Service Users' Experiences of Discharge from a Medium Secure Forensic Unit

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Thesis Declaration Form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Overview

Part 1: Comprises a systematic, narrative synthesis review, exploring the extent to which interventions for inpatient mentally disordered offenders adhere to principles of the Recovery Model. Articles were searched for direct and indirect references to recovery principles. Ten papers met the inclusion criteria and were reviewed. The evidence for recovery-focused interventions for this population was sparse indicating a need for risk to be managed within a recovery context.

Part 2: Describes a qualitative study exploring service users' experiences of the discharge pathway from a medium secure forensic unit. This study was one of the first to focus on the transition to the community, as experienced by conditionally discharged patients. Seven participants provided interview data, which was analysed using thematic analysis. The findings revealed a reluctance to seek help through fear this would jeopardise progress; along with challenges of motivation and the importance of building social networks in the community.

Part 3: Covers a critical appraisal of the research process. It explores the underlying assumptions and experiences that might have contributed to the way the research was conducted. Challenges of carrying out the research are also explored, along with the methodological concerns and dilemmas that surfaced.

Impact Statement

This study is one of few to focus exclusively on the first-hand experiences of mentally disordered offenders (MDO). This study was also the first to explore the discharge process for patients subject to continuing restrictions in the community. The findings thereby provide a unique and important insight into the experience of discharge for this population.

The findings illuminate how highly patients value the continuing support provided by their Forensic Community Teams, to manage the challenges of discharge. Crucially, they also reveal how patients might be reluctant to divulge issues or worries, particularly prior to discharge, due to a fear this might jeopardise their progress, or make them appear unfit for discharge. The findings suggest inpatient MDOs may use strategies to hide emotional states they perceive to be not conducive to discharge (e.g. low mood), despite recognising the benefit of the support that could be provided.

Potential consequences of this masking are that deteriorating mental health or well-being might not be identified and addressed as soon as possible, leading to avoidable relapse and poorer quality of life. This masking of emotional states also brings into question the reliability of risk assessments, particularly when patient compliance is used as an indication of reduced risk. This study emphasises the importance of fostering trust between inpatient MDOs and staff to facilitate help-seeking.

Findings have important implications for the way therapeutic resources (e.g. occupational and psychological) are sequenced throughout the discharge process. It suggests a 'window of engagement' for patients, a point where discharge is more tangible and motivation levels have increased. Resources focused within this window will facilitate maximum engagement, and have greater impact and effectiveness.

This study provides further evidence for the benefits of a staged process of discharge into the community, with participants valuing this as a means of facilitating adjustment. It gives added weight to the importance of continued support and monitoring of emotional and psychological well-being, for extended periods post-discharge.

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I would like to thank my research supervisors, Dr Alan Underwood and Dr Amanda Williams, for their guidance throughout this journey.

Part 1: Literature Review

Are Principles of Recovery Incorporated in Interventions for Inpatient Mentally
Disordered Offenders? Systematic Review and Narrative Synthesis

Abstract

Aims

This systematic review used a narrative synthesis approach to explore the extent to which current interventions for the inpatient Mentally Disordered Offender (MDO) population adhere to principles of the Recovery Model (Empowerment, Life-satisfaction and Positive Identity), as adapted from the conceptualisation by Resnick et al., 2005).

Method

A systematic search was carried out across four databases: PsycINFO, Embase, CINAHL and Web of Science, along with hand-searching of relevant journals and articles, and Cochrane and NICE guidance. After screening against the inclusion criteria, qualifying studies were quality assessed using the Effective Public Health Practice Project 'Quality Assessment Tool for Quantitative Studies' (EPHPP) (2004), and a total of ten studies were included in the review. The heterogeneity of the studies ruled out meta-analysis, therefore a narrative synthesis approach was adopted.

Results

Studies were assessed based on the content and aims of the intervention described. Only one study explicitly named a recovery-focused intervention (Laithwaite et al., 2009). Several programmes adhered to some recovery principles but

did not label their interventions as recovery-focused. Cognitive Skills Programmes (CSP) were most frequently reviewed in the literature, however these were the least aligned with recovery principles, tending to judge the effectiveness of the intervention by a reduction in criminal traits (e.g. violent attitudes), rather than by wider recovery principles.

Conclusions

There is a startling lack of evidence for recovery-focused interventions with the inpatient MDO population. This lack of evidence may be due to the challenges of combining recovery principles with risk management in the highly restrictive and highly regimented secure environment. This may also arise from sensitivity about public criticisms of rehabilitation insufficiently meeting expectations of punishment for offenders.

The skills focus of interventions, in the absence of wider contextual principles of the Recovery Model, raises questions about the generalisability of these interventions to the community. The findings also highlight a disparity between what current interventions report to deliver and what they actually deliver. Crucially, these findings suggest that the principles of 'equity of access' are not being applied.

Clinical Implications

Existing interventions should be brought more in line with recovery principles. In addition, greater emphasis should be placed on approaches such as the Good Lives Model (Ward & Brown, 2004), and on replicating and improving the methodology of

recovery-focused intervention studies. A recovery-focused approach to inpatient risk management would create an environment more conducive to recovery-focused interventions.

Introduction

The idea of Recovery as a model for treating mental illness gained ground in the 1980's marking a shift away from institutionalisation, to care and support in the community (Resnick, Fontana, Lehman, & Rosenheck, 2005). Since then it has been adopted and promoted by all stakeholders in mental health, from government to service users, and is widely used as a framework on which to design interventions across the spectrum of mental health (The Centre for Mental Health, 2012). The most commonly used definition of recovery is by Anthony (1993, p. 527), who describes it as a "deeply personal process of changing one's attitudes, values, feelings, goals, skills, and/or roles", a way of "living a satisfying, hopeful, and contributing life even with the limitations caused by illness", in order to "grow beyond the catastrophic effects of mental illness".

The mentally disordered offender (MDO) population represents a sub-group of the population who struggle with severe and enduring mental illness, alongside the added complexity of a criminal past.

MDOs are individuals who have committed a crime but for whom the Crown Court decides that, due to a severe mental illness, they would be better served in a secure forensic hospital, rather than prison (Ministry of Justice (MOJ), 2009). These patients are commonly held under Section 37 of the Mental Health Act (MHA) (1983, as amended 2007). Unlike a traditional prison sentence Section 37 does not have a

fixed end date but must be reviewed every six months by process of tribunal. The length of stay is therefore uncertain, dependent not only on the severity and nature of the crime but on the continuing mental health of the patient. For patients deemed to be a severe risk to public safety a Section 37 may also be combined with a Section 41, known as a Restriction Order. The Restriction Order adds greater restrictions and gives authority over decisions made about the patient to the MOJ, rather than the responsible clinician. A Section 41 may also continue when the patient is discharged into the community and requires adherence to certain conditions (similar to parole), with possible recall to hospital if these conditions are not met.

Risk reduction and management is considered the primary focus while working with this client group (Pilgrim, 2007), with the primary aim of protecting staff, public and other patients. While this is understandable, many argue it creates a highly restrictive and regimented environment in which it is difficult to foster and nurture recovery. (Centre for Mental Health, 2013; Clarke, Lumbard, Sambrook, & Kerr, 2015; Pouncey & Lukens, 2010; Turton et al., 2011).

Despite this apparent incompatibility between recovery and the secure environment, inpatient MDOs must work towards recovery and subsequent discharge into the community. On average, 500 patients are discharged from secure forensic units each year in the UK (Ministry of Justice, 2017). These individuals must make the transition from the highly restrictive and regimented secure environment back into the community, where they are expected to be more autonomous and self-sufficient. For this reason, access to inpatient recovery-focused interventions are crucial.

The principle of 'equity of access' to healthcare (Oliver, & Mossialos, 2004) states that all groups (especially those who are socially or economically disadvantaged) should have access to the same interventions as the general population,

if these interventions are deemed to be of benefit to health. This principle has subsequently formed a major part of current UK health policy (Health and Social Care Act, 2012; NHS England, 2015) and highlights the importance of providing inpatient MDOs with access to recovery-focused interventions, even though there may be challenges to implementing these in a secure setting.

In addition to this, NICE guidance (2016) recommends that care and support for people transitioning from inpatient mental health settings to the community should be person-centred and focused on recovery.

Concepts of Recovery

It is widely acknowledged that recovery is difficult to define in exact terms. This is due to its complex, multifaceted and idiosyncratic nature, and the fact that it is often used to refer to both process and outcome (Resnick et al., 2005). This can result in some confusion about which dimensions of recovery should be assessed.

Elliss and King (2003) raise concerns in relation to adherence to the Recovery Model in practice. They argue that, although the idea of recovery has become enshrined within policy and planning statements, there is often a gap between the adoption of recovery in principle and the implementation and fidelity to recovery in practice.

Some authors have attempted to clarify the components of the Recovery Model and this is important in order to reliably test the effectiveness of recovery-focused interventions. Resnick et al. (2005) developed an empirical conceptualisation of the recovery model using factor analysis. The authors measured aspects of subjective experience using data from a large (N=1,076), systematic study of schizophrenia and

identified four key concepts of recovery: (1) Knowledge: knowledge of mental health and of the mental health systems in which the individual is situated; (2) Empowerment: instilling self-responsibility, promoting autonomy and personal choice; (3) Hope and optimism: nurturing optimism and hope for the future, while encouraging the development of skills and ambition; and (4) Life satisfaction: supporting the nurturing of family and social networks, and providing support to become a valued member of society, with the opportunity to work and to access mainstream facilities and activities.

One important recovery concept not covered within Resnick et al.'s (2005) conceptualisation, but which has been identified by Bonney and Stickley (2008) and others (Coffey, 2012; Hall, Wren, & Kirby, 2013), is that of identity. These authors argue that mental health problems present a challenge to self-concept, creating a need to integrate experiences in order to redefine identity along more positive lines. They also argue the specific need for MDOs to develop a positive, social identity as they re-integrate into mainstream society.

Importantly, research has suggested that recovery principles are considered a high priority by forensic service users themselves. Clarke et al. (2016) carried out a narrative synthesis of the qualitative literature on forensic mental health patients' own perceptions of recovery. They found themes consistent with the principles of recovery identified in the literature of: connectedness, a sense of self and coming to terms with the past, freedom, hope and health.

Those experiencing serious mental illness are one of the most excluded and disadvantaged groups in society (Social Exclusion Unit, 2004). These individuals must try to define a meaningful life after mental illness, in tandem with overcoming the secondary effects of mental illness, which commonly include: problems of functional impairment, finding meaningful vocation, and fostering healthy relationships with

family and friends. MDOs must achieve these same tasks but within a more challenging environmental context (Simpson & Penney, 2011; Drennan & Wooldridge, 2014).

Discharge from a secure unit can be lengthy, often occurring over months or even years, particularly if the patient is subject to a Section 41 Restriction Order. MDOs can therefore find it challenging adjusting to life in the community; grappling with new-found responsibilities and greater autonomy, establishing new social networks in the context of continuing restrictions, maintaining their mental health, and avoiding falling into offending behaviours (Nolan, Bradley, & Brimblecombe, 2011).

The Bradley report (2009), while specifically addressing the prison population, emphasised the importance of recovery factors, such as social inclusion, in reducing re-offending. Given these considerations, the importance of embedding recovery, consistently, within secure units is self-evident.

Research Questions

Ward-based interventions and programmes are becoming more widely used in secure forensic units (Cloyes, 2007; Duncan, Nicol, Ager, & Dalgleish, 2006), with programmes primarily run on medium and low secure wards with patients on the path toward discharge into the community. Medium and low secure settings use the Recovery Model as a framework for care, in-line with general services (Young & Gudjonsson, 2007), and therefore it is important to evaluate the extent to which the interventions provided address the needs of recovery principles.

This systematic review explores the extent to which current interventions and programmes for the inpatient MDO population adhere to principles of the Recovery Model as adapted from Resnick et al. (2005).

The review addresses the following aims:

1. To explore the extent to which the content and aims of reported interventions fit with the recovery principles of: (a) Empowerment, (b) Life-satisfaction, and (c) Identity.

2. To explore the extent to which recovery principles are reflected in assessment instruments used to evaluate the effectiveness of the intervention.

Method

Establishing the Recovery Framework

In order to clearly and systematically evaluate the interventions in this review against the Recovery Model the conceptualisation by Resnick et al. (2005) was used as a framework. Owing to the fact that this conceptualisation applied to the Recovery Model as a whole, the framework was tailored to include only those components most relevant to interventions with the MDO population. As a consequence, the Knowledge component was removed based on the assumption that all interventions would impart some knowledge of mental health or mental health systems. The Hope and Optimism component was also removed, as it was difficult to objectively evaluate the presence of this within an intervention. Lastly a component of Identity was included, which has

been consistently identified elsewhere in the literature as an important recovery principle for MDOs.

The final conceptualisation included the following components (Sub-components of the framework can be found in Figure 1).

1. *Empowerment*

   The acquisition of positive skills, efficacy and agency. Instilling self-responsibility, promoting autonomy and personal choice.

2. *Life Satisfaction*

   Refers to life functioning and well-being. Involves individuals being supported to nurture family and social networks; alongside gaining access to mainstream facilities and activities.

3. *Identity*

   Refers to self-image, confidence and self-concept. Involves developing a positive, integrated sense of self, coming to terms with the past, and reclaiming identity.
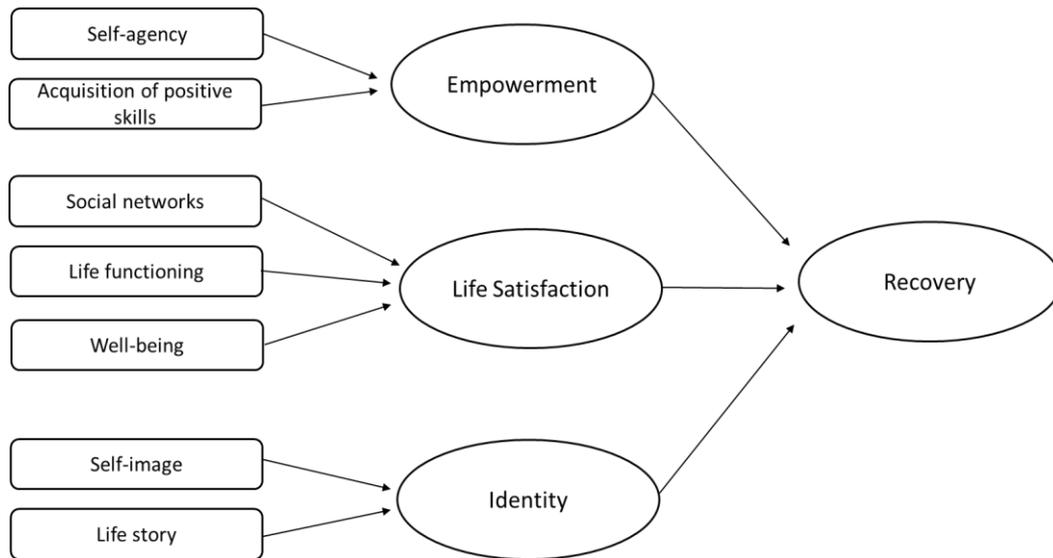
Figure 1. A recovery framework adapted from Resnick et al. (2005), showing components and subcomponents of the Recovery Model as applied to interventions for inpatient MDOs.

