The barriers and facilitators influencing the effectiveness of high secure forensic care:

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a critical realist qualitative study

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ABSTRACT

This thesis examines the barriers and facilitators influencing the effectiveness of high secure forensic care. Forensic psychiatric care is concerned with the assessment and treatment of mentally disordered offenders who are detained under various sections of the Mental Health Act. A prime function of forensic psychiatric care is the management of risk, and the protection of the public. In England, high secure forensic care is provided at Rampton, Broadmoor and Ashworth hospitals, and to be admitted to high secure care patients must be considered a grave and immediate danger to the public or themselves. This risk management places restrictions on the lives of patients however, there is a need to balance the management of risk, with promoting recovery and rehabilitation of patients with the need to maintain safety and security.

The study took place at Rampton Hospital, a large high secure hospital in the East Midlands of England and employed a series of qualitative semi-structured interviews. Questions focused on patients' experiences of care, and their views of factors which may be barriers or facilitators of their care. Interview questions were open ended, with follow up questions being posed to expand on points and to increase the richness of the data. Semi-structured interviews were chosen to give potentially vulnerable participants an opportunity to narrate their personal experiences to make their views known.

This study considered participants to be experts by experience of receiving high secure forensic care, with the study highlighting their narratives of factors which they described as barriers or facilitators of their care. The study applied a novel and innovative approach by using critical realism as a philosophical position for its literature review and empirical study.

This allowed broad consideration of a variety of factors which have the potential to impact on the effectiveness of high secure care

Study findings indicated that factors relating to role and identity, therapeutic activity policies and procedures, and significant relationships have the potential to impact on patient care, with role and identity being the most significant. This study clearly demonstrated the importance of role and identity in the care and recovery of high secure forensic patients and recommended that identity should be routinely considered in treatment planning.

The study also highlighted the difficulties in evaluating interventions in the area due to the many factors which have the potential to influence care. The study also emphasised the lack of research in this area and the difficulties associated with evaluation research particularly form a quantitative approach. It was therefore advocated that critical realism should be considered as a philosophical approach with the potential to enhance research in high secure forensic care.

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1:1. Introduction

This chapter will briefly describe forensic psychiatric care, particularly high secure care. The chapter will illustrate some of the main issues relating to high secure psychiatric care which will then become topics for purposive literature reviews which will highlight how they may act as causal mechanisms, acting as barriers or facilitators of effective high secure forensic care. The chapter will also consider relevant theoretical ideas including identity theory, mental health recovery and theories of change. The work will use illustrative vignettes to highlight some of these issues in relation to high secure patient care.

1:2. Forensic psychiatric care

Forensic psychiatric care is concerned with the assessment and treatment of mentally disordered offenders who are detained under various sections of the Mental Health Act 1983 as amended 2007 (DoH, 2008). The term forensic is often associated with the examination of crime scenes but has a more literal meaning of pertaining to the courts or legal system, and all patients detained in forensic care are in some way involved with the criminal justice system (McMurran, Khalifa and Gibbon, 2009).

A prime function of forensic psychiatric care is the management of risk, and the protection of the public, staff, social and professional visitors, and patients. This risk management places restrictions on the lives of patients, which may include restriction of movement around the hospital and access to the wider community. Restrictions may include access to a range of items such as bladed items, alcohol, and in some cases electrical items. Restrictions may also control family visits and potentially mail and phone communications. In daily practice these

restrictions are directed by three distinct aspects of security which are termed physical, procedural, and relational security (Exworthy and Gunn, 2003; Kennedy, 2002). Physical security refers to the provision and maintenance of physical elements which maintain safety and prevent absconding. These include fences, locked doors, and windows. Procedural security concerns the policies and practices put in place to manage risk, and include patient and staff searches, control of visitor access and the management of telephone calls and letters when necessary (Exworthy and Gunn, 2003; Kennedy, 2002). Relational security involves developing in-depth knowledge of patients, their offending, and potential risks, and is best maintained through the development of positive therapeutic relationships between staff and patients and preserving appropriate staffing levels (Exworthy and Gunn, 2003; Kennedy, 2002).

1:3. Levels of forensic psychiatric care

Inpatient forensic psychiatric care is delivered at three distinct levels of security: low secure, medium secure and high secure. Where patients are accommodated is dependent upon their assessed risk to themselves or others, rather than their offending history (McMurran, Khalifa and Gibbon, 2009). Patients should be able to be transfer across these levels of security according to their needs, with care taking place in the least restrictive environment needed to maintain security and safety (Kennedy, 2002; McMurran, Khalifa and Gibbon, 2009).

Low secure hospitals provide treatment focused on rehabilitation and reintegration into the community (McMurran, Khalifa and Gibbon, 2009). Patients treated in low security are likely to be accessing the community on a regular basis, taking part in opportunities such as education, voluntary work and in some cases paid employment (McMurran, Khalifa and Gibbon, 2009).

Medium secure hospitals care is a step down in levels of security in comparison with high security and care for patients who may be at differing stages in their recovery journey. For example, some patients whose mental state is relatively settled will be preparing for transfer to low secure care. These patients may already be accessing the community through escorted and unescorted leave, as a means of grading their exposure to wider society. Others may have recently committed their offence, and be in comparison more unwell, requiring the physical security provided by high fences and the structure and support provided by relational and procedural security.

In England, high secure forensic care is provided at Rampton, Broadmoor and Ashworth hospitals in what were previously referred to as the "special hospitals". Of the three hospitals, Rampton Hospital is the largest, accommodating approximately 350 patients and occupying a unique place by providing the national high secure service for women patients, the national high secure service for men with a learning disability and the national high secure service for Deaf men as well as admitting men with mental illness and men with a personality disorder (McMurran, Khalifa and Gibbon, 2009).

To be admitted to high secure care patients must be considered a grave and immediate danger to the public or themselves, often having an acknowledged index offence which may be serious in nature (DoH, 2008). This necessitates patients in high secure care being subject to restrictions on their daily lives and activities which in turn impacts on treatment provision (McMurran, Khalifa and Gibbon, 2009). At whichever level of care a patient is detained, the assessment and management of the risk a patient is deemed to pose to themselves, or others will be central, creating a balance between care and containment. This will again impact on the delivery of care, with the restrictions placed on patients being greatest in conditions of high security.

1:4. The development of high secure forensic care

The development of high secure care in England began with the opening of Broadmoor Hospital in 1863, followed by Rampton hospital in 1912. Ashworth Hospital, which was created after the amalgamation of Moss Side and Park Lane Hospitals, opened in 1989, with each hospital initially setting out to treat the criminally insane (Campbell, 2005; Richman and Mercer, 2000). Following the 1959 Mental Health Act these facilities became known as "special hospitals"; however, as the Prison Officers Association remained the predominant trade union, changing culture to balance detention with need for rehabilitation was challenging (Bartlett and Kesteven, 2010). Responsibility for administering the three special hospitals fell directly to the Home Office, rather than the National Health Service, and created an ambiguous situation where high secure mental health provision appeared to fall between prison and hospital care (Bartlett, 2010; Campbell, 2005).

The National Health Service Act (1977) underlined the Secretary of State for Health's duty to provide conditions of special security for patients with underlying dangerousness and violent criminal predispositions in the special hospitals. In the 1980s and 1990s, concerns were raised regarding the operation of these hospitals, particularly Ashworth which resulted in enquiries firstly by Blom-Cooper et al. (1992) and latterly under QC Peter Fallon (Fallon et al., 1999).

The Fallon report found serious breaches of security at Ashworth, with allegations of criminal activity including child grooming, drug misuse and ineffective service management (Fallon et al., 1999). Fallon recommended major changes in high secure care including the closure of Ashworth Hospital. Fallon agreed with previous reports, which accused the special hospitals of being geographically, therapeutically, and professionally isolated (Bluglass, 1992).

As a result of the Fallon report, a review of security procedures at all three special hospitals was undertaken by Sir Richard Tilt (Tilt et al., 2000), a former director of the prison service (Exworthy and Gunn, 2003). The Tilt report made wide ranging recommendations, focussing on the improvement of procedural and physical aspects of security. This included improved intelligence gathering, and the enhancement of perimeter fences, window, and door locks. The report, however, stated that enhanced security levels should apply only to patients who warranted such restrictions (Exworthy and Gunn, 2003).

The Fallon and Tilt reports may be a watershed in the development and modernisation of high secure care, more closely considering the needs of the patients and resulting in high secure services being brought into the mainstream of the National Health Service (Campbell, 2005). This modernisation promoted an improvement in the quality-of-service delivery, along with increased accountability through clinical governance (Campbell, 2005).

1:5. The organisational structure of high secure forensic care

As in other aspects of health care, the organisational structure of high secure forensic care is hierarchical in nature. At the peak of this hierarchy is central government, who have the power to enact mental health law which gives the courts the power to compulsorily detain individuals with a mental disorder, where appropriate treatment is available (Sarkar, 2010). The administration of mental health law is governed by the Ministry of Justice, which was formerly part of the Home Office (Sarkar, 2010). The primary concern of the Ministry of Justice is public protection, and this role can create conflicts with mental health professionals attempting to promote patient welfare with those serving the safety of the public (Sarkar, 2010).

The role of the Ministry of Justice highlights an important difference between forensic mental health and other aspects of health care. For example, the Ministry of Justice, through the authority of the courts, has the power to compulsorily detain and treat patients, and has the ultimate decision regarding the transfer of patients to lower levels of security and the discharge of patients.

Organisational control, of high secure hospitals is maintained through NHS trusts, hospital management and different services within hospitals. It follows that the way organisations react to changes in policy and influential reports controlled by a top-down approach. Different changes and interpretations are made at each organisational level, until the policy is finally enacted regarding patients' care. At a patient care level this hierarchical structure is maintained with the responsible clinician, who is usually the consultant psychiatrist being at the head of a multidisciplinary team. The responsible clinician coordinates and controls a patient's care pathway, although as mentioned, ultimate power may remain with the Ministry of Justice (Sarkar, 2010).

1:6. The Mental Health Act

All patients in high secure forensic care are subject to the Mental Health Act 1983 as amended 2007 (DoH, 2008), and so are detained under sections of this Act. For some patients, this may mean compulsory admission for treatment under Section 3 of the Act, with decisions regarding their detention remaining in the hands of their doctors. However, patients will be admitted to forensic care by the courts under Section 37 of the Act which allows mentally disordered offenders who pose a risk to themselves or others to be detained for hospital treatment rather than rather than being given a custodial prison sentence (Edworthy, Sampson and Völlm, 2016; Sarkar, 2010). Patients admitted to a secure hospital under a Section 37 hospital order may also be subject to a Section 41 restriction order, which deems

the patient may present a risk of harm to the public if released and places control over aspects of the patients care and movement in the domain of the Ministry of Justice (Edworthy, Sampson and Völlm, 2016; Sarkar, 2010).

Sentenced prisoners whose mental health deteriorates while in prison may be transferred to a secure hospital under Section 47 of the Mental Health Act due to a deterioration of mental health while in prison (Sarkar, 2010). Those admitted to secure hospital care from prison are likely to be subject to similar restrictions on their movement and care as patients admitted directly by the courts. It is probable that they will be subject to a Section 49 restriction order, again placing aspects of their care including possible return to prison and detention beyond their sentence tariff under the joint control of the responsible clinician and the Ministry of Justice (Edworthy, Sampson and Völlm, 2016; Sarkar, 2010).

1:7. Care in high secure forensic psychiatry

The complexity of patients in high secure forensic care results in complex treatment needs, with a wide range of interventions being delivered by a multidisciplinary team, including psychiatrists, psychologists, occupational therapists, pharmacists, nurses, and social workers (McMurran, Khalifa and Gibbon, 2009). Each professional discipline aims to provide their own unique contribution towards care but, in doing so, they maintain shared values in working towards common treatment goals (Lindqvist and Skipworth, 2000).

All professionals are individuals and the way they deliver care will be influenced by their previous life experiences and professional training. Occupational therapy training, for example, places particular emphasis on treating all patients with unconditional positive regard, irrespective of who they are or what they may or may not have done (Walsh and Ayres, 2003).

High secure psychiatric care aims to reduce the risk of offending and promote the recovery and rehabilitation of patients sufficiently to allow safe transfer to lower levels of security, and overall effectiveness of forensic care may be generally defined in this way (Tapp et al., 2013a). Interventions can be broadly termed pharmacological, involving, where appropriate, the use of antipsychotic medication; psychological, focusing on talking therapies; and social and occupational, which aim to equip the patient with the social and practical skills vital for recovery and rehabilitation (McMurran, Khalifa and Gibbon, 2009).

The therapeutic use of security is also an essential aspect of high secure forensic care. The use of relational security can help create an environment where therapy can effectively take place, by maintaining appropriate staffing levels and through staff forming positive relationships with patients to gain an understanding of their needs and concerns as well as their risks (Kennedy, 2002). These elements of care may change over the course of patient's high secure stay, depending on clinical need and the stage of a patient's recovery and rehabilitation journey (Glorney et al., 2010; Tapp et al., 2013b). However, patients have identified that maintaining therapeutic relationships throughout their care is an important aspect of their rehabilitation (Tapp et al., 2013b). This point is further emphasised by Deacon (2010), who argues that high secure care is largely a social process, with patients and professionals linked together in a relational matrix.

1:8. Treatment and treatability

The treatability of offenders, particularly those diagnosed with severe personality disorders, has long been the cause of debate, resulting in initiatives such as the dangerous and severe personality disorder (DSPD) programme (Howells, Krishnan, and Daffern, 2007). Treatability and a patient's treatment readiness is, however, individual to each patient (McMurran and Ward, 2010).

Several researchers have commented on issues regarding treatment and treatability in high secure forensic care. Glorney et al. (2010), for example, recognised the importance of timing interventions to capture a patient's readiness for treatment at the right stage of their recovery journey. The authors also recognised that patients' treatment needs will change during their stay and recognised the need for individualised care to meet the needs of complex patients. Blackburn (2004) previously voiced similar views regarding the need for individualised care and treatment programmes but commented on the lack of evidence regarding treatment efficacy through robust outcome research. Blackburn also debates difficulties in balancing rehabilitation needs with society's preoccupation with social control.

An example of this is the case of Michel Stone, who had allegedly been denied psychiatric care because he was considered untreatable, which was a catalyst for the introduction of the Dangerous and Severe Personality Disorder (DSPD) (Howells, Krishnan, and Daffern, 2007). The DSPD programme, which has now ended, offered treatments such as cognitive behavioural therapy to a group of previously marginalised patients; however, controversy surrounded the programme through the preventative detention of individuals deemed to be dangerous because of the severity of their personality disorder (Howells, Krishnan, and Daffern, 2007). This was made possible through the Mental Health Act 2007 which replaced the requirement for detention that the patient is treatable, which may have prevented people like Michael Stone from being detained in hospital, with the condition that 'appropriate medical treatment' is available (Greenall, 2009).

Public debate surrounding this case is widely considered to be influential in changing views on the treatability of personality disorder and the instigation of the DSPD programme, with accompanying preventative detention policies (Duggan, 2011; Howells, Krishnan, and Daffern, 2007). This case is also a key example of how policy can be influenced by high

profile cases which receive prominent media coverage (Duggan, 2011; Greenall, 2009). It is possible that the concept of mental health recovery may help to shift this balance and move the notion of treatability away from a medicalised model of care to one that fosters hope for the future (Hillbrand and Young, 2008).

1:9. Effectiveness of treatment

As in other areas of health care, evaluation of interventions in high secure forensic care is vital to ensure care is evidence based and the most effective available (Tapp et al., 2013 a). In a highly comprehensive literature review Duggan et al. (2011) examined the evidence regarding the efficacy and effectiveness of interventions. The paper makes many valid points, including the importance of interventions having proven efficacy and the need for more high-quality research into the effectiveness of interventions. Duggan et al. (2011) also commented on the influence of organisational policy and the role of influential reports in shaping interventions, arguing they may have a greater influence in service delivery than the evidence base.

Several authors, including Blackburn (2004), Glorney et al. (2010), Hodgins (2002), Tapp et al. (2013 a), have commented on the need for more research to examine the effectiveness of interventions in high secure care. However, for new research to have resonance, there may be a need to consider how current interventions are evaluated. In a systematic review of outcome measures used in forensic mental health research, Fitzpatrick et al. (2010) called for greater standardisation of outcome measures to aid consistency of evaluation, stating that the outcome measures used often focus on re-offending, at times neglecting rehabilitation outcomes.

1:10. Length of stay

A key outcome from high secure forensic psychiatry interventions is restoring a patient's functioning and reducing risk sufficiently to allow transfer to lower levels of security (Glorney et al., 2010). A systematic review of the international literature on the epidemiology of mentally disordered offenders (Badger et al., 1999), found that patients in England remained in high secure care forensic care for approximately eight years. Although this figure can significantly vary, the average length of high secure forensic care stay in the UK remains at approximately eight years (Glorney et al., 2010; Völlm, Bartlett and McDonald, 2016).

Factors which impact on a patient's length of stay include the seriousness of offending, which may lead to caution when considering discharge; the patient's ability or readiness to engage in treatment; the opportunities to develop positive relationships, including supportive family ties; and services' ability to follow the recovery philosophy, including promoting a positive outlook (Repper and Perkins, 2003).

1:11. High secure forensic patients

High secure forensic patients are an extremely diverse group, who are categorised by their prevailing disorder such as mental illness, personality disorder and learning disability. These classifications may lack meaning as they are based on legal classifications rather than clinical assessments, and many patients will present with multiple co-morbidities (Duggan et al., 2011). Patients detained in high secure forensic care are among the most dangerous and

challenging patients in the country, due to their potential for violence to others or for serious self-harm. Some patients will be considered high profile having committed serious offences such as murder, which have been widely reported in the media. Others, however, will have been convicted of comparatively minor offences but who have progressed from lower levels of security through to high security services due to the nature of their challenging behaviours.

It is important to emphasise that, although individuals detained in high secure forensic psychiatric hospitals may have committed crimes, they are not prisoners. Individuals residing in these hospitals are patients who are receiving assessment and treatment for mental disorders, not being punished for offences committed. They should, therefore, be able to expect the same high standards of efficacious care as would be demanded by any member of society receiving health care. Patients residing in high secure forensic settings are considered dangerous due to their offending with society being fearful of them. Paradoxically however, they may be considered to be one of the most vulnerable of patient groups and should be treated with dignity and respect irrespective of criminal convictions (West, Yanos and Mulay, 2014).

1:12. Case vignettes

High secure forensic patients are a heterogeneous group, with varying personal circumstances, and offending varying from minor criminal damage to the most serious homicide offences. The following composite pen pictures illustrate examples of patients who may find themselves in high secure care and may help to give an understanding of the differing needs and circumstances of high secure forensic patients.

1:12.1 John's story

John is a 39-year-old male from the north of England. John is from a supportive working-class family who reported changes in his behaviour from age about 17, with him becoming more withdrawn, neglecting his personal hygiene and to have difficulties concentrating. About this time John began taking illegal drugs as part of his involvement in the rave music scene.

John's drug taking began with occasional use; however, this quickly spiralled and was accompanied by changes in his mental health including hearing intrusive voices, having paranoid thoughts, and holding delusional beliefs. This ultimately led to John, aged 23, being involved in a confrontation with a shop keeper during which John punched the shop keeper and caused £50 of criminal damage. Following his arrest John's mental state proved a cause for concern, and he was quickly transferred from police custody to an acute psychiatric unit.

John remained mentally unsettled and following minor assaults on staff he moved through low and medium secure forensic care to high security under Section37/41 of the mental health act. John has now spent 16 years in the forensic mental health system, with six of those years being in high secure forensic care. Despite medication, John's mental health continues to be a cause for concern and at times, due to the risk of assault he can pose to staff and patients, John has spent time segregated from other patients, resulting in him spending extended periods in the confines of his room.

This creates challenges for the professionals working with John, who at times must deliver their interventions through small door hatches. He is, however, able to access some psychological therapies but his fluctuating mental health means that he is not currently able to gain the full benefit from these sessions. His main treatment area involves accessing low key

creative craft groups, which give John a sense of purpose, providing meaning to his day and helping to create a personal identity beyond that of a high secure patient. John has also been able to build good relationships with staff facilitating these interventions. They understand that at times he can be quite paranoid, but with help and support he can overcome this to lead a meaningful life, albeit, currently in the confines of high secure care.

1:12.2 Ahmed ’s story

Ahmed was a patient in the personality disorder service, with diagnosis of borderline, narcissistic and antisocial personality disorders. These conditions resulted in Ahmed feeling anxious, having difficulty in forming relationships with others and with a limited sense of identity.

Ahmed ’s offending centred on the sexual assault and abuse of young males and due to his risk, he was initially given an indeterminant sentence for public protection (IPP) before this was changed to a Section 37 /41 hospital order with restrictions on appeal. Ahmed was first sent to a medium secure hospital; however, he continued to offend against fellow male patients and so was transferred to a high secure hospital.

In high secure care Ahmed struggled to meaningfully engaging with health professionals, being avoidant of treatment and continuing to pose a risk to fellow patients. Ahmed ’s occupational therapist explored a variety of options to engage Ahmed in meaningful activity, with Ahmed resisting all suggestions. Ahmed was strongly encouraged by his multidisciplinary team to become more involved in his care and he eventually agreed to take part in vocational sessions in a printer’s workshop in the hospital.

