what made this experience difficult or successful.

Why have I been invited to take part?

The reason you have been asked to take part is because we are interested in talking to you about your time spent before, during and after your hospital admission. You have been referred to the study by a member of your clinical team. You are one of several individuals who have been invited to take part in the study, because you have had the experience of a conditional discharge.

Do I have to take part?

You do not have to take part in this study, and it is up to you to decide. Taking part in this study is not part of your treatment plan. This study is not connected to the care you receive from the community forensic or low secure team, and if you choose not to take part, it will not go against you. Before you decide to take part, we will go through this information sheet with you and tell you about the research. You can have a copy of this information sheet to keep.

What will happen if I decide to take part?

If you would like to talk about the study or ask any questions the researcher will meet with you in person or will telephone you. If you decide you then want to take part the researcher will arrange a time to meet and carry out the interview; you will receive details of this from the researcher. You will be asked to come into Whitchurch Hospital and attend the meeting; which will be arranged at a time to suit you. At this meeting we will ask you to fill in a consent form to show you have agreed to take part in the research. You will keep a copy of the consent form. After you have signed the consent form you can still decide not to take part, without giving a reason. When you have completed the consent form you will begin the interview with the researcher.

What will I have to do?

If you decide to attend the meeting, you will meet the researcher in a private room. To take part in the study you will be asked a number of questions in an interview setting with the researcher, and will only have to do this once. This interview may take up to two hours of your time. These interviews will be recorded using a tape recorder. During the interview you will be asked about your time spent in the community before you came into hospital, which may involve you talking about any past behaviour that may have brought you into contact with the law or a mental health team. You will also be asked questions about your time spent in hospital, and in the community after you were given a conditional discharge. For example, the questions will ask you about the care you have received and how helpful you found this. Even during the interview it is still OK to decide to withdraw from the study, just let the researcher know if you are not happy with continuing.

Travel Expenses

The researcher will arrange for your bus, train, fuel or taxi fare to be paid if you wish to take part in the study.

What are the possible disadvantages and risks of taking part?

If you decide to take part you will have to give up a bit of your time to complete the interview. It is very unlikely that taking part in this study will cause you any harm. However, some of the things we might ask you to talk about in the interview may bring back upsetting memories that might be difficult to talk about, but you do not have to discuss anything you do not feel comfortable with and you can refuse to answer any questions. However, If you do wish to talk about memories that might be upsetting, support will be there for you during and after the interview. Your mental

health team or the research team can provide support if you find the interview upsetting or need extra support. The following contacts are also available: The Community Advice and listening line – 0800 132737 and The Samaritans – 02920 344022.

What are the possible benefits of taking part?

We cannot promise that taking part in this study will help you personally, but we hope this research may help us improve the services offered to people who are given a conditional discharge in the future.

What happens after the research study stops?

After you have completed the interview you will be free to leave. You will not have to attend anymore appointments. Even after you have completed the interview, you can still decide to withdraw from the study. This can be done by contacting the researcher (details below) and letting them know. If you would like a summary of the study findings in the post, you will need to leave your contact information with the researcher.

If the study is stopped for any reason we will tell you. If any members of your clinical team think that it is in your best interest to withdraw from the study, this will be explained to you.

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

You can stop taking part in the study at any time. You do not have to give a reason, but this information can help us identify problems with the study. If you decide to stop taking part, it will not affect your future care or your legal rights and it will not go against you. If you withdraw then the information collected so far cannot be deleted and may still be used in the research report.

What if there is a problem?

If you are worried about any part of this study, you should speak to the researchers, their contact details are at the end of this information sheet. If you are still unhappy and want to complain you can do this through the NHS Complaints Procedure. Your mental health team will give you the details on how to do this.

Will my taking part in this study be kept confidential?

Yes. Your interview will be tape recorded and written up, but will not be identified with your name. The tapes will not have your name on them, and will be stored securely and confidentially.

The interview you take part in will only be used for this study. The results will be included in a research paper that may be published for the general public to access. The research paper may include some direct quotes that you have said, however your name or any identifiable information (names, dates, places and events) will not be mentioned in any of the results.

All information which is collected about you during the research will be kept securely and strictly confidential, and any information about you which leaves the hospital will have your name and address removed so that you cannot be recognised. An exception to this will be your consent form, which will include your name where you sign to consent to the study. Your consent form will be kept securely and confidentially at the University of Nottingham. If you wish to receive a summary of the study findings in the post you need to leave your name and address with the research team. Your name and address will be kept separate to any other data.

If you join the study, the researchers will look at your mental health records to collect and record some information. For example, details of your previous stays in hospital and diagnosis. The researchers will treat this information in the strictest confidence and only use it for the research. We will ask you to confirm on the consent form whether this is OK.

Will you tell anyone else that I'm taking part?

If you take part in this study we will make your responsible clinician aware that you are taking part in a research project so they will know what we will be talking to you about. We will ask you to confirm on the consent form whether this is OK.

The interviews are confidential. However, sometimes researchers must tell other people if important information is told to them. If during your interview the researcher thinks there is a serious concern about your safety, the safety of others, or the health, welfare or safety of children or vulnerable adults, the researcher has a professional duty to share such information. They must tell your clinical team. You will be told what has been said and to whom if this happens.

What will happen to the results of this research study?

The information collected from this study will be written up and published to tell others about the research. The report will not identify any individual participants and will not use any identifiable information about them.

Who is organising the research?

This study is being organised by The University of Nottingham and is being carried out at the Cardiff and Vale Local University Health Board.

Who has reviewed this study?

All research in the NHS is looked at by a group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by North Wales Research Ethics Committee (Central & East).

Further Information and Contact Details

For further information about this study please contact either of the researchers below:

Co- Investigator: Suzannah Tyler

Whitchurch Hospital
Community Forensic Team
Park Road
Cardiff
CF14 7XB
Tel: 02920336096
Email: lwxsmt@nottingham.ac.uk

Chief Investigator: Mary McMurran

University of Nottingham
Sir Colin Campbell Building
Triumph Road
Nottingham
NG7 2TU
Tel: 01158231299
Email: mary.mcmurran@nottingham.ac.uk

For further independent advice about taking part in the research please talk to a member of your mental health team, or visit the Patient Advice and Liaison Service found at www.nhs.uk.

Your mental health team:

The person who referred you to this study is_____

The team they work with is: Whitchurch Hospital Low Secure and Community Forensic Mental Health Team

Appendix 10: Consent Form

The University of Nottingham

CONSENT FORM
(Final Version 3.0: 31-08-2011)

Title of Study: Narrative Life Story Interviews
REC ref: 11/WA/0230

Name of Researchers: Suzannah Tyler (Co-Investigator); Mary McMurran (Chief Investigator)

Name of Participant: **Please initial box**

1. I confirm that I have read and understand the participant information sheet version number 3.0 dated 31-08-2011 for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐

3. I understand that relevant sections of my medical notes and data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential and I will not be personally identified in any published reports. ☐

4. I agree to my responsible clinician being informed of my participation in the study. ☐

5. I understand that the interview will be recorded and that anonymous direct quotes from the interview may be used in the study reports. ☐

6. If I want a copy of the study results I will have to provide my name and address, which will be kept separate from the study data. ☐

7. I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

(3 copies: 1 for participant, 1 for the project notes and 1 for the medical notes)

Appendix 11: Interview Schedule

The University of Nottingham

NLSI: Interview Schedule: Final Version 1.0; 05-07-2011

When you are ready to begin I will start the study interview and begin the tape recording.

(Any extra notes to be made on this form)

Participant Number: _____

*Date of Interview:*_____

Questions *(PROMTS IN BLUE INK)*

1. Identify Major Life Chapters

I would like you to begin by thinking about your life as if it were a book. Each part of your life composes a chapter in a book. Certainly the book is unfinished at this point; still it probably already contains a few interesting and well defined chapters.

For the purpose of this study I am specifically interested in three of your life chapters: these chapters are:

- Chapter a) The chapter before you came into contact with mental health services, including the time when you were involved in any behaviour that may have brought you into contact with a mental health team or the law.
- Chapter b) The chapter that describes your time spent in hospital, and any memories from this time in your life
- Chapter c)The chapter that describes your time spent in the community after you were given conditional discharge

If we take each chapter in turn, please could you describe each chapter in as much detail as you can remember, and you feel comfortable with, and give each chapter your own name.

Let's start with chapter a) The chapter before you came into contact with mental health services, including the time when you were involved in behaviour that may have brought you into contact with a mental health team or the law.

**Make sure participant understands exactly what this chapter is. This is time in the community, before you came into hospital or prison (if applicable)*

Would you like to give this chapter a name?

**Prompt individual to name this chapter, this can be done after the chapter has been described if easier*

Can you tell me about this chapter in your life?

**This includes time spent before and during any offending periods*

What can you remember about this period of your life?

Where were you living, and what were you doing at the time?

Can you recall having any signs of a mental illness at this time?
If yes: do you think this affected this period of your life?

What were the circumstances that brought you into hospital?

How did you feel about the court's decision?

How did you feel about this at the time?

Did anything change significantly for you?