Inclusion and Exclusion Criteria

Studies were included if they met the following criteria: (1) the target population was exclusively forensic inpatients detained on high, medium or low secure units, over the age of 18; (2) the study evaluated an inpatient intervention or programme; (4) the study was published in a peer-reviewed journal; (5) the study was reported in English, and carried out in the UK; and (6) the study was published between January 2007 and February 2018.

Owing to the paucity of literature on the subject, all research designs were included, except single case designs. The review was limited to studies conducted in the UK due to differences in the secure care pathway from country to country. Due to the heterogeneity of the study designs and outcomes, formal meta-analysis was not appropriate and a narrative synthesis approach was adopted.

Systematic Search Strategy

A brainstorm approach was first used to generate initial search terms. Keywords from relevant articles were then integrated into further searches. Different combinations of search terms were generated to further increase the sensitivity of the search (see Table 1).

Table 1. Search terms

Search Term	Synonyms
Intervention	Mediate
	Group
	Action
	Therapy
	Group therapy
	Group work
	Social skills training
	Social problem solving
	Skills training
	Offending behavio?r programme
	Offender behavio?r programme
	Group
	Social problem-solving skills programme
	Therapeutic communities
Recovery	Recovery
	Recovery model
	Empowerment
	Knowledge
	Hope and optimism
	Life satisfaction
	Quality of life
Forensic	Mentally disordered offenders
	Mentally ill
	Mentally ill offenders
	Mentally unwell
	Mentally unwell offenders
	Poor mental health
	Criminal offence
	Offending behaviour
	Offence
	Offender
	Section 37
	Section37/41
	Restriction order
Discharge	Pre-discharge
	Approaching discharge

To identify studies meeting the inclusion criteria, PsycINFO, Embase, CINAHL and Web of Science were searched for entries containing keywords and terms in Table 1, in the title, keywords or abstract.

The systematic search strategy in Table 2 was adapted for the different search platforms using a combination of free text and thesaurus searches. A hand search of clinically relevant journals including the 'Journal of Criminal Behaviour and Mental Health' and the 'British Journal of Forensic Practice' was conducted along with searches of the Cochrane and NICE databases.

Potentially eligible studies were selected on title and abstract. Full papers were then obtained and matched against the inclusion criteria. Studies were rejected at each stage based on the following: the sample was not exclusively inpatient MDOs, the study did not evaluate an intervention.

Table 2. Systematic search strategy

	Terms	Results
1	Mentally Ill Offenders or exp Forensic Psychiatry/ or exp Criminals/	22188
2	"mentally disordered offenders".mp. [mp=title, abstract, heading word.	658
3	forensic.mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword, floating subheading word]	19569
4	1 or 2 or 3	35513
5	"skills program* ".ab,id,tc,ti.	1215
6	"skills training".ab,id,tc,ti.	9332
7	"offender behavio?r program* ".ab,id,tc,ti.	5
8	"offender behaviour program* ".ab,id,tc,ti.	2
9	5 or 6 or 7 or 8	10367
10	4 and 9	138
11	limit 10 to (human and english language and "300 adulthood <age 18 yrs and older>" and "0110 peer-reviewed journal") [Limit not valid in Embase; records were retained]	31

Quality Assessment

The studies were then subjected to quality assessment using the Effective Public Health Practice Project 'Quality Assessment Tool for Quantitative Studies' (EPHPP) (Thomas, Ciliska, Dobbins, & Micucci, 2004). The EPHPP is shown to have moderate to good inter-rater reliability (Kappa between 0.61 and 0.77) (Armijo-Olivio, Stiles, Hagen, Biondo, & Cummings, 2012; Thomas et al., 2004), and was chosen due to its applicability both to non-randomised and randomised- controlled trials, and its specificity for intervention studies.

The EPHPP assesses studies on the following areas: (a) selection bias; (b) study design; (c) confounders; (d) blinding; (e) data collection methods; (f) withdrawals and dropouts; and (g) analysis, giving each a rating of Strong, Moderate or Weak. Studies with zero weak scores are given a final rating of Strong, those with one weak score are given an overall rating of Moderate, and those with two or more weak scores are given an overall rating of Weak (see Appendix A for EPHPP quality assessment form).

Since the intention of the current review was to explore adherence to recovery principles rather than establish effectiveness of the interventions, studies with a Weak rating were not automatically excluded from the review if the weak ratings occurred in the following areas: confounding, blinding, withdrawals and dropouts, and analysis. Although robustness in these areas is important (e.g. high withdrawals and drop-outs could indicate poor acceptability of an intervention), the challenges of conducting research with this population must be acknowledged and factored into the quality assessment. For example: the forensic population can be difficult to engage in interventions such as these; the forensic population is highly transient and discharge and transfer can happen at short notice; and researchers must often choose from a small pool of potential participants making matching difficult.

Results

An initial search of PsycINFO, Embase, CINAHL and Web of Science, including the term 'recovery', yielded zero results. The word recovery was then removed from the search (Table 2: 1 – 10), as it was assumed that some interventions may adhere to recovery principles without explicitly naming the intervention as

recovery-focused. A total of 31 articles were retrieved under this broader search. An additional 14 studies were identified through hand searches of relevant articles and journals (one of which was explicitly recovery-focused), totaling 45 articles. These articles were then screened against the inclusion criteria leaving 10 studies. Exclusion reasons for the remaining 24 studies are given in Figure 2.
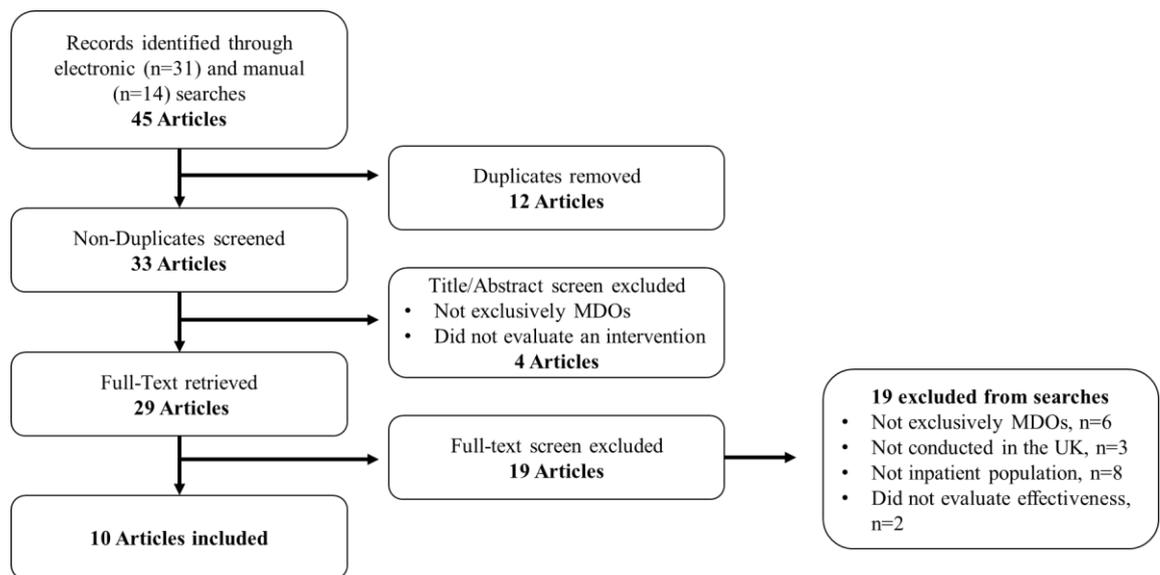
Figure 2. Study selection diagram

Quality Ratings

Four studies were rated Strong (Clarke, Cullen, Walwyn, & Fahy, 2010; Jotangia, Rees-Jones, Gudjonsson, & Young, 2015; Tapp, Fellowes, Wallis, Blud, & Moore, 2009; Yip et al., 2013), three were rated Moderate (Cullen et al., 2012; Laithwaite et al., 2009; Rees-Jones, Gudjonsson, & Young, 2012), and four studies were rated Weak (Fitzgerald, 2011; Long, Fulton, & Dolley, 2013; Young, Chick, & Gudjonsson, 2010). Blinding, analysis, design and selection bias were the most prominent areas of weakness across the studies.

Table 3. Effective Public Health Practice Project (EPHPP) quality ratings

Study	Clarke et al.	Cullen et al.	Fitzgerald	Jotangia et al.	Laithwaite et al.	Long et al.	Rees-Jones et al.	Tapp et al.	Yip et al.	Young et al.	
	2010	**2012**	**2011**	**2015**	**2009**	**2013**	**2012**	**2009**	**2013**	**2010**	
Study design	NRBS	RCT	NRBS	NRBS	NRWS	NRBS	NRBS	NRBS	NRBS	NRBS	
Sample source	2 sites	6 sites	1 site	6 sites	1 site	2 sites	10 sites	1 site	1 site	2 sites	
N	35	84	43	38	19	34	121	83	59	70	**Summary scores**
a. *Selection bias*	2	1	1	1	2	2	2	2	2	1	16
b. *Design*	2	1	2	2	1	2	1	2	2	2	17
c. *Confounders*	1	1	1	1	1	3	2	1	1	3	15
d. *Blinding*	2	3	3	2	2	3	3	2	2	3	25
e. *Data collection methods*	1	1	1	1	1	1	1	1	1	1	10
f. *Withdrawals and dropouts*	1	1	3	1	1	1	1	2	1	1	13
g. *Analysis*	1	1	2	2	3	2	2	2	1	2	18
Overall score	1=Strong	2=Moderate	3=Weak	1=Strong	2=Moderate	3=Weak	2=Moderate	1=Strong	1=Strong	3=Weak	

NRBS = non-randomised between subjects; RCT = randomised-controlled trial; NRWS = non-randomised within subjects; 1=strong; 2= moderate; 3 = weak. For Summary scores higher numbers indicate poorer performance in that area with a maximum of 30 and a minimum of 10.

Study Characteristics

Full study characteristics can be found in Table 4. Sample sizes ranged from 19 to 121. One study used a randomised-controlled design (Cullen et al., 2012), the remaining nine studies used a non-randomised controlled design (eight between-groups and one within-groups (Laithwaite et al., 2009)). Three studies used an exclusively high secure sample (Laithwaite et al., 2009; Tapp et al., 2009; Yip et al., 2013); one used an exclusively medium secure sample (Cullen et al., 2012); and one used an exclusively low secure sample (Fitzgerald, 2011), the remaining five studies used a mixture of medium/low or high/medium. Seven studies recruited male participants, two female (Jotangia et al., 2015; Long et al., 2013), and one used a mixed male and female sample (Fitzgerald, 2011).

Table 4. Study characteristics

Study		N	Security Level	Intervention Type	Study Design	Outcome Measures	Study Reported Significant Improvement on one or More Outcome	Effect Size Reported
Clarke et al.	2010	35 (male =100%)	Medium/ Low	R&R	NRBS	*Social Problem-Solving Inventory Revised-Short Form (SPSI-RS; D'Zurilla, Nezu, & Maydeu-Olivares, 2002).* *Coping Responses Inventory (CRI; Moos, 1993).* *Crime Pics II (Frude, Honess, & Maguire, 1998).*	X	
Cullen et al.	2012	84 (male =100%)	Medium	R&R	RCT	*Social Problem-Solving Inventory Revised-Short Form (SPSI-RS; D'Zurilla, Nezu, & Maydeu-Olivares, 2002).* *Crime Pics II (Frude, Honess, & Maguire, 1998).* *Novaco Anger Scale and Provocation Inventory (NAS-PI; Novaco, 1994).* *Blame Attribution Inventory (Gudjonsson & Singh, 1989).* *Interpersonal Reactivity Index (Davis, 1980).*	Xx[1]	Medium
Fitzgerald	2011	43 (male =84%)	Low	SIP	NRBS	*Model of Human Occupation Screening Tool (MOHOST; Parkinson, Forsyth, & Kielhofner, 2006).*	X	
Jotangia et al.	2015	38 (male =0%)	Medium/ Low	R&R	NRBS	*Maudsley Violence Questionnaire (MVQ; Walker & Gudjonsson, 2006).*	x[1]	Large

Laithwaite et al.	2009	19 (male =100%)	High	CFT	NRWS	*Locus of Control Scale (LoS; Nowicki & Duke, 1974).* *Social Problem-Solving Inventory Revised-Short Form (SPSI-RS; D'Zurilla, Nezu, & Maydeu-Olivares, 2002).* *Novaco Anger Scale and Provocation Inventory (NAS-PI; Novaco, 1994).* *Disruptive Behaviour and Social Problem Scale (DBSP; Young, Gudjonsson, Ball, & Lam, 2003).* *Social Comparison Scale (SCS; Allan & Gilbert, 1995).* *The Other as Shamer Scale (OAS; Goss, Gilbert, & Allan, 1994).* *Self-Compassion Scale (Neff, 2003).* *Beck Depression Inventory II (BDI-II; Beck, Steer, & Brown, 1996).* *Rosenberg Self-Esteem measure (RSE; Rosenberg, Schooler, Schoenbach, & Rosenberg, 1995).* *Self-Image Profile for Adults (SIP-AD; Butler & Gasson, 2004).* *Positive and Negative Syndrome Scale (PANSS; Kay, Fiszbein, & Opler, 1987).*	X^1 c	Small
Long et al.	2013	34 (male =0%)	Medium	DBT	NRBS	*Inventory of Interpersonal Problems (IIP-32; Barkham, Hardy, & Startup, 1996).* *Generalised Self Efficacy Scale (GSES; Jerusalem & Schwarzer, 1992).* *Camberwell Assessment of Need Forensic Version (CANFOR; Thomas et al., 2003).* *Health of the Nation Outcome Scale-Secure (HoNOS-Secure; Sugarman & Walker, 2007).* *Overt Aggression Scale (OAS; Yudofsky et al., 1986).*	X	

Rees-Jones et al.	2012	121 (male =100%)	Medium/ Low	R&R	NRBS	*Maudsley Violence Questionnaire (MVQ; Walker & Gudjonsson, 2006).* *Locus of Control Scale (LoS; Nowicki & Duke, 1974).* *Social Problem-Solving Inventory Revised-Short Form (SPSI-RS; D'Zurilla, Nezu, & Maydeu-Olivares, 2002).* *Novaco Anger Scale and Provocation Inventory (NAS-PI; Novaco, 1994).* *Disruptive Behaviour and Social Problem Scale (DBSP; Young, Gudjonsson, Ball, & Lam, 2003).*	X[1u]	Small
Tapp et al.	2009	83 (male =100%)	High	ETS	NRBS	*The Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM; Evans et al., 2002).* *Psychological Inventory of Criminal Thinking Styles (PICTS; Walters, 1995).* *Social Problem-Solving Inventory Revised-Short Form (SPSI-RS; D'Zurilla, Nezu, & Maydeu-Olivares, 2002).*	X	
Yip et al.	2013	59 (male =100%)	High	R&R	NRBS	*Novaco Anger Scale and Provocation Inventory (NAS-PI; Novaco, 1994).* *Ways of Coping Scale (WOCS; Lazaruse & Folkman, 1984).* *Social Problem-Solving Inventory Revised-ShortForm (SPSI-RS; D'Zurilla, Nezu, & Maydeu-Olivares, 2002).* *Disruptive Behaviour and Social Problem Scale (DBSP; Young, Gudjonsson, Ball, & Lam, 2003).*	Xx[1u]	Medium/ large
Young et al.	2010	70 (male =100%)	High/ Medium	R&R	NRBS	*Maudsley Violence Questionnaire (MVQ; Walker & Gudjonsson, 2006).* *Ways of Coping Scale (WOCS; Lazaruse & Folkman, 1984).*	X[1]	Small

Social Problem-Solving Inventory Revised-Short Form (SPSI-RS; D'Zurilla, Nezu, & Maydeu-Olivares, 2002).
Disruptive Behaviour and Social Problem Scale (DBSP; Young, Gudjonsson, Ball, & Lam, 2003).