Due to his avoidant history, staff remained sceptical regarding Ahmed ’s motivation to take part in these sessions, but almost immediately a change was noted in Ahmed as if “the

penny had dropped". Ahmed thrived on the real work nature of the area, which printed items for use through the hospital trust and was able to make positive relationships with both staff and peers in the area. Attending the printers appeared to give gave Ahmed hope for the future, which coupled with a new sense of identity and purpose helped to raise his self-esteem and self-efficacy.

Ahmed now began to engage more meaningfully with other aspects of his treatment, such as psychology and speech and language therapy. Ahmed 's new focus and improved sense of identity helped him to see possibilities beyond life in high security, with his risk to others being significantly reduced, allowing transfer to medium secure care.

1:12.3 Zachary's story

Zachary is a patient in the high secure learning disability service. Zachary has an index offence of murder, having killed a family member, and his case featured prominently in the press a time of his offence. Pictures of him in a floridly psychotic state, during which he experienced hallucinations and held delusional beliefs, were published in the press, accompanied by sensationalised statements such as "psycho killer" and "schizophrenic beast". The illusion of Zachary this potentially creates in the mind of the public is however, vastly at odds with his true presentation. When taking his medication, Zachary is a quiet man with a dual diagnosis of mild learning disability and schizophrenia, who has difficulty understanding the world, comes from a chaotic background and is easily influenced by others.

Near the time of his offence Zachary was encouraged by family members to stop taking his anti-psychotic medication, as they felt it was not helping him. This, unfortunately, had tragic repercussions. Following admission to high secure care Zachary quickly responded to

appropriate pharmacological treatment and was able to demonstrate a reduction in his risk which allowed him to access a wide range of creative and vocational activities within the hospital. Zachary now feels safe, secure, and cared for with all his basic needs met. Zachary's family situation remains difficult, with frequent family problems impacting on his mental state. Attempts have been made to transfer Zachary to lower levels of security; however, the serious and high-profile nature of his offending has resulted in caution from receiving medium secure units. Zachary himself also appears reluctant to leave a place in which he feels safe and secure and well looked after.

1:13. Complexity of patients

These pen pictures give a brief insight into the complexity of high secure forensic patients, and the challenges faced by professionals caring for mentally disordered offenders in a high secure setting. John's story for example, illustrates how patients who have committed relatively minor offences can remain in high secure care for extended periods due to their continuing risk and unstable mental state. Ahmed 's story highlights issues surrounding patients' motivation to engage meaningfully in treatment, and how developing a sense of identity away from that of an offender can begin to give hope for the future. The complexity of family relationships is highlighted in Zachary's story, which also illustrated the difficulties some high secure patients face when being asked to move away from an environment in which they feel safe and secure to new and unknown settings.

Badger (1999), Blackburn (2004), and Duggan et al. (2011) all commented on the heterogeneity of high secure forensic patients in terms of offending, mental disorder, personal circumstances and consequentially treatment needs. Glorney et al. (2010) also commented on the diversity of patient treatment needs and stressed the importance of individualised assessment and treatment programmes. Glorney et al. (2010) further stated that an

individualised approach to the care of mentally disordered offenders should include the management of risk and the promotion of their mental health recovery in the least restrictive environment possible to maintain safety and security.

1:14. Recovery

Mental health recovery is a user focused philosophy or ethos in which the patient takes control or begins to take control of their condition (Repper and Perkins, 2003). Mental health recovery does not indicate a cure, but rather management or coming to terms with a condition to live a life which has value and meaning to the individual (Repper and Perkins, 2003). Recovery is often about personal growth, and making choices and decisions that have personal resonance, and consequently each person's recovery journey will be different (Repper and Perkins, 2003).

Leamy et al. (2011) set out a conceptual framework for mental health recovery aims, with the objective of providing an empirical base for future research and practice. This framework uses the CHIME acronym to relate areas relevant to clinical research and practice. These are: connectedness; hope and optimism about the future; identity; meaning in life; and empowerment (Leamy et al., 2011).

The areas highlighted in the CHIME framework are pertinent to all patients with mental health conditions, and they appear to have particular resonance for those detained under the Mental Health Act, in high secure settings. Morrissey et al. (2017) highlighted the importance of the CHIME domains as well as associated factors, such as stigma, to the recovery of forensic patients with intellectual disabilities. The CHIME framework has however been criticised for being overoptimistic by not fully considering the difficulties that are inherent to the recovery process and the user experience. (Stuart, Tansey, and Quayle, 2017).

Nevertheless, the CHIME remains a suitable framework for consideration in this study due to its focus on identity and having meaning in life.

When considering the CHIME domains, the need for forensic patients to feel connected to the outside world, particularly in terms of family contact is a strong element of their progress and recovery. The CHIME framework also highlights the need for individuals to be optimistic about their prospects and have a life which has meaning which will in turn promotes a sense of empowerment. These constructs all have the potential to impact on a further domain of the CHIME framework that of identity.

Reclaiming a positive sense of identity is an important part of the recovery philosophy (Repper and Perkins, 2003). In a forensic setting reconstructing a patient's personal identity away from that of an offender is particularly important (McKeown et al., 2016). Ahmed's story gives an example of how participation in vocational activities can help to rebuild personal identity. This pen picture also reinforces the complexity of care and the stages that may be needed to reach this point. Ahmed's story illustrates how a patient can become more empowered, gaining a renewed hope for a future, outside the confines of a high secure hospital.

Mental health systems such as high secure hospitals may face challenges in being recovery focussed. Slade et al. (2014) contend that elements of secure care such as compulsory detention, and restraint are against the principles of recovery. Paid employment, independent living, control over finances and engagement with the wider communities have been identified as positive indicators of mental health recovery (Taylor et al., 2009). However, for individuals confined in high secure care opportunities for living life in this way are limited, which may impact on the recovery process.

High secure forensic care has a need to balance the recovery of the individual with maintaining safety and security and the management of risk. Perkins and Repper (2016) ague that traditional approaches to risk management in mental health settings focuses on professionals and organisations having control over managing potential risk based on historical precedent. They suggest a shared management and understanding of risk, which encourages the individual to take control of their own risk through a process of shared decision making and in-turn promotes opportunities and self-determination.

Mental health recovery is a highly individualised process comprising of the interconnected elements including those set out in the CHIME framework (Leendertse et al., 2021). Examples of this can be seen in the pen pictures with Ahmed ’s story highlighting the personal factors which helped dictate his treatment readiness and recovery. While Zachary’s story demonstrates how a range of factors such as mental state and family support can act as both barriers and facilitators to treatment readiness and effective care.

In high secure care, the factors associated with an individual’s recovery and treatment progress will be subject to a range of influences which have been previously discussed in the chapter. These include elements such as national and organisational policies, mental health law, risk management social support and stigma. It is important to understand how these influences impact on an individual’s recovery, with Leendertse et al. (2021) advocating for more research to gain an understanding of the interaction between the elements of recovery as well as clinical and social factors. It is also important to understand how these factors impact on the identity of high secure forensic patients and the effectiveness of their care.

1:15. Identity and high secure forensic patients

An individual's identity and the roles that make up that identity are central to self-actualisation and fully developing as occupational beings (Wilcock, 1999). An individual's identity is multifaceted containing productive, social, and spiritual dimensions, all of which are influenced by environment in which we grow and develop. The identity and associated roles of individuals with mental health conditions can also be affected by stigma, which can impact on an individual's opportunities and self-esteem, and this is particularly significant for patients who also have forensic backgrounds (Williams et al., 2011).

Identity theorists and social identity theorists provide theories as to how an individual's identity is developed, influenced, and maintained. They postulate that an individual's identity is formed through a process of self- identification or self- classification (Stets and Burke, 2000). In shaping identity, individuals will associate with various social groups in a variety of settings. These groups are bound together by shared norms and beliefs, and individuals will take on roles within these groups (Stets and Burke, 2000). The type of roles individuals enact will change depending on the setting and the nature of the group. Identity theorists see the enactment of meanings and expectations associated with roles as central to an individual's identity (Stets and Burke, 2000).

The roles that make up an individual's identity are likely to include roles such as a worker, a family member, a student, or an artist, amongst many others. However, for patient in high secure care, their ability to enact, maintain and develop these roles may be limited due to their mental disorder, previous offending background and their confinement in a high secure hospital. This results in labelling which will impact on the way they are viewed and treated by others (West, Yanos and Mulay, 2014).

As a consequence of their offending, they are assessed to have a mental disorder and are now placed in a high secure hospital, a forensic patient may also be labelled with the doubly stigmatised identity of a mentally disordered offender. (West, Yanos and Mulay 2014). In the pen picture, Zachary's story gives an illustration of how stigmatisation can limit a patient's progress and potentially lead to institutionalisation.

Institutionalisation can suppress an individual's sense of identity, taking away aspects of who they were, such as the ability to enact meaningful roles. For some, institutionalisation will lead to stagnation and a lack of personal growth and development into the person they would like to be (Kessing and Ravn, 2017).

Therefore, a patient's ability to change may be closely linked to their identity, how they see themselves and where they would like to be. However, for some, aspects of their identity may be linked to perceived status gained through offending, which may be difficult to relinquish. An individual's identity has a strong connection to their personal goals and to the life they want and type of person they want to be, or the person they see themselves as (Christiansen, 1999; Howells and Tennant, 2010). From a clinical perspective, supporting an individual to maintain or develop an identity can provide a framework for goal setting and building motivation (Christiansen, 1999). Tennant and Howells (2010) further argue that a change in identity from offender to patient is crucial for treatment engagement when treating individuals with personality disorder in high secure settings. Relinquishing an offending identity and constructing a positive and pro social identity can also be seen as an indication of readiness to change (Tennant and Howells, 2010).

1:16. Theory of change

To understand and conceptualise the process of change the transtheoretical model of change model was developed by Prochaska and DiClemente (Prochaska and DiClemente, 1982). This sequential model conceptualises six discrete stages in the process of change, with the stages being defined as precontemplation, contemplation, preparation/determination, action, maintenance and relapse or termination. The model acknowledges that change is not sudden or precipitous, but involves a clearly defined chain of events or circumstances (Casey, Day and Howells, 2005)

An important aspect of the model is identifying an individual's position in relation to change and helping target interventions to meet them at that stage, necessitating a move away from a one size fits all care pathway (Casey, Day and Howells, 2005). This also requires the individual acknowledging the problem and a need to change. Howells and Tenant (2010) highlight demonstrating willingness to relinquish an offending lifestyle as an important factor in an offender's readiness for change.

1:17. High secure patients and stages of change

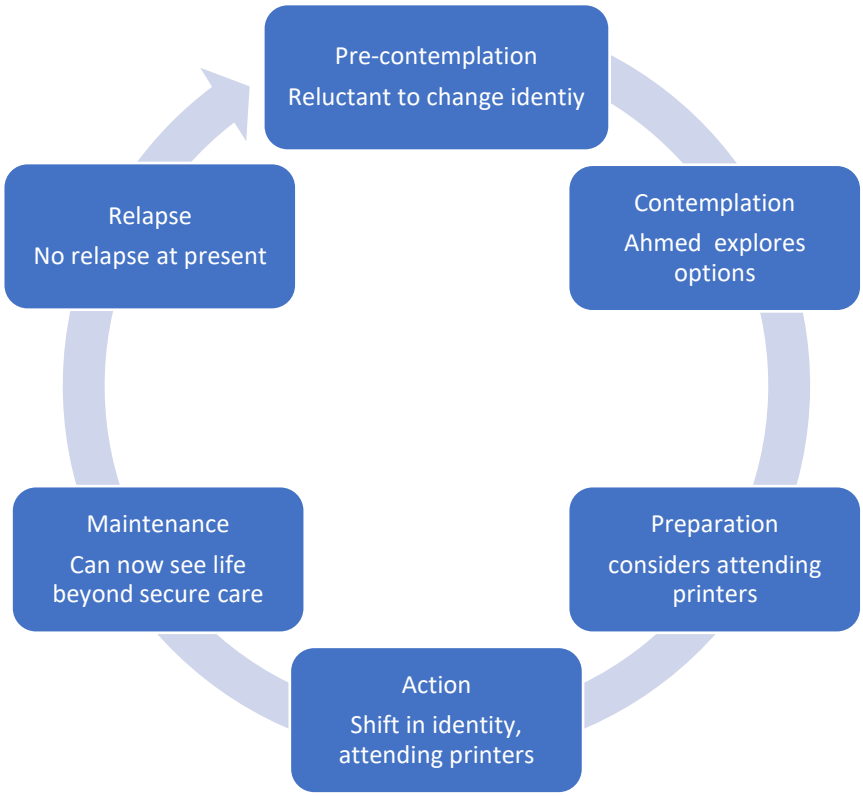
The composite pen pictures (section1:12) give a flavour of how an individual's identity can impact on their care and where they may be placed in relation to the transtheoretical stages of change model. For example, John's story describes a man who, despite several years in forensic care, is still mentally unwell and posing a risk to others. He is however, taking part in craft activities and building relationships with staff. This may indicate that John

is currently in the contemplation stage in the stages of change cycle, where he is aware that problems exist, but is having difficulty in wholeheartedly committing to change (Panting et al., 2018. Prochaska and DiClemente 1983).

Zachary's story tells of a man who has made some progress in his care. Zachary appears to have moved through the contemplation stage and is moving through the action stage (Panting et al., 2018; Prochaska and DiClemente 1983). However, due to his past experiences and having a stigmatised identity owing to press coverage of his offending, he is having difficulty truly committing to change enough to move forward to lower levels of security.

Ahmed's story, however, may surpass the previous two cases in demonstrating how the transtheoretical model of change can be used to conceptualise a high secure forensic patients cycle of change. Ahmed 's story tells us how he was initially reluctant to change. but has since gained an internalised perceived befit from his offending identity (pre-contemplation stage). Ahmed's occupational therapist and other MDT members explored options with him (contemplation stage). There appears to have been a shift in Ahmed's identity as he began to consider attending a printer's workshop (preparation stage). The shift in Ahmed's identity from offender and high secure hospital patient towards that of a worker, with pro-social skills and abilities helped Ahmed engage more meaningfully in his treatment (action stage). Ahmed can now see the possibilities of life after high secure care (maintenance stage). At the point when the case vignette concludes Ahmed has been transferred to medium secure care and has not undergone any relapse (relapse stage) (Panting et al., 2018; Prochaska and DiClemente 1983).

Figure 1.1 Transtheoretical model of change: Ahmed 's cycle of change



Adapted from (Panting et al., 2018; Prochaska and DiClemente 1983).

The above figure conceptualises how a shift in a high secure patient's identity may promote treatment engagement and ultimately the effectiveness of care. However, in a forensic setting an individual's capacity to change can be debated and the previously highlighted case of Michael Stone exemplifies this. It was suggested that Stone, and similar individuals, had deeply engrained antisocial personality disorder issues which rendered them unable to change and were therefore untreatable (Howells and Tennant, 2010). This is now considered to be erroneous (Pickerskill, 2013), but the capacity to change is likely to be a highly individualised process, which may be driven by internal and external factors including personal experiences.

An individual's identity may dictate their ability to cope with illness, such as mental disorders. Antonovsky developed his theory of salutogenesis, which concerned how specific

personal dispositions serve to make individuals more resilient to the stressors they encounter in daily life (Lindstrom and Ericsson, 2006). Antonovsky identified characteristics in an individual's identity which he claimed helped a person better cope by providing that person with a "sense of coherence" about life and its challenges (Antonovsky, 1996). This biopsychosocial approach postulates that a "sense of coherence" or a feeling of control over one's inner self and external environment promotes a sense of confidence and control, and an ability to meet life's challenges and stressors with a positive outlook (Antonovsky, 1996).

This theoretical approach may help to understand why some individuals are able to develop an overall sense of wellbeing, despite life's challenges, potentially linking to recovery theory and the maintenance of a positive identity. It may also explain why some forensic patients have more capacity to change than others.

The ability to change and how an individual copes with the life stressors associated with illness will be different for every person, as will their motivation to change. A lack of motivation has been highlighted as a barrier to change and a major challenge when working with mentally disordered offenders (Panting et al., 2018). Consequently, an individual's ability to change and to benefit from available interventions will ultimately impact on length of high secure hospital stay.

1:18. Evaluation of interventions in high secure forensic care

Systematic reviews are often regarded as fundamental processes in the evaluation of complex interventions in modern health care; they provide a framework for the systematic synthesis of relevant research evidence and aid decision makers in the development and implementation of interventions and services (Callum and Dumville, 2015).

Strengths of the systematic review include the robust manner in which they are conducted, with a well-developed research protocol including a clearly formulated, focused and answerable research question, well developed inclusion exclusion criteria and a clear plan for data extraction and analysis (Callum and Dumville, 2015; Moher et al., 2010). The quality of systematic reviews, and the credibility of their findings, however, depends on the quality of studies included. Authors such as Tapp et al., (2013a) have questioned the quality of current forensic research, citing vulnerability to bias and inconsistency of reporting as potential flaws.

The CONSORT guidelines, (controlled standards of reporting trials) provide clear guidelines for the reporting of randomised controlled trials (RCT), while the PRISMA statement (preferred reporting items for a systematic review and meta-analysis) sets guidelines to improve the reporting of systematic reviews in terms of quality and consistency (Begg et al., 1996; Moher et al., 2010). Despite this, the efficacy of using RCTs and systematic reviews to evaluate complex interventions such as forensic care has been questioned due to the complex, and at times conceptually challenging, nature of some health care interventions (Shepperd et al., 2009).

RCTs may therefore be of limited value in forensic psychiatry. RCTs of socially based interventions have been shown to be susceptible to bias which undermines their value and credibility (Lindsay, 2004). To successfully evaluate interventions in high secure forensic care, an alternative approach may be needed. A potential solution may be to evaluate interventions using a critical realist approach.

Critical realism originates from the writings of Roy Bhaskar who questioned the positivist approach as a basis for investigating the social world (Bhaskar, 2008; Sayer, 2000). Critical realism and the work of Bhaskar, will be explored in more detail in chapter 2 of this thesis as

an alternative to positivism and as a basis for researching the social world of high secure forensic care.

1:19. Personal statement

As an occupational therapist with extensive practice experience of high secure forensic care working with a range of mentally disordered offenders, it is important to recognise how my experiences have influenced my thinking and shaped how I have approached this research. My personal and professional philosophy instils a belief that each patient is treatable, and able to recover from their illness to lead a fulfilling life, whether this may be out in wider society, or within the confines of institutional care.

Occupational therapy, as a profession, seeks to help individuals to live their lives to their full potential, seeing people as individuals and treating people with unconditional positive regard (Walsh and Ayres, 2003). In a forensic setting, this involves setting aside their offending to see each patient as an individual, irrespective of the seriousness of their offences. My professional stance therefore shapes the way I relate to mentally disordered offenders as people who I believe are essentially no different from other members of society. Patients often have families who often care for them and, despite difficult situations they find themselves in, they all have hopes and dreams for the future, have the right to be treated ethically, and should expect the most effective treatment available.

When I first began working in forensic services as a newly qualified practitioner, I assumed that all interventions would be well researched, and would have a solid evidence base. I further assumed that they were implemented for the benefit of patients. As my career progressed, I began to challenge my previous assumptions and questioned not only the robustness of the evidence base but also the efficacy of interventions. It became clear to me

that a range of issues, which include the complexity of patients, the stigma which surrounds high secure forensic patients as well as government and hospital policy all impact on patient care at different levels. I felt that most current research failed to take full account of these issues, and so began to consider alternative approaches to evaluate interventions.

I would argue that adopting a critical realist approach, to gain an understanding of the causal mechanisms which may prove barriers or facilitators of effective high secure forensic care is an appropriate means of investigation. Adopting a critical realist position, which is often associated with an emancipatory approach and improving the lives of those socially excluded from aspects of society (Edgley et al., 2016). This fits well with my professional philosophy of trying to improve the lives of others and helping individuals live their lives to their full potential.

Reflexivity allows the researcher to consider how their actions and beliefs impact on a situation or research process and gives the researcher the opportunity to modify actions or at least to recognise their influence (Berger, 2015). Within qualitative research, reflexivity is essential to maintain the integrity and transparency of the research, and reflexivity has also been seen as a means of maintaining a critical stance (Newton et al., 2012).

I feel being mindful of my professional position as an occupational therapist should not, however, prevent me as a researcher challenging the current systems and practices which socially construct the world in which high secure care exists, not always to the enhancement of patient care and treatment.

1:20. Introduction to the research

This chapter has set out the background of high secure forensic care and highlights some of the complexities of care in this area, highlighting the complexities of patients and the difficulties in successfully evaluating interventions. To gain an understanding of the effectiveness of care from the perspective of patients receiving care an empirical research study was conducted and will be described in this thesis.

This qualitative study had a research question of "*What are the barriers and facilitators of effective high secure forensic care?" and* aimed to investigate factors which patients felt could impact on the effectiveness of their care.

The research question was set out in this way to add to the debate of "what works" in high secure forensic care from the perspective of the patients receiving care (Tapp et al., 20013b). Patients receiving care may be considered to be experts by experience and gaining an understanding of factors they consider to be barriers of facilitators of their care places the participants at the centre of the research.

This is an important consideration and fits with the critical realist philosophy of the work, and its potentially emancipatory nature (Edgley et al., 2016). This also relates to the researcher's background as an occupational, therapist and the occupational therapy philosophy which focuses on the priorities of patients, enabling them to achieve client centred goals.