Did you notice a change in yourself?

Where there any changes in your relationships with others around you?

If we move on to chapter b now, which is the chapter that describes your time spent in hospital, can you tell describe the transition from chapter a) to the next chapter?

**Make sure participant understands exactly what this chapter is. This is time spent in hospital under the care of a MDT. This can involve multiple placements following on from each other, and transfers from different hospitals*

Let's discuss chapter b.

Would you like to give this chapter a name?

**Prompt individual to name this chapter, this can be done after the chapter has been described if easier*

Can you tell me about this chapter in your life?

**This includes time spent in hospital under the care of a MDT. This can involve multiple placements following on from each other, and transfers from different hospitals*

What can you remember about this period of your life?

Can you recall having any signs of a mental illness at this time?
If yes: do you think this affected this period of your life?

What was the most difficult experience whilst being in hospital?

How did you cope during this time?

Can you remember anything about the type of care or help you were offered?

How did you spend your time during your stay in hospital?

Was there anything helpful about being in hospital?

How did you react to the care being offered or given to you during your time in hospital?

If we move on to chapter c now, which is the chapter that describes your time spent in the community after you were given conditional discharge, can you tell describe the transition from chapter b to the next chapter?

What were the circumstances that brought you out of hospital?

How did you feel about the court's decision to grant conditional discharge?

How did you feel about this at the time?

Did anything change significantly for you?

Did you notice a change in yourself?

Where there any changes in your relationships with others around you?

Let's discuss chapter c)

**Make sure participant understands exactly what this chapter is. This is time spent in the community with a conditional discharge, and includes current circumstances.*

Would you like to give this chapter a name?

**Prompt individual to name this chapter, this can be done after the chapter has been described if easier*

Can you tell me about this chapter in your life?

This includes time spent out of hospital in the community.

What can you remember about this period of your life?

Can you recall having any signs of a mental illness at this time?
If yes: do you think this affected this period of your life?

What was the most difficult experience whilst being out of hospital?

How did you cope during this time?

Can you remember anything about the type or care or help you were offered when you first left hospital?

I'd like you to tell me a bit about your current circumstances.

Is individual still in the community?

YES: ****(ONLY If individual is still in the community)***

What kind of care or help are you currently being offered?

Is there anything about his support that is helping you in the community?

How do you spend your time in the community now?

How do you cooperate with the care being offered or given to you currently?

Do you think you are resettling successfully?

What's been helpful in helping you change?
**(Now go to Q2)*

NO: ****(If individual has been recalled, or due to an informal admission is now a current inpatient)***

What were the circumstances leading to your recall/informal admission?

Who or what do you believe was responsible for your recall/informal admission?

How is this current admission different from (the) previous admission(s)?

What are the next steps in your current care plan?

2. Identify Key Events

Thank you. I'd like to move on now to some key events in your life. Can you tell me about a time when you underwent a significant change in your understanding of yourself or a turning point?

What happened?

Where were you?

What did you do?

What were you thinking at the time?

What were you feeling at the time?

Try if you can to convey the impact this event has had in your life story and what this event says about you as a person.

Did this event change you in any way, if so in what way?

Can you tell me a bit about the most difficult period in your life story?

What happened?

Where were you?

What did you do?

What were you thinking at the time?

What were you feeling at the time?

Try if you can to convey the impact this event has had in your life story and what this event says about you as a person.

How did you deal with it?

Did this event change you in any way, if so in what way?

Can you tell me a bit about a high point in your life story?

What happened?

Where were you?

What did you do?

What were you thinking at the time?

What were you feeling at the time?

Try if you can to convey the impact this event has had in your life story and what this event says about you as a person.

How did you deal with it?

Did this event change you in any way, if so in what way?

What would you consider to be the most important intervention in your lifetime?

When did this occur?

Who was responsible?

How did it affect you?

3. Identify Significant Others

Most individuals' life stories involve a few significant people who have had a major impact on their life. These may include parents, children, friends, spouses, carers or members of the team who were responsible for your care or still are.

- Chapter b) were there any significant people who played an important part in your life during this time?

Can you describe the relationship you had with them and how they have made an impact on your life – this impact can be positive or negative.

- Chapter c) were there any significant people who played an important part in your life during this time?
-

Can you describe the relationship you had with them and how they have made an impact on your life – this impact can be positive or negative.

4. Discuss a future Script

Now you have told me about your past and present, I would like you to think about the future. Think of this part of the interview as your future plans for what happens next in your life.

Goals?
Interest?
Hopes?
Aspirations?
Wishes?

Is individual still in the community?

YES: ***ONLY if the individual is still in the community***

What do you think would help you to stay successful in the community?

What do you think has helped you to remain successful in the community?

NO ***ONLY if the patient has been recalled or admitted informally and is an inpatient***

What are your plans towards discharge?

What are your hopes for future discharge?

What do you think needs to change in your care for you to remain successful in the community in the future?

5. Discuss Stresses and Problems

All life stories include significant conflicts, unresolved issues, problems to be sorted and periods of stress. I would like you to think about some of these now.

Are there any areas of your life now where you are experiencing

- Significant stress?
- A difficult problem or challenge that must be addressed?
- Do you have any current treatment needs?

**For each applicable one:*

Can you describe the nature of the stress?

Can you describe the problem or conflict in some detail?

Can you outline the source of your concern?

Can you provide a brief history of its development?

Do you have any plans for dealing with it in the future?

6. Consider Personal Ideology

Can you tell me a little about your beliefs and values?

Eg: religion, beliefs, values.

Have these changed over time?

7. Describe an overall life theme

Looking back over your story can you describe a central theme or message, or idea that runs throughout?

What is the major theme of this period in your life?

Debriefing

The interview is now finished. Many thanks for your time and cooperation. Your participation is greatly appreciated.

- Do you have any questions?
- Was there anything that we have discussed that has upset you or you think might upset you at a later date?
- Would you like to leave your contact details with me so that you can receive a summary of the results? These results will be posted to you.

I'd like to remind you that your participation will remain completely anonymous and confidential and you may still decide to withdraw if you wish. If you should decide to withdraw from the study please contact me, or let a member of your clinical team know. Please feel free to ring me if you have any further questions regarding this study. If this study has caused you any distress please does not hesitate to contact either myself or a member of your clinical team for further support or information. You may keep a copy of the participant information sheet, and I will be giving you a copy of your consent form

**Participants to be given a travel expenses reimbursement form for them to claim any expenses that occurred as part of their participation. Inform participants of where and how they can collect this money.*
**In the event that any disclosures to the clinical team must be made discuss with participant the details that will be disclosed, the reason for disclosure and to whom the disclosure will be made.*

Appendix 12: Letter to Responsible Clinician

The University of Nottingham

Letter to Responsible Clinician: Final Version 3.0: 31-08-2011

[Address]

[Insert Date]

Dear [Insert Responsible Clinicians name]

Re: [Patients name and D.O.B]

The above named individual has voluntarily taken part in a research study organised by The University of Nottingham. This study has gained favourable ethical approval by the North Wales (Central & East) Research Ethics Committee. Taking part in the study involved attending an interview with the researcher and discussing previous life events. In particular we discussed the patient's experience of their previous conditional discharge into the community.

The interview took place on [insert date and time] at Whitchurch Hospital.

If you would like further information on the study, or to speak to someone regarding the patient's involvement, please do not hesitate to contact the research team. A copy of the Participant Information Sheet for the study is attached for your information. [Attach NLSI Study: Participant Information Sheet: Final Version 3.0: 31-08-2011]

Yours sincerely,

Suzannah Tyler,
Co-Investigator

Mary McMurran
Chief Investigator

Appendix 13: Summary of Results for Participants in Study

The University of Nottingham

[Address]

[Insert Date]

Dear [Insert participants name]

Re: Narrative Life Story Interview Study

As you may remember, you kindly took part in a research study at Whitchurch Hospital. The study was looking at how people experience hospital and how people cope with the experience of conditional discharge. The study aimed to gather information about what made these experiences difficult or helpful. At the time of your interview I told you I would send you a copy of the results if you so wished. I have now completed all of the interviews and I am writing to let you know what I found. Below is a summary of the main study findings:

- The early days of hospital can be difficult due to a loss of freedom, restrictions, and unhelpful medication. Being diagnosed with a mental illness can also be a difficult experience.
- At times, having staff around is helpful, but sometimes having to talk to people is not easy.
- Whilst in hospital the support of friendly and helpful staff is important. Having family and friends around to offer practical and emotional support can also be helpful, but sometimes friendships and family relationships can be difficult to keep when in hospital.
- Following a conditional discharge, moving into supported accommodation with staff for support can sometimes be helpful.
- Supported community accommodation is sometimes more relaxed and comfortable than hospital, and the staff support can sometimes be helpful if things go wrong.
- Moving through hospital and into the community is sometimes seen as a 'journey'.
- When it works, medication can be helpful.
- Having goals for the future can help to stay positive about things.

I am extremely grateful for your participation in the study. If you have any questions please feel free to contact me.