CFT = Compassion Focused Therapy, R&R = Reasoning & Rehabilitation, ETS = Enhanced Thinking Skills, DBT = Dialectical Behaviour Therapy, SIP = Social Inclusion Programme; X = significant improvement on primary outcome measure, x= significant improvement on secondary outcome measure, [1] = power calculated, [u] = underpowered, c = did not adjust for multiple comparisons in analysis; NRBS = non-randomised between subjects; RCT = randomised-controlled trial; NRWS = non-randomised within subjects. All studies used binary definitions of gender (male or female), therefore if male=0% female=100%.

The only study purporting to examine the use of a recovery-focused intervention for inpatient MDOs was by Laithwaite et al. (2009). The authors evaluated the effectiveness of a 20 session intensive group programme called the 'Recovery after Psychosis Programme' in a high secure, female population. This intervention was based on Compassion Focused Therapy (CFT), a third wave CBT approach which focuses on the relationship to the self and others along with fostering compassion and understanding (Gilbert & Irons, 2005).

The programme was divided into three modules: (1) Understanding psychosis and recovery; (2) Understanding compassion and developing the ideal friend e.g. the development of compassionate responses towards self and others; and (3) Developing plans for Recovery after Psychosis e.g. the development of a Recovery After Psychosis (RAP) plan focusing on triggers, early warning signs, responding to setbacks and help-seeking.

The aims of the intervention, as reported by the authors, fulfilled the three recovery principles of: (a) Empowerment: fostering self-agency through identifying value-laden recovery goals; (b) Life satisfaction: encouraging patients to think beyond recovery as merely symptom reduction, to recovery in terms of their environment and their relationships with others; and (c) Identity: helping patients to conceptualise the holistic nature of their mental health problem and the impact of this on various aspects of their lives.

Non-recovery focused interventions

The interventions detailed in the remaining nine studies were not labelled as recovery-focused. These studies were examined to see whether the intervention aims (the desired effects of the interventions) fulfilled any of the three recovery principles.

1. *A manualised group DBT programme.*

Long et al. (2013) tested the effectiveness of a 12 session manualised group cognitive behavioural treatment programme with medium secure female MDOs. The programme was adapted from Dialectical Behaviour Therapy (DBT), a third wave CBT approach focusing on interpersonal relating and emotion regulation (Linehan, 1993).The programme focused on improving interpersonal effectiveness and comprised of three modules: (1) Understanding relationships: e.g. rewarding and unrewarding relationships; (2) Understanding the principles of self-management in relationships: e.g. understanding and recognising needs in relationships; and (3) Skills for self-management in relationships: e.g. teaching skills for improving relationships.

Although not explicitly recovery-focused, the aim of improving interpersonal effectiveness is a key factor in the recovery principle of Life-satisfaction, through improving the quality of relationships and increasing social networks.

2. *A Social Inclusion Programme.*

Fitzgerald (2011) tested the effectiveness of a Social Inclusion Programme (SIP) on occupational functioning for low secure male and female MDOs. This intervention was rooted in occupational therapy practice and based on the bidirectional correlation between mental illness and social exclusion (Fitzgibbon & Cameron, 2007). The programme consisted of five intervention types: (1) leisure; (2) literacy; (3) stepping stone to education; (4) college; and (5) work. These interventions were organised in a hierarchy of complexity, with progression reflecting improvements in service users' presentation and functioning.

The aims of the intervention were to: (a) increase engagement in community-based activity, reducing occupational deprivation; (b) introduce complex task performance and goal-orientated activity; and (c) engage patients in normative learning. Although not explicitly labelled as a recovery-focused intervention, occupational functioning is a key factor in facilitating both Empowerment (through the mechanisms of increased self-agency) and Life satisfaction (through the building of social networks).

3. *Cognitive Skills Programmes.*

Cognitive Skills Programmes (CSP) were by far the most prevalent intervention identified in the sample, with seven out of 10 studies using this framework. CSPs emerged in the 1980's and were originally designed and implemented with non-MDOs. They are robustly structured and manualised group interventions with a focus on improving cognitive flexibility and teaching prosocial skills and values (Ross, Fabiano, & Ewles, 1988).

a. Reasoning and Rehabilitation programme.

By far the most prevalent CSP in the review was the Reasoning and Rehabilitation programme (R&R), with six studies evaluating the effectiveness of the programme on high and medium secure MDO populations, including one randomised-controlled trial (Clarke et al., 2010; Cullen et al., 2012; Jotangia et al., 2015; Rees-Jones et al., 2012; Yip et al., 2013; Young et al., 2010).

The programme was originally developed and evaluated with the prison population (Ross & Fabiano, 1985) and later adapted for MDOs (R&R2) (Young & Ross, 2007). It was formulated on the premise that many offenders have failed to develop core socio–cognitive skills and are therefore less reflective, more impulsive and concrete in their thinking, and more likely to offend (Ross & Fabiano, 1985).

The authors label the R&R programme as a 'Prosocial Competence Training Programme' with the aim of teaching the following cognitive, emotional and behavioural skills: (a) metacognition; (b) emotional competence; (c) interpersonal skills; (d) active listening; (e) relapse prevention; and (d) motivation. They also highlight the importance of building a 'prosocial life story' and developing 'prosocial self-efficacy'; but these are not included in the core programme as topics in their own right.

The programme consists of 16, 90-minute sessions split into five treatment modules that reflect the desired skills: (1) neuro-cognitive (e.g. learning strategies to improve attentional control, memory, impulse control and planning); (2) problem-solving; (3) emotional control; (4) prosocial skills; and (5) critical reasoning. The

authors also stress the importance of facilitating the transition into the community through social inclusion (Young & Ross, 2007).

The stated aims of the programme relate to the three recovery concepts: (1) Life-satisfaction: the nurturing of social networks and relationships through developing emotional competence, interpersonal skills and active listening; (2) developing a positive Identity through building a prosocial life story; and (3) fostering Empowerment through developing prosocial self-efficacy (it is worth noting that two and three are not yet topics in their own right).

b. The Enhanced Thinking Skills Programme.

The second CSP in this review is the Enhanced Thinking Skills (ETS) programme, with one study evaluating its effectiveness for high secure male MDOs (Tapp et al., 2009). The ETS programme developed by Clark (2000), is a 20-session group programme widely delivered in the UK prison and probation service (MOJ, 2009). The areas of focus are similar to those of the R&R programme ((1) self-control; (2) cognitive style; (3) interpersonal problem solving; (4) social perspective taking; (5) moral reasoning; and (6) critical reasoning); however, there is a greater emphasis on reducing criminal thinking, and no adaptations currently exist for MDOs.

3.1 Prescribed aims of individual studies using Cognitive Skills Programmes, in relation to recovery principles.

It was acknowledged that studies testing well-established CSPs may vary in their fidelity to the model. For this reason, the aims of the individual CSP studies included in the review were examined in relation to the aims of the manual and the three recovery principles.

With regards to the R&R studies, although the R&R manual prescribed some recovery-focused aims, four out of the six studies using the R&R intervention (Clarke et al., 2010; Jotangia et al., 2015; Rees-Jones et al., 2012 & Young et al., 2010) did not state aims that could be matched to Life satisfaction, Empowerment or Identity, instead aiming solely to reduce criminal thinking or violent attitudes and behaviour (see Table 5.). Two R&R studies (Cullen et al., 2012 & Yip et al., 2013) described two recovery-focused aims, which related to Empowerment (locus of control) and Life-satisfaction (social functioning) (see Table 5.).

The study using the ETS intervention (Tapp et al., 2009) did not report any recovery-focused aims. This is perhaps not surprising considering the original manual's focus on recidivism and specification for the non-MDO population.

Exploration of Outcome Measures

The outcome measures used in the 10 studies were assessed in relation to whether they measured (a) Empowerment (e.g. acquisition of positive skills, self-efficacy and agency); (b) Life satisfaction (e.g. life functioning and well-being); and (c) Identity (e.g. self-image, self-concept and the self in relation to others).

Seven out of the 10 studies, and all six R&R studies, did not employ a measure of life satisfaction or well-being to test for effectiveness. Even some studies whose

aims fulfilled all three recovery principles (Fitzgerald, 2011) did not use a measure of well-being as part of their evaluation (see Table 6).

Studies using CSPs (R&R & ETS) were more likely to use recovery-focused measures related to empowerment and the acquisition of positive skills (e.g. the Social Problem-Solving Inventory (D'Zurilla, Nezu, & Maydeu-Olivares, 2002) and the Ways of Coping Scale (Lazarus & Folkman, 1984)).

Eight out of the 10 studies used non-recovery-focused outcome measures, which measured the reduction in undesirable qualities or criminal traits, e.g. violent attitudes (The Psychological Inventory of Criminal Thinking Styles, (Walters, 1995)) (see Table 6). Four out of six R&R studies used violent attitudes as their primary outcome measure (Jotangia et al., 2015; Rees-Jones et al., 2012; Yip et al., 2013 & Young et al., 2010), despite the R&R manual's stated primary objective of developing socio-cognitive skills.

Table 5. Intervention aims in relation to recovery principles

Study	Clarke et al.	Cullen et al.	Fitzgerald	Jotangia et al.	Long et al.	Rees-Jones et al.	Tapp et al.	Yip et al.	Young et al.
	2010	2012	2011	2015	2013	2012	2009	2013	2010
N	35	84	43	38	34	121	83	59	70
Recovery focused aims									
a. *Empowerment*	-	X	X	-	-	X	-	-	-
b. **Life** *satisfaction*	-	X	X	-	X	X	-	-	-
c. *Identity*	-	-	X	-	-	-	-	-	-

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Table 6. Study outcomes in relation to recovery principles

Study	Clarke et al. 2010	Cullen et al. 2012	Fitzgerald 2012	Jotangia et al. 2015	Laithwaite et al. 2009	Long et al. 2013	Rees-Jones et al. 2012	Tapp et al. 2009	Yip et al. 2013	Young et al. 2010
N	3	5	1	5	5	4	5	3	5	4
Recovery focused OM										
a. Empowerment	X	X	-	X	-	-	X	X	X	X
b. Life satisfaction	-	X	X	-	X	X	-	X	-	-
c. Identity	-	-	-	-	X	X	-	-	-	-
Non-recovery focused OM										
d. Reduction in non-desirable qualities	X	X	-		-	X	X	X	X	X

OM = outcome measure.

Findings of Reviewed Studies

All studies reported statistically significant improvements post-treatment on at least one primary outcome measure assessing psychosocial functioning (nine studies on the primary measure and one study (Jotangia et al., 2015) on a secondary measure (see Table 4, p. 30). Only six studies reported effect sizes, which are important in establishing the size and clinical importance of a statistically significant change (Cohen, 1988; Kirk, 1996; Vacha-Haase, 2001). Three studies reported small effect sizes (Laithwaite et al., 2009; Rees-Jones et al., 2012; Young et al., 2010), two medium (Cullen et al., 2012; Yip et al., 2013), and two large (Jotangia et al., 2015; Yip et al., 2013).

It is worth noting other potential methodological short-comings of several of the studies highlighted in the EPHPP quality assessment (see Table 3), including the confounding effects of sampling bias, attrition, small sample sizes, a lack of matching or randomisation, and the fact that only four out of 10 studies used power calculations to determine the required sample size (Cullen et al., 2012; Jotangia et al., 2015; Rees-Jones et al., 2012; Yip et al., 2013), two of which were underpowered (Rees-Jones et al., 2012; Yip et al., 2013).

The self-report nature of the majority of outcome measures used to examine the effectiveness of the interventions must also be taken into account. The in-patient MDO population is a group with a vested interest in reporting socially desirable answers in order to show readiness for discharge and this therefore raises the risk of response bias.

Several studies also found less improvement on some indices compared with the treatment as usual group (e.g. negative problem orientation (Cullen et al., 2011; Rees-Jones et al., 2012)).

Discussion

The aim of this systematic review was to explore the extent to which interventions for the inpatient MDO population were recovery-focused, by measuring their aims and outcomes against concepts of the Recovery Model adapted from Resnick et al. (2005). The findings of this review highlight the continuing paucity of research with the inpatient MDO population, particularly with regards to recovery-focused, ward based interventions.

The challenge of facilitating independence and recovery in ward settings is widely acknowledged (Clarke et al., 2016; Henagulph, McIvor; Clarke, 2012; Pouncey & Lukens, 2010; Turton et al., 2011), and may be partly responsible for the lack of recovery-focused interventions. The fact that risk management and reduction take precedence over promoting autonomy (Pilgrim, 2007) creates an environment which, contrary to facilitating recovery, contributes to experiences of occupational deprivation, underachievement, low motivation and low self-esteem.

In relation to the focus on risk management, the findings of this systematic review show there is a tendency to judge the effectiveness of interventions by a reduction in criminal traits or undesirable qualities (e.g. violent attitudes), as opposed to the acquisition of positive traits, skills or values. Measuring progress merely by the absence of a trait is not in line with recovery principles.

The tendency to equate the reduction in undesirable qualities with effectiveness and eventual reduction in offending, may have negative implications for the long-term benefits of these interventions. Chadwick (2002), Kelly and Gamble (2005), and Repper and Perkins (2003) argue that a holistic recovery process is needed to facilitate true personal growth, where one changes attitudes and values, leading to a higher level of functioning and a greater chance of long-term recidivism.

Ryan and Deci's (2000) theory of intrinsic and extrinsic motivation also supports the idea of sustained, longer-term outcomes from a more holistic, values-based approach. This theory stresses the difference between intrinsically motivated activities (e.g. those activities performed because of the pleasure and satisfaction of the activity itself; linked to personal goals and values) and extrinsically motivated activities (e.g. behaviours performed to achieve an external outcome, such as attainment of a reward or avoidance of a sanction; less value-oriented). Ryan and Deci (2000) argue that intrinsically motivated activities are more likely to continue unmonitored and that extrinsically motivated practies must be internalised and actively embraced by the individual in order to be sustained.

Crucially, the lack of recovery-focused interventions for inpatient MDOs suggests that the 'equity of access' principle (Oliver & Mossialos, 2004) is not being fulfilled with this population. This is despite NICE guidance (2016), strongly recommending that people transitioning from inpatient mental health settings to the community are supported with a person-centred and recovery-focused approach.