An important aspect of the recovery philosophy is a move away from the medical model which has a focus on diagnosis and treatment, with power often centred, in a forensic setting around the patients responsible clinical (Edgley et al., 2012). The medicalisation of illness

places power in the hands of professionals, whilst the recovery philosophy encourages a shift in power with patients taking control of their care (Hui and Stickley, 2007).

The research question was framed in terms of barrier and facilitators to allow consideration of participants views of factors which may act as facilitators of their rehabilitation and recovery, and in turn factors which may act as barriers to their care and recovery. Framing the question in this way links previous literature regarding "what works in forensic care" (Tapp et al., 2013b), the recovery philosophy and occupational therapy theory which centres on a client centred approach.

Framing the research question in terms of barriers and facilitators of recovery and rehabilitation goes on to link to the previously discussed CHIME framework and the five recovery constructs of connectedness, hope and optimism about the future, identity, meaning in life and empowerment (Leamy et al., 2011). The constructs which make up the CHIME framework are highly relevant to the recovery and rehabilitation of forensic patients, and the CHIME framework was considered appropriate as a theoretical framework, as how these factors are considered in forensic care will link to potential barriers and facilitators of high secure forensic care. The research was therefore conducted using critical realism as a philosophical position and following on from previous discussions the CHIME framework Leamy et al. (2011), was employed as a theoretical framework for the study.

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1:21 Theoretical framework

Theoretical frameworks help to ground the theoretical constructs of the research adding meaning and direction to the process (Varpio et al., 2020). The theoretical framework of a research study is based on existing theory or theories that underpins the research and gives focus to the study (Osanloo and Grant, 2016). The theoretical framework for this study therefore sets out the need to balance the recovery and rehabilitation needs of the patients, with the need to maintain the safety of the public, and to manage risk.

As highlighted in section 1:14, Leamy et al. (2011) set out a conceptual framework for mental health recovery aims, with the objective of providing an empirical base for future research and practice. Using the CHIME acronym, the framework emphasised that connectedness; hope and optimism about the future; identity; meaning in life; and empowerment are key to an individual's recovery (Leamy et al., 2011).

In a clinical setting, creating a physical, social, and organisational environment which allows patients to meaningfully achieve these goals can be challenging. Several researchers including Robertson and Walter (2008), Völlm, Bartlett and McDonald (2016), and Ward (2012), have discussed the "dual role" in forensic psychiatry which balances the need to provide the most appropriate care and advocate for the patients with the need to maintain safety and security. In a high secure setting, where great restrictions are placed on patients, providing truly recovery focused care may be challenging. This needs to be considered to promote offender recovery, and professionals may need to challenge their own pre-existing thoughts and beliefs (Barker, 2012; Drennan and Alred, 2012).

Using the CHIME framework (Leamy et al., 2011), this study will therefore consider the balance between rehabilitation and security, and how recovery and risk might be better managed. Perkins and Repper (2016) discussed the concept of risk versus recovery

postulating that many aspects of mental health law are inherently discriminatory, and that services enacting these laws become risk averse, and have difficulty in maintaining a recovery focus. They further argue that services should focus on creating opportunities for recovery rather than manage risk, in a partnership based on trusting relationships.

1:22. Summary

This chapter has set out the background in which high secure forensic care takes place and set out the basis for an empirical study in this area. The chapter has also discussed the difficulty in evaluating interventions in this area. Following chapters will discuss critical realism as a philosophical approach to enhance research and will outline a critical realist review of the literature, before describing the empirical study.

Chapter 2 Critical realism

2:1. Introduction

This chapter will outline critical realism as a philosophical basis to investigating high secure forensic psychiatry and debate critical realism in contrast to other philosophical positions such as positivism.

2:2. Critical realism

Critical realism derives from the work of Roy Bhaskar, and in his book "A realist theory of science", originally published in 1975, Bhaskar set out his philosophical vision which formed the foundations of critical realism (Bhaskar, 2008). Bhasker questioned the positivist approach to science and the ontological position of empirical realism, which argues that there is an observable reality that can be studied (Bhaskar, 2008).

Central to Bhaskar's alternative to positivism is the domains of the real, the actual, and the empirical (Bhaskar, 2008; Edgley et al., 2016; Sayer, 2000). From a critical realist perspective, the real refers to the structure and causal power of objects, which may act independently of observable events (Bhaskar, 2008; Collier, 1994; Edgley et al, 2016). The actual considers what may happen if these powers are triggered (Bhaskar,2008, Sayer, 2000). The empirical relates to experiences, and can be both observed and unobservable (Sayer, 2000).

Critical realists argue that Bhaskar's view of these domains has implications for the way causality is understood (Collier, 1994; Edgley et al., 2016; Sayer, 2000). From a positivist's standpoint, causality involves a successionist interpretation, where one event will cause

another, and where cause and effect have a degree of regularity (Sayer, 2000). This in turn, positivists would argue gives predictability (Sayer, 2000). However, Bhaskar argued that only in closed systems could this clear cause and effect occur (Bhaskar, 2008).

A closed system is one where conditions are tightly controlled to eliminate factors which may serve to act as confounding variables, potentially influencing outcomes (Bhaskar, 2008; Collier, 1994; Edgley et al., 2016). Critical realists would further argue that only in laboratory type conditions, can such closed systems be maintained, and any consistent cause and effect regularity be achieved (Sayer, 2000). Such closed systems are, however, unlikely to exist in the social world, more realistically, open systems will be the norm. An open system is one which is subject to a variety of influences and causal factors. Edgley et al. (2016 p 6), state that "*the social world is by definition an open system"* which is prone to changes such as individual action and organisational conditions. This makes accurate prediction of events and actions problematic as causal powers may result in differing outcomes (Edgley et al., 2016).

Following on from the work of Bhaskar other authors expanded on the development of critical realism as a philosophical position for investigating the social world

Sayer (2000) for example discussed that critical realism is linked to interpretative social sciences by the view that social phenomenal are context dependant. However critical realists differ from interpretivism by believing that causal explanation may be possible but qualifying this by stating that causality may not be linier, and that a wide range of factors may influence the causal process.

2:3. Causal mechanisms

Critical realists believe that objects and structures have causal powers which may exert influence to produce change in the social world (Bhaskar, 2008; Sayer 2000). These objects and structures are usually referred to by critical realists as causal mechanisms (Bhaskar, 2008; Sayer, 2000). Hedström and Ylikoski (2010) describe casual mechanisms as the "cogs and wheels" of the causal process, while Pawson (2006) describes them as the engines of explanation in realist analysis. A causal mechanism can be defined as a social or physical entity which has the ability to act on the relevant participants or actors (Pawson, 2006). From a healthcare perspective, these participants and actors will be those who plan, deliver, and receive care.

Causal mechanisms do not act uniformly but will be influenced by context and conditions to produce differing outcomes (Pawson, 2006), a view which is contrary to the positivist successionist theory of cause and effect (Collier, 2004). In open systems, the same causal mechanisms may well have differing influences, depending on the contextual situation (Sayer, 2000). Even in open social systems, however, there may be a degree of regularity, which may allow researchers to suggest what may happen but not predict with certainty will happen, within given systems (Pawson, 2006). Researchers should therefore be prepared to expect the unexpected, as causal mechanisms can create unrecognised conditions which result in unintentional consequences (Sayer, 2000).

2:4. Levels of reality

Critical realists contend that the social world is layered into different levels of reality, with this stratification is dictated by the complexity of the social world (Roberts, 2014). Bhaskar referred to the multiple strata of nature and social science which can be ordered but qualifying this by stating that it is causal mechanisms rather than events or things which are stratified (Bhaskar,2008; Collier, 2004). The multi layered nature of the social world therefore results in a need for multilevel analysis (Westra, 2019).

Interventions in healthcare are "*embedded in a range of attitudinal, individual, institutional and societal processes*" (Pawson and Tilley, 1997. p216). Healthcare interventions are therefore rooted in multiple social systems, with all interventions being affected by multiple layers of contextual influences (Pawson 2006). These influences consequently produce outcomes that are generated at macro, meso and micro levels (Pawson and Tilley, 1997)

Causal mechanisms have the potential to work across macro, meso, and micro levels to influence the delivery and effectiveness of care. Tambuyzer, Pieters and Audenhove, (2014) identified that mental health care takes place across these levels, with the macro level referring to mental health policy, the meso level consisting of mental health care services and institutional care and the micro level consisting of individual patients and staff. From a high secure forensic care perspective, I would therefore argue that the macro level relates to government policy, the enactment of law, the impact of relevant reports and influence of the media. The meso level refers to hospital policy and procedures, relational security, outcome measures, and professional training While at the micro level therapeutic relationships, enactment of recovery policy, stigma, family support and the management of risk. Any of the

above can all be considered mechanisms of influence, having the potential to act as causal mechanisms

Causal mechanisms will not, however, act purely across one level and the stratification of causal mechanisms acknowledges the influence and the power relationships which exist between them (Sayer, 2000). As well as acting across levels, causal mechanisms may combine to form even more complicated causal influences (Hedström and Ylikoski, 2010). Complex healthcare interventions such as those in high secure forensic psychiatry are therefore influenced by a range of causal mechanisms. These mechanisms may act as both barriers and facilitators of care, with their capability to impact on care being dictated by a variety of contextual factors (Sayer, 2000).

These causal factors may create problems for researchers by acting as confounding variables and impacting on the validity of evaluation research (Pawson, 2006). It is, therefore, important to understand how causal mechanisms may impact on intervention outcomes. Gaining an understanding of the causal mechanisms which may be at work will not give a complete understanding of the causal process. However, by identifying the crucial elements which may be at work, a broader understanding of potential actions and outcomes which may occur (Hedström and Ylikoski, 2010).

2:3. A critical realist alternative

Healthcare research is often conducted from a positivist perspective, (McEvoy and Richards, 2003) with randomised controlled trials (RCTs) often considered to be the gold standard of research. When evaluating the effectiveness of interventions, and systematic reviews (SRs) of RCTs' frequently provide the basis for evidence-based health care (Clegg, 2005; Eccles et al., 2003).

While the value of this approach cannot be underestimated, particularly in areas such as pharmacological trials where confounding variables are more readily controlled, their use in the evaluation of socially based interventions in open systems may be problematic (Clegg, 2005; Shepperd et al., 2009). RCTs provide quantitative data and attempt to eliminate as many other variables as possible. However, in forensic psychiatry, the available population is relatively small, so it is difficult to get adequate sample sizes to achieve statistical power (Clegg, 2005; Eccles et al., 2003).

In turn SRs of RCTs often aim to combine and examine pooled data from trials by means of meta-analysis; however, in forensic mental health this is rarely achievable because of heterogeneity of studies. Complex healthcare interventions such as those which take place in high secure forensic settings are made up of numerous components and characteristics which interact together and include settings, timings, the frequency of interventions and the skill and experience of practitioners; all of which makes effective evaluation difficult (Craig et al., 2008; Bowling, 2014). Consequently, while RCTs may be well suited to address questions as to whether an intervention leads to a difference. However, they don't inform as to why that difference occurs, for which purpose qualitative or realist methods are more appropriate (McEvoy and Richards, 2003).

As mentioned, positivists argue that the existence of causal laws leads to empirical regularity (Cruickshank, 2007). Variations on the positivist position such as logical positivism have been put forward in an attempt to defend and strengthen the positivist empiricism position (Corry, Porter and McKenna, 2019). Logical positivists argue that empirical knowledge was the only valid form of knowing based on the principle of verification, and that theories can only have meaning if they can be verified by direct observation (Corry, Porter and McKenna, 2019) As an alternative to this critical realists

contend that causal mechanisms may generate outcome patters which may then allow theories to be developed, which can thein in turn be tested (Pawson and Tilley, 1997; Hedström and Ylikoski, 2010).

2:4. Critical realism as an emancipatory approach

Pawson and Tilley (1997) argued that evaluation research should be "realistic" and for the benefit of the public, practitioners, and policy makers, not purely for the benefit of "science". They further commented that there is little value in evaluation research if it is not for the benefit of wider society (Pawson and Tilley,1997). Adopting a critical realist approach may contribute to this process by allowing established conventions to be challenged as a means of promoting change (Edgley et al., 2016; Hammersley, 2002).

This potentially emancipatory process critically explores theories and ideas as a means to promote social justice (Edgley et al., 2016; Hammersley, 2002). Specifically, this approach can empower people to challenge issues such as health inequalities, class discrimination and racism (Collins et al., 2015). In doing so, this gives researchers a platform to help gain an understanding inequalities and power relationships which exist in society, such as those which exist in healthcare systems (Edgley et al. 2016). Critical realism, therefore, gives an opportunity to change the prevailing social order and in doing so promote social change (McEvoy and Richards, 2003).

2:5. Conclusion

Adopting a critical realist approach can inspire researchers to look beyond surface appearances to examine the underlying processes at work (McEvoy and Richards, 2003). When considering the patient population being studied, critical realism is an ideal platform on

which to base emancipatory research (Wilson and McCormack, 2006.) High secure forensic patients are among the United Kingdom's most disenfranchised and stigmatised groups, and if the effectiveness of their care is to be meaningfully investigated an approach which encourages a wider exploration of the issues at play is necessary (Edgley et al., 2012). Critical realism is concerned with exploring experiences to consider change, and this approach allows the researcher to consider the full depth and meaning of the situation of interest (Walsh and Evans, 2014).

Chapter 3: A critical realist review of the barriers and facilitators of care in high secure settings

3:1. Introduction

Forensic care is a multifaceted complex intervention which does not easily yield itself to positivist methods such as systematic reviews (Tapp et al., 2013a). As discussed in Chapter 2, a critical realist approach appears appropriate to derive a comprehensive understanding of what works and what doesn't in this area. To recognise the barriers and facilitators of effective care in a high secure setting it may be therefore necessary to take a step back to critically analyse policies and societal attitudes which have shaped forensic care and the political and social climate in which they are delivered. The following section will discuss how a critical realist review was applied to these complex questions.

3:2. Critical realist review

A critical realist review of the literature allows the researcher to consider the social processes, policies, and national and local agendas which along with historical custom and practice shape the nature of healthcare (Edgley et al., 2016). Through examining these potential causal mechanisms, it may be possible to gain a deeper understanding of the various influences which may be at play.

A review from a critical realist perspective has the potential to add to the knowledge base through its emphasis on factors which may not always be empirically observable and measurable (Edgley et al., 2016). This is because a critical realist review of health care enables the consideration of the social practices relating to interventions and permits a broad approach which gives the researcher the opportunity for creativity and original thinking

(Edgley et al., 2016). Through understanding the barriers and facilitators which impact on effective interventions in high secure care, it may be possible to consider how these mechanisms impact on current interventions and the parts they play in their efficacy (Tsang, 2014). By gaining a greater understanding of factors at work in the delivery of forensic care, it may be possible to evaluate them more effectively and to consider their effectiveness more successfully.

A strength of a critically focused review is its ability to consider conflicts which may exist in a research area, particular when there are inconsistencies, or the area is underdeveloped, which can in turn help to give focus and direction to future studies (Paré et al., 2015). Critical reviews give the researcher the opportunity to explore all relevant literature with a freedom not usually permitted in systematic reviews, so that the literature can be explored critically with relevant issues and themes explored (Bates and Stickley, 2013). The themes developed from key papers may not always be derived from the overriding subject of the paper, but maybe from important side issues raised (Bates and Stickley, 2013; Edgley et al., 2016).

3:3. Theory development

It is unlikely that this critical realist review will provide definitive answers regarding the effectiveness of care in high services; however, it may promote theory development regarding the effectiveness of interventions, and why or why not an intervention works (Pawson, Greenhalgh and Brennan, 2016). By identifying barriers and facilitators to effective care the work may pave the way for empirical research to be undertaken, retaining the critical realist approach with the need to improve care for patient benefit being at the heart of the work (Edgley et al., 2016).

3:4. Research question

In this review the primary research question is:

What are the barriers or facilitators of effective care in high secure services?

This will promote discussion giving rise to categories under which data may be summarised and discussed. The process promoted a literary journey through which the full depth and breadth of the topic was explored. Critical realism proposes to go past recording the associations between observed empirical events to consider practical explanations of what causes these events within the social world (Okoli, 2015).

Search terms were developed using the PICO (population, intervention, comparator, outcome) format as set out by Bettany-Saltikov (2012). Initial search terms were developed to identify articles relating to potential mechanisms, and how they may act as barriers or facilitators of high secure forensic care.

The review developed organically, as themes and issues emerged: consequently, search terms and strategies followed a similar creative course, which allowed a full range of the literature to be discussed (Edgley et al., 2016). Initially, the broad debates were explored by examining literature from multidisciplinary sources and including governmental and local policy documents. This allowed the generation of themes which could then be developed through smaller focused searches to potentially develop theories and concepts (Edgley et al., 2016).

3:5. Aims and objectives

The aim of this review was to examine the literature relating to a range of causal mechanisms which may act as either barriers or facilitators of effective care in high secure forensic

services. The objective of the review was to review critically relevant issues which arose from the literature, and through discussion consider theories as to how these issues impact on the effectiveness of high secure care. A series of potential causal mechanisms was developed, based on the background literature relevant to the review and from the writer's personal experience of working in high secure forensic care. Although the categories may not be exhaustive, the topics discussed in sections 3:9 onwards seemed to be the most relevant.

3:6. Inclusion and exclusion criteria

No strict inclusion and exclusion criteria were attached to search strategies or to the type of literature searched. Papers and other material were selected if they were relevant to issues relevant to high secure care and the quality of care in these setting. Articles were selected for inclusion by means of a purposive method, using searches of PsycINFO, CINAHL, Cochrane Library, Embase and Medline databases, as well as reference lists to identify literature most relevant and illuminating to the area of interest in a "snowballing" approach (Edgley et al., 2016; Mason, 2002). Realist and critical realist approaches allow for the inclusion of both quantitative and qualitative research, to consider factors impacting on why and how interventions are implemented and their effects (Paré et al., 2015; Pawson et al., 2005).

This allowed the inclusion of papers seen as key from a variety of research traditions, as well as government policy and guidelines, books, and the media. Typically, critically focused reviews do not set out to systematically review the entire literature on a topic but are more likely to consider key works which highlight and explain the topic or problem area (Paré et al., 2015). No assessment of study quality was conducted, as in a critical realist review the quality of research is not necessarily an inclusion or exclusion criteria. This is because a study which may be considered to have flaws overall may still have elements which can add to the general debate (Paré et al., 2015).

3:7. Data extraction

For each identified category, a small scale rapid, purposive literature review was conducted, which aimed to capture the most relevant literature to illustrate most accurately the key arguments (Pawson et al., 2005). The review followed the rapid review method as described by Khangura et al. (2012). Khangura et al. (2012) acknowledged that there is no agreed definition or method for a rapid review. They do, however, argue that the rapid review provides the opportunity to use a dynamic approach, particularly in topic areas which have proved difficult to address (Khangura et al., 2012). This method promotes critical thinking in examining how one concept may impact on another.

The reference list of key papers was then examined to elicit additional studies. Grey unpublished literature, obtained through personal contacts, was also explored in an attempt to gain a full understanding of the issues involved. The use or reference lists and citations is considered a valuable strategy for health researchers in identifying relevant studies from earlier research and is often termed the ancestry approach or footnote chasing **(**Polit and Beck, 2014).

3:8. Data management and analysis

Consideration of how this review should be structured, and in what order causal mechanisms should be reviewed helps to illustrate the complex nature of high secure forensic care and the difficulties in identifying how causal mechanisms impact on care.

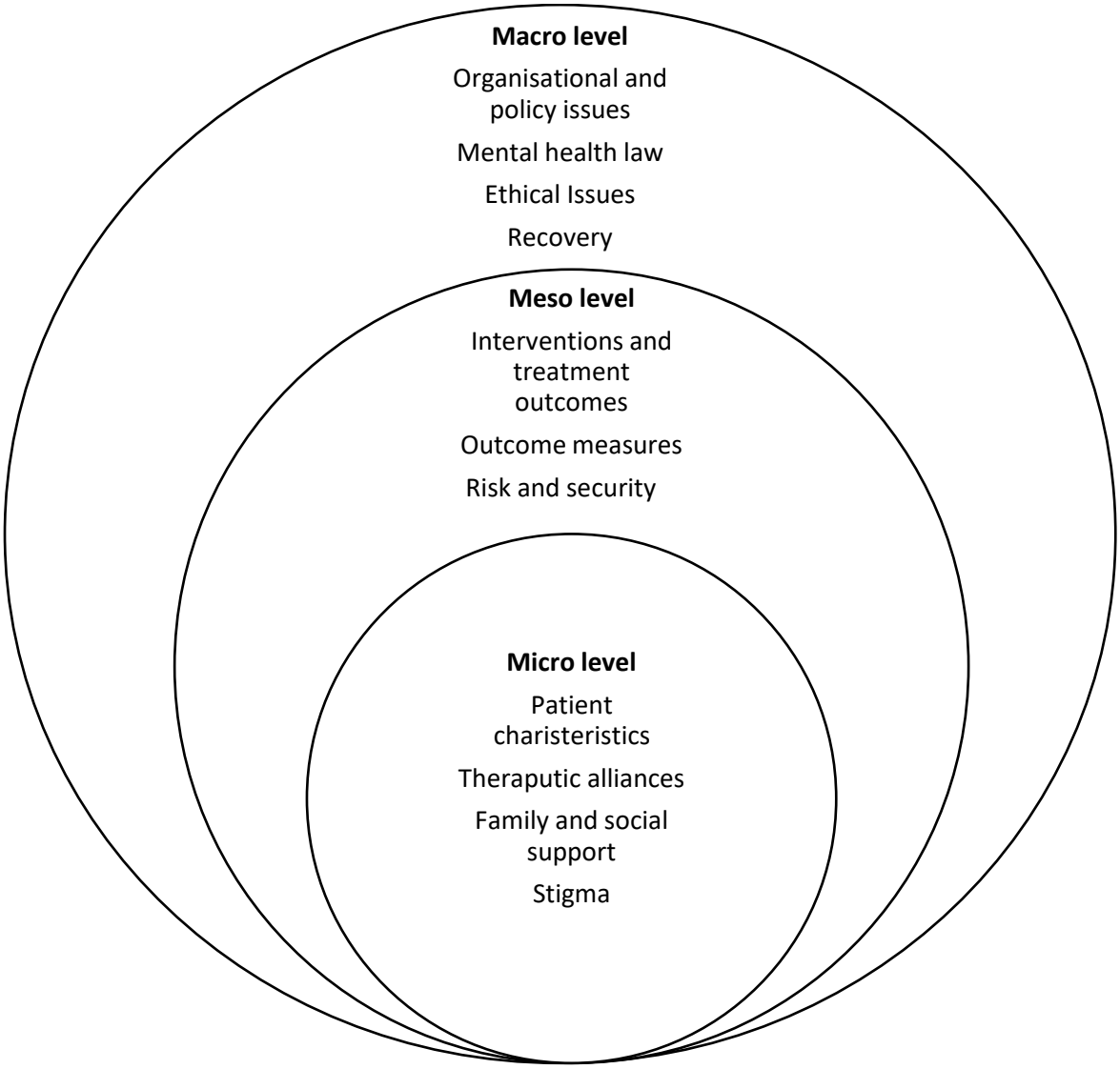
It may be argued that the first mechanism to be considered should be the patient, who should be at the centre of care. It may be hypothesised for example that the complexity of patients, their multiple treatment needs, offending, and risk history have the potential to act

together with other causal mechanisms to create the political, social environmental, and clinical environment in which their care takes place.