Thanks once again for taking part in this study,

Yours sincerely,

Suzannah Tyler, Trainee Forensic Psychologist

Appendix 14: Coding Frame

	CODE	DESCRIPTION	EXAMPLES
1.	FREEDOM-WANTING	When participants talk about wanting to have their freedom back, and how having their freedom taken away from them was difficult.	*My freedom was taken away from me.* *There was nothing difficult about it just losing my freedom really* *... I think the most difficult part was having your freedom taken away, the ability to just go out, if you want to go to the shops just go...yes its difficult being locked up...*
2.	FREEDOM - HAVING	When participants talk about having freedom, when they were out of hospital, any instances where freedom is discussed as a positive outcome when in the community	*I was really happy, I was glad to get out and have my life and my freedom back, to get on with things and do something with my time. I was able to go for walks and that then, whenever I wanted. It made me a lot happier.* *...I was having overnights...so it was giving me a taste of freedom then, and it was, and nourishment for my soul really, when I was able to be free again... it's great to be able to just go out, go on a bike, or catch a bus somewhere...it's the freedom...*
3.	INDEPENDENCE	Participants talk about being independent, and enjoying independence	*...I loved having my flat on my own...I had some good times, I loved having a place of my own...* *... I'd like to live independently without any medication, but I realise I need it so that's ok.*
4.	AUTONOMY-LOSS	Participants talking about when decisions were made for them and they didn't have a say, or weren't sure of what was happening, or weren't happy with decisions made on their behalf	*Well as far as I see it, it doesn't matter what my plans are. I don't know what I'm supposed to do to get out, and I mean, well I don't know why I'm even here, so how would I know how to get out! I don't have a say, and no one tells me anything about what's going on.* *They don't tell me everything about my care either, and I think this is because they think I will worry too much, but I would like to know what's going on.*
5.	AUTONOMY-TAKING	Participants attempting to regain control over their own lives and their care, and taking responsibility for their wellbeing	*Myself. Looking after myself has helped.* *...I've got to give myself a pat on the back,... I've worked hard, umm so I don't see anything wrong with saying I've helped myself to remain successful...the staff can't do everything for me, and the staff can't do everything for me, some of it has to come from me...*

6.	EMPLOYMENT	Any discussion of employment, whether in the past, or current, or hopes for in the future. Any discussions of employment difficulties or breakdowns, or periods of unemployment.	*I was unemployed through all that, on the dole and that.* *...when I came out of prison I actually got a job, didn't keep the job for very long about 6 moths, got the sack cos I never used to turn up to work...*
7.	NORMAL LIFE	Participants refer to their life before hospitalisation or illness as 'normal', or talk about wanting to live a 'normal' life. Note what their definition of normal is when coding.	*...I mean I had a normal life, I had friends, and I used to go out fishing regularly with some friends, umm, I had a girlfriend and that sort of thing. Normal sort of stuff really...Yes I can say I was living a normal life before I became ill.* *In Hospital the hardest thing to do was umm, just live a normal life, because it wasn't a normal existence.* *... by then I had a house, I had a mortgage, a car a job, I had all that stuff...*
8.	LOSS OF MEMORY	Participants cannot answer a question because they can't remember	*I can't remember what I was doing then* *I can't remember*
9.	SUICIDE	Participants talk of suicide in the context of: feeling suicidal at a point in their life or discuss a specific suicidal attempt	*It was suicide. I was trying to top myself, and according to the law, attempting to commit suicide is wrong... after I came in, it wore off.* *I actually tried to take an overdose while I was there, because they were giving me drugs, psychiatric drugs and umm, I used to store them up, you know...*
10.	STIGMA-HOSPITAL	Participants talk about the stigmatising effects of being in hospital. Often referred to as 'a place like this'. Any incidents where 'hospital' is referred to as a place which is seen in a negative light. Any reference to other patients as being 'worse'	*... I felt like I was a criminal when I was there, because I was with lots of people who had done awful things, murders and rapists and all that sort of thing... I started questioning myself as to whether I was a criminal, I was evil or whether I was dangerous to the public* *... some of these I know from the hospital, and they're not good people, I don't like them. So I don't really like being here... they're not good people. Some of them have done terrible things, and I don't want to be around people like that.*

11. STIGMA-ILLNESS	Participants talk about the stigma of being a mental health patient or a patient under a section.	*...they don't seem to realise, they see you as just a danger when your back and forth like this...they labels you and it's hard to come off it.* *The stigma of mental health, that's got to change ...because the media are so so, umm sensational, in their, in...they want people to have a history of mental illness, you know when someone kills someone or something like that the first thing they say is oh they had a history of mental illness...and it makes us feel terrible you know.*
12. BLAME-DRUGS	Where a participant blames their mental illness or offending on their drug use	*... I've just smoked a lot of cannabis, which can make you paranoid, and sometimes I lose concentration, and don't realise what I'm doing.* *I was on drugs, but when I was arrested I stopped taking them, and then I just got better really... I didn't know what I was doing I was off my head at the time, if I was alright I wouldn't have done it.*
13. BLAME-OTHERS	Reference to other people outside of hospital who were a bad influence, not other patients or staff, but people in the community.	*...I used to get paranoid about the neighbours...who were being raided by the police and that, they weren't very good characters really.* *...what you find with some of the hostels, umm boys who are drinking and using drugs and umm...it's hard not to get involved like, umm...a lot of people seem to do it,*
14. BLAME - STAFF	Staff are seen as responsible for relapses or when things go wrong in their care	*It wasn't until the outreach stopped and they relaxed it that I ended up in hospital again...I do worry that if I end up, when I get into the community again, will I have enough input from the staff here or clinical teams or will I become ill again?...*
15. BLAME - SELF	Where a participant talks about feeling guilty or blames themselves for their circumstances	*I've messed up my whole life.* *I felt guilty because I was in prison and I couldn't help.*
16. +IVE HOSPITAL DESCRIPTION	Participants describe the hospital environment in a positive light	*... you can come out and about you can watch TV, it's amazing compared to what it's like in prison... It was a wonderful place actually...* *... I remember... having people around me all the time, looking out for me, looking after me which was quite nice.*

17.	+VE HOSPITAL EXPERIENCE	Participants describe the experience of being in hospital as a positive or helpful one	*... I didn't feel threatened there or anything like that... it helped me get well. I was very pleased with the decision to send me there. I always thought I should try and see a different team, of helpers you know.* *Well the time I spent in hospital really helped me see, they've out me on medication now, and it's alright. Yea, I mean years ago when I was first in hospital I used to hear voices and stuff, and would talk to them. And as I was in hospital more you know, it started to go away...I felt ok I had no problems...*
18.	-IVE HOSPITAL DESCRIPTION	Participants describe the hospital in a negative light, recalling negative aspects of the hospital environment	*... I was manhandled onto the ward, and out into a cell, I'll never forget this. It wasn't a padded cell, but it was small cell, with a small window and a blacked out door. I remember thinking I'll never get out and I was going to be stuck there for eternity...* *...well It wasn't that good, I didn't like it there. I had a few problems like, staff being attacked; a guy on the ward had a heart attack and died. I didn't like it there...*
19.	-IVE HOSPITAL EXPERIENCE	Participants describe the experience of being in hospital as a negative or unhelpful one	*...wasn't a nice experience, I don't think the staff were very good in those days. And I came back home...and I just became so crazy after everything happened...* *There's nothing to do here, you're just lounging around the ward, there's no occupational therapists, or activities, they seems to be on the sick all the time, quite often.*
20.	+IVE SUP.ACC.	Participants report a positive experience of being in supportive accommodation.	*But yea, this place has been very very good, for my health, I can talk to anyone I want, I don't just talk to anyone, but some people I can confide in. I can talk to people and iron out my problems before they get any worse*
21.	-IVE SUP.ACC.	Participants report a negative experience of being in supportive accommodation.	*I was then in supported accommodation 24/7, which is no different to hospital* *Surrounded by people still in the supported accommodation, 24/7, staff, constantly asking questions. How are you supposed to be independent you know?*
22.	+IVE WARD STAFF	The participant makes particular reference to the staff on the wards during their stay in	*... a lot of help and care really, it was mainly through the staff, there were some courses, move on courses which I did, relapse indicators and stuff like that, they were helpful. But it was more the staff on the wards, and*

		hospital, referring to them in a positive manner	*also my psychiatrist.* *umm...I suppose the understanding that the staff have, you know I suppose the staff have seen it all before you know...if you are ill you can do things, and umm, other people around you are fully aware that you have a mental illness... suppose that's helpful...*
23.	-IVE WARD STAFF	The participant makes particular reference to the staff on the wards during their stay in hospital, referring to them in a negative manner	*I felt the staff couldn't really be bothered to help or do anything, they're off sick most of the time like.* *Nah, no one really wants to help you, they're just told to. And even the ones who are supposed to help you can never really be bothered when you really need their help.*
24.	+IVE COM. STAFF	The participant makes particular reference to the staff in the community looking after them, referring to them in a positive manner	*... I always know that if something happens I have people who I can call, and depend on, people who know what they are talking about, not just friends, but people who can help me with things I don't understand. I feel safe in my house, and it's good to know someone is on hand if it all goes wrong!*
25.	NO ONE CARES	Where participants state that no one really cares about their welfare or what happens to them	*... its only wants she wants, she never asks 'what you want in life?' You know what I mean, she never says that to the patients, it's what she wants, she demands over the patients. ...I mean the staff are all there, and doctors but that's not their job to listen, they're not really interested in your life, they just give you food and medication and stuff like that.*
26.	SECTION	Where participants report feelings/thoughts/ emotions towards being given a section and being on a section	*I felt bringing me into hospital was blackmail.* *...It's easy to go on a section, but hard to come off it.*
27.	+IVE MEDS	Participants discuss the benefits of medication, how they help, how they have worked, if they are responsible for their recovery	*... I'm good with my medication... Its keeping me well altogether. I mean the meds work, you'd be stupid not to take them!* *...the medication helps, it settles you down,*