Another important finding of this review relates to the way inpatient interventions are labelled, or 'sold' to commissioners and the public. Although some interventions adhered to one or more recovery principles, these were not labelled as recovery-focused. This suggests a reluctance to frame interventions for inpatient

MDOs as recovery-focused, which is in stark contrast to other populations. A brief search of PsycINFO titles generated over 200 articles relating to recovery-focused interventions for: mental health, substance use, asylum seekers, and psychosis, amongst others.

The lack of explicit reference to the Recovery Model for inpatient MDOs could be driven by several factors. The first relates to implicitly held beliefs and attitudes towards offenders in terms of punishment and rehabilitation. Although the importance of rehabilitation for offenders is now widely accepted (Grimwood & Berman, 2012), there has long existed a narrative that punishment should supersede rehabilitation, and that fostering recovery principles (e.g. Empowerment, Life satisfaction and positive Identity) diminishes the punishment offenders should be receiving whilst incarcerated.

This narrative is arguably promoted by the Ministry of Justice (2010), which, for example, applauds the Enhanced Thinking Skills Programme for its ability to reduce immediate reconviction rates of non-mentally disordered offenders, whilst neglecting to evaluate or highlight its effectiveness for other aspects of recovery. Clinicians and researchers working with offender populations may feel interventions have to be framed as 'risk-reducing' rather than 'recovery-promoting' in order to be embraced.

These points relating to effectiveness as a reduction in undesirable qualities is relevant when we consider that several studies did not employ a measure of well-being, even though this is routine with other populations. Is this driven by the implicit belief that MDOs do not deserve to recover? Lerner's (1978) Just World Hypothesis can be used to further explore this. The 'Just World hypothesis' theorises that people are motivated to believe that the world is a just place where people get what they deserve and deserve what they get. The belief in a 'just world' serves adaptive functions, and

individuals will try to protect this belief when they are confronted with injustice. In relation to MDOs, this phenomenon could make it difficult for individuals and institutions (e.g. MOJ) to look beyond the criminal activity; even though it is widely accepted that offending is positively correlated with social deprivation, adversity, poverty and childhood trauma (Allen et al., 2014; Davidson & Mcglashan, 1997).

Cognitive skills programmes (CSP) are one such group of programmes operating primarily in a risk-focused way. CSPs were the most frequently evaluated interventions found in this review; however, they were also the least recovery-focused in the way they were implemented in practice. For example, even though the R&R2 (Young & Ross, 2007) programme details some recovery-focused aims, many studies using this framework described none, placing emphasis instead on the reduction in violent attitudes as a measure of the effectiveness of the intervention. It therefore seems as though there is a mismatch between the intentions of some programmes and the way they are implemented in practice.

The nature of CSPs also generates a focus on specific skills and not wider contextual principles, like those found in the Recovery Model. This raises questions around whether the content can be generalised outside the programme or delivery setting, and may produce a disparity between what these programmes purport to deliver and what they actually deliver.

The findings of this systematic review indicate that that the current emphasis on risk management and reduction is negatively impacting the implementation of meaningful recovery-focused interventions for inpatient MDOs, which are crucial considering eventual discharge into the community. This review highlights the importance of managing risk alongside recovery in secure inpatient settings so that

recovery-focused interventions can be facilitated; and suggests that risk reduction needs to be considered within a recovery context.

A Recovery Approach to Risk Management

Repper and Perkins (2016) have proposed a recovery-focused approach to risk and safety called 'recovery-focused safety planning'. It is based on co-produced safety plans that enable patients to do the things they value, as safely as possible, offering the opportunity to pursue aspirations and personal growth. The authors propose four steps toward this: (1) moving away from managing risk to promoting safety and opportunity; (2) using co-produced safety plans to create a shared responsibility for safety; (3) supporting the individual's personal recovery plans; and (4) nurturing trusting relationships between services and MDOs, based on the understanding that trust is a two-way process.

A recovery-focused approach to risk would create inpatient environments more conducive to facilitating recovery-focused interventions. Certain recovery based approaches can be used to shape these interventions, such as the Good Lives Model (GLM) and the Life Skills Programme (LSP).

The Good Lives Model

The Good Lives Model (GLM) (Ward & Brown, 2004) is a strengths-based approach to offender rehabilitation. Increasingly trialed in prison services and with youth offenders (Fortune, 2017; Ziv, 2017), it uses a holistic approach, in line with the recovery principles of Empowerment, Life-satisfaction and Identity. The GLM

assumes that everyone has similar aspirations and needs, and that offending behaviour occurs when individuals lack the internal and external resources to satisfy their values using pro-social means (Ward & Stewart, 2003). The model therefore aims to assist offenders to construct and achieve meaningful life plans that are incompatible with future reoffending (e.g. promoting individuals' personal goals while reducing and managing their risk for future offending) (Laws & Ward, 2011; Ward & Maruna, 2007).

Life Skills Programmes

LSPs also take a more recovery-focused approach, in line with the GLM. They arose out of a multidisciplinary movement towards promoting effective psychosocial functioning, rather than reducing pathology, based on the theory that reductions in criminal activity will follow (Segrin & Givertz, 2003). This approach focuses on developing competence and practical skills in five main areas of human functioning: (1) self; (2) family; (3) leisure; (4) community; (5) and job/education (Conger & Mullen, 1981; Reddon et al., 2008). The model is based on the theory that some individuals have skills deficits (e.g. goal setting and active listening) that are generally acquired via social learning during childhood. These skills fail to adequately develop due to a variety of environmental, cognitive, or emotional factors, leading to poorer well-being and increased likelihood of criminal activity (Gazda & Brooks, 1985; Pratt & Mueser, 2002; Wine & Smye, 1981).

Conclusions and Recommendations

There is currently a startling absence of recovery-focused interventions for the inpatient MDO population and a tendency to frame interventions as risk-reducing rather than recovery-promoting. Some existing programmes do advocate for a recovery focus to some degree (e.g. R&R2), but this is rarely reflected in how these interventions are implemented in practice. With approximately 28% of all patients discharged from secure care returning each year (MOJ, 2017) and each additional stay costing an average of £165,000 per year (Centre for Mental Health, 2017), there is a strong argument for recovery-focused interventions alongside recovery-focused risk planning to improve long term outcomes and reduce readmission rates.

Existing, widely used interventions, such as the R&R programme must be adapted to become more in line with the recovery principles of Empowerment, Life-satisfaction and Identity. Recovery-focused interventions (informed for example by the Good Lives Approach and the Life Skills Approach) should be implemented, tested and replicated.

It is now widely agreed that treatments for offenders, mentally disordered or otherwise, should aim to improve mental health and well-being alongside reducing offending behaviour (Grimwood & Berman, 2012; McMurran, Khalifa, & Gibbons, 2013). Specifically, the importance of the rehabilitation of MDOs is widely accepted, with service models for inpatient care emphasising recovery principles (e.g. relapse prevention, improving prosocial and independent living skills and facilitating re-integration into the community (Jotangia et al., 2015; Young & Gudjonsson, 2007)). It is therefore crucial that accompanying interventions and programmes adhere to these same recovery principles, and that an effective balance can be struck between risk management and personal recovery.

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Part Two: Empirical Paper

Service Users' Experiences of Conditional Discharge from a Medium Secure Unit

Abstract

Aims

      This project aims to explore the experiences and attitudes of service users who have been conditionally discharged from a medium secure forensic unit (MSU) from a Section 37/41. By drawing on concepts of recovery I hoped to explore the following: (a) the experience of increased responsibility and freedom; (b) barriers and facilitators to progress and reintegration into the community; and (c) changes in perceived identity throughout the discharge process.

Method

      Seven individuals from three Forensic Community Teams (FCT) took part in the study, satisfying the following inclusion criteria: male, over the age of 18, discharged between two months and five years ago, without a diagnosed learning disability and not experiencing a deterioration in mental health at the time of interview. Each participant took part in one semi-structured interview regarding their experience of the discharge process.

Results

      Interview transcripts were analysed using thematic analysis, adhering to principles set out by Braun and Clarke (2006). Seven themes were identified (1) The uncertainty of the discharge timeframe; (2) Fear of jeopardising discharge; (3)

Progress; (4) Engagement with community life; (5) Barriers to social engagement; (6) Evolving identity; and, (7) Someone to turn to; along with 11 subthemes.

Conclusions

Conditional discharge from secure care to life in the community, although gradual, is a considerable transition. Challenges include: finding motivation early on in the process, adjusting to greater responsibility and autonomy in the community, and building new social networks once conditionally discharged.

The findings highlight the importance of fostering trust between mentally disordered offenders (MDO) and their care team and encouraging help-seeking behaviour. Findings suggest that resources should be sequenced appropriately throughout the discharge process, to match the 'window of engagement' for patients and maximize impact and effectiveness.

Introduction

Discharge from hospital settings following an admission under the Mental Health Act is often challenging, with the experience of patients regularly characterised by loneliness, unemployment, stigma and fear of relapse (Nolan, Bradley, & Brimblecombe, 2011). Conditional discharge from a Medium Secure Unit (MSU) presents additional challenges, stemming from the added restrictions and the dual role

of effective treatment and public protection. Yet, the views of this client group are rarely sought.

This project aimed to explore the experiences of service users who have been conditionally discharged from an MSU, from Section 37/41 of the Mental Health Act (MHA) (1983, as amended 2007).

The Medium Secure Setting

MSUs provide treatment to people with a severe and enduring mental health problem who are assessed to be a risk to others (NHS England, 2018). The security level is lower than in a high secure unit, allowing individuals to work towards rehabilitation and discharge into the community (NHS England, 2018).

Section 37/41

All individuals held in an MSU are detained under the MHA, commonly under Section 37/41. Under Section 37, the Crown Court decides that, instead of going to prison after committing an offence, the person in question would be better served in a secure psychiatric hospital to receive treatment. Section 41 is commonly known as a Restriction Order and is applied in addition to the Section 37, if the patient is deemed to be a risk to public health (Ministry of Justice (MOJ), 2009). It limits the powers of the responsible clinician to make decisions about the patient; and, unlike a traditional prison sentence, does not have a fixed end date but must be reviewed every six months by process of tribunal (MOJ, 2009).

When conditionally discharged into the community that individual will remain under statutory care and will be allocated a number of professionals, whose duty it is, both to support reintegration, and to monitor mental state and risk. More often than not, restricted patients will remain under Section 41 for some time post-discharge (MOJ, 2018) meaning they will be subject to certain conditions and will remain liable to be recalled to hospital if these conditions are not met.

The Secretary of State has powers to recall any restricted person under Section 42 of the MHA (1983, amended 2007), and the decision to recall will largely depend on the degree of risk the individual might pose to others and the gravity and imminence of that risk (MOJ, 2018). Individuals can also be recalled for non-compliance with medication or if formally admitted to a psychiatric hospital.

There are currently approximately 4,811 restricted patients detained in secure hospitals in the UK, with the number of restricted patients conditionally discharged from hospital standing at approximately 2,611 (MOJ, 2018).

Milestones to Discharge

Discharge from a Section 37/41 will only be sought when the level of continuing risk arising from the patient's condition can be safely managed with resources in the community. Prior to this there is a lengthy preparation period involving the patient and their care team, before a formal request of discharge is made to the MOJ (MOJ, 2009).

The process of discharge is marked by milestones which map the staged pathway through and out of secure care. These milestones include: (a) ground leave; (b) escorted community leave; (c) unescorted community leave; (d) overnight stays in

the community; and (e) conditional discharge from hospital (NHS England, 2018). Throughout this process, comprehensive rehabilitative activity is undertaken to facilitate a process of reintegration into the community, including: occupational therapy, psychological treatment and psychiatric treatment.

Current Literature

The management and mitigation of risk is arguably the main focus throughout the forensic discharge process, from the initial granting of Section 17 leave (leave granted for specific therapeutic activities) to managing life in the community. As a result, the majority of the literature in this area examines reoffending and readmission.

Reoffending and readmission

Several studies have analysed the re-offending rates of conditionally discharged patients and have found rates, post-discharge, that range from 30% to 50% (Coid, Hickey, Kahtan, Zhang, & Yang, 2007; Davies, Clarke, Hollin, & Duggan, 2007). Other studies have proceeded to investigate the accuracy of prediction of re-offending once discharged from secure hospital (Coid, Kallis, Doyle, Shaw, & Ullrich, 2015; Fazel, Singh, & Grann, 2012; Yang, Wong, & Coid, 2010). Among this literature there seems to be a consensus that risk management tools such as the HRC-20 (Webster, Douglas, Eaves, & Hart,1997) only go some way to predicting re-offending.

Studies have also analysed the re-admission rates of MDOs. Jewell et al. (2018) followed 101 conditionally discharged MDOs for two years post-discharge and reported readmission rates of 44.5%. Davies et al. (2007) followed over 500

discharged MDOs over a 20-year period and found that 38% were readmitted to hospital at some point within the follow-up. Statistics provided by the MOJ (2018) report that 1,345 patients were readmitted to secure care in 2017, this means that 28% of all those admitted in 2017 were re-admissions.

Lived experience in the literature

Although research concerning risk is valuable, the focus on this specific area of discharge has led to a distinct lack of research into the broader, lived experience of discharge from secure forensic units.

One of the few studies to focus on the lived experience of discharge was by Coffey (2012), who interviewed patients and staff about their understandings of the discharge process. The primary focus of analysis became the notion of identity, specifically the challenges associated with creating "non-deviant" identities in the outside world. The findings suggested that certain factors made this more challenging, primarily the continued supervision and monitoring, which could make it difficult for individuals to gain distance from the past and form new, more positive, identities.

In a separate qualitative study, the same author (Coffey, 2013) found a high prevalence of references to time across the dataset. The author hypothesised that this served the dual purpose of helping to order discharge experiences, whilst also establishing distance between the present self and the negative events of the past. Coffey (2013) also noted that patients tended to compare themselves with others who had successfully reached full discharge, creating an unofficial time-frame.

Recovery in Forensic Mental Health

Since the 1980s there has been a consistent move in mental health away from long term, institutional care towards care in the community (Davidson, 2005), with services organised around the 'Recovery Model'. Central to this model is that individuals can live fulfilling lives, while still experiencing residual symptoms of mental illness. Cornerstones of the model are: personal autonomy and empowerment, life satisfaction, social inclusion, hope and optimism and a positive sense of identity (Bonney & Stickley, 2008; Resnick, Fontana, Lehman, & Rosenheck, 2005). The Recovery Model places great emphasis on social recovery in addition to clinical recovery, and the importance of participation in wider society (Anthony, 1993; Repper & Perkins, 2003).

Ryan and Deci (2000) state that in order to foster personal growth and recovery, environments must facilitate the following: (1) competence, (2) relatedness, and (3) autonomy. Due to the necessity of public protection and risk management, secure hospital environments are not naturally conducive to this; however, patients must still work towards recovery while making the transition into the community.

Research Aims

Greater autonomy, responsibility and community integration are the aims of a successful discharge from a secure unit (Gudjonsson & Young, 2007); however, this contrasts with the highly controlled and restricted environment which characterises much of inpatient life. It is therefore important to explore patients' experiences of

adapting to these changes across the discharge process, and to investigate what it is like working towards recovery while transitioning into the community.