Conversely it could be hypothesised that national and local policy as well as influential reports may interact with other causal mechanisms to create these conditions. While both hypotheses may to some degree be true, it may be helpful to consider the literature relating to these causal mechanisms at the level in which they appear to have the most effect

Figure 3:1 gives an illustration of how the causal mechanisms which were examined in the review may act across the micro, meso and micro levels. The figure demonstrates how mechanisms have the potential to act across levels, potentially proving barriers or facilitators of effective forensic care.

Figure 3:1. Causal mechanisms within forensic psychiatry



The review therefore commenced by analysing the macro level, before considering meso and micro influences. As each category was researched, arguments and theories developed as to how each theme proves to be a barrier or facilitator of effective care in high secure forensic settings.

3:9. Macro level causal mechanisms

3:9.1. Organisational and Policy issues

High secure forensic care is governed by a range of legislation, policies and procedures which often focus on the assessment and management of risk. Many of these policies have their origins in reports by Fallon et al. (1999) and Tilt et al. (2000), which were seen as a watershed in the development of high secure forensic care. These reports influenced the High Security Services Directions 2019 (NHS England, 2019) which give highly detailed instructions regarding the day-to-day management of patients, impacting on all aspects of patients' day to day lives.

The restrictions placed on patients by these directions impact upon how care is delivered, and potentially also upon the effectiveness of interventions. Duggan et al. (2011) suggested that influential reports and drivers regarding risk and security have a greater impact of care than research-based interventions.

It has been contended that these reports and restrictions make high secure care more closely embedded in the NHS and more accountable (Campbell, 2005). However, the focus on physical security has been criticised as it may have been at the expense of therapeutic engagement (Exworthy and Gunn, 2000; Walsh and Ayres, 2003; Tighea and Gudjonsson, 2012). It has been argued that current regulations and practices are overly restrictive, adding to the medicalisation and politicisation of care as well as being at odds with a recovery-focused philosophy and thus resulting in a lack of autonomy and choice (Cronin-Davis and Sainty,2017; Edgley, et al., 2012).

Policy and organisational issues in forensic care are complex and may prove a barrier to the rehabilitation of patients and inhibit stepping down from high to lower levels of security (Völlm, Bartlett and McDonald, 2016).

3:9.2. Mental health law

The Mental Health Act 1983, as amended in 2007 (DoH, 2008) and other legislation have the potential to act as causal mechanisms to become barriers or facilitators of effective care in high secure forensic hospitals. It has been contended that mental health law and the focus of the Ministry of Justice, when considering restricted patients, is primarily on risk management and the protection of the public (Young, 2011). Within forensic psychiatric care there is a constant balance between public protection and the rights of the individual, with several writers contending mental health law has increasingly focused on social control and public protection rather than the rights and treatment needs of the individual (Wrench and Dolan, 2010; Pilgrim 2007; Humphreys and Kenney-Herbert, 2000).

Mental health law allows for preventative detention and coercive treatments to be employed, and both measures have raised human rights concerns (Bindman, Maingay and Szmukler, 2003; Davidson, 2002). This again highlights tensions between the rights of the individual, the rights of society and the balance between care and custody (Bindman, Maingay and Szmukler, 2003; Pilgrim, 2007; Davidson, 2002).

Bindman, Maingay and Szmukler (2003) considered several cases relating to the Human Rights Act (Hoffman and Rowe, 2006). Compulsory detention and coercive treatment were at the centre of these cases, which at times was considered to be disproportionate. The fact that mental health law in effect removes mentally disordered patients from the criminal justice system, and detains them, potentially indefinitely, in hospital care has huge implications for

the human rights and autonomy of the individual, and for the nature and effectiveness of their care (Edworthy, Sampson, and Völlm, 2016).

3:9.3. Ethical issues

Ethically, all patients should receive the most effective available care, and this includes patients in forensic high security; however, Blackburn (2004) acknowledged that this involved balancing the tensions which exist between providing effective care and protecting society. Clinicians in forensic psychiatry face a dual role which involves balancing patients' rights, and duties of care towards patients, with duties towards the wider society, which can create tensions, potentially undermining the therapeutic role of mental health professionals (Palermo, 2009; Völlm, Bartlett and McDonald, 2016).

The dual role is further complicated as it also involves serving the requirements of a range of interested parties including courts, the government, service providers, carers and the wider public. This may put a strain on clinicians' therapeutic relationships with patients, as well as placing a burden of responsibility on responsible clinicians as they seek to balance the best interests of all while adhering to their own professional standards (Robertson and Walter (2008).

Writers including Adshead (2000), Buchanan and Grounds (2011), Carroll, Lyall and Forrester (2004), Forrester (2002), Hui, Middleton, and Völlm (2013) commented on how coercive interventions such as the uses of restraint, seclusion, involuntary medication, and preventative detention can be at odds with the principles of ethical care. Völlm, Bartlett and McDonald (2016) argued that a reconsideration of the role of forensic psychiatry is needed to address ethical matters relating to patient detention and public protection issues to refocus services towards the effective care and treatment of patients.

3:9.4. Recovery

Recovery in mental health is not a specific intervention but is a philosophy or ethos of working which allows more specific interventions to flourish. Adopting a recovery approach may act as a facilitator of care, with writers considering this to be essential, having a positive impact on treatment outcomes and stressing that there is a life beyond mental illness (Drennan et al., 2014; Glorney et al., 2010; Perkins and Repper, 2003). In high secure forensic care, however, there are distinct challenges to fully engaging with the recovery agenda, with the ongoing dilemmas around patient autonomy, choice control conflicting with risk management and public protection issues (Drennan and Alred, 2012; Shepherd et al., 2016).

Inman, McGurk and Chadwick,2007; Mckeown et al., 2016; Tapp et al., 2013b; Völlm, Panesar and Carley,2014) have all highlighted the importance of meaningful activity, and particularly vocational activities as a key aspect of forensic patients' recovery. Meaningful activity can have an impact on overall wellbeing, improving self-efficacy and self-esteem and reducing risk behaviours such as self-harming. Meaningful activity may help to shape a new identity away from previous offending behaviours.

The recovery philosophy aims to shift the locus of power and control over an individual's condition away from the clinician and back into the hands of the patient (Edgley et al., 2012; Stickley and Felton, 2006; Watkins et al., 2001).

However, a focus on risk and the medicalisation of care, and at times coercive treatments, may pose challenges for organisations to fully commit to the recovery agenda (Edgley et al., 2012; Slade et al., 2014; Stickley and Felton, 2006). Despite this, Hillbrand and Young (2008) contend that a basic goal of effective forensic care is to instil hope and to foster a sense of optimism. They argue that without hope treatment is unlikely to succeed and effective treatment requires the restoration of hope.

3:10. Meso level causal mechanisms

3:10.1. Interventions and treatment outcomes

The overall aim of treatment in forensic high secure hospitals is to reduce a patient's risk to allow transfer to lower levels of secure care by following a treatment pathway (Tapp et al., 2013a). To that end many interventions are delivered which can generally be categorised as pharmacological, psychological, and social interventions (McMurran, Khalifa and Gibbon 2009).

The evidence for their effectiveness, however, is limited, with authors including Barnao and Ward (2015), Duggan et al. (2011), Hodgins (2002), Tapp et al. (2013a), commenting on the need for more research to understand the efficacy and effectiveness of interventions.

In 2013 Tapp et al. conducted a systematic review of outcome evidence and concluded that the quality of evaluation evidence is also limited, and so must be regarded cautiously. The absence of high-quality research may be due to the difficulty of robustly conducting research studies such as randomised controlled trials due to the social nature of many interventions and problems in controlling confounding variables (Tapp et al., 2013a). The literature indicates that this is still the case, with the necessity to evidence the effectiveness of treatment being high due to spiralling costs and lengthy admission periods (Völlm, Bartlett and McDonald 2016).

Glorney et al. (2010, p138) postulated that high secure forensic interventions should be based on "*therapeutic engagement, risk reduction, education, occupational, mental health recovery, physical health restoration, cultural and spiritual needs, and care pathway management"*, with these areas of need being present in all patient's treatment programmes.

Barnao and Ward (2015) added to this argument by stressing the need for a joined up conceptual framework of care which would have benefits for overall effectiveness.

3:10.2. Outcome measures

Evaluation of health interventions in a modern health service is vital to evidence the most clinically and cost-effective treatment in an open and robust way (Ham, 2004). Appropriate outcome measures are, therefore, central to the evaluation of the effectiveness of interventions by regularly recording changes in the mental health and care of individuals with a mental disorder (Smith et al., 2015).

Fitzpatrick et al. (2010) stated that outcome measures used in forensic mental health often considered the risk of reoffending as well as assessing changes in mental health, but found research regarding quality of life, social function, and psychosocial outcome measures to be more limited.

Many studies (Chambers et al., 2009 Duggan et al., 2011; Fitzpatrick et al., 2010; Ryland et al., 2021; Yiend et al., 2011) have commented on the large number of outcome measures used and the need for greater standardisation. Chambers et al. (2009) found that when assessing the most frequently used outcome measures for reliability, validity, and responsiveness that evidence from the forensic literature was limited. Within forensic services research, there appears to be little agreement or standardisation regarding the choice of measures (Chambers et al., 2009; Edworthy and Khalifa, 2014; Fitzpatrick et al., 2010; Ryland et al., 2021; Yield at al., 2011).

This lack of consistency impacts on the confidence which can be placed on outcomes, and consequently impacts on their ability to demonstrate patient change (Tapp et al., 2013a). However, Edworthy and Khalifa (2014) argued the creation of an outcomes data base would

be an ideal opportunity to begin to standardise forensic outcome measure use to compare study results and create a reliable, validated battery of assessments that are relevant to the area and understood by researchers and clinicians (Chambers et al., 2009).

3:10.3. Risk and security

Patients admitted to high secure care generally have a wide range of interconnecting risk factors such as poor mental health and patterns of offending which are likely to impact on their care and recovery (Sheldon and Krishnan, 2009). Risk factors are broadly categorised as historical or static risk and dynamic or clinical risk and are assessed through structured clinical judgment to monitor changes (Easden and Sakdalan, 2015; McMurran, Khalifa and Gibbon, 2009).

The Historical, Clinical and Risk Management – 20 (HCR-20), (Dolan and Blattner, 2010) provides a framework for clinicians to use structured clinical judgments regarding a patient's risk of violence (McMurran, Khalifa and Gibbon, 2009; O'Shea and Dickens, 2015). Research has been completed on the use of the HCR-20 in forensic settings, with writers such as Belfrage, Fransson and Strand (2000) and Dolan and Blattner (2009) confirming its value in predicting violence and in clinical decision making. However, O'Shea and Dickens (2015) cautioned its use in treatment planning, recognising the importance of wider issues such as improved social functioning when considering change.

Authors including Boardman and Roberts (2013), Drennan et al. (2014) and Perkins and Repper (2016) have argued for a collective approach to risk management which promotes a shared responsibility between patient and clinicians. This approach would encourage patients to take responsibility for their own risks (Boardman and Roberts, 2013; Perkins and Repper, 2016). It would also place greater emphasis on relational security and maintaining a

therapeutic environment (Deacon, 2010; Kennedy, 2002). This may also involve therapeutic risk taking to promote opportunities and patient autonomy in line with the recovery approach (Stickley and Felton, 2006). McCullough et al. (2020) concluded that a reduction in risk, participation in meaningful activity and mental health recovery were indicators of progression to lower levels of care. The authors called for more research to examine if outcome measures of risk and recovery as well as therapeutic activity resulted in actual benefits for patients.

3:11. Micro level causal mechanisms

3:11.1 Patient characteristics

As mentioned previously (section1:11), forensic patient population is highly diverse, in terms of offending and clinical and legal diagnostic classification. Mentally disordered offenders have overlapping clinical conditions and diverse dynamic risk factors (Blackburn, 2004). The heterogeneity of the forensic patient population therefore presents challenges to the rehabilitation process and to risk reduction (Blackburn, 2004).

Glorney et al. (2010) and Thomas et al. (2004) commented that the heterogeneity of high secure patients and the complexity of their care needs highlights the need for individualised care and treatment pathways, which are constantly reviewed. Glorney et al. (2010) further commented on the importance of timing interventions to gain the optimum clinical outcome, stressing the importance of patients being “treatment ready” to improve clinical outcomes. Other writers (McMurran, Khalifa and Gibbon, (2009); Wolfson, Holloway and Killaspy, (2009) have commented on “treatment readiness” as a patient characteristic which can have a significant effect on treatment outcomes and the effectiveness of care.

McMurran and Ward (2004) and Howells and Tennant (2010) comment on the role an individual’s identity can play in their motivation to change and readiness for treatment. For a

patient to be treatment ready, there may be a need to relinquish their offending identity; however, this is not a straightforward process (Howells and Tennant, 2010). It is important to understand the many factors which contribute to an individual's identity and the role they play in an individual's pattern of offending. For treatment to be effective the individual's identity should be compatible with the need to change, including adequate self-belief and hope for the future (McMurran and Ward, 2004; Howells and Tennant, 2010).

3:11.2 Therapeutic alliances

Several research studies have highlighted the importance of supportive therapeutic alliances to high secure forensic care, confirming their importance in maintaining patient motivation and generating positive treatment outcomes (Coffey,2006; Willmott and McMurran, 2013; Tapp et al., 2013b).

Therapeutic patient professional alliances based on the principles of recovery can make have a positive effect on care, with relationships being characterised by trust, collaboration and shared decision making wherever possible (Drennan et al., 2014; Souter, 2015; Tapp et al., 2013b).

Challenges to therapeutic alliances include staffing inconsistencies (Holley, Weaver and Völlm, 2020; Lindqvist and Skipworth 2000; Tapp et al., 2013b), the use of restraint, and the power imbalances that exist between staff and patients (Knowles, Hearne, and Smith, 2015). Therapeutic alliances can however play an important role in risk management (Hamrin, Iennaco and Olsen, 2009). The development of trusting therapeutic alliances can help to instil in patients an internal mechanism of control, empowering and validating patients, which may alleviate hopelessness and so help maintain safety (Campbell and McGauley, 2005; Carroll, Lyall and Forrester 2004).

Research has indicated (Barnao et al., 2014; Tapp et al., 2013b) that forensic patients feel the therapeutic relationships are central to their care, through supporting them to discuss difficult issues, and in helping to maintain motivation (Coffey, 2006). It is therefore, argued that maximising therapeutic alliances through consistency of care should be a target for high secure service providers to ensure effective care (Tapp et al., 2013b).

3:11.3 Family and social support

Forensic psychiatric patients often originate from troubled and disadvantaged backgrounds. However, several authors (Dorkins and Adshead, 2011; Lindqvist and Skipworth, 2000; Shepherd et al., 2016) have identified the importance of maintaining family and social contacts as part of their recovery journey. Continuing family and social contact can also help maintain hope for the future and can have a positive impact on risk reduction (Parks and Freshwater, 2012; Shepherd et al., 2016).

Lindqvist and Skipworth (2000) and Shepherd et al. (2016) argued that sustaining a family role is crucial to an individual's identity and is important in maintaining an identity beyond that of a mentally disordered offender. Contact with family and friends also creates links to wider society can help high secure forensic patients feel les marginalised and socially excluded (Gillespie, Quayle and Judge, 2021; Simpson and Penney, 2011).

However, maintaining contact may not be straightforward, as forensic patients may be geographically isolated from their families and communities. Previous problems in the family, including offending behaviour and abuse can cause emotional difficulties within the family which may also result in reduced contact and social isolation (Canning et al., 2009; Dorkins and Adshead, 2011; Gillespie, Quayle and Judge, 2020; Madders and George, 2014).

Roberts and Boardman (2013), Tapp et al. (2013b) and Williams et al. (2011) identified the importance to high secure patients of peer support and learning form the experiences of others. This was seen as an important aspect of the recovery journey, demonstrating the possibilities of progressing despite their pasts. However, Böhm et al. (2014) highlighted challenges to peer support, including the hierarchical nature of organisations, issues relating to confidentiality, and the possibility of exploitative relationships.

3:11.4 Stigma

The stigmatisation of individuals with a diagnosis of a mental disorder is well recognised, but the impact of stigma on individuals who also have an offending history and are admitted to high secure forensic care is doubly compounded (Williams et al., 2011). West, Yanos and Mulay (2014) and Williams et al. (2011) have argued that admission to high secure forensic care is an inherently stigmatising process, accompanied by labelling that will have lifelong implications in terms of a patient's future rehabilitation and recovery.

The impact of stigma is further complicated by self-stigmatisation. Livingston, Rossiter and Verdun-Jones (2011), West, Yanos and Mulay (2014) and Yanos et al. (2008) argue that self-stigma has a negative effect on treatment outcomes by promoting avoidant coping strategies, creating hopelessness, and treatment non-adherence to both pharmacological and psychological treatment. Yanos et al. (2019) discussed how working to reduce self-stigmatisation can impact on mental health recovery, highlighting how shifting identity away from a patient role can aid a patient's recovery.

Bates and Stickley (2013) and Rao et al. (2009) have argued that health professionals can perpetuate stigmatising attitudes towards those with enduring mental illness, and especially those who have been detained in secure hospitals. This stigma is often driven by negative

stereotypes attached to individuals with mental disorders which may subsequently result in the use of more restrictive practices (Angermeyer and Schulze, 2001).

3:12. Findings and discussion

This critical realist review has considered 11 causal mechanisms which may act as barriers and facilitators of effective high secure care with the following findings. These may be summarised in the following six paragraphs.

3:12.1. Mental health law, policies and procedures and ethical principles.

Mental health law, policies and procedures and ethical principles are bound together in creating the environment in which interventions in high secure care are undertaken. It may be argued that these factors provide a barrier to effective care by creating a culture which may risk averse and anti-therapeutic. To facilitate effective care for mentally disordered offenders in a high secure setting a change in culture may be necessary and should include ethically sound patterns of care which are based on mental health law and procedures which are flexible enough to form a framework to fulfil the dual role of public protection and effective care.

3:12.2. Recovery

Adopting the principles of recovery can be a facilitator of effective care in high secure services and help individuals achieve their full potential. By promoting a culture of hope and positivity an individual may see the possibilities of recovering from a mental disorder and redefining their personal identity away from previous offending. Through instilling hope for the future and developing positive self-esteem, high secure forensic patients may engage more meaningfully in treatment programmes and so improving treatment outcomes. In forensic psychiatry treatment and recovery goals should involve working in collaboration

with the patient to develop self-esteem and self-confidence as well as the practical skills needed to ensure successful discharge to lower levels of security

3:12.3 Interventions, treatment outcomes and outcome measures

High secure forensic patients are a heterogeneous group, and although some treatment needs will be present in many patients at various stages of their care, treatment planning and implementation should be undertaken on an individual basis.

A large number of outcome measures are used in this area with a need for greater standardisation, as the large number of outcome measure impacting on the generalisation and reliability of evaluation research. It therefore appears clear that, if evaluation research into the effectiveness of interventions in high secure care is to be a true facilitator of effective high secure care, there needs to be a reliable, validated battery of assessments that are relevant to the area and understood by researchers and clinicians (Chambers et al.,2009).

3:12.4. Risk and security

Risk management to maintain safety and security is a causal mechanism with influences at the macro, meso, and micro levels and is an integral and essential aspect of effective high secure care. Risk assessment and management may not; however, be viewed in totally negative terms. The use of relational security, understanding patients' dynamic risk factors and developing trusting relationships, has been identified as effective in building therapeutic environments which can be facilitators of care (Kennedy 2002 Tapp et al. (2013b).