28. -IVE MEDS	Participants discuss the negative aspects of medication, how they make things worse, if they didn't work or if they are responsible for their failure to recover	*... I was on haloperidol, which was, which made me so depressed for the first time in my life, id never been depressed before, but when I went on this I remember I couldn't see properly or move my limbs properly, I had very negative thoughts, I remember looking at my life and thinking what have I done in my life to deserve this. I remember walking through the hospital in a daze really, I remember hugging the wall, I couldn't walk straight at the time, I had to cling to the walls, and I couldn't speak because I was heavily drugged.*
29. ILLNESS-PAST	Where the participant discusses previous mental illness in the past	*I was sort of ushering in a mental illness... the whole world came crashing in on me...* *..., the voices were keeping me up, I was paranoid... one day, round a friend's house, I said there's someone in the attic listening to us, and umm, he said, nah man your just schizophrenic...and I was like what? He was just like yea, yea you've got a mental illness, all the drugs you've been doing you've got a mental illness, and that was the first time id really thought about it...*
30. ILLNESS - NOW	Where the participant openly discusses current signs of illness. The participant also shows an insight into their illness and their relapse indicators	*...I have these horrible thoughts in my head which alienates me from everyone else...* *... I realise there are certain things that I need to do, like taking my medication because I know I suffer from a mental illness, and that keeps my mental state stable...*
31. ILLNESS-DENIAL	Where a participant denies ever having had a mental illness, or minimises the illness	*...there's sick people out there but the doctors can't get off their arses and find them, they've gotta keep someone like me, a waste of tax payers money, when I haven't got anything wrong with me as far as I know...* *I didn't have an illness...No, none at all really* *But I've got no mental problems, the only problem I've got is being here.... I shouldn't really be here though...They say I'm a schizophrenic, but I don't think so.*
32. INDEX - INSIGHT	Where the participant discusses the index offence, and is able to reflect on it, displaying insight	*... But I understand I frightened people, it wasn't my intention to frighten people, I was only trying to wave them on to safety, because I thought they weren't safe. And they got very very scared, understandably... I just put the gun in the air and waved it around, and it really frightened them you know I didn't think*

		it would but it did... I know what I did was frightening, but I didn't intend on frightening anyone.
33. INDEX -DENIAL	Where the participant minimises the index offence and the impact it has.	*I don't really like talking about the index which happened, I'm sure it's been well documented.*
34. WARD ACTIVITES	Participants discuss the specific activities they were involved in on the ward and enjoyed	*... I was going out with the FAST team, playing pool, swimming, badminton, table tennis, cycling, seeing places, going on trips and all that.* *...I did weight lifting, boxing, running, woodwork, cooking...*
35. ADHERENCE	Where participants talk about how they complied with what was asked of them or how they are complying now.	*... I just got on with it, did what they told me to do to get better.* *I mean I do as I'm told, I don't make any problems or anything. I don't try and start any fights or that* *... I realise there are certain things that I need to do, like taking my medication because I know I suffer from a mental illness, and that keeps my mental state stable...*
36. NON-ADHERENCE	Where a participant discusses incidents where they were con-compliant with attempts to help them	*... I think the big mistake, that I made, and that a lot of boys make, is cutting off ties with the hospital...umm, because, navigating my way through, and umm, when you have that conditional discharge and you move on and then maybe supported accommodation...but when you get to your flat, it's a different world you know, instead of what you've been living for a long time...*
37. PSYCHOLOGIST	Any reference to 1:1 work with a psychologist	*With the psychologist, I was doing confidence building, something about negative and positive thinking. I've still got some of the work, I go back and have a look at it, it's helpful, I've got a folder by my DVDs.*
38. TALKING	Where particular emphasis is given to the fact that talking to someone, or having someone to talk to is helpful	*Well I can talk to people about the worse elements of my illness... people I can discuss any paranoia with, or just someone to say hello or to talk, not always to talk about illness just talking about everyday life, its, I need to have someone in my life other than family.*

39.	+IVE LEISURE	Where participants talk about what kinds of recreation they enjoy, and value taking part in	*I play pool, table tennis, go for McDonalds, play badminton. Visit my mother on a Sunday.*
40.	FRIENDSHIP-PAST	Where a participant talks about friendships he had in the past	*I think the best time I had was when I was with the band... I miss that, that's the only good thing in my life, everything has been crap. It's because I was around friends, now I don't have any. I don't know where they are...*
41.	FRIENDSHIP-PRESENT	Where a participant talks about current friends and the value of friendship	*Friends who visited like, when I was in, well they're still there now... I've got other friends too, who are there for me, they buy me food and clothes and are very helpful* *... having my friends there probably, they keep me in touch with what's going on and that*
42.	FAMILE +VE PAST	Where a participant talks about how important family was to him when he was in hospital	*My mum, major part of my life. Always there, she'd come in every week to see me rain sleet or snow, she's been a diamond, my rock like, she's wicked...* *My dad stuck by me thick and thin, over the years, always visiting me. Always looks out for me.*
43.	FAMILY +VE PRESENT	Where a participant talks about positive family relationships and their values	*... I think my parents have seen a difference, I'm more outgoing with them, able to make jokes, you know, just we're closer now as a family. I've put them through a lot in my life, and I think the family ties are very close now.*
44.	DEATH IN FAMILY	Participant talks about a death in the family that impacted upon them, or changed circumstances	*Three of my family members died when I was in hospital, so it was hard...* *Losing my family... This was difficult because I wasn't there for them, and didn't really have anyone to talk to about it. I mean, I mean the staff are all there, and doctors but that's not their job to listen, they're not really interested in your life, they just give you food and medication and stuff like that.*
45.	+IVE OTHERS	Participant talks about people who have made decisions on their behalf, and acts to look out for them, which they appreciate	*... they deliberately kept me in a bit longer so they could get me a place here, which was a very good decision...thank goodness, and I got over it basically, talking to staff, they stopped my driving for a bit as well, which was just as well I suppose, but they did help me.* *It was the right decision because I needed the help at the time. I was just trying to get better.*

46. SEXUAL RELATIONSIPS	Participants discuss sexual relationships	*I had a normal family relationship, girlfriend, that sort of thing...Hopefully I'll get a girlfriend in the future as well.*
47. CHILDREN	Participants talk about having or wanting children	*Umm, I wish I's had kids, or wish I could have kids, I, umm, I haven't given up on that yet (laughs) even though I'm 44, there's like in the old dog yet (laughs)*
48. TIME	Participants make reference to time	*Time just went by, it was quite quick when I was there, 16 months, not too long. Because the last time I was in hospital... it was 2 and a half years...* *Yea, I thought it took a long time to get well, but I got there.*
49. COPING	Where participants make reference to how they 'coped' or how they are 'coping'	*...I'm just getting on with my life really. There have been a few blips, but I'm getting there.* *...as I say, I'm trundling on ok at the moment, so I'm getting on ok at the moment.*
50. RECOVERY	Where participants make reference to how they 'recovered' or how they are 'recovering'	*... I'm learning and recovering over the years, and recognising it...* *... gradual recovery. Because it is gradual, I have made steps, I haven't stagnated or anything, I'm making steps to get better.*
51. RELIGION -IVE	Where a participant discusses that religions are not helpful	*Well I did have belief, but even that's a waste of time...beliefs don't sort your problems out, they were just invented my society, to brainwash people, to keep them happy. I don't believe in after life, don't see what the point is, why would I want to come back to life and start all over again?*
52. RELIGION +IVE	Where a participant discusses his religion in the context that they have been helpful	*...I started praying the Christian god, and I've actually had my prayers answers a few times, so I believe in it... Those experience make me feel like my prayers are answered, because prior to that I was adrift, I was in a kind of limbo...*
53. PLANS	Where a participant discusses plans for the future	*Sadness. The life I have at the moment is sad, but I hope it changes, I want something better for myself.* *I don't know, my life is going good so far, and I think it's getting better.*
54. BAD PRISON EXPERIENCE	Where a participant discusses a bad prison experience	*They left me naked in the cell, with just a mattress, it was awful, that's what they did to me*