This project aims to explore the experiences and attitudes of service users who have been discharged from an MSU, from a Section 37/41 with continuing restrictions in the community, with the hope of gaining a rich, detailed account, contributing to a more effective evaluation of the discharge pathway.

Research aims will explore:

- The experience of increased responsibility and freedom.
- The perceived barriers and facilitators to progress and community reintegration.
- Changes in perceived identity throughout the discharge process.

Method

Participants

Setting

Participants were recruited from five Forensic Community Teams (FCT) within a large inner city mental health trust. These FCTs provide psychiatric care and monitoring to individuals discharged from secure hospitals in the locality. They are multi-disciplinary teams consisting of: psychiatrists, psychologists, community psychiatric nurses, occupational therapists and support staff.

Inclusion and exclusion criteria

Participants were considered for recruitment if they fulfilled the following inclusion criteria:

1. Male (females were excluded due to the small number within the FCTs, and the participation of these individuals in other research).

2. Detained on a Section 37/41 and conditionally discharged from inpatient care, remaining on a Section 41 at the time of interview.

3. Discharged between two months and four years ago.

4. Over the age of 18.

Participants were excluded if:

1. They were currently self-harming.

2. They were currently experiencing a relapse in a diagnosable mental health condition, as judged by their responsible clinician.

3. They had a diagnosed intellectual disability (IQ<70).

Sample Size

Twenty service users were identified as meeting the inclusion criteria and were subsequently invited to participate in the study; seven participants agreed to take part. Several factors can help determine a suitable sample size in qualitative research, including the quality of the data, the method of analysis, and the nature of the study (Morse, 2000). Patton (1990) describes the variability in qualitative samples and the possibility of achieving depth with both small and large samples, depending on the research question. On the basis of this, the sample size was thought to be sufficient for yielding valuable results and achieving saturation.

Participant Demographics

Participant demographics can be found in Table 1. All but one participant were white British. The time since discharge ranged from four months to four years and the length of time in detention ranged from five years to ten years. All participants were living in supported, community accommodation at the time of interview.

The demographics of particular individuals in this sample have been kept intentionally brief to protect participant anonymity. However, patients under the care of the FCTs tend to have a primary diagnosis of paranoid or treatment resistant schizophrenia, and a long-standing history of mental health problems prior to the index offence (the offence for which they were admitted under Section 37/41 of the MHA (1983, as amended 2007)). Index offences can include: manslaughter, grievous bodily harm, sexual offences, arson and robbery, amongst others.

Table 1. Participant demographics

Participant Number	Age Range	Ethnicity	Time Since Discharge	Length of Detention
1	28-34	White British	2 years	5 years
2	48-54	Black Caribbean British	14 months	8 years
3	38-44	White British	2.5 years	5 years
4	48-54	White British	3 years	10 years
5	48-54	White British	4 years	8 years
6	38-44	White British	5 months	8 years
7	38-44	White British	4 months	7 years

Ethics

Ethical approval for this study was obtained through NHS Ethics (Project ID: 17/LO/0786; see Appendix B). All participant data was processed, stored and disposed of in accordance with the Data Protection Act (1998). Every phase of the research was carried out in a way that ensured participants' rights were protected, for example, taking steps to make sure participants did not feel pressured into participating by making it clear that the study was independent of their clinical care.

A speech and language therapist was consulted with regard to the content and layout of the Participant Information Sheet (see Appendix C), advising on accessibility and ease of understanding for the target population.

Procedure

Caseloads were screened by the researcher and members of the FCTs for individuals meeting the inclusion criteria. Suitable participants were first contacted by a FCT clinician, and provided with a brief introductory letter outlining basic information about the study. The researcher then contacted those patients who wished to participate. Written consent was obtained and participants received a £10 supermarket voucher for their time.

Semi-structured interviews

The interview schedule was developed specifically for this study due to the lack of previous qualitative research into this topic. Each participant took part in one semi-structured interview lasting between 60 and 90 minutes and the content of the interviews was directly informed by the research questions. Milestones of the discharge pathway were used as a framework for the schedule (See Appendix E for Interview Schedule).

I referred to the guidelines set out by Barker and Pistrang (2015) for adopting the most appropriate interview style: (a) maintaining a loose structure in order to gain an in depth account of the topic; (b) maintaining an empathic, non-judgmental stance while showing genuine interest; (c) using core therapeutic skills, such as empathy and clinical intuition; (d) giving the respondent plenty of time to talk whilst resisting the urge to put words into his/her mouth; and (e) using mostly open-ended questions which do not restrict the answer, and reduce the degree to which respondents' initial responses are influenced by the researcher's framework.

All interviews were conducted at FCT bases. Participants were given the additional option to conduct the interview within an interview room at their supported accommodation, if this was more convenient.

Thematic Analysis

Qualitative approaches enable the study of more complex aspects of subjective experience, and were therefore most appropriate for this study. The interview data was analysed using thematic analysis (Braun & Clarke, 2006). The particular benefit of thematic analysis in comparison to some other qualitative methodologies is the fact that it is not bound to a specific theoretical framework; this inherent flexibility allows a focus on specific research questions, while also allowing for the identification of potentially unexpected themes.

The following steps recommended by Braun and Clarke (2006) were followed:

1. *Transcription of the data.*

All seven interviews were transcribed by hand, allowing for greater accuracy and detail. The interviews were transcribed in accordance with recommendations from Barker, Pistrang and Elliott (2002) (e.g. verbatim speech content, without information about the tone, loudness or speed etc.) (see Appendix F for an extract of a transcribed interview).

2. *Immersion in the data.*

Transcribing the interviews by hand allowed for a greater level of immersion and familiarisation with the data. I then re-read all transcripts a second time before commencing the coding stage.

3. *Generating initial codes.*

Transcripts were coded by hand, using a process of systematically working through each individual transcript and coding each unit of meaning. All data were coded without directly relating to the research questions. This was to protect against the loss of potential themes or sub-themes. At this stage, some codes were absorbed into others.

4. *Searching for themes.*

Analysis then focused on the broader level of themes, where I began a process of systematically sorting the identified codes. These codes were grouped, using the research aims to merge or discard themes based on meta-level meaning.

5. *Reviewing and redefining themes.*

I then re-examined the themes using Patton's (1987) criteria, which state that categories should be internally homogenous and externally heterogeneous; in other

words, codes should be similar enough to each other to constitute a wider theme, and themes should be different enough from each other to constitute separate constructs.

Quality Evaluation

I adhered to the guidelines set out by Elliott, Fischer and Rennie (1999) for good practice in qualitative research: (a) disclosure of perspective (reflexive statement p.79), including personal characteristics of the researcher that might influence the collection and analysis of the data; (b) adequately describing the sample so that readers can see how far the findings can be generalised; (c) grounding interpretations in the data by demonstrating a link between the primary data and the conclusions drawn; (d) demonstrating coherence of the interpretive framework, providing an integrated picture; and (e) providing credibility checks such as triangulation and testimonial validity.

Reflexive statement

I am a female trainee clinical psychologist in my late 20s, completing my doctorate at University College London. I would classify myself as having transitioned from a working-class to a middle-class background. I am of mixed ethnicity and have entered the profession as a BME (black or ethnic minority) trainee. The above factors have allowed me the opportunity to mix with different socio-economic and cultural groups; this was instrumental to me developing an interest in the contribution of socio-economic factors to mental health and crime.

I have worked clinically with male and female MDO's on medium secure units and in community settings. These experiences led me to develop an interest in research with the MDO population, specifically pathways out of secure care and the process of reintegration into the community.

I gravitate towards a social constructionist standpoint, that human experience is profoundly influenced by culture, history and language (Berger & Luckmann, 2007). I maintain a relativist epistemological position (believing multiple realities are possible).

I endorse the idea that psychological research should prioritise understanding lived experience before generating scientific theories about the world. In line with this is my interest in applied research, which addresses practical questions with the potential for direct clinical implications.

Credibility checks

Inter-rater agreement of themes was established to improve the reliability of the study. This involved asking another researcher to code two randomly selected transcripts. These coded transcripts were then compared to my own initial themes, and the degree to which they corresponded was discussed.

Attempts were made to gather testimonial feedback from the participants. This involved consulting participants on the logic of the coding and the constructing of themes to make sure they accurately reflected their experiences. All participants were sent a summary of the study's themes accompanied by three questions: (a) Does this match your experience? (b) Would you change anything? (c) Would you add anything?

Unfortunately, no participants provided testimonial feedback, with four declining to take part and three not responding.

Themes

Analysis of the data produced seven themes and 11 sub-themes. These were grouped under two clusters pertaining to whether the theme referred mainly to inpatient experience or discharged experience (see Figure 1. for Thematic map). Participants are numbered so that P1 indicates Participant number one.
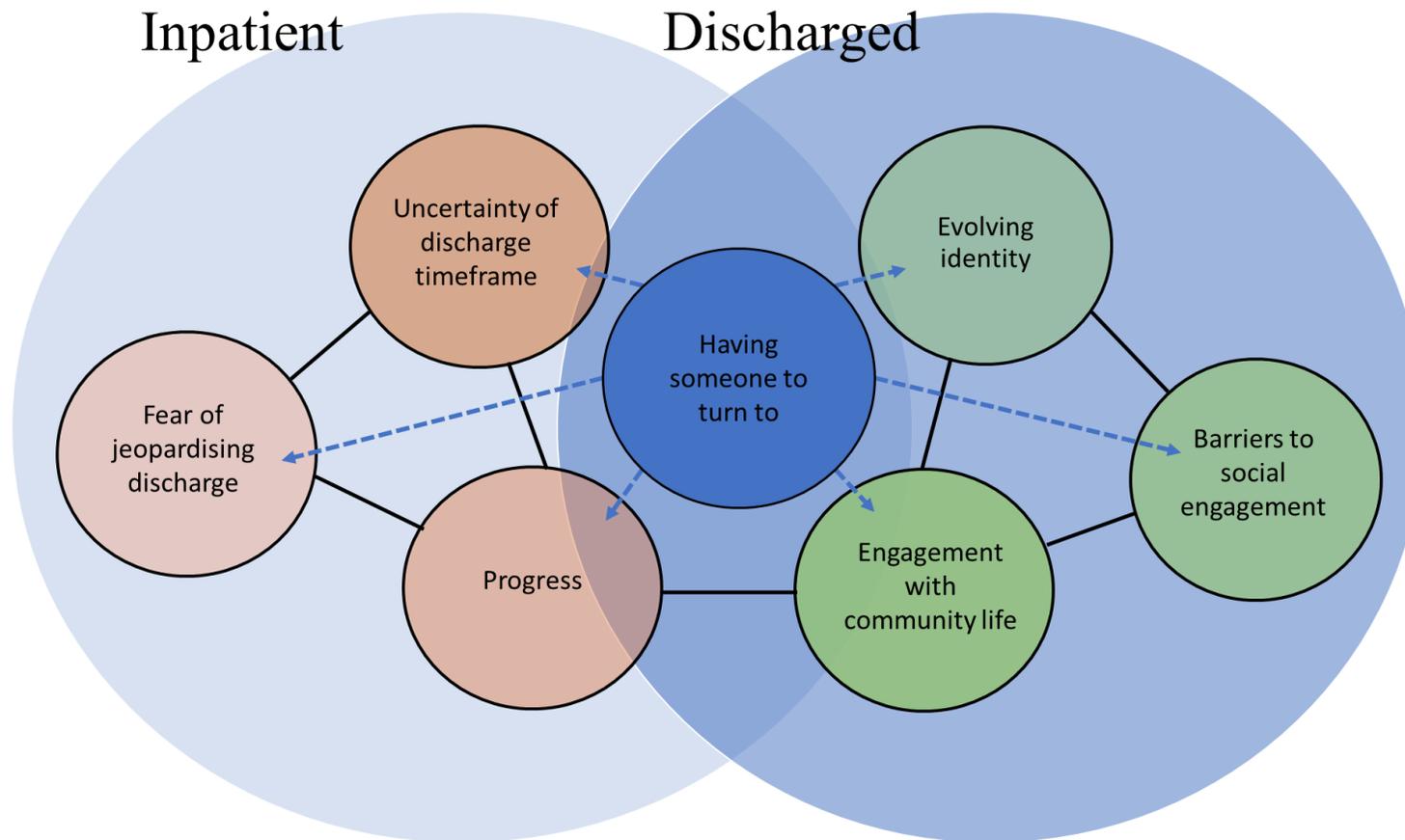
Figure 1:Thematic Map

This map shows the overlap between pre-discharge and post-discharge experiences. Those themes positioned across both were identified to some degree in both pre-discharge and post-discharge experience; for example, 'Engagement with community life', which begins pre-discharge and continues post-discharge.

Cluster 1: Pre-discharge experience

This cluster of themes pertains to how participants described experiences specific to the phase before discharge into the community. This includes all activities undertaken prior to full, conditional discharge. It is worth noting that because of the fluid nature of the discharge process, some aspects of these themes may also be applicable to the post-discharge experience.

1.1: The uncertainty of the discharge timeframe

Six participants described the uncertainty around the discharge timeframe, in terms of the length of stay on the MSU, time until discharge, and time between milestones, such as gaining unescorted community leave. Participants endorsing this theme spoke of the intangibility of discharge and how it could often seem unattainable, especially in the early stages of the process.

P4:   *…. on this section 37/41 I was there for a long time and sometimes you couldn't see, like, freedom.*

P5:   *….. nothing's guaranteed. So my first concern when I was in hospital with the possibility of discharge was actually to get out of hospital! So I couldn't actually plan and say "I'm gonna get out this date" or that date until I actually go to that tribunal and they say "you've got your discharge" and even then it's a drawn out process …….. so you're constantly working toward that goal but it's not set out in stone for you, it's a bit of an unknown.*

Several participants elaborated on how the intangibility of discharge made it difficult for them to find motivation while in hospital. This meant they were unable to take up certain offers of occupational activities even though this might have supported progression.

P5:   *It's difficult because everything's so rigid in hospital, erm, when you're gonna get out, if you're gonna get out, so you get into a lazy routine where you don't want to do anything. So even if they did offer you more OT (occupational therapy) for example or cooking and stuff like that, which they did offer me and I didn't go to, it would be a struggle to get up and grapple and grasp how this is going to help you on the outside world …….. not knowing when you're gonna get out or not is a bit of a conflict.*

Three participants spoke about how the uncertainty of the discharge time-frame was frustrating, both in the short term (e.g. not knowing the length of time between milestones) and in the longer term (e.g. not knowing when they would receive discharge into the community). Some participants made reference to the frustration of having to wait for criminal justice agencies, such as the MOJ, in order to provide approvals. Linked to this was the tension of being ready to progress but feeling held back by the system.

P1:   *It's horrible, it's horrible …….. cos they say it's up to twelve weeks so I'm thinking its gonna come before twelve weeks-maybe five or six weeks, so everyday when I'd come back from leave I'd be like "is there any word from the ministry?", and they'd be like "no".*

1.2: Fear of jeopardising discharge

This theme captures the many references made to the anxiety around actually achieving discharge, and the fear of moving backward along the pathway. This theme was endorsed by all seven participants and was further split into two sub-themes: (1) fear of making mistakes; and (2) managing self-image.