3:12.5. Therapeutic alliances and family and social support

Therapeutic alliances based on the principles of recovery can have a positive effect on care by encouraging patients to begin to take control of their lives and start to manage their difficulties, to live meaningful lives even within the confines of a forensic hospital (Souter, 2015). Therapeutic alliances, as well as family and social support, promote positive treatment outcomes, which patients indicate are the most important factor in their recovery

3:12.6. Stigma

To combat the negative effects of stigma to the detriment of high secure forensic care, it is vital that stigma is confronted on all levels. This may involve all members of society challenging their own views regarding those with mental disorders and especially those who have also committed crime. Eradicating the stigma which surrounds forensic patients is not an easy task. However, providing patients with the opportunity to discuss stigma in a safe and secure environment may be a facilitator of effective care.

3:13. Strengths and limitations

This review has several strengths and limitations. A strength of this review is the adoption of a critical realist approach which has allowed evaluation of a large amount of literature to gain an in-depth understanding of the issues involved. The reviewer's professional background as an occupational therapist working in high secure care gives him an insight into the complexities of care, and an ability to bring the issues to light.

Similar issues may however be a limitation to the review, with the purposive selection of articles included in the review possible reflecting the reviewer's personal position of a

clinician working in this field. Another limitation is that the boundaries between macro meso and micro levels are somewhat arbitrary. However, the review has attempted to describe how factors at one level can have effects at others, either larger or smaller scale.

Much of the available literature reviewed was UK-centric, giving a representation of high secure care in the UK. However, many of the issues surrounding secure care and mental health recovery are likely to be similar in other countries.

3:14. Future research implications

Interventions in forensic psychiatry take place in a world which is socially constructed resulting in a care environment which is shaped by political agendas and the medicalisation of care, with outcomes that are determined by social and organisational expectations rather than patient led priorities (Carey, 2016; Lindekens and Jayawickrama, 2019). This critical realist review has examined some of the causal mechanisms in which help to construct the social world in which high secure care takes place, central to which are the power differentials they create. Research from a critical realist perspective aims to consider how these potentially causal powers impact on high secure care (Edgley et al., 2016). Research priorities many be at a macro level to investigate the impact of government policies, mental health law. At a meso level a research priority may be to investigate the interpretation and implementation of those policies on the development of care strategies. Research at a micro level would then investigate how these policies and their implementation impact on the delivery of care, particularly in terms of risk management and recovery.

If future research is to understand what makes an intervention in high secure forensic psychiatry effective or places limitations on effectiveness, it may be advantageous to consider the research from a critical realist perspective. In a social environment, such as a high secure

hospital, the positivist approach to predicting what will happen is problematic (Edgley at al., 2016). A critical realist approach would more readily allow consideration of some of the interrelated factors highlighted in this review to examine the real impact of these issues on forensic care (Edgley at al., 2016).

3:15. Conclusions of the review.

This critical realist review of high secure forensic care has allowed the examination of a complex range of causal mechanisms which may influence the effectiveness of care. These independent factors have the potential to act at and across different levels of care to impact on care outcomes.

The work has placed an emphasis on areas of influence that may not be empirically observable such as the impact of organisational policy, stigma, culture, the influence of society and the press. This approach embraces the breadth, depth and originality necessary for innovation, and seeks to bring conceptual innovation or theoretical development to the issue under analysis (Edgley et al., 2016). This critical realist review has provided the opportunity to challenge some of the preconceptions and stereotypical views regarding high secure care by analysing the literature of its social practices. The review has also provided a platform for empirical research to examine the barriers and facilitators of high secure forensic care using a qualitative approach and from a critical realist standpoint.

Chapter 4. Research method

4:1. Introduction

This chapter sets out the research method for a study to investigate barriers and facilitators influencing the effectiveness of high secure forensic care. This qualitative study was conducted from a critical realist perspective and aimed to consider how a range of potential mechanisms impact on care (Edgley et al., 2016).

4:2. Research question

This qualitative study had a research question of "*What are the barriers and facilitators of effective high secure forensic care?",* and it aimed to investigate factors which patients felt could impact on the effectiveness of their care.

This study aimed to address these issues, by:

1. Investigating factors which may prove to be barriers and facilitators of high secure forensic care.
2. Examining the effectiveness of high secure forensic care from the perspective of patients receiving treatment and who may be considered to be experts in their care.
3. Considering the interrelating factors which have the potential to impact on the effectiveness of high secure forensic care.

4:3. Study Location

The study took place at Rampton Hospital, a large high secure hospital in the East Midlands of England. The study employed a series of qualitative semi-structured interviews, with questions focusing on patients' experiences of care, and their views of factors which may be barriers or facilitators of their care. Interview questions were open ended, with follow up questions being posed to expand on points and to increase the richness of the data. Semi-structured interviews were chosen to give potentially vulnerable participants an opportunity to narrate their personal experiences in a private setting and to make their views known (Silverman, 2005).

4:4. Participants

All participants were male, aged over 18 years, and patients detained for assessment and treatment at Rampton Hospital. Participants were recruited from the mental health (MH), personality disorder (PD) and learning disability (LD) services at Rampton Hospital.

4:5. Inclusion criteria

Patients who had been resident in the hospital for 3 years or more were eligible for inclusion in the study. All patients included were deemed able to give informed consent to take part and would not be adversely affected by taking part. This was assessed as part of the recruitment process, in conjunction with each patient's named nurse and confirmed through communication with their responsible clinicians.

4:6. Exclusion criteria

Patients residing in the hospital for less than 3 years were not considered as they may still be early in their treatment pathways, and still forming opinions of the effectiveness of care. Patients from the female and Deaf services at Rampton hospital were excluded from the study, due to the specialised care they receive in terms of meeting specific needs. For example, the use of interpreters for Deaf patients and gender specific care for female patients (McMurran, Khalifa and Gibbon, 2009).

Patients whose treatment and mental health may be adversely affected by participation were also excluded from the study, as were patients who were deemed unable to participate on the grounds that their risk to others or themselves was too great as assessed by their clinical team.

4:7. Sampling

Purposive sampling (Hicks, 2009) was used to capture a range of patients at differing stages of their treatment. For example, some participants were engaged in treatments such as the violent offender treatment programme, while others were preparing for step down to lower levels of security. Purposive sampling was achieved during the recruitment process, in collaboration with the ward manager and named nurses of potential participants. A purposive method also ensured the inclusion of patients for whom treatment may not be clearly effective, as the voice of these patients is not always heard, and it is important to capture their thoughts and opinions.

4:8. Ethics and approvals

Researchers who conduct studies within the NHS must seek approval from a Research Ethics Committee, which will assess whether the study is safe and ethical for participants (Pandya-Wood, Barron and Elliott, 2017). Prior to commencing this research, a range of approvals were gained.

Firstly, ethical approval was granted by the University of Nottingham Research and Ethics committee (ref:18007) as sponsors of the research. An application to conduct the research was then made through the NHS Integrated research application system, and favourable opinion gained from South, Central Oxford B Research Ethics Committee, REC reference: 18/SC/0301.

Following the favourable ethics opinion, permission to conduct the research was granted by the NHS Health Research Authority. Permission to carry out the research was also gained from the Nottinghamshire Healthcare NHS Foundation Trust Research and Innovation department as host organisation. Nottinghamshire Healthcare also carried out a capability and capacity assessment to ensure the research could practically be completed.

During the study, no participant medical or personal information beyond that of the patient's name and home ward was obtained. All information was considered confidential, and disclosure to third parties was prohibited. Participant confidentiality was further ensured by utilising identification code numbers for study participants.

The study was conducted in line with the standards set out in the University of Nottingham Code of Research Conduct and Research Ethics (2016), and all aspects of data collection and management complied with the Data Protection Act http://www.ico.gov.uk/. The study was also conducted in accordance with the ethical principles that have their origin in the

Declaration of Helsinki, 1996; the principles of Good Clinical Practice, and the Department of Health Research Governance Framework for Health and Social care, 2005.

All paper data was kept in a filing cabinet in a locked room in the Therapies and Education office, Southwell Centre at Rampton Hospital. Data stored electronically was held on a study specific drive, password protected on the Nottinghamshire Healthcare computer system.

Access to the data, and study specific drive was restricted to the researcher and supervisors, one of whom is an employees of Nottinghamshire Healthcare played a major role, in date anonymisation. Data collection and input took place on the secure Nottinghamshire Healthcare computer system, which is routinely used to process patient information.

4:9. Participant recruitment

To identify potential participants, the investigator first approached patients' ward managers and named nurses to ask them to identify potential participants. The initial approach was then made by the patient's named nurse, who informed them about the study and gained their permission to be approached by the investigator. Prior to including participants, the investigator contacted potential participants' responsible clinicians to confirm that there were no clinical reasons why the patient should not participate in the study.

The investigator then informed the participant of all aspects pertaining to participation in the study and issued them with a participant information sheet. At this stage participants had the opportunity to ask questions about the study 21 participants were recruited to take part in the study, seven each from the MH, PD and LD services.

Six patients withdrew before interview and before written consent was gained, two from each of the three services. The reasons given were that they did not wish to be recorded (two patients from MH); two had left the hospital (one each from PD and LD), one no longer wished to take part (LD) and one gave no reason (PD). Therefore, written informed consent was gained from 15 participants, and 15interviews were completed, five each from the MH, PD and LD services.

4:10. Participant information

Information about the study was given in an accessible form, to meet the needs of individual participants. All participants had English as a first language, so no interpreter services were needed.

4:11. Data collection

The study employed a series of semi structured questions, which focused on patients' experiences and their views of factors which may prove to be barrier or facilitators of their care. Interview questions were uncomplicated and open ended, with follow up questions being posed to expand on points and to increase the richness of the data.

Semi structured interviews took place in a private interview room on the patient's ward. As the study took place in a high secure hospital the study complied with local policy and risk management procedure to ensure the safety of all. This involved elements such as informing ward staff of the whereabouts of the researcher and participant, with ward staff then maintaining discreet observation. Interviews were digitally recorded on encrypted, and password protected equipment that had been approved and supplied by the host organisation.

4:12. Anonymisation

An identification code was attached to each recording and transcription to maintain a duty of confidentiality and preserve participants' anonymity. During transcription further anonymisation took place, such as the removal of any identifiable information and the modifying of directly attributable comments. Date anonymisation was counter-checked by research supervision to confirm the rigour of the anonymisation process.

4:13 Analysis

Data was analysed using thematic analysis, which focuses on what is said rather than how it is said (Bryman, 2004). Thematic analysis is a process for identifying and analysing patterns or themes that emerge from qualitative data (Braun and Clarke, 2006). Thematic analysis allows themes to emerge from the data, not being rigidly bound to pre-existing theory or hypothesis (Braun and Clarke, 2006).

Thematic analysis is considered to be compatible with a critical realist approach as it reports experiences, meanings and the reality of study participants (Braun and Clarke, 2006, Fletcher, 2017). The approach recognises that individuals attach meanings to their experiences, and consequently the broader social context in which those meanings exist (Braun and Clarke, 2006). Thematic analysis can be used within a range of theoretical frameworks to also reflect the reality that emerges from the data (Braun and Clarke, 2006).

Critical realism looks for trends and patterns in the data that are often termed demi-regularities or demi-regs (Fletcher, 2017; Pawson, 2006). Identifying these demi-regs in the data coding process can give a semi-predictable outcome pattern to the data, allowing theories to be developed (Fletcher, 2017; Pawson, 2006).

NVivo software, which allows the researcher to classify, sort and arrange qualitative data, as well as examining relationships within the data, was used as part of the data analysis process (Woolf and Silver, 2018). Data was also read and re–read, as part of the coding process, before coding into categories which occurred during analysis and finally being developed into themes which emerged from the data to capture the essence of participants' experiences (Bowling, 2014).

4:14. Reporting

Following data analysis, no discernible difference in issues raised between participants from the three services of MH, PD and LD was noted. Therefore, it was deemed appropriate to report results as a whole. Rather than differentiate participants from these services each participant was allocated a pseudonym used in reporting results.

4:15. Conclusion

This chapter has set out the methods used in a qualitative study to investigate the barriers and facilitators of high secure forensic care. The following chapter will set out the findings of this study.

Chapter 5. Study Findings

5:1. Introduction

This chapter presents the results of the study and summarises participants' views of factors which may impact on their care. This study considered participants to be experts by experience of receiving high secure forensic care. The chapter will therefore highlight their narratives of factors which they described as barriers or facilitators of their care.

Four main themes emerged from the data: role and identity; therapeutic activity; policies, procedures and organisational issues; and significant relationships. Within these themes a total of 13 sub themes were also generated (see Table 5:1). Each theme and sub theme identifies aspects of high secure care which have the potential to act as either a barrier or facilitator of care, and on occasions as both a barrier and facilitator of care. The themes generated directly relate to participants' experiences of care and are summarised in Table 5:1, with the number of participants who commented on the theme or sub theme identified in parentheses.

When reporting the results pseudonyms have been attached to each participant rather than attaching a numerical coding. This was done to bring the comments of participants to life and give a sense of personal meaning to the data as well as helping to preserve its richness and integrity (Saunders et al., 2015).

Table 5.1. Interview themes

Theme	Definition
1. Role and identity (15)	Being able to maintain meaningful life roles. Having an individual identity beyond that of a mentally disordered offender
1.1 Institutionalisation (11)	Effects of being in long term institutional care
1.2 Normalisation (9)	Living a normal life in an abnormal society. Doing "normal" things
1.3 Freedom and trust (11)	Having autonomy, gaining trust, and consequently having more opportunities for self-fulfilment.
2. Therapeutic activity (13)	Activity which gives purpose and structure to the day.
2.1 Self-esteem (6)	How patients feel about themselves.
2.2 Preparing to move on (4)	Moving on from high security, usually to medium security, but in some cases to prison.
3. Policies, procedures, and organisational issues (15)	High secure directions and interpretations of security directions; accumulating frustrations which may arise. A range of policies and procedures which are designed to maintain security and safety.
3.1 Mental Health Act (10)	How MHA 1983 influences patient care
3.2 Safety (15)	The policies and procedures that are put in place to keep people safe and to produce a safe environment in which therapy can take place. Participants feeling safe. Often the first-time people have felt safe/experienced stability.
3.3 Security (15)	Physical security, relational security. Containment and confinement
3.4 Medication (12)	Expectations and effects of medication
3.5 Staffing and communication (9)	Staffing levels and their effects on patient care. Effective communication from the organisation to patients, i.e., informing patients about cancellations and changes.
4. Significant relationships (15)	Importance of having significant meaningful and trusting relationships.
4.1 Therapeutic Interventions (15)	Formal, planned, 1-1 sessions with psychology OT and named nurse (as opposed to casual everyday interactions with staff)
4.2 Family and friends (13)	Maintaining family contact. Having friends

5:2. Interview themes and sub-themes

5:2.1. Theme 1 Role and identity.

The first theme to be considered is that of role and identity. An individual's identity and the roles that make up that identity are central to self-actualisation and fully developing as occupational beings (Wilcock, 1999). Participants in the study highlighted the ability to enact meaningful roles and to maintain a positive sense of identity as important facilitators of their care. While, conversely, being unable to maintain and enact meaningful roles was seen by participants as a barrier to effective care.

Every individual has a personal identity which is composed of many factors and includes values, interests, habits, employment, beliefs, and ambitions. These factors to some extent define us as individuals to others, and potentially more importantly to ourselves (Unruh, 2004). For individuals detained for treatment in high secure forensic care, role and identity is just as important as it is for any other members of society. For many people, the productive aspect of their lives is important, with people often self-identifying through a worker role. The importance of maintaining and developing a sense of identity through work was apparent in the data. Participants emphasised the importance of developing work-related skills which can contribute to a sense of identity and establish positive meaningful roles.

"So, for me it's about getting off the ward, and having a bit of time out. Learning something, like I have learnt bricklaying. Like woodwork, I never did woodwork until I came here. Now I am pretty good at it, and I enjoy it. Gardening, and you spend time out feeding the animals. Digging. Learning things. So, it's just about keeping your head busy, learning this stuff that you can use in the future'" (Luke).

"I think it is just getting off and doing things like woodwork or what have you, it makes you feel normal for a bit, like an everyday normal person. You just switch off, you just forget, while you are in there making whatever you are making, that you are in a hospital, that you have got [states mental health condition], that you have got problems. You forget it for that time you are in the workshop. So that's how I have benefited. Same as doing music and stuff like that, you know just feel normal for a short time". (Michael).

The comments of Michael and Luke illustrate the importance patients place on a worker role, and in doing things which will allow then to become more complete individuals.

A further aspect of identity is religion and spirituality. Everyone is likely to have an individual set of beliefs and values. These may include a commitment to an organised and recognised religion, or to a much vaguer and individualistic set of beliefs, including a lack of religious belief. For many people, their beliefs provide a set of values and customs which dictate how they live their lives including prayer and religious services.

Luke discussed the importance of his religion, and how he felt that its importance was not always recognised or prioritised within the hospital, particularly when staffing was short.

"Staffing issues is a big thing at the moment, there's not enough staff to run this, and my prayers gets cancelled now and again, which I believe should be the last thing to get cancelled. Obviously, I pray in my room, but Friday afternoons, like today, it's a nice day, you are around Muslims you pray and come back, you feel relaxed. That to me is like taking an anxiety tablet, your body is slowed down and relaxed". (Luke).

Luke's comments clearly indicate how important his religion is to him, and that following his religion is to him, a crucial role which is central to his identity. However, Luke's

comments also suggest that he feels the importance he places on his faith is not always recognised by others, and the lack of recognition he feels may contribute towards a barrier to effective care in his case.

The stigma which surrounds mental health and high secure hospitals is well documented (Williams et al., 2011). and has the potential to impact on an individual's identity. Paul discussed the stigmatising beliefs that widely exist in society around high secure hospitals and how he felt when admission to Rampton Hospital was first discussed with him.

"When they first mentioned Rampton, I had very negative views about it, because of exactly that. When I was at court initially, they offered me a hospital order in Rampton, and I turned it down. Because what I knew or what I thought I knew. Wish I hadn't now because I would have been out a long time ago". (Paul).

Another participant, Christopher, also commented on how stigma could act as a potential barrier to his care. Christopher indicated that people do not see the full picture and may be influenced by unhelpful stereotypical generalisations that are often perpetuated by the media (Williams et al, 20011).

*"There is a lot of stigma with mental health, you see in the media and internet and all that, there is a lot of stigma with mental health even though they are doing a lot of good work to try and get away from that stigma, but it's still kind of affects you because you think to yourself it's just basically bad labels. What I mean by that is they don't tend to go into hospitals and RSUs and talk about the good side of treatment or the recovery or people when they become stable and are ready to move on, they always focus on when a person is at their illest or most at risk or most when they are going to be harmful to another person or themselves, do you know what I mean?". (*Christopher).

5:2.1.1. Sub theme 1:1 Institutionalisation

Institutionalisation relates to the impact of on the individual of long-term residential care. Institutionalisation can be conceptualised in differing ways, which may refer to the physical environment, the policies and procedures that define the care regime and the power differentials which exist between those providing care and those who are residents receiving care (Chow and Priebe, 2013). Many participants in the study had resided in institutional care settings, of one form or another, for large periods of their lives. This has inevitably shaped participants' views of care, how they engage in treatment, and their potential lives beyond long term care. David discussed some of these issues, and the difficulties he had in changing due to the length of time he had spent in institutional care.

"I think it's because I am set in my ways and I am like an old dinosaur, because I have been here for that long, as I said [states number] years, I think you get institutionalised don't you". (David).

Participants were largely accepting of the restrictions placed on their lives and didn't always view them as a barrier to their care. However, the acceptance of restrictions may be due to institutionalisation as many participants have spent the majority of their lives in institutions.

"Well, those fences and locked doors have to be there for a certain reason. It has never got in the way of my care. I have been in and out of prison since I was [states a young age], so I am used to being in closed environments where you are locked in and that sort of thing, so I wouldn't say it has had an impact on me because I am used to it". (Michael).

Michael's comments tell the story of a person who has spent a large percentage of his life in institutionalised care. His "normality" is therefore a world where a restricted and closed environment is the norm.

5:2.1.2. Sub theme 1:2. Normalisation.

The theme of normalisation relates to being able to live life with a sense of normality within the confines of high secure care. This can be achieved by doing things that most people would consider to be normal parts of everyday life. Several participants discussed aspects of their care which have a normalising effect, with David describing how gaining permission to access part of the hospital grounds without escort had resulted in his situation being to some degree normalised.

"Oh! You are in your own world, you can get away from everyone, you can read a book, be on your own, you have members of the public, professionals talking to you. All you have to remember is to be polite and courteous". (David).

Another participant, Simon also discussed how having normalising factors benefited him and to some degree lessened the impact of being in a secure environment:

"And just been able to walk around on your own on ground access it normalises. You don't feel you are locked up in a maximum secure hospital for something that is really bad. Because if you were in such a bad frame of mind, you have the sun shining, so you are not in such a bad frame of mind you haven't got the staff with you, so you don't feel locked up so much. You can walk about so you are getting your exercise and feel generally healthy. Anything that takes us away from the locked up forced elements, necessary but forced elements into a more normalised more human understanding". (Simon).

In contrast to this Paul felt that some of the rules and regulations which govern all aspects of a patient's life and care created a situation which lacked normality.