55. DRUGS-QUIT	Where a participant talks about coming off drugs or staying abstinent	*Yea I felt much better really, yea, you know, I saw life more clear, off the drugs and I felt better, and I've not taken them since, I never have and I never will.*
56. WORRIES	Where participants discuss current worries	*Just the worry about going back inside.* *I see my psychiatrist every fortnight now, because I'm on clozapine, so my only worry is my medication now, where I pick it up from, that sort of thing.*
57. IDENTITY	Where a participant makes reference to their identity	*I suppose umm, I need to come off my section... I really want that as a finalisation of my past, just, you know, I had a mental illness once, once upon a time, or you know I was in Whitchurch once, you know, and just move on from there, leave it all behind*
58. INTERACTIONS WITH RESEARCHER	Where the participant interacts directly with the researcher	*I've got to tell the truth, I wouldn't lie to you. Whatever I say to you is the truth. I'm going to tell the truth to you about everything that is part of my life.*

Appendix 15: 15 Point Checklist of Criteria for Good Thematic Analysis (Braun & Clarke, 2006)

Process	No	Criteria
Transcription	1	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for accuracy
Coding	2	Each data item has been given equal attention in the coding process.
	3	Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive.
	4	All relevant extracts for all each theme have been collated.
	5	Themes have been checked against each other and back to the original data set.
	6	Themes are internally coherent, consistent, and distinctive.
Analysis	7	Data have been analysed – interpreted, made sense of - rather than just paraphrased or described.
	8	Analysis and data match each other – the extracts illustrate the analytic claims.
	9	Analysis tells a convincing and well-organised story about the data and topic.
	10	A good balance between analytic narrative and illustrative extracts is provided.
Overall	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.
Written report	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated.
	13	There is a good fit between what you claim you do, and what you show you have done – i.e., described method and reported analysis are consistent.
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis.
	15	The researcher is positioned as *active* in the research process; themes do not just "emerge".

Appendix 16: Sponsorship Statement from the University of Nottingham

The University of Nottingham

Our reference:
RIS 11051
Your reference:
11/WA/0230

Research Innovation Services
University of Nottingham
King's Meadow Campus
Lenton Lane Nottingham
NG7 2NR

0115 9515679
paul.cartledge@nottingham.ac.uk

North Wales REC - Central and East
REC Office
G1/G2 Croesnewydd Hall
Croesnewydd Road
Wrexham Technology Park
Wrexham
LL13 7YP

Professor Mary McMurran, Chief Investigator
Faculty of Medicine & Health Sciences
University of Nottingham
Sir Colin Campbell Building
Triumph Road
Nottingham
NG7 2TU

7th July 2011

Dear sir or madam,

Sponsorship Statement

Re: Post-Discharge Narrative Life Story Interviews with Conditionally Discharged Mental Health Patients

I can confirm that this research proposal has been discussed with the Chief Investigator and agreement to sponsor the research is in place.

An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.*

Any necessary indemnity or insurance arrangements will be in place before this research starts. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.

Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.

The duties of sponsors set out in the NHS Research Governance Framework for Health and Social Care will be undertaken in relation to this research.**

* Not applicable to student research (except doctoral research).
** Not applicable to research outside the scope of the Research Governance Framework.

Yours faithfully

Paul Cartledge
Head of Research Grants and Contracts
University of Nottingham

Appendix 17: Ethical Approval Letter from the Research Ethics Committee

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

North Wales Research Ethics Committee (Central and East)
G1/G2 Croesnewydd Hall
Croesnewydd Road
Wrexham Technology Park
Wrexham
LL13 7YP

Tel: 01978 726377

06 October 2011

Professor Mary McMurran
Professor of Personality Disorder Research, Faculty of Medicine & Health Sciences
Insitute of Mental Health, The University Of Nottingham
University of Nottingham
Sir Colin Campbell Building
Triumph Road, Nottingham
NG7 2TU

Dear Professor McMurran

Study title:	**Post-Discharge Narrative Life Story Interviews with Conditionally Discharged Mental Health Patients**
REC reference:	**11/WA/0230**
Protocol number:	**11051**
Amendment number:	**AM01**
Amendment date:	**13 September 2011**

The above amendment was reviewed at the meeting of the Committee held on 05 October 2011.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
GP/Consultant Information Sheets	3.0	31 August 2011
Participant Consent Form	3.0	31 August 2011
Participant Information Sheet	3.0	31 August 2011
Protocol	3.0	31 August 2011
Notice of Substantial Amendment (non-CTIMPs)	AM01	13 September 2011
Covering Letter		31 August 2011

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

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

11/WA/0230:	**Please quote this number on all correspondence**

Yours sincerely

T A. Hughes

p.p. **Professor Alex Carson**
Chair

E-mail: Tracy.Hughes4@wales.nhs.uk

Enclosures: List of names and professions of members who took part in the review

Copy to:

Mr Paul Cartledge
Research Innovation Services
Kings Meadow Campus
Lenton Lane
Nottingham
NG7 2NR

Prof Jonathan Bisson
R&D Office
Cardiff & Vale University Health Board
2nd Floor TB2, Room 2, University Hospital of Wales
Heath Park
Cardiff
CF14 4XN

North Wales REC (Central and East)

Attendance at Committee meeting on 05 October 2011

Name	*Profession*	*Capacity*
Mrs Celia Blomeley	Lay Member	Lay Plus
Professor Alex Carson	Associate Dean (Research)	Lay Plus
Dr John Clifford	Consultant Psychiatrist	Expert
Dr John Delieu	Anatomist & DI for HTA Licence	Expert
Miss Joy Hickman	Consultant Orthodontist	Expert
Ms Alison Ledward	Lay Member	Lay
Mr Philip Richards	Associate Specialist - Surgery	Expert
Ms Eunice Vincent	Lay Member	Lay
Dr Anthony White	Consultant Care of the Elderly	Expert
Dr Diane Williamson	Consultant Dermatologist	Expert

Also in attendance:

Name	*Position (or reason for attending)*
Mrs Lucy Lewis	Newly appointed expert member
Ms Tracy Hughes	Research Ethics Committee Co-ordinator

Appendix 18: Ethical Approval Letter from the Research And Development Department

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Ysbyty Athrofaol Cymru
University Hospital of Wales

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Ffacs 029 2074 3838
Minicom 029 2074 3632

Eich cyf/Your ref
Ein cyf/Our ref
Welsh Health Telephone Network 1872
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Tel: 029 20746986
Fax: 029 20745311
CAV_Research.Development@wales.nhs.uk

From: Professor JI Bisson
R&D Director
R&D Office, 2nd Floor TB2
University Hospital of Wales
Cardiff
CF14 4XW

05 October 2011

Miss Suzannah Tyler
Trainee Forensic Psychologist
Psychology Forensic
Cardiff and Vale University Health Board
Community Forensic Team
West Homes
Whitchurch Hospital

Dear Miss Tyler

Cardiff and Vale UHB Project Ref : 11/MEH/5179
NISCHR PCU Ref: 80750
Title: : Post-Discharge Narrative Life Story Interviews With Conditionally Discharged Mental Health Patients

The above project was forwarded to Cardiff and Vale University Health Board R&D Office by the NISCHR Permissions Coordinating Unit. A Governance Review has now been completed on the project.

Documents approved for use in this study are:

Document	Version	Date
Protocol	3.0	31/08/11
Patient Information Sheet`	3.0	31/08/11
Letter to Clinician	3.0	31/08/11
Advertisement of Study	2.0	09/08/11
Patient Consent Form	3.0	31/08/11

I am pleased to inform you that the UHB has no objection to your proposal.

You have informed us that the University of Nottingham is willing to act as Sponsor under the Research Governance Framework for Health and Social Care.

Please accept this letter as confirmation of permission for the project to begin within this UHB.

May I take this opportunity to wish you success with the project and remind you that as Principal Investigator you are required to:

- Inform NISCHR PCU and the UHB R&D Office if any external or additional funding is awarded for this project in the future
- Submit any substantial amendments relating to the study to NISCHR PCU in order that they can be reviewed and approved prior to implementation
- Ensure that the study is conducted in accordance with all relevant policies, procedures and legislation
- Provide information on the project to the UHB R&D Office as requested from time to time, to include participant recruitment figures

Yours sincerely,

Professor Jonathan I Bisson
R&D Director

CC **Sponsor contact Paul Cartledge**
CC **R&D Lead Prof Nick Craddock**

Appendix 19: Additional Quotes to Illustrate Themes in Thematic Analysis

Theme 1: Initial Negative Experiences in Secure Settings

Subtheme 1: The Institution Experience

Participant 1:

"...medication really, the early days of medication... I don't know what I used to do, just sat in silence and suffered really..."

Participant 2:

"... I think the most difficult part was having your freedom taken away, the ability to just go out, if you want to go to the shops just go...yes it's difficult being locked up..."

Participant 3:

" ... I had a very severe delusion where I thought the whole world was evil, and that they were filming me, the whole world watching me on TV and everyone could read my mind, and people were going to kill me on live TV, and I think that that was really a turning point in my life."

Participant 5:

"Umm, I dint really wanna come to the hospital, because I thought as my 5 months was up in prison that was it, I thought I was gonna get out. I thought my 5 months was done and I was going to get out. I ended up doing 16 years!"