Sub-theme 1.21: Fear of making mistakes.

Six participants referred to making mistakes throughout the discharge process. These participants described the types of mistakes they feared making, the potential consequences and how they reduced the likelihood of this happening.

Participants referred to perceived pressure and anxieties linked to making poor decisions on unescorted community leave, or falling into old habits with drugs or alcohol. In addition to this they spoke of not using time wisely or coming back late, and the fear that one mistake would result in the indefinite set-back of their discharge.

P3:   *.... if they give you two hours you have to be two hours, because you can't come back (late)..... if you come back fifteen minutes late they take your leave away, you know? Which is quite difficult.*

P4:   *When you go out with someone for the first time, you do need that support, cos just being around people and places, you know……you're thinking "Where am I gonna go? What am I gonna see? Am I gonna get into the same situation that brought me here?"*

Linked to this perceived pressure and anxiety was the idea that good behaviours tend to get overlooked by staff, whereas mistakes carry more weight.

P2:   *You have to like, condition yourself to get it all right and not do a wrong because one thing about cases like this is it gets noted and documented but if you do a right it gets overlooked. So you could do ten rights and just one wrong out of ten rights and the single wrong …….. . will go on file forever! And all the nine rights, they ignore that. So, you don't wanna make a mistake, you know?*

Participants also described observing the mistakes made by others and how these acted as a deterrent or a guide for how to conduct themselves while moving through the discharge process.

P7:   *(talking about tobacco) ….. they'd lose their leave …… losing their leave a lot of the time and they'd have to wait weeks or months to get it back, then they'd lose it again and that process was going back and forth - and I could see this process was ridiculous, this losing it all the time then waiting to get it back, it's just prolonging your stay there……… and it goes on forever.*

Sub-theme 1.22: Managing self-image.

This sub-theme referred to comments made by four participants about how they felt they had to carefully manage the way they presented themselves to others, in order not to arouse doubts that they were ready to be discharged.

Participants spoke of feeling unable to show how they were truly feeling at times, especially when their emotions were negative. Some participants felt they had to put on a front in order to show they were holding it together; for some this resulted in masking negative emotions.

P1:   *Sometimes you just wanna put your head in your hands and just say "when am I getting out of here!?".... and you can't really do that in front of other people ... it gets reported saying, saying, oh "X was a bit depressed or something"; but it never did get reported back cos I was good at putting on a front.*

Participants spoke about maintaining a process of self-monitoring and self-correction in order not to arouse concern and to prove readiness for discharge. Participants had different ways of doing this, including carefully managing interactions with both staff and patients on the ward, complying with all requests from staff, and in some cases, isolating themselves to avoid trouble.

P6:   *...... I might do something that could be misconstrued as worrying or erm, you know supposing I started walking too quickly, it might be something that was noted or if I did something that was note-worthy ....*

P7:   *..... yeah, you've gotta watch yourself all the time, so that can cause a bit of anxiety actually......*

P2:   *There's a thing a mate of mine told me when he was about to get out ….. for the first time in my life I heard the word 'Gate Fever'…..That's when …… you've been locked up for years, say five or six years, and you're about to be discharged into the community …….. you get all excited and say "oh I don't wanna do anything wrong, any little thing I do wrong now they're gonna say I'm not going anywhere anymore. I've gotta please patients, I've gotta please staff, I can't get into trouble, I can't get into a fight, I can't get into a verbal argument, I've gotta do everything the team tell me so it goes smooth…".*

1.3: Progress.

This theme pertained to references made about progress and was broken down into two sub-themes: (1) making progress; and (2) maintaining progress.

Sub-theme 1.31: Making progress.

All seven participants endorsed this sub-theme, which referred to comments made in relation to making progress toward discharge and the milestones by which they knew this progress was being achieved.

Three participants spoke of gaining unescorted community leave as an important indication that they were making progress toward discharge, referring to this as both memorable and exciting, but also anxiety-provoking.

P4:   *I nearly cried on the bus when I first got on....I thought you know "I'm gonna be free, I've got my freedom back, sooner rather than later now" and I took it all in my stride you know?*

P2:   *……. it was a good feeling, it's a step toward progress and getting out and you know you're achieving something and doing it right cos if you weren't they wouldn't give (it to) you.*

In addition to this, participants spoke of the sense of achievement gained through acquiring greater responsibility; using this as an indication of the progress they had made towards discharge.

Sub-theme 1.32: Maintaining progress.

This subtheme refers to comments made by six participants relating to the strategies that helped them to maintain the progress they had made, and not regress to a former stage in the discharge process. These comments referred to both pre- and post-discharge.

These participants spoke about the importance of having structured activities while on unescorted community leave and how this helped them to avoid untoward activities (e.g. drinking). Participants also commented on how structure in the community helped to improve their motivation and allowed them to keep making progress towards their goals.

P5:   *(referring to a training position in the community) It gave me a routine and a reason to get up, because you have to do it, which I needed because I was laying in a lot in bed, which is what you do in hospital - that inertia of getting up in the morning is really, really difficult once you come out of hospital.*

Some participants referred to the role of continuing restrictions (Section 41) in the community and how these restrictions along, with the awareness that they were still being monitored by staff, helped them to stay on track.

P7:   *……. those restrictions are in place for a reason to help me stay away from involvement with the police and the criminal system again, so it's wise that they're in place because I don't wanna go back to prison ever again…*

Similarly, five participants detailed how, on reflection, they found the staged process of discharge helpful.

P4   *It helped me …….. doing it in different stages like I say you know. So that does help, slowly but surely.*

P5   *I feel it was a necessary process…… and, erm, I think it went very well as a whole, and erm, I think it got me used to the outside world.*

Some participants made reference to psychology groups and individual psychology sessions completed on the MSU, and how these helped them to develop coping strategies to manage the anxieties and challenges of community life.

P6:	(talking about unescorted community leave) .... I probably had more preparation for that because by then I was doing one to one psychology. We talked about the possibility of drugs and alcohol playing a part in my freedom because I had a history (with substances)..... I was able to work on that in psychology sessions......

P2:	(talking about psychology) It helped educate me on how to cope with stress and living in the community.....

Cluster 2: Post-discharge experiences

This cluster of themes pertains to how participants described experiences after conditional discharge into the community. It is worth noting that because of the fluid nature of the discharge process some aspects of these themes may also be applicable to the pre-discharge experience.

2.1: Evolving identity.

This theme contains comments made in relation to changing identity throughout the discharge process. This theme is further split into two sub-themes: (1) identifying as a patient; and (2) identifying as 'normal'. The word normal has been chosen as it was used by participants during interviews to describe the identity they wished to achieve.

Subtheme 2.11: Identifying as a patient.

Five participants said they identified as a patient while in hospital, one person was not sure and one said he never identified as a patient. Of those five, only one said he continued to do so in the community. This particular person spoke of this as a permanent label linked to the continuing uncertainty around his mental health.

P1:   *I think I will for a long time, even when I'm off my section…… Cos with (mental health) like, when you go to jail and there's nothing wrong with you, you come out and then the slate is wiped clean, you've served your time. But with the mental health thing you've got a responsibility to keep your mental health in good order so you don't reoffend. (Interviewer: "so, there's something quite….?") …. permanent about it…..*

Sub-theme 2.12: Identifying as 'normal'.

Reference to being or becoming a 'normal' or 'real' person occurred seven times across the dataset with the word 'normal' being used five times by four different participants.

P6:   *…… we had a McDonalds and we went to the local Argos and, you know, I felt like a real person after having been in hospital for so long.*

Participants described certain factors as aiding the process of feeling 'normal' or 'real' which included having money for the first time when granted community leave, and being given more responsibility and autonomy.

P6:   *(Interviewer – "what do you think it was about that experience that made you feel like a real person as you said?")*
Well the freedom ..... and being in a crowd of people…… seeing, you know, everyday people going about doing everyday things, having money, having cash rather than credit in a hospital ….......

P5:   *Seeing normal people. Seeing normal people working and who don't know anything about my past.*

2.2: Engaging with community life.

This theme pertains to references made to experiences of engaging with community life. This theme was split into three sub-themes: (1) community life is challenging; (2) the importance of building relationships in the community; and (3) being actively involved in community life.

Sub-theme 2.21: Community life is challenging.

This sub-theme was endorsed by all seven participants who were able to detail specific aspects of community life that they found challenging. Six participants spoke of finding it difficult to adapt to the lack of structure after being in the highly restrictive MSU setting, and subsequently found the freedom and responsibility difficult to manage.

P4: ....*going out doing shopping, making yourself something to eat ..... cos it was all sort of done for you. You know, like when you're in hospital .... I found it quite hard to start with....*

One participant voiced his worry about a lack of support when he moves on from supported to independent living.

P3: *I've not had a case of independent living for quite some time, and I think it would be quite scary............ Yeah, it's more than scary it's a nightmare (laughs)...... if I don't get any sleep, or my anxiety and stress keys up I need someone to talk to...*

Participants also described how the realities of community life can become apparent some-time after being discharged, and often following an initial period of excitement and happiness.

P1: *I think most people do, they come out on a high, then they realise life has to go on, and they've gotta get back to normal life and it's a bit daunting.*

P4: *(Interviewer – "it sounds like you really wanted the freedom but there was something about it that was quite difficult to handle, at first?")*
Yeah, yeah ....Probably you know, I was sort of like, thinking this isn't a lot worse or better than it was (on the ward). When I sort of got used to it I was ok and it was probably better that way than the other way ....sort of going out there and thinking you'd have the world at your feet.....

Sub-theme 2.22: Importance of building relationships in the community.

Five participants contributed to this sub-theme. They described how forming new social networks in the community helped to make them feel part of the community, and helped decrease the sense of isolation they sometimes felt.

P6:   *(talking about isolation) It's decreased. I've actually started doing some activities in the community, drawing classes at college. I'm thinking I might start doing the sculpture classes as well which is another interest of mine …..*

Some participants spoke of the importance of associating with people who did not know their past; however, others commented on the importance of also having people in their social network who had a shared forensic history, or who had experienced mental health problems.

P4:   *The people in the care home which I'm living I've got things in common with them, cos they've been in the system for so long but also we can all identify to each other ….....*

Sub-theme 2.23: Being actively involved in community life.

This sub-theme was endorsed by all seven participants, who described the importance of being actively involved in community life and of feeling like an active member of society.

All seven participants reported feeling like active members of their community and some were able to identify factors that facilitated this. For example, several participants stated that finding work or other meaningful activity had helped increase their sense of belonging.

P5: *I had some help with the employment training and education advisor……I had some support there …… and she did after work stuff as well like going out to meet ups…….. It was very helpful yes, I enjoyed myself……….. because it got me out to meet people I would never have met before.*

Similarly, other participants spoke about the positive effects of attending meaningful social activities in the community.

P6: *…. there's a community activity organised here, which I think is going to be bowling so I think I'm gonna do that…… But this is progress because I'm meeting people in the community…*

2.3: Barriers to social engagement.

This theme was divided into two sub-themes: (1) loss of old relationships; and (2) difficulty forming new relationships.

Sub-theme 2.31: Loss of old relationships.

Four participants reported making the choice to distance themselves from friends or associates who might not be a positive influence, or who might lead them astray. These people were often linked to their old lifestyle prior to admission.

P4:   *With being on a 37/41 in a way you're recalled ahead of time, ... So sometimes I feel better on my own you know, because I don't wanna go back to hospital, and some people feel its ok for them.*

P2:   *I'm never going back to (hospital) and my friends - anyone whose misbehaving or fooling around, I don't go out with them …...... I cut them out completely, the mates I have are all dedicated to staying in the community and never going back to hospital.*

Participants also spoke of viewing these friends less positively after their hospital experience.

P6:   *I haven't picked up on any previous relationships …...... I think I can see people more clearly without substances and alcohol, erm, so sometimes that's good, sometimes you see people's less colourful side, that maybe people that I thought*

were great company, I might not enjoy their company in the same way anymore. I've

moved on.

Other participants described how the loss of old relationships was not their choice. One participant spoke of being ostracised and rejected by old friends he had known since childhood because of the crime he had committed.

P1:   ...... basically, all my friends that I used to know I don't speak no anymore. .....because my offence was ..... so shocking .... They probably think I'm some sort of lunatic .....it was upsetting, sad like, and people I've known all my life don't answer the phone to me.

Sub-theme 2.32: Difficulty forming new relationships on the outside.

Five participants spoke of having found it difficult at times to form new relationships or establish social networks once they were discharged from hospital. Some were able to describe the factors that made this challenging and the effect this had. Several participants spoke of experiencing anxiety, uncertainty or conflict about how much of their criminal and psychiatric past to divulge to new acquaintances. They reported subsequently feeling that their criminal identity hung over interactions they had with people in the community.

P1:   I told one boy (XXX), who I became friends with, I told him in the end, I told him exactly what I'd done and he was shocked.... I didn't tell anyone else.....

P2:   *The problem when the obstacle came … (was when) I got out I met a woman I liked and my consultant said if I wanted to get into a relationship in the community I've got to report it, and I said "yeah but that might scare my girlfriend off you know" ….. So that was quite difficult, so up to now I haven't got a girlfriend and part of the reason why is the condition that I've gotta report the relationship.*

3: Someone to turn to.

This final theme captures the many references made by all seven participants to the importance of emotional and practical support throughout the discharge process.

Four participants referred to the role staff played in providing emotional support and the importance of having a named person to talk to. These participants described how speaking to a member of their care team about anxieties and concerns was helpful.

P2:   *I don't like crowds so …….. that was an obstacle and it was a big problem …….. I got over that by reporting it to my team, you know? I speak to my key worker twice a week and I speak to the consultant once a week or once every two weeks …….. You're taught you've gotta nip it in the bud …….. you don't have to wait that long for the problem to be blown out of proportion…*

P5:   *(Interviewer – "was there anything that helped you to manage or cope with that transition period?")*
Trust me it was the team, because everyone is allocated a key worker …….. Whenever I would get a paranoid feeling, suspicion, confused - I would go straight to my key

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worker …….. I speak my mind, what's on my mind what I'm scared of …….... You can't pull it off on your own, it can be very difficult.

Some participants also worried about the potential consequences of not having support in the future and how this might impact negatively on their mental health.

P3:   *If I'm in independent living I hope I've got a phone number of a CPN or something like that so I can ring them and say "look, look at this I'm having problems."……*

Participants also referred to the value of receiving support from family and friends throughout the discharge process.

P1:   *My family's supported me the whole way through, even when I was in XXX (prison)……*

P1:   *(talking about preparing to move out into the community) I was bringing stuff from hostel to my parents' house in the lead up to moving to the hostel so I had bags of stuff at my parents' house…*

Those without the support of family felt the discharge process would have been easier if they did; they also commented on the importance of friends and romantic relationships in the absence of this.