"It's horrible. Even when you go to get a cup of coffee, they do it at a set hour. So, at 9 o'clock the shutter goes up, and if you are not sat there, you can't have a coffee. And they make the drink for you. Which makes some people paranoid anyway because they can't see it getting made. Whereas on the treatment ward you can go and make a drink anytime you want". (Paul).

Normalisation allows patients confined in high secure hospitals to maintain and develop a sense of identity. It may be described as living a normal life in an abnormal society, and in doing so recognising that a positive and fulfilled future may be possible, whether that is in the confines of secure care, or in the wider community. Creating a culture of normality may have a positive effect on patients' ability to engage positively in all aspects of their treatment. The concept of normality appears to have a strong association to the recovery agenda and allows participants such as David and Simon to live a life which has value and meaning for them as individuals (Repper and Perkins, 2003).

5:2.1.3. Sub theme 1:3. Freedom and trust

The theme of freedom and trust links closely to the previous theme of normalisation and relates to patients having a sense of autonomy of action through gaining a greater level of trust within the confines of the hospital. This consequently results in patients more opportunities for self-expression and fulfilment.

Participants in the study discussed some of these issues, with Clive commenting on how a less restrictive regime, which is available on certain wards, benefited his care.

"I've been on the [names the ward] since it opened, and on this ward, you get more freedom, to go to your room whenever you want to get a drink or snack whenever you want. On other wards you have restrictions, you can't go to your room and there are certain times for drinks, but on this ward, it is about freedom and trust". (Clive).

This view was echoed by Luke who felt gaining trust was a reward for his hard work and something that he did not wish to lose.

"Like I say it's a trusted thing. You have to work really hard to get it. So, It's like a protective factor". (Luke).

The comments from participants appear to indicate that gaining more freedoms and gaining trust was felt to be a facilitator of their care. This may be important as gaining more freedoms and having a greater level of trust is often seen as a mark of positive progress in their care, and a step towards moving on to lower levels of security.

5:2.2. Theme 2: Meaningful activity

Leading on from previous themes, therapeutic activity provides patients with opportunities to develop meaningful roles and express their individual identity. For some, meaningful therapeutic activity can add to the sense of normalisation, by taking part in activities they have previously valued. Therapeutic activity often involves access to tools and materials, which may be prohibited to newly admitted patients. It can be used to demonstrate greater levels of trust and progress in care. These issues relate to those previously highlighted in John and David's stories and show how participation in meaningful activity helps in developing a sense of identity away from that of an offender can begin to give hope for the future.

Most therapeutic activity takes place away from the patient's home ward. This may be significant as off-ward settings may more normalised than ward situations. Steven commented on how this change of environment and participation in purposeful activity can be seen as a facilitator of his care.

"Being on the ward you can sense a lot more tension between patients and staff when there is a problem behaviour wise. But going off ward is a release; you forget about the ward for a few hours and do your own thing and feel better and able to cope better. Basically, getting off the ward switches your brain off so you can concentrate on things you like doing best. For instance, with me, I go swimming on Sunday and for me it is release 40, 50 lengths, whatever, and that's a way of letting off steam and being myself. Getting rid of anger things like that". (Steven)

A further participant, Simon, highlighted the positive effect therapeutic activity had on his care. Simon felt that, for him, participation in therapeutic activity was in some ways the most important aspect of his care. And he was keen to highlight this point.

"Yes, activities keeping yourself busy is the most important thing. More perhaps than the groups and psychology sessions is giving us an interesting daily routine. Because otherwise we are sitting in our rooms, twiddling our thumbs, dwelling in our heads, and it's not healthy. And the more I keep myself busy, the better frame of mind I am in on a day-to-day basis. And the fact that we can get pool balls out and play pool here, unattended by staff is great. After I have seen you, I will go and play a mate at pool. And we will have a couple of hours where we just chill and play pool and it is most important to be able to do such things". (Simon).

5:2.2.1 Sub Theme 2:1. Self-esteem

Several participants also talked about meaningful activity in terms of what they had achieved in vocational areas in the hospital, and the positive impact this had on their self-esteem. Study participant Clive talked about what he had achieved working in a printer's workshop in the hospital.

"It makes me feel happy, because obviously, I have made calendars, books, diaries for staff, so it just helps, in knowing you are doing something right". (Clive).

James echoed the comments of Clive, appearing to be proud of what he had achieved through vocational participation.

"But it's like a feeling of accomplishment. That I have done it, and people are happy with it. And other people have made comments, not just staff, patients as well, so it gives a feeling of satisfaction, you know?". (James).

Many patients in high secure care have had difficult lives with limited opportunities, which can result in low self-esteem. The comments made by Clive and James suggest that vocational participation has a positive effect on their self-esteem which may in turn be a facilitator of their care.

5:2.2.2. Sub theme 2:2 Moving on

The majority of high secure patients will move on to continue their recovery journeys at lower levels of secure care. However, for patients whose treatment is less successful their stay in high security may be protracted, while some may be returned to prison. Thomas commented on how he felt ready to move on but was concerned that without the support available in high secure care he may relapse.

"I am ready to move on, but I get the odd day when I say hang on a minute, I need to stay a bit longer you know. When I first come in, I knew I needed to be here but when the voices went… but I get up some mornings thinking I'm glad I'm here but others wishing I wasn't, so I can't fault the staff or any of the procedures, they have got me back to my normal self, before my voices came". (Thomas).

However, for some the prospect of moving on may be daunting and David talked about the difficulties that may be encountered when moving into a changing world.

*"Everything's changing and you are not going with the times, because you're still stuck here. But you have to get used to it when you get out at some point". (*David).

In contrast, John commented on how his treatment was starting to prepare him for moving on.

"Yes, because what this ward is about, is helping you get ready for going out into the community and everyday living. It's about building some kind of esteem where you can cope on the outside". (John).

Many patients in high secure care would hope to move on to lover levels of security at some stage. For some this may be a daunting prospect. For people like Thomas the prospect of moving on may be double edged, where he feels ready to move on but knowing that he will miss the support from staff and the environment which have helped him in his care. For others, like David, a changing world and the impact of institutionalisation may make moving on difficult and result in a longer stay in high security than is necessary.

5:2.3. Theme 3 Policies, procedures, and organisational issues

Patient care and everyday life in high secure hospitals are regulated by the many policies and procedures which must be followed. Examples of such measures include personal rub-down searches, room searches, patients being confined to rooms at night, and limited access to items such as any bladed items, electrical equipment and excessive lengths of cabling. Participants in the study commented on how policies and procedures impacted on their daily lives. Some restrictions, such as the need for physical security, appeared to be generally understood by participants. However, some policies and procedures can at times become contentious among participants as the following quotations from Christopher highlighted.

"*Some of them are frustrating, because not all of them make sense, and they are not always explained. Staff themselves don't understand some of them. "Some of them are obviously necessary, the fences and the locked doors, you are not going to question them because that is security. But some of the other things it's not really necessary".* (Christopher).

"It's the environment, and there is no way of escaping it, it is very restrictive, very restrictive, and there is a lot that reminds you that you are locked up and the reasons you are locked up. Because you only have to look around the cameras, the fences, the locked doors on the wards". (Christopher).

Paul expanded on this by talking about hospital procedures at mealtimes and the management of these times which he found particularly frustrating.

"And one specific one I find frustrating and that is mealtimes. So, you have to sit down, you get your meal, you eat your meal, and then you can't leave. So, you might finish, but you have got to wait for everyone else to finish. Which then, which happened to me quite a lot. If

you are the last person to finish, you feel under intense pressure to finish. Mealtimes should be an enjoyable time, but it turns into a horrible time, and no one enjoys it. They just want to get fed and get out". (Paul).

The quotations from Christopher and Paul begin to highlight how patients' everyday lives are governed by policies, procedures, and organisational issues. Many of these factors are essential for the management of risk, and this was acknowledged by participants. However, as discussed in Chapter 3, some policies and procedures may be at odds with the recovery principles of instilling hope, control and opportunities. It may therefore that although some policies and procedures will facilitate care, others may prove to be barriers to effective care.

5:2.3.1. Sub theme 3:1 Mental Health Act 1983

All patients in high secure forensic care are subject to the Mental Health Act 1983, and compulsorily detained for assessment and treatment. Usually, this detention is through the courts and mostly against the patient's will. Many patients are also subject to restriction orders which dictate the level of security in which patient are cared for and control their movements. For many of the participants interviewed, aspects of their care, such as when they may move to lower levels of security, are therefore ultimately controlled by the Ministry of Justice through the Mental Health Act rather than purely by health professionals.

This is an unusual situation in healthcare, and participants Simon, James and Michael commented on this with Michael feeling that being on a section supported his care, while Simon and James found it intimidating but appeared resigned to accept the situation with a degree of equanimity.

"It's a bit daunting, having people who don't know me on a personal level making decisions about me, but it's the way it is, I just have to accept it. It is easier to accept it than to become bitter and frustrated about it". (Simon).

"Well, I am not jumping for joy about it, but I am also not down in the dumps about it. I don't feel I particularly deserved it when I got it because it was only [names offence*] that I got it for. Which normally you would get [*states short custodial sentence]. *So, I am not fully happy about it, and that means it can be a lot harder to get out. It takes longer to get permission to move on".* (James).

"I am glad that I am on a section because I know that at least here I am going to get the help that I need, do you know what I mean? And I have got the help that I have needed, so without that section I wouldn't be in the hospital". (Michael).

The comments of participants appear to indicate a complex relationship between the conditions imposed by the Mental Health Act and the views of patients whose movement and conditions of care are dictated by it. In consequence, this complex relationship may have the potential to be both a barrier and facilitator of care.

5:2.3.2. Sub theme 3:2. Personal safety

Many of the policies and procedures which are in place in high secure hospitals are in place to keep patients and staff safe. Often patients confined in high secure care have had chaotic lives and may have rarely felt that they are in a safe place. Mark commented on the importance of following policies and procedure to maintain safety and how he felt less safe when policies and procedures weren't followed correctly.

*"The policies and that are there for a reason, but when I point them out, I then sort of get looked at. He's trying to cause trouble, he's trying to get people into trouble, and it's not. I just want it to be safe. It doesn't make me feel safe that sort of thing goes on". (*Mark*).*

Another participant Paul, commented on how he needed to feel safe in the environment:

"It's about safety as well, because say the cookery room. I wouldn't go in the cookery room with people I don't know or any tooled session particularly because the anxiety is already there. Whereas if you're in with people you know you just feel relaxed and it's a more enjoyable session". (Paul).

5:2.3.3. Sub theme 3:3. Security

Leading on from safety a prominent feature of high secure care is the physical security of locked doors and high fences. Participants had mixed views on how this impacted on their care, and several participants felt the level of physical security impacted on their identity and not always conducive to a hospital environment.

"I hate the fences and the locked doors. I was an outdoor kind of person when I was out. I used to go to nature reserves, and I used to [states outdoor activity] and things like that, I was a [states hobby]. So, to come indoors, and to spend all my time locked away indoors, behind fences and closed doors really annoys me". (Simon).

"I sometimes feel I am like a prisoner at Rampton, but you have to go with the flow because it is a high secure hospital, and they are going to have fences. But as I am making progress towards medium secure, those fences now used to bother me and I used to feel like a prisoner in my own home, I had fences about me, I had gates about me staff had keys so they could open all the gates. I felt intimidated staff had keys and could come and go as they please, patients can't". (Steven).

The views of Simon and Steven demonstrate how the need to maintain a secure environment to manage risk can at times be at odds with a hospital setting. This can impact on patient's identity and give a feeling of being a prisoner rather than a patient, factors which may not always be conducive to care in a health setting.

5:2.3.4. Sub theme 3:4 Medication

For many patients in high secure care, taking medication to help manage their mental health as part of their treatment is an everyday occurrence. At times, medication can be a contentious issue, with participants having conflicting views regarding its use and effectiveness. Christopher and Thomas commented on how they felt taking medication was important to their care

"Some days I feel alright about it, but others I think what's the point, (taking it) but those are the days when I have to remind myself why I take meds, because I am a voice hearer, I knows what I am like without meds so in other words meds are important to get me through the day". (Christopher).

"It has been very helpful, I'm frightened not to take it, it's done us that well that I'm frightened of missing medication". (Thomas).

Michael offered a different viewpoint and highlighted some of the negative side effects of taking mental health medication:

"Honestly, I am not happy with taking medication. It slows me down; I have never liked it since I started taking it. Just cus you feel a bit dull and sort of slow and a bit sedated. I still get on and do my activities and stuff like that, but it sort of impacts on my motivation.

*Especially in a morning, I always miss breakfast cus I can't get up. No, I don't like taking medication, never have done. And I guess the first opportunity I have to come off medication I will come off it". (*Michael).

The comments made by Christopher, Thomas and Michael describe the complex relationship participants have with their mental health medication. While Christopher and Thomas recognise its importance in their care, while Michael focused on how side effects impacted on his alertness and motivation. From these comments it appears clear that, for some, taking mental health medication can be a facilitator of their care, while at times its sedating effect can be a barrier to effective care.

5:2.3.5. Subtheme 3:5. Staffing and communication

Staffing consistency and effective communication between staff and patients are important aspects of relational security and understanding patients' concerns, needs and risks (Kennedy, 2002). Study participants Christopher and Peter highlighted how inconsistency in staffing, in terms of professionals leaving their posts, and staff shortages leading to cancellations, impacted on their care.

"One of the other things which has been a big problem of late is I have had a lot of changes in psychiatrists and psychologists so on this ward at the minute I have had RMOs one minute and had another RMO a couple of months later. So, because they are like the key factor to your treatment that's kind of got in the way, because they make all the decisions, it's the same for psychologists. One minute we've had two psychologists and all of a sudden, we are down to one again or none and of course they are supposed to be there to help and support you and obviously help your treatment pathway so that's kind of got in the way as well". (Christopher).

"So how does that make you feel when things are cancelled? (interviewer). Er Nobody……. I don't matter…. people say, oh it's not you it's not you but it always seems to be my sessions that gets cancelled or knocked on the head (unintelligible) like sewing group cross stitch on a Monday used to love going there, but it's cancelled. Although I enjoy getting off the ward and doing things it's a waste of time". (Peter).

The views of Christopher and Peter stress the importance of consistency in staffing and effective communication in their care. Their views appear to highlight how changes to staff, and poor communication can make them feel unvalued, impacting on their self-esteem which may have implications for their overall care.

5:2.4. Theme 4 Significant relationships

The previous sub theme touched on the importance participants place on trusting relationships and Christopher commented on the importance of relationships with staff at times when he was struggling with his care.

"Because therapeutic relationships to me are the most important, because they remind you that people were there for you in your dark days, and it reminds you that people weren't there in your darker moments, so the ones that you value are obviously the ones you remember because they have been there when you have been unwell". (Christopher).

However, some relationships were considered to be less than ideal, and Simon reflected on how some members of staff had difficulty in forming effective therapeutic relationships.

"A lot of them do but a lot of them are a bit more aloof as well which can be annoying, you know some staff area bit aloof and they don't talk to you on a one-to-one level, it's always on a professional level. So, you always feel a bit sort of you can't go to them so much.

Whereas other staff they talk to you on a one-to-one level on a more equal footing, and it's just as enjoyable to speak to them about something as it is one of our mates in here and that helps bridge the gap and makes us feel more at home and at ease being here". (Simon).

These comments highlight the importance of having a good therapeutic relationship to facilitate effective day to day communication between staff and patients. To overcome barriers, it may be necessary for staff to present as being friendly towards patients but without becoming friends.

5:2.4.1. Subtheme 4.1. Therapeutic interventions

In addition to day-to-day informal interactions, more formal therapeutic interventions with professionals such as psychologists, occupational therapists and named nurses take place as part of routine high secure care. These interactions were clearly valued by participants as comments made by Luke and Thomas suggest.

"When I first came here, I had a lot of anger issues, a lot of trust issues. And [psychologist] kind of broke down those barriers so you can trust someone, and not everyone is out to hurt you. I don't know, [psychologist] sat with me when I was distressed. Helped me work through my childhood issues……. I have done therapy in jail, and it's never really worked. So, to come here and find support from somebody is a great thing. And that's just her saying you've done the work, but you can't really tell someone how much they have helped you. Do you know what I mean?" (Luke).

"It's just the same thing, someone who will listen to you, you know, someone who is sat there and will listen to what you say, what more do you want from psychology, someone to listen and sort your problems out between you, as long as they listen to you, I am quite happy". (Thomas).

The comments made by Luke and Thomas indicate that more formal talking therapies which are focused and have a regular time scheduled are valued by participants as facilitators of care. These sessions are potentially more valued than day to day interactions with staff due to the therapeutic bond which is created in these sessions.

5:2.4.2. Theme 4:2. Family and friends

The support given by family and friends was seen as vital and different to the support given by professionals. Paul indicated that this contact added to a sense of normality in his life.

"Your friends can support you and be there. Staff support you mentally, and what's the word, professionally. Whereas your friends can just distract you and you can do something normal with them. Whether it's playing a game or having a chit chat. And that normality has just as much impact as the professional side of things. Sometimes more because you want it. You don't want to be heavy all the time problem, problem, problem. You want to have that break, and you want to be a normal person, escape from the problems of the world". (Paul).

Matthew, however, spoke about the difficulties of having limited contact with family and friends.

*"Missing family. Not doing normal stuff like going on holiday and having a girlfriend, seeing old mates I get on with, stuff like that". (*Matthew).

Maintaining contact with family and friends can be problematic for high secure patients such as Paul and Matthew. High secure hospitals are often distant from the homes of family and friends which can make visiting difficult. The support given by family and friends was

however seen as different from that given by professionals in terms of closeness of relationships and consequently a facilitator of care.

5:3. Conclusion

This chapter has set out the results of a critical realist qualitative study investigating the barriers and facilitators influencing the effectiveness of high secure forensic care. Comments made by participants suggest that these barriers and facilitators of care impact on the conditions in which a patient's care takes place, and in turn may reflects a patient's ability to fully benefit from the clinical interventions on offer. This may also impact on the reduction of risk, and ultimately how long a patient remains in high secure care.

The chapter has endeavoured to tell the story of high secure care through the views of patients receiving care and may therefore be deemed to be experts by experience. The key messages which emerged from participants comments are:

1.The importance of maintaining an identity beyond that of a mentally disordered offender and having opportunities to enact meaningful roles such as a worker role.

2. The value participants placed on being able to live a life which has a sense of normality within the confines of a high secure hospital.

3. The policies and procedures in place often helped support then in their recovery journey, but at times got in the way of progress with a need to balance risk management with promoting recovery.

4. The importance participants placed in positive relationships with staff, peers and family members.

5. The identified themes were often closely linked, with the potential to have a symbiotic influence on patient care.

In the next chapter the results of this study will be discussed in terms of their implications for high secure forensic care and for research in this area.

Chapter 6. Discussion

6:1. Introduction

In this study, themes of role and identity; therapeutic activity; policies, procedures, and organisational issues; and significant relationships emerged from the data. Participants across mental health, personality disorder and learning disability services highlighted similar themes which have the potential to act as barriers or facilitators of their care. The above themes and associated sub themes will be discussed in relation to critical realist theory.

6:2. Theme 1 Role and identity

Study participants indicated that factors relating to their life roles and identity were central to making progress in their care, and making the changes need to reduce their risk and to live a fulfilling and productive life. An individual's identity and the roles that make up that identity are central to self-actualisation and fully developing as occupational beings (Wilcock, 1999).

Identity is multifaceted, containing productive, social, and spiritual dimensions, all of which are influenced by the environment in which people grow and develop (Phelan and Kinsella, 2009). The identity and associated roles of individuals with mental health conditions can also be affected by stigma, which can impact on an individual's opportunities and self-esteem, and this is particularly significant for patients who also have forensic backgrounds (Williams et al. 2011).

Participants in the study identified elements of activities such as maintaining and learning new skills as important, and these are essential elements of promoting and developing identity. Shepherd et al. (2016) identified developing a sense of personal identity as a key theme in the forensic recovery process. It may be argued that coming to terms with and

understanding offending and mental health issues is a challenge for forensic patients in reconstructing their identity as part of the recovery journey (Howells and Tennant, 2010).

An element of identity discussed by participates is spirituality. Glorney et al. (2019) in the first study of its kind highlighted the importance of spirituality to the recovery of offenders. The sense of identity brought by spirituality was seen as being removed from that of an offender, having personal meaning and supporting the recovery of the individual. Religion and spiritualty may provide people, including mentally disorder offenders with an opportunity to develop a sense of belonging and connectedness (King, 2003) which will foster personal growth and for some, providing a sense of control which is lacking in other aspects of their lives

Participants also identified stigma as a factor with the potential to impact on their identity and the effectiveness of their care. Participants felt that patients in high secure hospitals are incorrectly portrayed in the media and that high secure hospitals in general are misunderstood by the public (West, Yanos and Mulay 2014).

These comments concur with the wider literature which indicates that admission to high secure forensic care is an inherently stigmatising process. As mentioned in Chapter 3;11.4., forensic patients face not only the double stigma of offending and mental disorder but also self-stigmatisation, which further undermines their self-worth and motivation to take part in treatment (West, Yanos and Mulay 2014); (Williams et al., 2011).

Many patients in high secure forensic care have a long history of offending, which may range from offences committed while in institutional care to very severe offences such as murder. In some cases, an individual's identity may be defined by perceived status achieved through offending. It may therefore be argued, that in some cases an individual's offending is

an attempt to meet basic needs and to achieve satisfying rewarding goals in a way they have been unable to do in a pro-social manner (Colquhoun, Lord and Bacon, 2018).