Participant 6:

"...when you're in hospital you can't do much really, quite often I wasn't even allowed off the wards in the earlier stages..."

"They don't tell me everything about my care either, and I think this is because they think I will worry too much, but I would like to know what's going on."

"I wasn't happy with the staff and what they were doing with me; I felt they were messing with my mind. I went out one time, and smoked some cannabis, because they were really doing my head in."

Participant 7:

"I thought there was a plot to do away with me, involving the government and that sort of thing...I was convinced everyone in the country was talking about me...I had horrible thoughts in my head that I couldn't get rid of, psycho self-destruction really..."

"Well a significant turning point was going to Hospital...It made me appreciate my freedom as well a lot more."

Participant 9:

"They said to me when I was in prison that I would have my freedom back after a certain time."

"There's nothing to do here, you're just lounging around the ward, there's no occupational therapists, or activities, they seems to be on the sick all the time, quite often."

"Just that no matter what I do I can't seem to get well enough."

"I want to have my freedom back, I want to go travelling, you can't do it, can't do it on a 37/41, there's restrictions aren't there. I just want my freedom back. It's like having a death sentence, no I mean a life sentence..."

"What am I a human being or am I just a guinea pig to them..."

"My Doctor... she's the one calling the shots, and deciding what my treatment needs are..."

Subtheme 2: Illness Related Distress & Suffering

Participant 1:

"...I consider myself well, the only thing that I'm being held for, is umm, drinking... I just used to get anxieties and stuff, I suppose I'm more anxious than most people but I mean...you know that's quite a common thing isn't it, anxiety, and worries and things like that."

Participant 2

"...when I took the overdose, I felt like I didn't want to go on, I felt, negative, and very depressed, umm, and I really didn't feel motivated. I felt like my life was going out of control. It all seemed pretty hopeless and pretty desperate, but slowly after I went into hospital yea things got better."

Participant 5:

"I was on drugs... I didn't know what I was doing I was off my head at the time, if I was alright I wouldn't have done it."

Participant 7:

"..I had time to assess my life...I knew I needed to stop doing stupid things, like with a gun and that, made me think about what I was doing with my life. It was sort of a short sharp shock, which is probably what I needed, because when I went back into the community there was no way I was going to commit a crime again. It was a good job I was arrested really. And the even at that time of my life, it was a good time to get out of all the stupid criminal thoughts and that, I realised it was the end of the road to think like that."

Theme 2: Managing Support Networks

Subtheme 1: Support of Staff

Participant 1:

"... it was a strange feeling because it was like, even though everything was inside my head, the confines of the wall were like some sort of safety net...you know, and umm I didn't feel as ill, but umm I was on the hospital wing, they wanted to keep an eye on me..."

Participant 2

> "... you have absolutely everything done for you, you know they cook for you, they clean for you, there's always someone there for you, someone there you can talk to, you know everything is looked after and done for you, and coming out of that environment to just go out on your own can be a little bit daunting."

> "...it was almost like a comfort blanket, oh they won't let me out so I can't do anything wrong, you know, it was almost like a comfort blanket...it was a little bit comforting actually, to be, to think that oh I can't I'm locked up a and I can't do anything I want, but it's not that bad..."

Participant 3:

> "...I needed help...the staff there were really welcoming of me and understanding, so it was a big relief really... and the staff there, they just really helped me basically...So they helped me to develop in many ways..."

Participant 4:

> "Where I live now is absolutely wicked, I get on with all the staff and it's great... "

Participant 5:

> "Well the staff here make me feel better, taking me out places and stuff like that. Talking to them like about my future and things like that... it's been really positive really."

Participant 6:

> "... I remember... having people around me all the time, looking out for me, looking after me which was quite nice."

Participant 7:

> "Well I can talk to people about the worse elements of my illness... people I can discuss any paranoia with, or just someone to say hello or to talk, not always to talk about illness just talking about everyday life, its, I need to have someone in my life other than family."

> "But yea, this place has been very very good, for my health, I can talk to anyone I want, I don't just talk to anyone, but some people I can confide in. I can talk to people and iron out my problems before they get any worse."

Participant 8

> "... I always know that if something happens I have people who I can call, and depend on, people who know what they are talking about, not just friends, but people who can help me with things I don't understand. I feel safe in my house, and it's good to know someone is on hand if it all goes wrong!"

Subtheme 2: Managing Friendships

Participant 1:

> "... he just used to wrap me up in a blanket saying he understood, not in a creepy way, just like a brotherly love... he really toughened me up... boys who have looked after

me, though, you know like, you know violent issues...they say, ah no they're not going to touch you, I'll be here to sort them out..."

Participant 3:

"... I made some friendships there...when I was living ... I was totally isolated and wouldn't talk to anyone really, there were friends but I didn't really speak to them."

Participant 5:

"When I was living on my own, I was into drugs and stuff like that. I had friends and we were doing the same things..."

Participant 7:

"...being around decent people...you know they guys here are pretty good as well...there's not a bad mix here..."

"... I had friends, and I used to go out fishing regularly with some friends..."

Participant 8

"... having my friends there probably, they keep me in touch with what's going on and that."

"... I used to have a lot of friends back then and we all spent a lot of time together, none of us had girlfriends or anything like that, we just played football, went clubbing, and all stuff like that really.... well after a while of doing stuff like that, things started to change you know, I suppose you can't go on like that forever, well I did at the time, but they didn't...my friends all settled down after a few years, got married, had kids, got a job all that. Did those kinds of things."

Subtheme 2: Family Relationships

Participant 1:

"...my dad couldn't take it anymore...and umm... I was living on the streets for quite a while, not that my dad was responsible for that, but like you know, but like you know I could see that I couldn't really go on ,living with my dad and putting him under that pressure, so I um, I lived on the streets for quite a while..."

"My dad stuck by me thick and thin, over the years, always visiting me. Always looks out for me."

"I used to see my family regularly. I think I made big steps in becoming more confident, umm...especially with my mum..."

Participant 2

"...my parents were concerned about my well being and mental state...my parents obviously became increasingly more worried about my behaviour..."

"In hospital, the support off my parents, because let's face it id been pretty shitty with them up to that point, and they'd put up with a hell of a lot..."

Participant 4:

> "... I think more now about my family now, because when I was in there I didn't really get to see anybody, and you know a lot of things happened...my aunty died, so a lot of things happened, you know."

Participant 5:

> "I used to call my foster parents, which I kept in touch with; I'd call them every week..."

Participant 6:

> "Three of my family members died when I was in hospital, so it was hard, and when the gym instructor came up to me and told me he had some bad news, I was like what now, and when he said my gym was stopped I was really angry."

Participant 8

> "... my father had died whilst I was inside, but that wasn't anything I had control over."

Theme 3: Threats to Identity

Subtheme 1: Awareness of Stigma

Participant 2:

> "...some of the guys were a bit negative about it, saying you know 37 you know that's a good, to use a quote, that's a bitch of a section, that's a really hard section to get off...obviously it plays on your mind because it's a serious section...I understand the reasons why they added the 41 restrictions on it as well... "

Participant 5:

> "... I've had driving lesions before, but both instructors had a problem with me... they just judge me you know, because I'm an ex patient, they've got a problem with me..."

Participant 7:

> "I don't think I should be on it anymore... I haven't displayed any criminal tendencies, nothing like the index offence has happened since."

Participant 9:

> "...they don't seem to realise, they see you as just a danger when you're back and forth like this...they labels you and it's hard to come off it."

Subtheme 2: 'I'm not like them'

Participant 2:

> "I remember a guy from hospital came down and saw ...I remember joking with him and saying oh I've seen that film one flew over the coco nests...Jack Nicholson goes to a psychiatric hospital and doesn't realise...and I joked with him about it...and I was like no, I'm not going there..."

> "... there's the usual conversation everywhere I've ever been, hospital, prison, when someone new comes in its 'so what did you do to get here' and blah blah blah, so you

always get that it's kind of the standard conversation, I don't know what it is, someone must write a script and give it to them, you know cos its always the first conversation when you first go into one of these places, so what did you do to get here, arson and blah blah blah etc..."

"...what I found hard, was staying out and not becoming emotionally involved with people in conflicts like that, so you know, that I found difficult, especially when you have to see them the next day, and the next day and the next day, and you're stuck on a ward with them, some of these people, so that I found hard, that I found very uncomfortable and difficult."

Participant 6:

"I'm not that kind of man, I'm a burglar, a robber, not that."

"... some of these I know from the hospital, and they're not good people, I don't like them. So I don't really like being here... they're not good people. Some of them have done terrible things, and I don't want to be around people like that."

Participant 7:

"... some of the people I was on the ward with, there was a couple of murders...quite a crew you know, l, which made me wonder what the hell is wrong with me..."

Participant 9:

"It's sad that society doesn't know what actually happens to people in places like this, in hospital, it's ridiculous... there's people spitting on the floors, it's disgusting, I mean how do you start to get better you know what I mean? It's ridiculous."

Theme 4: Autonomy

Subtheme 1: Recognition and Acceptance

Participant 1:

"...I still have a pretty good insight into mental illness as a whole, not just myself but mental illness as a whole, I mean, I know about chemical imbalances in the brain, and umm, what drugs you know, do to you, umm, you know, drugs and prescription drugs...."