P4:   *I would say family's a big thing, there are people who have been in prison or hospital for much longer than I have but they have families and I haven't had that.*

P5:   *I grew up in foster care so I don't have any family to worry about. …….I had a fortunate position I met a girl in hospital, so I had that carried on afterwards …… We were together for seven years so erm, that helped me a great deal coming out of hospital with somewhere to go, and we talked with her friend as well everyday.*

Relationship between themes

These themes were then brought together into the thematic map seen in Figure 1. (p. 74), based on how they related to one another across the discharge pathway (pre-discharge cluster and post-discharge cluster). Themes were then interconnected within and between the two clusters (e.g. uncertainty of the discharge timeframe and progress). Participant accounts support how identity is shaped through both positive social experiences ('engagement with community life' theme) and less positive social experiences ('community life is challenging' theme). Having someone to turn to feeds into all themes at all points along the discharge pathway and is represented in such a way in the thematic map (see Figure 1.).

Discussion

Using a qualitative approach this study aimed to explore service users' experience of Conditional Discharge from a Medium Secure Unit (MSU) with continuing Section 41 restrictions in the community. This study was one of the first to

explore the discharge process solely from the service users' point of view, and is one of the few pieces of research in this field where the primary focus is not risk. The findings will now be discussed and interpreted in relation to the research questions, the existing literature and relevant psychological theory.

Experience of Increased Freedom and Autonomy

The first research question concerned service users' experience of increased freedom and autonomy, a widely agreed cornerstone of recovery (Bonney & Stickley, 2008; Mancini, 2008; Resnick et al., 2005).

Although the participants in this study generally welcomed the increased freedom and autonomy that discharge brought, many were reluctant to take back full responsibility due to a lack of confidence in their ability to make good decisions. This was demonstrated in the 'fear of jeopardising discharge' theme, which strongly reflected how highly anxious service users were about making mistakes that could jeopardise their discharge or set them back.

Before discharge, the fear of jeopardising this process seemed to be driven by an awareness of the consequences of making mistakes, drawn partly from watching this happen to fellow inpatients. For many participants in this study, this awareness led to a perceived need to constantly monitor and manage the way they appeared to staff involved in their care.

The motivation for maintaining desirable behaviours can be theorised more extensively using Ryan and Deci's (2000) notions of intrinsic and extrinsic motivation. Intrinsic motivation refers to those activities performed because of the pleasure and satisfaction of the activity itself and is strongly linked to personal values. Extrinsic

motivation describes behaviours performed to achieve an external outcome, be this attainment of a reward or avoidance of a sanction; these activities tend to be less value-oriented and are less likely to continue without sanctions. However, extrinsically motivated practices can become more internalized, or 'actively embraced', when the individual moves from mere passive compliance to developing a degree of personal commitment to the behaviour (Ryan & Deci, 2000).

For participants in this study, the change in attitude toward restrictions throughout the discharge process (e.g. moving from finding restrictions and monitoring frustrating at the start of the discharge process to finding them helpful and supportive towards the end) might be an indication of a move from passive compliance (driven by avoidance of jeopardising discharge) to personal commitment to restrictions. This could occur as participants realise that the restrictions will help them to achieve their personal goals, and facilitate recovery and wellness in the community.

Barriers and Facilitators to Progress and Community Integration

The second research question related to barriers and facilitators to reintegration into the community. Among all participants there seemed to be a general consensus that the discharge process had been challenging, and that these challenges occurred a short while after discharge, often following an initial period of excitement and happiness. The reasons for this varied among participants but included a lack of vocational activity, loneliness, a lack of direction and poor sleep.

Discharge from an MSU to the community, although gradual, is a considerable transition. Moving from the highly restricted and regimented inpatient environment to the freedom and responsibility of the community. Schlossberg's (1981) Transition

Theory highlights how transitions result in a change in assumptions about oneself and the world, and thus require a corresponding change in one's behaviours and relationships. Schlossberg identifies three factors that interact to influence the quality of a transition: (a) the perception of the transition, i.e. gain or loss, positive or negative, gradual or sudden, permanent or temporary, certain or uncertain; (b) the characteristics of the pre-transition and post-transition environments, i.e. support systems (personal and institutional) and physical setting; and (c) characteristics of the individual, i.e. psychosocial competence, life stage, value orientation, previous experience and other socioeconomic factors. For recently discharged MDOs a number of potentially depleting factors coincide shortly after discharge; where: that which has been lost is yet to be replaced, support and social contact has reduced, and they have not yet had enough time to develop and practice psychosocial competencies that work in their new community environment.

One specific barrier consistently identified by participants in this study was a lack of motivation. Many participants reflected on not being able to find the motivation to take up activities that might have helped support their progress, particularly early on in the discharge process. Psychological theories of motivation can help us understand why this might occur at this stage in the process, the first being Bandura's Social Cognitive Theory (1997). Central to this theory is the relationship between self-efficacy, (how confident an individual is in his/her ability to achieve a desired goal, in the presence of perceived barriers and facilitators) and outcome expectancies, (what s/he believes the outcome of performing a particular goal-directed behaviour will be) (Bandura, 1998, in Norman, 2000). In other words, 'unless an individual believes they can achieve desired effects by their actions, they will have little incentive to act' (Bandura, 1997, p. 2). The Expectancy Theory of Motivation (Vroom,1964) also states

a similar hypothesis; that motivation is driven by the belief that one's effort will result in a desired performance, and the belief that one's performance will result in a desired reward. In terms of patients at the start of the discharge process, the uncertain time-frame can make the end goal of discharge seem intangible and unattainable; thereby reducing the belief that the effort will lead to discharge, and undermining motivation.

The contribution of the restricted and regimented MSU environment to the low motivation reported by these participants must also be considered. Due to the focus on risk management, secure inpatient environments often fail to nurture those basic environmental needs necessary to facilitate recovery and personal growth: (a) the need for competence; (b) the need for relatedness; c) the need for autonomy (Ryan and Deci, 2000). In a sense inpatient MDOs must 'swim against the tide' to battle the demotivating effects of their environment.

The theme 'someone to turn to' captured how highly service users valued having staff to turn to, for emotional, psychological and practical support, throughout the challenges of the discharge process. There was, however, a stark paradox caused by the fear of jeopardising discharge, which prevented participants from disclosing certain concerns because of the fear that this could jeopardise their discharge. This highlights an important conflict between patients recognising the value of raising concerns with staff, but also feeling unable to disclose these concerns.

Changes in Perceived Identity Throughout the Discharge Process

The theme 'evolving identity', with its specific subtheme of becoming a 'normal' or 'real' person, reflected how many participants strove for a more positive identity in the community, distanced from their forensic and mental health histories.

Service user accounts suggest the process of becoming 'normal' is strongly bound with community integration, and building new social networks with people who do not know their criminal and psychiatric pasts.

The value placed on becoming part of 'normal' society can be understood using Social Identity Theory (Tajfel & Turner, 1979). This theory argues that self-concepts are built based on belonging to groups, and how losing membership to a group, (even if that group is considered undesirable) can be challenging. This is because many aspects of the self, developed through membership to that group, can be lost. According to Jetten (2012), this challenge can be managed by increasing the number of groups to which one belongs. This elucidates the importance participants in this study placed on forming new social networks post-discharge; in the context of limited opportunities to gain membership to other groups whilst in secure care, and the loss of membership to a group upon discharge.

Consistent with research on forensic identity (Coffey, 2012), many participants felt the need to distance themselves from old friends and fellow service users in order to maintain progress. However, the potential negative consequences of leaving one group without having others to join (Jetten, 2012; Tajfel & Turner, 1979) may have presented a conflict for some service users. This is evidenced by participants who referred to the importance of continued engagement with people who had had similar experiences to them and to whom they could relate, whilst also expressing the desire to gain distance.

Limitations

There are several potential limitations to this study and these must be considered when interpreting the findings.

It was not possible to define characteristics of those who declined to take part, which raises the possibility that those who took part were different in some way to those who declined. For example, the theme 'someone to turn to' was endorsed by all participants, however it is possible that those who declined to take part might not have felt so positively about help-seeking and this might have influenced their decision not to take part in the research.

There was a lack of ethnic diversity within the sample with only one non-white participant. This did not reflect the overrepresentation of black and ethnic minority individuals on forensic Sections in the UK (Approximately: 8.5% Black British, 5.6% Asian and Asian British, and 12.5% mixed ethnicity (Care Quality Commission, 2013)). The reason for the lack of BME participation in this sample is difficult to ascertain, however, factors cited as deterring BME individuals from utilising generic mental health services e.g. mistrust of services, lack of cultural appropriateness, social stigma, and shame (Islam, Rabiee, & Singh, 2015; Keating & Robertson, 2004); Sainsbury Centre for Mental Health, 2002) may apply.

I believe I obtained honest and full accounts from participants, however this cannot be said for certain. The possibility remains that participants censored their accounts to some degree. If this was the case, the 'fear of jeopardising discharge' theme suggests it would likely result in a minimising of fears, emotional problems or challenges. Unfortunately, it was not possible to gather testimonial feedback from participants, as they either declined or did not respond. This resulted in a missed opportunity to test the credibility of my interpretation.

Despite the relatively small sample size, the data collected from all participants was rich and detailed, and instances of the seven themes and 11 sub-themes were consistently evident across the dataset.

Conclusions and Clinical Implications

This study is one of the first to solely focus on patients' experience of discharge, and to use a sample of participants' subject to continuing restrictions in the community.

Participants appreciated the continuing restrictions and monitoring in the community, and saw these as a means of keeping them on track and maintaining progress.

They identified several challenges, including: managing increased autonomy, developing social networks in the community and finding motivation to engage in activities that would support their recovery, especially at the start of the discharge process. This last finding has important implications for the way that resources are sequenced throughout the discharge process. It suggests a 'window' of engagement for patients, a point where discharge is more tangible and motivation levels have increased. It is likely that resources focused within this window will facilitate maximum engagement, and have greater impact and effectiveness. This finding also highlights a potential mismatch, particularly early on in the discharge process, between the expectations of the care team and those of the patient, in terms of motivation and speed of progress.

Importantly the findings of this study suggest that individuals use strategies to hide emotional states they perceive as not conducive to discharge (e.g. low mood),

despite highly valuing support. A potential consequence is that deteriorating mental health or well-being may not be addressed as early as possible, and may lead to relapse and poorer quality of life. The tendency for individuals to hide negative emotions also brings into question the reliability of risk assessments, particularly for staff using patient compliance as an indication of reduced risk.

In addition to this, the findings point to a possible disparity between what patients believe to be circumstances under which discharge would be jeopardised, and the realities of this as stated by the MOJ (2009). Individuals may benefit from knowing where flexibility exists and this could reduce anxiety and promote help-seeking.

All participants in this study highly valued the help and support provided by their Forensic Community Team. It might be the case that those who value help are more likely to seek help, and that this contributes to successful discharge. If this is the case, fostering trust between inpatient MDOs and staff, alongside encouraging help-seeking on wards, will be beneficial.

The findings of this study provide further evidence for the benefits of a staged process of discharge into the community with participants valuing this as a means of smoothing adjustment. The importance of continued support and monitoring of emotional and psychological well-being, for an extended period post-discharge, has been highlighted. Although all patients expressed a desire to put the discharge process behind them, they also saw the process as necessary in moving them towards recovery in the community.

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Part 3: Critical Appraisal

Introduction

My critical appraisal will cover some of the considerations that arose for me during the research project, and will expand on some of the points raised within the empirical paper. It is divided into three parts. The first examines my pre-existing beliefs and theoretical orientation, and the foundations of these in my life experiences and personal background. The second will cover some of the challenges of conducting this research with the mentally disordered offender population (MDO), who can be difficult to access and engage in studies such as this. In this section I will present links to the limitations of the study along with the methodological dilemmas that arose. The third area I will discuss is what I might choose to do differently, were I to undertake similar research in the future.

Pre-existing Beliefs and Theoretical Orientation

Personal background and experiences

I am a female trainee clinical psychologist in my late 20s, completing my doctorate at University College London. I would classify myself as having transitioned through social classes throughout my childhood and adolescence, from working-class to middle-class. As a result I experienced existing in both; for example I attended a mixture of public and private schools throughout my education and lived on a local authority housing estate for much of my early childhood. I am also of mixed ethnicity and have entered the profession as a BME (black or ethnic minority) trainee. My mixed

ethnicity has influenced the way I view and experience the world especially in terms of idiosyncrasies in experience caused by observable, physical difference.

My dual heritage and class transition has allowed me the opportunity to mix with different socioeconomic, cultural and ethnic groups throughout my life, and I greatly value this. I believe it was this diversity of experiences that led me to become interested in how socioeconomic factors shape the way we experience the world and the way the world experiences us. This interest led to a curiosity in the idiosyncrasies of human experience and I developed an interest in the contribution of socio-economic factors to mental health and crime. I also became intrigued by life transitions, having made several myself, particularly how individuals manage transitions and how these transitions impact identity and sense of self in relation to others.

Theoretical orientation

This interest in the variety of human experience drew me toward the social constructionist standpoint, that human experience is profoundly influenced by culture, history and language (Berger & Luckmann, 2007).

I believe in the value of applied research, which addresses practical questions with the potential for direct clinical implications, and this drove me to seek a research project with the NHS population.

My endorsement of both social constructionism and relativism drove my desire to carry out a qualitative study. My experience working clinically with MDOs pre-training gave rise to my desire to focus my research project on this population.

When working on a medium secure unit I saw few opportunities for patients' voices to be heard, or for patient contributions to service planning; I understood this

as a missed opportunity to improve service delivery, quality of life and reduce recidivism and readmission. Due to my clinical role I also spent time evaluating patient case histories, often going back to early childhood. This highlighted the correlation between social deprivation and childhood trauma, and poor mental health and criminal behaviour (Allen, Balfour, Bell, & Marmot, 2014), and further compelled me to undertake research with this population.

I strongly support giving a voice to sub-groups of people who are rarely given a platform. I am interested in notions of power and how these effect people's experiences of the world. I believe in order to obtain a fuller picture of the world, we must seek different perspectives, including those of people less highly regarded in society (e.g. offenders). I argue that the cost of not seeking certain experiences, even if they are socially undesirable or objectionable, leaves a hole in our knowledge and understanding.

Through this research I wanted to capture the first-hand experiences of conditionally discharged MDOs and my previous clinical experience working with MDOs meant I felt confident in my ability to conduct qualitative research with this client group.

Challenges and Barriers

Limited research experience

The first barrier I encountered was my limited experience of conducting a major research project, and my perceptions of how this would affect the standard of my work. This caused me to doubt my abilities, particularly with regards to writing up my findings. This applied mostly when encountering concepts or hypotheses that were abstract and therefore required confidence and conviction in how they were conveyed (e.g. interpretations of the literature review findings in relation to the Recovery Model). With the support and guidance of my research supervisors, I developed the confidence to trust in the authority, and value, of my own skills, opinions and intuitions.

Practicalities of conducting the research

There were some practical elements of the research process that I found challenging. One of these was the NHS ethics process, which was incredibly time consuming and laborious. This was my first experience of applying for NHS ethics and it was something I was keen to do. The process taught me the importance of good organization and record-keeping, in addition to sound knowledge of the research proposal and rationale.