Such individuals may have had limited opportunities for success and achievement in their lives. In such cases there may be a need to help individuals deconstruct an identity based on values against societal norms and reconstruct a more positive prosocial identity. To achieve this, there is a need to structure care around the principles outlined in the CHIME framework, with a focus on hope, optimism and a recognition that recovery and meaningful change is possible (Leamy et al., 2011). It is therefore important that forensic institutions provide conditions where personal growth and recovery is not only possible, but activity encouraged, with opportunities to develop identity fostered (Senneseth et al., 2022).

People who reside in closed care facilities such as high secure hospitals are likely to be affected by institutionalisation. Participants in the study discussed issues relating to institutionalisation is closely associated with historical, asylum style care. Due to their history the high secure hospitals, despite changes can be closely associated with this model of care, where containment to manage risk is a prime driver (Chow et al, 2019).

Buck et al. (2012) discussed how individuals with mental health disorders can experience a loss of their usual roles and identity which can promote feelings akin to bereavement. This effect is compounded for individuals in psychiatric settings where institutionalisation has been linked to a loss of identity particularly in terms of how they see themselves and the world beyond (Chow and Priebe, 2013).

This has implications for care, particularly in terms of moving on from high secure care and secure psychiatric environments in general. Patients may become accustomed to and accepting of institutional care, which becomes their normality, resulting in a lack of motivation to leave (Chow and Priebe, 2013).

A true sense of normality is difficult to achieve in this environment, and this is suggested by the comments of participants. In some ways patients in high secure care strive to live a normal life in what may be described as an abnormal society. Normalisation relates to having the opportunities to complete tasks or activities which can be seen as normal aspects of everyday life. Examples of such activities may be to go for a walk, to make a cup of tea or coffee, and even to choose when to, leave a dining table. These examples of normal life are not routinely available to high secure patients.

Study participants discussed aspects for their care which brought a degree of normality, such as being able to walk in the hospital grounds unescorted. Participants valued being able to maintain a worker role and to do the things they and done in the past, such as play instruments. Others however, commented on how the restrictive regime made them feel safe and secure.

The mental health recovery principle of having agency, which involves individuals gaining or taking back control of lives (Repper and Perkins, 2003). However, this may not always be easy to achieve in a high secure setting, but this does not diminish its importance.

The study indicated, that as set out in the theoretical framework, Chapter 1, 1:21, there is a clear need to balance the need to maintains safety and security with the need to promote opportunities, instil hope and give control, all of which foster a sense of normalisation (Leamy et al, 2011; Perkins and Repper, 2016). However, study participants discussed how at times, the highly regimented routine created an environment which may be at odds with what most people consider to be normality which has further implications for an individual's identity.

The theme of role and identity has a close association with the principles of mental health recovery. Having the freedom and trust to do "normal" things such as make a drink or spend

time in the personal space of their bedroom without restrictions or permissions was viewed as important by participants. Gaining trust and acquiring a greater sense of freedom within the hospital was viewed positively by participants as a sign of progress in their care. Freedom and trust links strongly to normalisation as patents need to gain freedom and trust before they can access elements which help to bring normalisation such as unescorted grounds access.

The amount of freedom which is allowed to individuals in high secure forensic care is dictated by an array of policies and procedures, this impact of which will be discussed later. However, participants highlighted issues outlined in the theoretical framework (1:21), and discussed in Chapter 3, regarding the ethical debate which exists between forcible detention and restrictive care, which creates tensions between the right to individual freedoms and the protection of society (Davidson, 2002).

6:3. Theme 2 Therapeutic activity

Participants in the study commented on the high value they placed on all forms of therapeutic activity. These ranged from formal off-ward sessions to less structured sessions which may take place on the ward. Formal sessions are often occupational therapy led, and participants commented on how an off-ward environment was often more relaxed which allows these sessions to take place in a less formal more normalised environment. One study participant placed the impact of meaningful activity above all other interventions in his care.

The benefit of therapeutic activity for an individual's recovery is well recognised for its role in developing the self-esteem and self-efficacy of individuals with mental disorders and increasing hope for a positive future (Repper and Perkins, 2003).

Meaningful activity also links to normalisation by doing normal things and identity through developing skills which may be work-related. This may be beneficial for care by helping individuals rediscover a sense of self and positive aspects of their identity, such as a

worker role (Mckeown et al, 2016). In a study of what works in high secure care by Tapp et al. (2013b), participants identified that opportunities to work were essential to their overall wellbeing, improving self-efficacy and self-esteem and reducing risk behaviours such as self-harming.

Study participants made links between developing new skills and having opportunities to succeed through meaningful activity as having a positive impact on their self-esteem. Participants discussed having a sense of pride and a sense of achievement through what they achieved in vocational type sessions. The sub theme of self-esteem is strongly associated with previous themes of identity, meaningful activity and normalisation and developing self-esteem is a means of combating stigma.

Low self-esteem is common amongst forensic patients due to previous experiences including abuse, institutionalisation, repeated failures in life and the beginning of mental illness (Mezey et al., 2010). Being valued, cared for and being respected are thought to have a positive impact on the self -esteem of forensic patients (Mezey et al., 2010).

An improved sense of self-esteem appears to have links to positive progress in an individual's care, and participation in meaningful activity appears to have benefits in this area. Participants described having a sense of accomplishment and satisfaction, as well as feeling happy and gaining pleasure from knowing they were doing something right. Through participation in therapeutic activity participants appear to gain a greater sense of self, which equates to a greater understanding of who they are as individuals accompanied by a greater sense of hope for the future (Davidson, 2002).

Moving on from high secure care can be challenging for patients and participants in the study highlighted issues relating to this. Comments from participants appear to indicate that

moving on from high secure care is not straightforward process. It is possible that patients' progress to lower levels of security may be affected by "gate fever".

Gate fever refers to the anxieties someone may feel before moving on from a secure setting and on occasions patients may engineer events to deliberately to take a backward step in their care (Fish and Morgan, 2019). Gate fever can result in a revolving door situation where patients are re-admitted following a step down as their anxieties leave them feeling unable to cope in a less restrictive environment (Fish and Morgan, 2019).

These issues link to institutionalisation which has been discussed previously, and the need for patients to feel safe and secure, which will be discussed later. However, as participants in the study acknowledged the importance of increasing their self-esteem to help develop the skills, they need prior to leaving to secure care may be significant in the management of gate fever, and it is likely that increased self-esteem is linked to the development and maintenance or roles and identity.

6:4 Theme 3 Policies, procedures, and organisational issues

As highlighted in the background and literature review of this work, there are many policies, procedures and organisational issues which set out the conditions and environment in which care takes place. These policies and procedures aim to manage and reduce risk and maintain the safety of both staff and patients.

Participants in the study commented on these conditions and highlighted that they felt they are very restrictive and were a constant reminder that they are detained in a custodial environment. Participants accepted the need for some restrictions, but they questioned certain aspects of procedures such as highly regimented mealtimes. These issues link theme of normalisation, and the highly regimented conditions and routines which exist in high secure

care. These conditions create what many people would consider to be an abnormal society when compared with how most people live their lives.

High secure forensic care is also different from other aspects of health care by the high-profile nature of many patients who are cared for in these settings. High secure hospitals are often in the public eye, frequently featuring in the press due to some of their patients. However, the reality may differ from public perceptions. Patients residing in high secure care are there because they are affected by mental disorders, rather than purely due to an offending history. Patients in the study commented on the stigma surrounding high secure hospitals and how it impacts on them and influences their identity, possible to the detriment of their care and future recovery.

The Mental Health Act 1983 provides a legal framework around which decisions regarding the care of people affected by mental disorders in England and Wales are framed (Glover-Thomas, 2018). Participants in the study had differing views regarding the impact of this act on their care with some participants feeing daunted by the way it influenced their care while others felt that it was a protective factor which ensured they received the care their needed.

The Mental Health Act provides an unusual situation in health care when ultimate control over certain aspects of a patient's care ultimately lies with the Ministry of Justice rather than health professionals. While this can have a positive impact in many cases, some writers have contended that it is now overly restrictive potentially to the detriment of care (Pilgrim, 2007; Humphreys and Kenney-Herbert, 2000; Wrench and Dolan, 2010).

Personal safety relates to participants living in an environment in which they feel safe and protected, and various policies and procedures contribute to this. Participants comments stressed how important this was to them. This may well link to people detained in high secure

care often having chaotic lives and living in unsuitable accommodation. This links to other themes of normalisation, institutionalisation and moving on. For example, gaining a feeling of safety through detention in high secure care may be their normality. This then links to people becoming institutionalised, while gaining a feeling of safety may create a reluctance to move on.

Participants in the study commented on security and the physical environment. High secure hospitals are characterised by high fences and locked doors and windows. The physical conditions are largely dictated by the High Secure Directions (NHS England, 2019) and the influential Tilt report (Tilt et al., 2000).

Participants broadly understood the need for physical aspects of security, but found them daunting and intimidating, making them feel like prisoners rather than patients. This is a constant dilemma for high secure hospital care. In what is termed the "dual role" professionals need to balance the care and rehabilitation of patients with the need to protect the public (Völlm, Bartlett and McDonald, 2016). It may therefore be difficult to create a truly recovery focused environment when patient care needs to be balance with the need to maintain security and safety

The use of medication was another area where participants had conflicting views. Many patients in high secure care will take medications to help them manage their mental health and patients admitted for treatment under the mental health act can be treated against their will including the administering of medication (McMurran, Khalifa and Gibbon, 2009). Some study participants recognised the value of taking mental health medication, while others struggled with side effects and would stop taking medication if given the option.

Poor compliance with medication is considered to be a dynamic risk factor amongst high secure forensic patients (Easden and Sakdalan, 2015). However, the use of medication also

has implications for the dual role occupied by clinicians and balancing the rights of patients with the need to manage risk.

6:5. Theme 4 Significant relationships

The theme of significant relationships explored the social environment in the hospital as well as connections to family and friends beyond the hospital setting. Study participants indicated the importance of therapeutic relationships, of having staff they could rely on and who would be there to support them in difficult times.

It has been argued that high secure care is a social process (Deacon, 2010) and that therapeutic relationships are central to person centred care Tapp et al. (2013b). Positive therapeutic relationships involve staff being open honest and respectful with a focus on recovery orientated care (Marshall and Adams, 2018). It is important that these qualities extend to the way staff communicate with patients. However, barriers to positive therapeutic relationships may include negative preconceptions and beliefs held by staff regarding forensic patients as well as the need to enforce rules and boundaries (Marshall and Adams, 2018).

Therapeutic relationship is also a central aspect of relational security which involved gaining an in-depth knowledge of patients (Exworthy and Gunn, 2003; Kennedy, 2003). Significant relationships also form part of an individual's identity and gaining a sense of feeing valued through these relationships can help enhance an individual's self- esteem.

Participants in the study highlighted the value they placed on regular formal sessions with professionals, appearing to appreciate the protected time available for them to talk. In these sessions strong professional bonds can be formed and appear to be highly valued by participants. It is often necessary for deep and trusting relationships to develop due to the

sensitive and potential challenging nature of discussions. These relationships may fill a void in the lives of forensic patients due to the social isolation patients may experience (Barnao, Ward and Robertson, 2016).

The importance of maintaining contact with family and friends was emphasised by participants, with this contact again linking to a sense of normality. However missing family and not being able to take part in normal family things such as holidays was difficult for participants.

Maintaining the role of family member is part of an individual's identity. Family contact can be maintained by visits, telephone calls and letters, however, at times visits may be difficult as high secure hospitals are often in graphically isolated locations, with family members often having to travel long distances. It is important that professionals to work in a family-oriented way to strengthen and maintain family contact, and if possible overcome difficulties associated with past offending (Hörberg et al.**,** 2015).

Other forms of communication are also not straightforward. Mobile phones are banned, patients may have to wait for staff being free to make telephone calls, some calls may be monitored, and its security considerations weren't it mail may be monitored. High secure hospitals have been slow to embrace new technology such as Skype and zoom due to security concerns, although the recent COVID -19 situation where face to face visits were prohibited, has helped accelerate progress in the area, with virtual visits now taking place (Lemieux et al., 2020).

It is noteworthy that none of the participants mentioned intimate relationships as sexual contact between patients and between visitors is prohibited. This aspect of an individual's identity is therefore removed or suppressed, which further indicates a lack of normalisation. Participants responses around these issues may, however, be due to social acceptability or

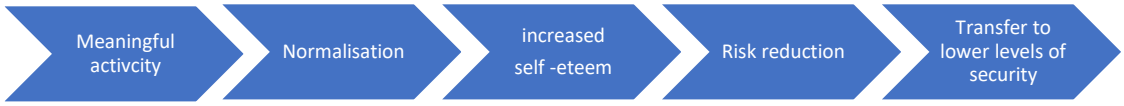
social desirability bias, which guides participants to respond in a way deemed appropriate to the situation (Bergen and Labonte, 2020).

6:6. Impact of mechanisms on the effectiveness of care

The themes discussed in this chapter identified a range of mechanisms which influence the political, physical, and social environment in which care takes place. In Chapter 1 (section 1:12.2.), Ahmed's story outlined how a combination of mechanisms can act together to influence a patient's care and recovery. In. Ahmed's case, meaningful activity in the normalised setting of a printer's workshop helped increase his sense of identity. This in turn had a positive impact on his self-esteem and helped reduce the risk he posed to facilitate moving on.

Based on the transtheoretical model of change model as outlined in Chapter 1, section1:7. (Prochaska and DiClemente, 1982), figure 6:1 demonstrates how mechanisms can help facilitate change in Ahmed's case. It may be argued that in Ahmed's case the change would have been achieved without the vocational intervention, as other mechanisms are also likely at play. The impact of these mechanisms may be quite subtle and not clearly visible or recognisable, however, the following highlights how change may take place.

Figure 6.1. Causal mechanisms and change

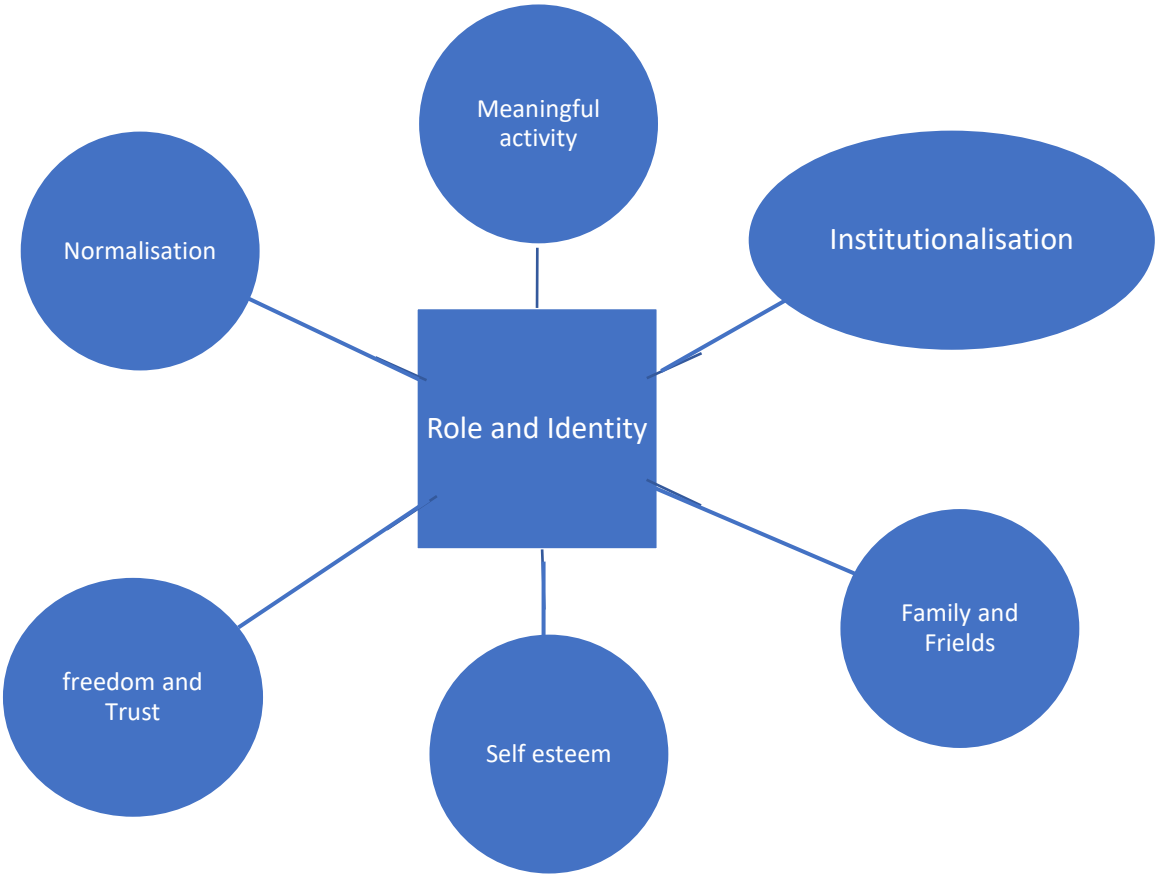


6:7. Study implications care and patient identity

Many of the themes and sub themes identified in this study were related to identity. Linking this to the above model of change, it may be argued that developing a patient's roles and identity is the start of their therapeutic journey. Consequently, is it important to work on understanding the patient's perceptions of their identity and their future goals. It may be further hypothesised that patients who have developed or maintained a greater sense of identity may be in a better place to benefit from care and the specific treatments available.

Figure 6:1 conceptualises how a range of causal mechanisms have the potential to impact on an individual's identity. If linked to Figure 6:2 causal mechanisms and change, it can be seen how potential mechanisms may be at work together.

Figure 6:2. Causal mechanisms and identity



In Ahmed's case, it seems that participation in meaningful activity in the more normalised situation of a printing workshop promoted a sense of normalisation and combated the effects of institutionalisation. Attending the area demonstrated increased freedom and trust, with the staff and patients in the area providing an increased support network. It also gave the patient a sense of achievement and recognition of progress which served to increase self-esteem.

This may have implications for care and the timing of treatment. It may be that there is a need to give greater emphasis for interventions which help patients develop meaningful roles and begin to understand and develop their identity. A specific example of this may be through therapeutic activity and vocational skills.

Participants in the study clearly valued the opportunities to develop new skills through vocational activities. However, it may be the case that patients are only able to access vocational sessions after they have developed the necessary freedom and trust, and so this option may not be available at the start of their admission. So again, timing of interventions and coordination of care are important.

Mental disorder may result in a loss or interruption of an individual's sense of self and developing identity through meaningful activity may be a means or recapturing or developing a sense of self (Davidson, 2020). Wilcock (1999), in the influential occupational therapy text "Doing, Being and Becoming", described meaningful activity or "doing" as a means for social and societal interaction and personal growth. Being relates to the essential sense of the individual, or what makes them who they are, and becoming is being able to fulfil the potential for an individual's future development, opportunities, and hope. This links to Maslow hierarchy of needs and the importance of self-actualisation (Maslow, 2013).

Several studies have considered patients' quality of life within high secure hospitals. These studies appear to have focussed on maintenance and satisfaction rather than development and growth (Swinton, Oliver and Carlisle, 1999, Völlm et al., 2017). To be recovery-focused and to increase the effectiveness of care, more emphasis should be placed on the patient's personal growth and helping them to redefine their identity.

However due to the long-term effects of stigma and low self-esteem it may be difficult for patients to see the value of such interventions. Professional considerations and adherence to a medicalised model of care may be a barrier to fully embracing the value of developing and individual's identity generally, and particularly through meaningful activity.

As mentioned, participants felt some policies and procedures reminded them that they are in custodial care. Howells and Tennant (2010) discussed the importance of shifting identity

from offender to patient as an important step in treatment engagement and readiness for change in personality disordered patients. A dilemma of high secure care is helping patients reconciling the shift in identity from offender to a patient with a mental disorder (Howells and Tennant, 2010). From the views of participants, it may therefore be beneficial for care to have greater focus on identity and normalisation, helping patients to deconstruct and reconstruct their identity and to live as normal a life as possible within a high secure environment.

As a primary aim of care is to reduce risk to allow patients to be moved on to lower levels of security, it is important that care considers all factors to ensure its effectiveness. This should involve consideration of the political, physical, and social environment in which care takes place as well as numerous multifaceted interventions such as psychological interventions, occupational therapy, speech and language therapy, and nursing interventions (Tapp et al., 2013a). However, it was highlighted in the literature review to this work that there is little evidence regarding the effectiveness of care in a high secure setting. It would therefore be valuable to consider how evaluation research in a high secure setting may be better considered.

6:8. Study implications for care and research.

This study has contributed to the evidence base in high secure forensic psychiatric care by highlighting that role and identity are crucial to the recovery and rehabilitation of mentally disordered offenders. Many researchers, including Leamy et al. (2011), Howells and Tennant (2010), McMurran and Ward (2004) and Repper and Perkins (2003) have highlighted the importance of individual gaining a "sense of identity" as part of an individual's recovery journey, however issues relating to identify are not always fully explored.