Participant 2:

"...I did get really stressed last year, around exam time, would I say it was mental illness? It wasn't as severe as the illness that got me into hospital, you know, it was stress, I was stressed, it is a stressful time...So yea I did get stressed, but I don't think it was so bad that I would need to be brought back into hospital, you know I was stressed... I didn't think I was in danger of relapsing... I wasn't relapsing I was just stressed, and it wasn't that serious, it was just stress. You know and people get stressed, get ill, you know I've had the flu since I've been out, that not a relapse factor is it you know what I mean."

Participant 3:

"I still feel stressed talking to people. Umm, that's it really, talking with people, you know, can be very difficult for me. Like today. I spent a lot of time alone, and even after 3 years in the system; I still find it difficult to communicate with people."

"...it's all about development. I see it as development. I do believe in God, I do read the Bible most days. My religion...um I'm not sure if I can say I never believed in god, I always believed in Jesus in some way... I've always been interested in the beginning of the universe and things like that. I wouldn't say it's happened by accident, its happened due to creation, so I'm not sure if you could say that's one man god or whatever, but that's the most important thing I've discovered in life...

Participant 4:

"I see my psychiatrist every fortnight now, because I'm on clozapine, so my only worry is my medication now, where I pick it up from, that sort of thing."

Participant 6:

"Just the worry about going back inside."

Participant 7:

"...I have these horrible thoughts in my head which alienates me from everyone else..."

"But there was a feeling of relief, to finally shake of the shackles, so to speak."

Participant 8

"... I'm good with my medication... Its keeping me well altogether. I mean the meds work, you'd be stupid not to take them!"

"I've got more freedom; I can walk around the grounds now outside. I like to watch the cars go past see."

Participant 9:

"I was really happy, I was glad to get out and have my life and my freedom back, to get on with things and do something with my time. I was able to go for walks and that then, whenever I wanted. It made me a lot happier."

Subtheme 2: My Journey

Participant 1:

"... I want to live in the community...I want to work...they boys want me singing in the band...these are all things that I suppose I do want to do..."

"... I'm learning and recovering over the years, and recognising it..."

"... I want to change...I'm glad I lived, very glad I lived, umm, I knew things were going to change, well I knew things had to change, and I was all geared up to do the best I could to change, you know, my lifestyle, and I mean I am changed"

Participant 2

"...there are conditions on it, which you take on board and think yea I can work with that, you know it's not the end of the world, umm, and yea to be honest I felt quite positive about it..."

Participant 3:

"I had to get through it basically."

"... I'm over the worst of it now... I've developed, but I'm still me, and still the same person... who is a quiet person, doesn't want to cause a fuss, wants to spend time alone."

Participant 4:

"Well, I've sent off for my provisional licence, so I want to learn to drive, I'd like to be able to drive by the summer. Another goal is the volunteering, go for, they're going to put me in for my basic food and hygiene, and I'll carry on then and look at college. I enjoy cooking, so I'm thinking about doing that. My hopes are that I continue to stay out of hospital, and take my meds, and move on with my life now."

"... slowly but surely getting better each day."

Participant 5:

"I still want to play in a band, because I still play drums, I play every day; I've also got a few guitars. I wouldn't mind putting the band together again still. I've also been thinking about having vocal lessons, but I don't know about that yet..."

"I don't know, my life is going good so far, and I think it's getting better."

Participant 6:

"I've had a really bad life. But who knows, maybe in the future something good may happen."

"Sadness. The life I have at the moment is sad, but I hope it changes, I want something better for myself."

Participant 7:

"...as I say, I'm trundling on ok at the moment, so I'm getting on ok at the moment."

"... gradual recovery. Because it is gradual, I have made steps, I haven't stagnated or anything, I'm making steps to get better."

Participant 8

"...I'm just getting on with my life really. There have been a few blips, but I'm getting there."

"... I'd like to pass my driving test. Well I mean I've got to have driving lessons first, but that's only when my Dr says I'm fit and ready"

Participant 9:

"Just got on with things, had to..."

Appendix 20: Case Study Consent Form

The University of Nottingham

CONSENT FORM

Name of Trainee: Suzannah Tyler

Name of Client: XXXXXXXXXX **Please initial box**

1. I confirm that I have spoken to the trainee about my involvement in the study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected. ☐

3. I understand that relevant sections of my medical notes and data collected may be looked at by the trainee where it is relevant to my taking part in this study. I give permission for this individual to have access to these records and to collect, store, analyse and publish information obtained from my participation. I understand that my personal details will be kept confidential. ☐

7. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Trainee	Date	Signature

Appendix 21: Summary of Intervention Sessions

Session 1: Introduction Session: During this first session the overall content of the intervention plan was discussed. Mr N was introduced to the concept that the way we think about things influences how we feel and respond. Mr N was made aware of the value of monitoring his own thoughts. The ABC model was introduced to Mr N, as a model to help him understand how thinking occurs between an event and the reaction to the event, which influences behaviour. Relationships between thoughts and behaviour were explored. Step one of the problem-solving strategy was introduced, where the need to define a problem was described. This was to encourage Mr N to see his problems in terms of a gap between how things are and how he wants them to be, to prevent him from jumping to solutions without fully comprehending the problem. Mr N was then asked to carry out a practice exercise using problem definitions material. Mr N was asked to review the session, summarise the main points and was prompted to discuss how the session had been relevant or useful for him. As homework, Mr N was encouraged to consider how his thoughts affect his behaviour outside the sessions.

Session 2: Improving Self Control: At the start of the session the homework was discussed. Mr N discussed how he had been trying to monitor his own thoughts during the last week, and felt he had made improvements in terms of thinking about the relationship between his thoughts and behaviour. During this session, Mr N completed an exercise to demonstrate the importance of stopping and thinking, and the second step of the problem solving strategy was introduced – Stop and Think. Mr N was encouraged to plan tasks to help him stop and think, and having considered how errors in processing occur, techniques to avoid errors in information processing and behaving impulsively were covered. The concept of impulsivity was introduced and defined, and Mr N was able to provide examples of where he has acted impulsively in the past. Techniques to improve self-control were covered, for example, using self-talk as an aid to concentration to change Mr N's style of thinking and be less impulsive. Mr N was asked to review the session, summarise the main points and was prompted to discuss how the session had been relevant or useful for him.

Session 3: Making Decisions: During this session steps three and four of the problem solving strategy were introduced. During step three, Mr N was encouraged to explore how good information can help in decision making and what type of information is most useful. Mr N was encouraged to seek out information prior to making decisions and to comprehend the difference between good and poor sources of information. During the introduction of step four of the problem solving strategy, the technique of brainstorming was introduced and practiced in relation to defining problems and generating alternative solutions. Mr N was asked to review the session, summarise the main points and was prompted to discuss how the session had been relevant or useful for him.

Session 4: Consequences: This session continued the development of the problem-solving strategy through the introduction of step five of the problem solving strategy – thinking about consequences. Mr N was introduced to the cost-benefit analysis technique to use when considering all consequences, and carried out a practice example. This was introduced to encourage Mr N that there are always costs and benefits to any course of action, both short and long term. Mr N was encouraged to consider all costs and benefits before making an important decision. The concept of immediate gratification was discussed, and Mr N was encouraged to think of ways he could control it. The concept of probabilities was also introduced, where his ability to assess probability and the role this can play in decision making was discussed. Mr N was asked to review the session, summarise the main points and was prompted to discuss how the session had been relevant or useful for him. Mr N was asked to complete a cost-benefit analysis of a behaviour of his choice as homework.

Session 5: Planning and Action: At the start of the session Mr N discussed his homework. He had chosen to carry out a cost-benefit analysis on the topic of future offending. He was able to identify the short-term and long-term costs and benefits of future offending, and this was discussed successfully. During this session the first five steps of the problem solving strategy were recapped, and the final two steps - planning and action – were introduced. The final seventh step in the strategy was then reviewed and practiced. Mr N was encouraged to apply the problem-solving strategy he had learnt to a range of different situations and interpersonal problems to avoid causing problems and to reach desired goals. Mr N was asked to review the session,

summarise the main points and was prompted to discuss how the session had been relevant or useful for him.

Session 6: Understanding Thinking: Having completed the problem solving strategy in session five, Mr N was encouraged to refer back to the ABC model introduced in session 1 and consider the how the influence of extreme thinking and personal bias can hinder effective implementation of the problem solving process. Mr N was encouraged to consider how his emotions may hinder effective thinking, and how following the structured problem-solving strategy can help in reducing/controlling the effects of emotions. Mr N was introduced to the concept of extreme thinking, and role-play scenarios were used to demonstrate how it can be a hindrance to creative thinking, problem solving and decision making. Attention was also drawn to stereotyping and how this occurs, with emphasis given to how it is shaped by past experience and emotions. Mr N was encouraged to examine his thinking to become aware of when he is using stereotypes. Mr N was asked to review the session, summarise the main points and was prompted to discuss how the session had been relevant or useful for him.

Session 7 – Assertiveness: During this session, Mr N was introduced to the idea that there are different ways of behaving which can affect interactions with others, preparing Mr N for the social skills to be covered in later sessions. Mr N was able to identify the different ways other people are involved in his problems, and acknowledged that solutions always involve some form of interaction with others. Mr N was encouraged to explore the differences between behaving assertively, aggressively and passively, and how behaving in a particular way can make it more likely that that type of behaviour us used in future. The idea that assertive behaviour is the basis of successful interactions with other people was introduced, as was the idea of circles of behaviour – to demonstrate how behaviour can reinforce thinking. Mr N was encouraged to use 'I' language statements to help him assertively by taking responsibility for his own feelings and actions whilst respecting other people. The 'I' language script was offered as a means of helping Mr N to prepare for situations and to communicate with the other people involved in his problems. Role-play scenarios were used to practice this. Mr N was asked to review the session, summarise the main points and was prompted to discuss how the session had been relevant or useful for

him. As homework Mr N was asked to complete a handout on a situation where he had acted assertively.

Session 8: Listening, Asking and Convincing: Mr N was first asked to review his homework, which he had completed on a situation involving an incident with his cell mate who had asked him for tobacco. Mr N reported that he found it difficult to use 'I' language statements, but did make attempts to remain assertive with his cell mate. This appeared to have a positive outcome for Mr N, which he appeared very pleased with. Two related social skills were then covered in this session, listening and asking for help. Emphasis was placed on the relevance of these skills for Mr N, and links were made between the two skills – that listening is important when asking for help. Active listening was demonstrated through the use of role-playing exercises, and methods of communication were brainstormed. Mr N was also provided with steps for convincing others and asking for help effectively and in a pro-social way, and was encouraged that convincing others and asking for help can be more effective when the skill steps are followed. Mr N was asked to review the session, summarise the main points and was prompted to discuss how the session had been relevant or useful for him. Homework included completing a handout to detail an occasion where he had used the convincing others skills steps and an occasion where the asking for help skill steps were used

Session 9 – Irrational Thinking: The homework assignment was initially discussed, where Mr N was able to provide details of an occasion where he had convinced a fellow prisoner to return property he had leant to him. He was pleased with his ability to follow the steps, and the outcomes he achieved. He also spoke of an incident where he had asked a prison officer for help in relation to being escorted to his prison job at a later time due to an appointment with the prison nurse. This was praised, as Mr N had previously not felt confident in his ability to negotiate with staff and achieve his objectives. During this session Mr N was introduced to the concept of critical reasoning skills that were considered important in effectively solving problems. We discussed how it was important that he needs to be aware of his thinking and able to pose questions to himself about why he thinks the things he does and how this can affect his behaviour. This session explored how Mr N's emotions can lead him to behave irrationally and interfere with his ability to solve problems, by identifying and

managing his irrational thinking. Irrational thought chains and types of irrational thoughts were explored and challenged. Mr N was also provided with the skill of responding to failure, which offered a way of dealing with irrational thoughts when he was reacting to being told he had failed at something. Mr N was asked to review the session, summarise the main points and was prompted to discuss how the session had been relevant or useful for him. As homework Mr N was asked to think about how he responds to failure, using an example over the next week.

Session 10: Managing Emotions: At the start of this session Mr N's homework assignment was discussed. He reported an event where he had not completed the necessary work he was expected to in his prison job, this left him very despondent and he found it difficult to utilise the responding to failure skills steps. This was discussed. The session then continued with the opportunity for Mr N to review how his emotions affect him, and how he can identify emotions in himself and others. Mr N was encouraged to think about how in interactions with others, the words he uses may sometimes be less important than the non-verbal messages he is sending. This was considered in relevance to perspective taking and problem solving. The role of body language in understanding emotion was discussed and the problems Mr N experiences in interpreting others' emotions. Role-play exercises were utilised to model this concept. Mr N was asked to review the session, summarise the main points and was prompted to discuss how the session had been relevant or useful for him.

Session 11: Negotiation and Responding Skills: The first part of this session discussed the issue of rules and regulations, both inside prison and in the community, in terms of how they are essential to enable people to work and live together. Mr N was able to offer his perspective of rules at work, which followed a discussion of he finds it difficult to follow rules set by others. We then discussed the topic of negotiation and compromise, where negotiation skills steps were introduced, and ways of reaching a compromise. This session further developed Mr N's repertoire of skills by presenting responding to others skills, where Mr N was provided with steps for responding to persuasion effectively and in a pro-social way. This was aimed to provide Mr N with a strategy for dealing with occasions when others try to convince him of something, or equally when someone attempts to cajole or manipulate him. Role-play exercises were utilised to practice the skills. Mr N was then asked to

review the session, summarise the main points and was prompted to discuss how the session had been relevant or useful for him. As homework Mr N was asked to complete a handout describing a situation outside the session where he had used the negotiation skills steps and responding to persuasion skills steps, including an evaluation of how well he followed the steps.

Session 12: Bringing it all together: The session began with a review of Mr N's homework assignment. He brought an example of when he had used the negotiation skills steps and responding to persuasion skills steps effectively and this was discussed. Both situations involved his prison job. He had managed to successfully negotiate a tea rota with other prisoners at work, which he felt was a good accomplishment. This situation was linked to the responding to persuasion situation, where he felt he was being taken advantage of at his prison job. This session brought together all the main aspects of the intervention, and demonstrated how the various points covered in the sessions fit together. Mr N worked through the whole problem solving strategy and presented a chosen solution for a problem he had thought of. At the end of the session he was given an inventory of a wide range of social skills which he was encouraged to use to implement his solutions. Mr N was encouraged to develop an action plan for the areas covered during the intervention that he could take forward. Mr N was asked to review the session and was prompted to discuss how the sessions had been relevant or useful for him. Mr N was also asked to complete the post-intervention measures.

Appendix 22: CRIME-PICS II Questionnaire Items

SA Strongly Agree A Agree N Neither agree nor disagree
D Disagree SD Strongly disagree

1	In the end, crime does pay	SA	A	N	D	SD
2	I have never hurt anyone by what I've done	SA	A	N	D	SD
3	I will always get into trouble	SA	A	N	D	SD
4	Crime has now become a way of life for me	SA	A	N	D	SD
5	Crime can be a useful way of getting what you want	SA	A	N	D	SD
6	I believe in living for now, the future will take care of itself	SA	A	N	D	SD
7	Most people would commit offences if they knew they could get away with it	SA	A	N	D	SD
8	I definitely won't get into trouble with the police in the next 6 months	SA	A	N	D	SD
9	I don't see myself as a real 'criminal'	SA	A	N	D	SD
10	Committing crime is quite exciting	SA	A	N	D	SD
11	I find it hard to resist an opportunity to commit a crime	SA	A	N	D	SD
12	Many so-called crimes are not really wrong	SA	A	N	D	SD
13	My crimes have never harmed anyone	SA	A	N	D	SD
14	If things go wrong for me, I might offend again	SA	A	N	D	SD
15	I am not really a criminal	SA	A	N	D	SD
16	I always seem to give in to temptation	SA	A	N	D	SD
17	When people have no money, they can't be blamed for stealing	SA	A	N	D	SD
18	There was no victim of my offence(s)	SA	A	N	D	SD
19	I wouldn't commit the offence again	SA	A	N	D	SD
20	Once a criminal, always a criminal	SA	A	N	D	SD

RAW SCORES: G..... A..... V..... E.....

Scale G *– General Attitudes to Offending*	***Items: 1,3,4,5,6,7,8,9,10,11,12,14,15,16,17,19,20***
Scale A *– Anticipation of Reoffending*	***Items: 3,4,8,9,14,19***
Scale V- *Victim Hurt Denial*	***Items: 2,13,18***
Scale E *– Evaluation of Crime as Worthwhile*	***Items: 1,5,7,10***

Appendix 23: CRIME-PICS II Problem Inventory

BP Big Problem **P Problem** **SP Small Problem** **NO No problem at all**

Problems with money	**BP**	**P**	**SP**	**NO**
Problems with relationships	**BP**	**P**	**SP**	**NO**
Problems with employment/prospects	**BP**	**P**	**SP**	**NO**
Controlling temper	**BP**	**P**	**SP**	**NO**
Need for extra excitement in life	**BP**	**P**	**SP**	**NO**
Family problems	**BP**	**P**	**SP**	**NO**
Problems of health and fitness	**BP**	**P**	**SP**	**NO**
Tendency to get bored	**BP**	**P**	**SP**	**NO**
Problems with housing	**BP**	**P**	**SP**	**NO**
Problems with drink/drugs	**BP**	**P**	**SP**	**NO**
Problems with gambling	**BP**	**P**	**SP**	**NO**
Depressed	**BP**	**P**	**SP**	**NO**
Problems with feeling good about self	**BP**	**P**	**SP**	**NO**
Problems with lack of confidence	**BP**	**P**	**SP**	**NO**
Lots of worries	**BP**	**P**	**SP**	**NO**

RAW SCORE (P) : .....

Appendix 24: Studies Utilising the CRIME-PICS II

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