This study, however, goes further by placing an individual identity as the central factor in the recovery and rehabilitation of mentally disordered offenders. This requires care providers to create conditions where personal growth is not only possible but actively encouraged. This may involve deconstructing a previous identity, which may be based on perceived gains from a criminal lifestyle (Tennant and Howells, 2010), and reconstructing a positive prosocial identity which gives the scope for personal growth and development. However, creating conditions where this shift in identity may be challenging for high secure hospitals, as it may involve adopting an emancipatory approach, providing individuals with the opportunity to "escape" from the secure care system (Llewellyn-Beardsley et al. 2019).

In the study, participants identified a range of mechanisms which have the potential to act as barriers or facilitators of their care, which may have implications for the planning, timing, and effectiveness of care. For example, when planning care, they may be a greater need to recognise how a range of factors can impact on care and delivery. Interventions should be timed to ensure that patients gain the greatest benefit, so treatment readiness is key.

There may therefore be a need for patient to take part in "identity-related sessions" in preparation for interventions such as psychology sessions. Such sessions may involve helping

patients focus on positive aspects of their past life to recognise achievements and reflect on positive experiences. Other sessions may help patients, who are confined in institutions feel connected to the outside world, by using a creative approach to bring patients closer to national and international events. Addressing these issues may consequently have a positive impact on their effectiveness. their effectiveness.

In addition, these mechanisms may have implications for the evaluation of interventions and research into its effectiveness. As high secure care is multifaceted, comprising of a variety of interventions that may take place simultaneously, the research and evaluation of individual interventions is problematic. For example, a patient's care may involve occupational therapy, psychology and speech and language therapy sessions taking place in the same stage of a patient's treatment pathway. The patients will also be exposed to a general therapeutic milieu, created by the environment in which they live, which in itself can be regarded as a therapeutic intervention. Therefore, identifying which interventions or components of interventions are the active elements in care is difficult.

In addition, the effectiveness of interventions may be influenced by the previously discussed mechanisms which may enhance the effectiveness of interventions or may prove a barrier to effectiveness. The impact of these mechanisms is not linear or static or easy to predict. As indicated in the responses from study participants, how the mechanisms influence an individual's care may well be dependent on their previous experiences. Their experiences may then shape individual responses to care interventions, with responses potentially dictated by an individual's beliefs and identity (Senneseth et al, 2022).

This is problematic for all evaluation research, but it may have particular implications for research conducted from a quantitative perspective. As previously highlighted, it is important that high secure care is evidence based and has proven efficacy (Duggan et al.,2011; Tapp et

al. 2013 a). However, several writers have commented on the lack of outcome research and the need for more research to understand the efficacy and effectiveness of interventions in high secure care (Duggan, et al., 2011; Hodgins, 2002; Tapp et al. 2013a).

Comments made by participants in the study describe a complex environment, made up of factors which are not always observable. To better understand these factors, it may be beneficial to adopt a critical realist approach. A critical realist approach would allow the researcher to consider the social processes, policies, and national and local agendas which along with historical custom and practice shape the nature of healthcare (Edgley et al. 2014).

Each of the previously discussed themes and sub themes which emerged from the data have the potential to act as causal mechanisms with the potential to influence care. Causal mechanisms do not act uniformly but will be influenced by context and conditions to produce differing outcomes (Pawson, 2006). As has been shown in Chapter 3 (see Figure 3.1), causal mechanisms have the potential to act across macro, meso, and micro levels. From a high secure forensic care perspective, the macro level relates to government policy, the enactment of law, the impact of relevant reports and influence of the media. At the meso level, hospital policy and procedures, relational security, outcome measures, and professional training can all act as causal mechanisms. While at the micro level therapeutic relationships, enactment of recovery policy, stigma, family support and the management of risk can all be considered mechanisms of influence.

By conducting research from a critical realist perspective, it may be possible to evaluate complex interventions, such as those in high secure forensic psychiatry more critically. It may allow consideration of a range of mechanisms such as those identified by participants in this study. As care is influenced by a range of causal mechanisms which may act as both barriers and facilitators of care, with their capability to impact on care being dictated by a

variety of contextual factors (Sayer, 2000). It is important that these factors are considered fully in evaluation research.

6:10. Strengths and limitations of the study

This study had several strengths and limitations. A strength of this study is its critical realist approach. This allowed the conditions in which high secure scare takes place to be examined in depth. The study allowed patients who may be considered to be experts by experience to comment on these factors in a way that is not always open to them. In doing so it gave voice to the patients, who are underrepresented in much of the literature. This is an important strength to the study which elicited the importance participants placed on factors relating to role and identity.

Potential limitations did however exist. Due the complexity of high secure care it is likely that some significant issues have been overlooked or not raised by participants. These may include intimacy, sexual needs and racism.

A further limitation is that the researcher is an occupational therapist working in high secure forensic care, and his professional standpoint and training may have influenced the study. Similarly, as the researcher was known to some participants it may have influenced the response of some participants. In terms of participants female and Deaf patients were omitted from the study, and their inclusion may have offered a different perspective.

The study was initially intended to be part of a mixed methods study, but due to practical considerations the quantitative aspect was omitted following the completion of a pilot study. The quantitative part of the research had been designed to examine the effects of therapeutic interventions upon risk reduction and clinical outcomes. Completing this research may have helped link the views of participants to clinical outcomes

6:11. Conclusions and recommendations

This study has clearly demonstrated the importance of role and identity in the care and recovery of high secure forensic patients. Participants in the study discussed areas which they felt acted as barriers or facilitators of they care. and highlighted a range of factors which impact on their care and the development of roles and identity.

The study has also highlighted a range of causal mechanisms which have the potential to impact on care delivery and its effectiveness. The study emphasised the lack of research in this area and the difficulties associated with evaluation research particularly form a quantitative approach. Critical realism, as used in this study, was discussed as a philosophical approach with the potential to enhance research in this area.

It is therefore recommended that:

1. A patients' identity is of paramount importance in their recovery journey and should be regarded as such.
2. Patients' roles and identity should be routinely considered in Care Programme Approach meetings and in treatment planning.
3. Occupational therapy and other interventions should be routinely used to help enhance role and identity.
4. The causal mechanisms that have the potential to impact on forensic care are considered when planning interventions and when researching this area.
5. Critical realism is considered as a philosophical and methodological approach when conducting evaluation research.

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Appendices

Appendix 1. Health Research Authority Approval letter.

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Associate Professor Najat Khalifa
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University of Nottingham
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NG7 2TU

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Research-permissions@wales.nhs.uk

17 July 2018

Dear Professor Khalifa

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

Study title:	**The barriers and facilitators influencing the effectiveness of high secure forensic care: a critical realist qualitative study**
IRAS project ID:	**242068**
Protocol number:	**18007**
REC reference:	**18/SC/0301**
Sponsor	**University of Nottingham**

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

How should I continue to work with participating NHS organisations in England and Wales?
You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the "*summary of assessment*" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed here.

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

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

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

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

What are my notification responsibilities during the study?
The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

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

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?
You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name: Angela Shone
Tel: 01158467103
Email: angela.shone@nottingham.ac.uk

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

Your IRAS project ID is **242068**. Please quote this on all correspondence.

IRAS project ID	242068

Yours sincerely

Chris Kitchen
Assessor

Email: hra.approval@nhs.net

Copy to: *Ms Angela Shone, University of Nottingham (Sponsor Contact)*
Mrs Shirley Mitchell, Nottinghamshire Healthcare NHS Foundation Trust (R&D Contact)

IRAS project ID	242068

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Copies of advertisement materials for research participants [Study poster]	Final Version 1.0	03 May 2018
Covering letter on headed paper [response letter]		13 July 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [UoN sponsor insurance]	Final version 1.0	13 April 2018
GP/consultant information sheets or letters [Letter to participants RC]	Final Version 1.0	03 May 2018
HRA Schedule of Events [SoE]	1	29 May 2018
HRA Statement of Activities [SoA]	1	29 May 2018
Interview schedules or topic guides for participants [Interview schedule]	1.1	15 July 2018
IRAS Application Form [IRAS_Form_11052018]		11 May 2018
IRAS Checklist XML [Checklist_11052018]		11 May 2018
Letter from sponsor [Letter from sponsor]	Final Version 1.0	10 May 2018
Participant consent form [Participant consent form]	Final Version 1.0	03 May 2018
Participant information sheet (PIS) [Participant information sheet]	1.1	15 July 2018
Research protocol or project proposal [Study 18007 protocol]	Final Version 1.0	03 May 2018
Summary CV for Chief Investigator (CI) [Najat Khalifa CV]	Final Version 1.0	03 May 2018
Summary CV for student [John Guite CV]	Final Version 1.0	03 May 2018

IRAS project ID	242068

Summary of assessment

The following information provides assurance to you, the sponsor and the NHS in England and Wales that the study, as assessed for HRA and HCRW Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England and Wales to assist in assessing, arranging and confirming capacity and capability.

Assessment criteria

Section	Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	A Statement of Activities will form the agreement of the NHS organisation to participate.
4.2	Insurance/indemnity arrangements assessed	Yes	No comments
4.3	Financial arrangements assessed	Yes	The study is funded by grants from Nottinghamshire Healthcare NHS Foundation Trust and NIHR CLAHRC East Midlands Institute of Mental Health. As per the Statement of Activities, no funding will be provided to the participating organisation.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any	Yes	No comments

Section	Assessment Criteria	Compliant with Standards	Comments
	applicable laws or regulations		
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Yes	No comments
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England and Wales

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.
This is a non-commercial study with a single participating NHS organisation. A Statement of Activities and Schedule of Events have been provided. The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England and Wales in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. Where applicable, the local LCRN contact should also be copied into this correspondence. If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England and Wales which are not provided in IRAS, the HRA or HCRW websites, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net or HCRW at Research-permissions@wales.nhs.uk. We will work with these organisations to achieve a consistent approach to information provision.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and Wales, and the minimum expectations for education, training and experience that PIs should meet (where applicable).
A Principal Investigator is expected to be in place at the participating organisation. As per the Statement of Activities, the sponsor will not provide training. The sponsor expects researcher team members to undertake or to have undertaken Trust mandatory training, MA Health

Research Methods and ethics training.

GCP training is not a generic training expectation, in line with the HRA/HCRW/MHRA statement on training expectations.

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken

For research team members that do not have existing contractual relationships with the participating organisation, Letters of Access should be in place if the activities undertaken at the NHS site involve contact with patients (e.g. to take consent), on the basis of Research passports (if University employed) or NHS to NHS confirmation of pre-engagement checks letters (if NHS employed). The pre-engagement checks should include standard DBS checks and Occupational Health Clearance.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales to aid study set-up.

The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix 2. Participant information sheet

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

Participant Information Sheet
(Final version 1.0.: 28/05/18)

IRAS Project ID: 242068

Title of Study: **The barriers and facilitators influencing the effectiveness of high secure forensic care: a critical realist qualitative study**

Name of Researcher: John Guite

I would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

What is the purpose of the study?

Purpose of the study is to help us understand what helps patients in high secure hospitals progress in their care and things which get in the way of progress. In the long term it is hoped this research will make a contribution to improving care in high secure hospitals

Why have I been invited?

You are being invited to take part because you have been cared for in a high secure hospital for more than 3 years. You now have a great deal of knowledge of high secure care and we would like to learn about your experiences. I am inviting about 20 participants like you to take part in the study.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

What will happen to me if I take part?

If you agree to take part in the study, you will be asked to take part in an interview which will take no longer that 1 hour. The interview will take place on your ward or in another place you are familiar with, such as the Southwell Centre, a day centre at Rampton Hospital. The interview will be carried out by John Guite who is an occupational therapist and PhD student, who you may know. The interviewer will ask you about your experiences of high secure care. You will be asked about what has helped you in your care and things which get in the way of progress.

The interview will be audio recorded, but what you say will be confidential, unless things you say could be a risk to yourself of others. Recordings will be transcribed by me for analysis. All your

information will be kept safely, and you will not be identified in anyway, when the research is written up. You will have the chance to see the results of the research when it is written up. If you choose to take part in the study what you say will not affect your care in any way

Expenses and payments

No payment will be made to people participating in the study

What are the possible disadvantages and risks of taking part?

There should be no disadvantages to taking part in the study. If taking part in the study does impact on you in any way please let me know, and you will be fully supported.

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get from this study may help make high secure care better in the future.

What happens when the research study stops?

When the research stops all information will be anonymised, analysed and written up as part of a PhD study

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do his best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting Rampton Hospital Independent Patient Advocacy Service.

Will my taking part in the study be kept confidential?

If you agree to take part in the study, we will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, we will use information collected from you during the course of the research. This information will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database at the University of Nottingham. Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights we will use the minimum personally – identifiable information possible.

You can find out more about how we use your information and to read our privacy notice at:

https://www.nottingham.ac.uk/utilities/privacy.aspx.

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

It should not be necessary for anyone outside your care team to access your medical records except to record your consent to participation. Information about you which leaves the Rampton Hospital will have your name and address removed and a unique code will be used so that you cannot be recognised from it, however sometimes we need to ensure that we can recognise you to link the research data with your medical records so in these instances we will need to know your name and date of birth. By signing the consent form, you agree to the above.

Your contact information will be kept by the University of Nottingham for 6 -12 after the end of the study so that we are able to contact you about the findings of the study (unless you advise us that you do not wish to be contacted). This information will be kept separately from the research data collected and only those who need to will have access to it. All other data (research data) will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team given permission by the data custodian will have access to your personal data.

In accordance with the University of Nottingham's, the Government's and our funders' policies we may share our research data with researchers in other Universities and organisations, including those in other countries, for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. Data sharing in this way is usually anonymised (so that you could not be identified) but if we need to share identifiable information we will seek your consent for this and ensure it is secure. You will be made aware then if the data is to be shared with countries whose data protection laws differ to those of the UK and how we will protect your confidentiality.

Although what you say to us is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons

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

Your participation is voluntary, and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw then the information collected so far cannot be erased and this information may still be used in the project analysis. If you decide to withdraw from the study, it will have no impact on your care

Involvement of the General Practitioner/Family doctor (GP)

Your Responsible Clinician will be contacted by email to make sure they have no objections to you taking part in the study

What will happen to the results of the research study?

The results of the research will be written up as part of John Guite's PhD study. The results will also be written up for publication and will form part of presentations. A summary of the research will be made available for all study participants and participants will be kept informed about publication of the results.

Who is organising and funding the research?

This research is being organised by the University of Nottingham and is being funded by CLAHRC East Midlands / Nottinghamshire Healthcare NHS Foundation Trust.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by [*please add name of committee submitting* to/ to be confirmed] Research Ethics Committee.

Further information and contact details

If you need to contact me or would like more information. please ask your named nurse to get in touch with me or use the hospitals internal mail system,

John Guite Occupational Therapist Southwell Centre Rampton Hospital

Appendix 3. Participant consent form

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

PARTICIPANT CONSENT FORM
(Final version 1.0. 28/05/18)

Title of Study: The barriers and facilitators influencing the effectiveness of high secure forensic care: a critical realist qualitative study

IRAS Project ID: 242068

Name of Researcher: John Guite

Name of Participant: **Please initial box**

1. I confirm that I have read and understand the information sheet version number 1.0 dated 28/05/18 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. It should not be necessary for anyone outside your care team to access your medical records, but 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. ☐
4. I understand that the interview will be recorded and transcribed, and that anonymous direct quotes from the interview may be used in the study reports. ☐
5. I understand that the information collected about me will be used to support other research in the future and may be shared anonymously with other researchers. ☐
6. 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 4. Study interview schedule

The barriers and facilitators influencing the effectiveness of high secure forensic care: a critical realist qualitative study

Interview schedule Final version 1.0 03/05/2018

Opening

This interview is about your experiences of care and treatment while at Rampton Hospital. The interview will aim to find out about the things which have helped you in your recovery journey and which things have got in the way.

General care

Can you tell me about your care and treatment at Rampton Hospital?

- What thinks have been helpful in your care and treatment
- Are their things which have been particularly helpful?
- Are you able to maintain social and family contacts?

Prompts – being busy – therapeutic activities, psychology, named nurse sessions etc

- What things have got in the way of your care and treatment
- Can you tell me about any particular things that have got in the way of your treatment?
- How has your relationships with staff effected your care?
- Does the way other see you impact on your care and treatment – and if so how
- Prompts stigma, media, the law

Managing risk

- What things have helped you to reduce your risk
- e.g. procedural, relational and physical security
- What things get in the way of reducing your risk

Managing impact of mental disorder

- What things have helped you to manage your mental health
- what things have got in the way when trying to manage your mental health
- are you able to maintain contact with family and friends

Improving functioning

- what things have helped you do things better
- are there things you have difficulty with
- what more could be done to help you

Closing questions

- Is there anything else that has either helped you or got in the way of your care

Appendix 5

This section will outline changed ,made and where they are made.

Pg 129 -130 section added to answer point 1.

This qualitative study had a research question of "*What are the barriers and facilitators of effective high secure forensic care?" and* aimed to investigate factors which patients felt could impact on the effectiveness of their care.

The research question was set out in this way to add to the debate of "what works" in high secure forensic care from the perspective of the patients receiving care (Tapp et al., 20013b). Patients receiving care may be considered to be experts by experience and gaining an understanding of factors they consider to be barriers of facilitators of their care places the participants at the centre of the research.

This is an important consideration and fits with the critical realist philosophy of the work, and its potentially emancipatory nature (Edgley et al., 2016). This also relates to the researcher's background as an occupational, therapist and the occupational therapy philosophy which focuses on the priorities of patients, enabling them to achieve client centred goals.

An important aspect of the recovery philosophy is a move away from the medical model which has a focus on diagnosis and treatment, with power often centred, in a forensic setting around the patients responsible clinical (Edgley et al., 2012). The medicalisation of illness places power in the hands of professionals, whilst the recovery philosophy encourages a shift in power with patients taking control of their care (Hui and Stickley, 2007).

The research question was framed in terms of barrier and facilitators to allow consideration of participants views of factors which may act as facilitators of their rehabilitation and recovery, and in turn factors which may act as barriers to their care and

recovery. Framing the question in this way links previous literature regarding “what works in forensic care” (Tapp et al., 2013b), the recovery philosophy and occupational therapy theory which centres on a client centred approach.

Framing the research question in terms of barriers and facilitators of recovery and rehabilitation goes on to link to the previously discussed CHIME framework and the five recovery constructs of connectedness, hope and optimism about the future, identity, meaning in life and empowerment (Leamy et al., 2011). The constructs which make up the CHIME framework are highly relevant to the recovery and rehabilitation of forensic patients, and the CHIME framework was considered appropriate as a theoretical framework, as how these factors are considered in forensic care will link to potential barriers and facilitators of high secure forensic care. The research was therefore conducted using critical realism as a philosophical position and following on from previous discussions the CHIME framework Leamy et al. (2011), was employed as a theoretical framework for the study.

Pg 95- 115

Discussion section revised with additional and added references to meet point 2.

Please see text throughout

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3. **Bias and reality**

Reality removed and his true presentation inserted.

Pg 111.

Biased changed to influenced.

Pg 28

Bias changed to- my professional position as an occupational therapist

Line removed - In adopting this approach, however, I have needed to maintain a balanced position, being mindful of how my enthusiasm could lead to bias.

4. **Typographical errors**

Pg3

Medium secure hospitals care is a step down in levels of security in comparison with high security and care for patients who may be at differing stages in their recovery journey. For example, some patients whose mental state is relatively settled will be preparing for transfer to low secure care

Pg6.

The role of the Ministry of Justice highlights an important difference between forensic mental health and other aspects of health care.

Organisational control, of high secure hospitals is maintained through NHS trusts, hospital management and different services within hospitals

Pg 9 a sentence that doesn't make sense (page 9).

Pg14.

"Indeterminant" don't see the issue?

Pg17.

difficulties that are inherent to the recovery process and the user experience.

Pg21.

Relinquishing an offending identity and constructing a positive and pro social identity can also be seen as an indication of readiness to change

Pg27. "believe are who are"

as people who I believe are

Pg34. "rather that events"

rather than events

Pg 46. “ day today”

day-to-day

Pg58. “High secure forensic are”

High secure forensic patients are

Pg 78. “This was view was”

This view was

Pg 94. “also identified as stigma as”

identified stigma as

Pg. 97/98. There is a repletion of the findings from Tapp et al., 2013

Pg. 98section removed As highlighted in Chapter3, Tapp et al. (2013b) found that the opportunity to take part in vocational activities was a key aspect of what works in the care of high secure patients. Tapp et al. (2013b) further reported that felt that opportunities to work was essential to their overall wellbeing, improving self-efficacy and self-esteem and reducing risk behaviours such as self-harming.

Pg 111 “as the research was known”

as the researcher was

Pg 111 “to ling the views”

may have helped link the views of participants

references

Pg 6

Reference added for MHA - (DoH, 2008).

Pg 20.

Bracket added (West, Yanos and Mulay, 2014).

Pg 26.

Double reference removed (Tapp et al., 2013a).

Pg 47.

Citation amended

(Young, 2011).

Pg 47.

Citation referring to Human rights act added

Hoffman, D. and Rowe, J. (2006). *Human rights in the UK: an introduction to the Human Rights Act 1998* (2nd ed.). Pearson Longman.

Pg 126 reference added

Hui, A. and Stickley, T. (2007). Mental health policy and mental health service user perspectives on involvement: a discourse analysis. *Journal of advanced nursing*, *59*(4), 416-426.

Pg.49.

Citations amended

Inman, McGurk and Chadwick,2007; Mckeown et al., 2016; Tapp et al., 2013b; Völlm, Panesar and Carley,2014)

Pg 52.

HCR -20 Citation added

(Dolan and Blattner, 2010)