Maintaining good relationships with the five different research sites was challenging, especially as they were far away from where I was based. I tried hard to maintain a presence in team meetings, however it was difficult to allocate sufficient time between placement days. It is possible that the smaller than desired sample size reflected this. This experience did highlight to me the importance of maintaining a physical presence at research sites, to maintain interest, enthusiasm and motivation in

the study. I realised this fact early on in the recruitment process and was frustrated when I could not make it to sites as often as necessary.

Engaging service users

A separate set of challenges related to obtaining participant/service user involvement throughout the research process. Early on in the project I attempted to involve service users in the design of the interview schedule, however this was not achievable due to a lack of engagement. Attempts were also made to gather testimonial feedback from the participants. This involved consulting interviewees on the logic of the coding and the constructing of themes to make sure they accurately reflected their experiences. Unfortunately, all participants either declined to take part or did not respond to invitations for feedback. I wondered whether this weakened the credibility of my findings, however there is currently some debate within the literature as to the value of testimonial feedback. While proponents of testimonial checks argue their use in confirming and enhancing the credibility of findings "the member check…. is the most crucial technique for establishing credibility" (Lincoln & Guba, 1985, p. 314)(Lo, 2014); others, such as Thomas (2017) question their usefulness. Thomas (2017) conducted a review of the published literature regarding member checks, to identify the purposes and procedures for seeking feedback from participants, along with the outcomes reported. He found limited evidence that member checks improved research findings, and suggested instead that they are most useful for obtaining participant approval where anonymity cannot be guaranteed.

It could also be argued that the emphasis on testimonial feedback goes against the relativist position promoted by qualitative research, in light of analysis representing the researcher's unique interpretation of the patient's experience.

Conducting the semi-structured interviews with participants was enjoyable and successful. I developed a detailed interview schedule, with questions ordered in a way to make participants feel at ease and not pressured into divulging sensitive information too quickly. I also feel the skills acquired from my clinical experience (e.g. positive regard, empathy, clinical intuition) in addition to following guidance from Barker & Pistrang (2015) (e.g. maintaining a loose structure, maintaining an empathic, non-judgmental stance etc.) helped to facilitate openness from a population who can often be difficult to engage and reluctant to disclose information.

Despite this, and perhaps not surprisingly, I still found participants to be guarded at the start of interviews. For this reason I found it beneficial to repeat some questions further on in the interview, if I received a limited answer the first time. On reflection establishing a longer maximum interview time of up to 90 minutes allowed time for participants to become comfortable in the interview.

Overall I felt that participants responded well to repeated assurances about my independence from the forensic Community Teams, and reassurance that what they disclosed would not be communicated to the clinicians involved in their care.

Methodological dilemmas

The decision to stop collecting data at seven interviews initially presented a dilemma for me, as my original target was between 10 and 15. A combination of factors led me to stop at seven rather than continuing to recruit. The first related to the limited time I had to complete the project, after discussing with my supervisors it was agreed that it would be more beneficial to analyse the data I had collected, especially as this was rich and detailed. The second factor concerned the limited pool of clients who fit the inclusion criteria and who wished to take part in the study. This reduced the likelihood of successfully recruiting additional participants. The struggle with recruitment is consistently reported as a challenge when conducting research with the MDO population.

I subsequently consulted the literature regarding acceptable sample sizes for qualitative studies and found consistent agreement for a flexible approach to determining sample size. Morse (2000), for example, argues that sample size will depend upon several factors including: the scope of the research question (broader scope will require a larger sample size); the nature of the topic (the more 'obvious' the topic, the smaller the sample size); the quality of the data (the richer and more detailed the data, the smaller the sample size); the study design (a longitudinal design where a group is the unit of analysis may require a smaller sample size than one in which there is one interview per participant); and 'shadowed' data (information revealed about others' perspectives, in addition to the interviewee's own, may require a smaller sample size). Similarly Patton (1990) describes the possibility of achieving depth with both small and large samples, depending on the research question.

Adler and Adler (in Baker, 2012) describe how qualitative studies with small sample sizes have produced important and well respected findings. They also propose that when studying hidden or hard to reach populations, such as MDOs, a dataset of

six to 12 interviews could be extremely valuable and may represent adequate numbers for a research project. Sim, Saunders, Waterfield, & Kingstone (2018) posit that the decision over what constitutes an adequate sample size to meet a study's aims is "a process of ongoing interpretation by the researcher ….. an iterative, context-dependent decision made during the analytical process as the researcher begins to develop an increasingly comprehensive picture of the developed themes….." (p. 630).

Based on this I believed that the sample size, although smaller than hoped, would be sufficient for yielding valuable results and achieving saturation.

An additional dilemma involved the inclusion criteria for my sample. Although including females may have added to the breadth of experiences, the small number of female patients within the service, and the fact that these females were engaged in other studies, made this unattainable. I also questioned my inclusion criteria for the maximum length of time since discharge. This was initially set at two years to improve the depth and quality of participants' memories of the discharge experience. However, the smaller than expected pool of potential participants meant this had to be broadened. It was hoped that widening the criteria would add to the breadth of experiences represented in my sample.

Staff changes and restructuring within FCTs meant it was not possible to access data to define the characteristics of those who refused to take part in the study. This information would have been useful in examining whether any differences existed between those who took part and those who declined. For example, the service users who took part in the study may have experienced more successful relationships with professionals (substantiated by the theme 'someone to turn to'). It is possible that participants who refused may not have experienced such positive relationships, and might not have endorsed the same themes. As mentioned in the limitations of the

empirical paper, there was also a striking lack of ethnic diversity within the sample (one non-white participant), even though recent statistics show that black and ethnic minority groups are over-represented in secure care (Care Quality Commission, 2013). The minority experience of the discharge process is therefore missing from this study and may have presented a variation of themes.

Communicating the findings

The data collected from participant interviews was rich and detailed, with high endorsement of all themes, despite the smaller than desired sample size. The large number of themes (7) and sub-themes (11) created a challenge in how to present the themes diagrammatically; which I thought was important so that the relationships between themes could be accurately displayed. I decided to depict this using a Venn diagram, with clusters for pre-discharge and post-discharge experiences; which enabled me to show the overlap of some themes. I chose not to include sub-themes in the diagram in order to maintain clarity and ease of reading; however, I wondered if this resulted in the loss of some information about the discharge experience relating to sub-themes.

What I might Have Done Differently

Overall, I feel the research was conducted appropriately, resulting in credible findings. The methodological dilemmas and challenges I faced do highlight some changes that could have been made.

On reflection I may have set aside more time to maintain greater contact with the recruitment sites. In an ideal world I would have engaged the help of a research assistant to do this. I would have also explored the possibility of including more sites in different location and trusts in order to maximise the sample size.

Despite the current debate in the literature regarding the value of testimonial feedback, I personally would have valued this feedback for my project. I question whether meeting with participants to obtain feedback verbally, rather than sending the questions by email, may have resulted in better uptake.

Conclusions

Through conducting this major research project, I have developed the confidence to trust in the value of my own research skills. I am grateful to have had the opportunity to conduct a piece of research in a subject area of great personal interest to me, and I am hopeful that this enthusiasm is reflected in the finished work.

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Appendices

Appendix A: Effective Public Health Practice Quality Assessment Tool for Quantitative studies

QUALITY ASSESSMENT TOOL FOR QUANTITATIVE STUDIES

COMPONENT RATINGS

A) SELECTION BIAS

(Q1) **Are the individuals selected to participate in the study likely to be representative of the target population?** 1 Very likely
2 Somewhat likely 3 Not likely 4 Can't tell

(Q2) **What percentage of selected individuals agreed to participate?**
1 80 - 100% agreement 2 60 – 79% agreement 3 less than 60% agreement 4 Not applicable 5 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

B) STUDY DESIGN

Indicate the study design
1 Randomized controlled trial 2 Controlled clinical trial 3 Cohort analytic (two group pre + post) 4 Case-control 5 Cohort (one group pre + post (before and after)) 6 Interrupted time series 7 Other specify _____ 8 Can't tell

Was the study described as randomized? If NO, go to Component C.
No   Yes

If Yes, was the method of randomization described? (See dictionary)
No   Yes

If Yes, was the method appropriate? (See dictionary)
No   Yes

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

C) CONFOUNDERS

(Q1) Were there important differences between groups prior to the intervention?
1 Yes 2 No 3 Can't tell

The following are examples of confounders:

1 Race 2 Sex 3 Marital status/family 4 Age 5 SES (income or class) 6 Education 7 Health status
8 Pre-intervention score on outcome measure 9 difference in security level (low/medium/high) 10
duration in hospital

(Q2) **If yes, indicate the percentage of relevant confounders that were controlled (either in the design (e.g. stratification, matching) or analysis)?**

1 80 – 100% (most) 2 60 – 79% (some) 3 Less than 60% (few or none) 4 Can't Tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

D) BLINDING

(Q1) **Was (were) the outcome assessor(s) aware of the intervention or exposure status of participants?** 1 Yes
2 No 3 Can't tell

(Q2) **Were the study participants aware of the research question?**
1 Yes 2 No 3 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

E) DATA COLLECTION METHODS

(Q1) **Were data collection tools shown to be valid?**
1 Yes 2 No 3 Can't tell

(Q2) **Were data collection tools shown to be reliable?**
1 Yes 2 No 3 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

F) WITHDRAWALS AND DROP-OUTS

(Q1) **Were withdrawals and drop-outs reported in terms of numbers and/or reasons per group?**
1 Yes 2 No 3 Can't tell 4 Not Applicable (i.e. one time surveys or interviews)

(Q2) **Indicate the percentage of participants completing the study. (If the percentage differs by groups, record the lowest).**
1 80 -100% 2 60 - 79% 3 less than 60% 4 Can't tell 5 Not Applicable (i.e. Retrospective case-control)

RATE THIS SECTION	STRONG	MODERATE	WEAK	
See dictionary	1	2	3	Not Applicable

G) INTERVENTION INTEGRITY

(Q1) **What percentage of participants received the allocated intervention or exposure of interest?**
1 80 -100% 2 60 - 79% 3 less than 60% 4 Can't tell

(Q2) **Was the consistency of the intervention measured?**
1 Yes 2 No 3 Can't tell

(Q3) **Is it likely that subjects received an unintended intervention (contamination or co-intervention) that may influence the results?**
4 Yes 5 No 6 Can't tell

H) ANALYSES

(Q1) **Indicate the unit of allocation (circle one)** community
organization/institution   practice/office   individual

(Q2) **Indicate the unit of analysis (circle one)** community
organization/institution   practice/office   individual

(Q3) **Are the statistical methods appropriate for the study design?**
1   Yes
2   No (p values not adjusted for multiple comparisons)
3   Can't tell

(Q4) **Is the analysis performed by intervention allocation status (i.e. intention to treat) rather than the actual intervention received?**
1 Yes 2 No 3 Can't tell

GLOBAL RATING

COMPONENT RATINGS

Please transcribe the information from the gray boxes on pages 1-4 onto this page. See dictionary on how to rate this section.

A	**SELECTION BIAS**	**STRONG**	**MODERATE**	**WEAK**
		1	2	3
B	**STUDY DESIGN**	**STRONG**	**MODERATE**	**WEAK**
		1	2	3
C	**CONFOUNDERS**	**STRONG**	**MODERATE**	**WEAK**
		1	2	3
D	**BLINDING**	**STRONG**	**MODERATE**	**WEAK**
		1	2	3
E	**DATA COLLECTION METHOD**	**STRONG**	**MODERATE**	**WEAK**
		1	2	3

F	WITHDRAWALS AND DROPOUTS	STRONG	MODERATE	WEAK	
		1	2	3	Not

GLOBAL RATING FOR THIS PAPER (circle one):

1	STRONG	(no WEAK ratings)
2	MODERATE	(one WEAK rating)
3	WEAK	(two or more WEAK ratings)

Appendix B: Ethical Approval Letter

NHS
Health Research Authority

London - Camden & Kings Cross Research Ethics Committee

Jarrow Business Centre
Rolling Mill Road
Jarrow
NE32 3DT

Telephone: 0207 104 8086

Please note: **This is the favourable opinion of the REC only and does not allow you to start your study at NHS   sites in England until you   receive HRA Approval**

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05 June 2017

Dr Alan Underwood
[Address Redacted]

Dear Dr Underwood

Study title:	**Service Users' Experience of Discharge from a Medium Secure Forensic Unit**
REC reference:	**17/LO/0786**
IRAS project ID:	**218254**

The Research Ethics Committee reviewed the above application at the meeting held on 22
May 2017.   Thank you to Ms Tanya McDonnaugh for attending to discuss the application.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact hra.studyregistration@nhs.net outlining the reasons for your request. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below. .

Conditions of the favourable opinion

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

    1.   Removal of the following statement from the participant information sheet:
- "You will also be given the cost of your travel expenses to and from the meeting."

    2.   Amendment to the consent form to include the following statement
- "I understand that confidentiality will be broken in the event that I disclose anything criminal that had not already been disclosed, or anything that may put myself or others at risk."

You should notify the REC once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Revised documents should be submitted to the REC electronically from IRAS. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which you can make available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

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

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA Approval (England)/ NHS permission for research is available in the Integrated Research Application System, at www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

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

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

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

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

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

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

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

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

Ethical review of research sites
NHS Sites

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

Summary of discussion at the meeting

Other ethical issues were raised and resolved in preliminary discussion before your attendance at the meeting.

Ethical issues raised by the Committee in private discussion, together with responses given by the researcher when invited into the meeting

The Chair welcomed Ms Tanya McDonnaugh to the meeting and thanked her for attending.

The Chair noted that there were three observers present. The applicant confirmed that the observers could remain in the room for the discussion of this application.

Social or scientific value; scientific design and conduct of the study

The Committee sought clarification as to whether the home office needed to be aware of the research.

Ms McDonnaugh explained that the home office did not need to be aware that the research was happening and commented that their input would be to be involved in the discharge of patients and supervision within the community.

It was queried whether participants would be considered as under the care of the NHS or the Ministry of Justice (MOJ).

Ms McDonnaugh clarified that participants would currently be under the care of the NHS but on a section which could only be changed by the MOJ. She confirmed that participants would definitely be under the care of the NHS.

The Committee accepted this response.

The Committee queried whether all participants would have been discharged at the point of taking part as the interview schedule contained questions about preparing to be discharged.

Ms McDonnaugh confirmed that all participants would have been discharged and commented that the interview schedule had been organised to detail specific stages through the discharge process that participants would be asked to recall.

The Committee accepted this response.

Recruitment arrangements and access to health information, and fair participant selection

The Committee queried whether travel expenses would be reimbursed.

Ms McDonnaugh explained that participants would be given a £10 voucher for taking part but it was not possible to also give travel expenses. She clarified that the voucher would be for a supermarket and would not be redeemable for alcohol or tobacco.

The Committee requested that this be made clear within the participant information sheet.

Care and protection of research participants; respect for potential and enrolled participants' welfare and dignity

The Committee noted the initial assessment information for the REC in regards to compliance with the data protection act. Members queried whether the researchers would have access to identifiable data prior to consent being obtained.

Ms McDonnaugh confirmed that researchers would not have access to identifiable data without consent. She explained that she would be provided with the clients' name and contact details if they had agreed to this being provided for the purpose of discussing the study and obtaining consent and added that, after consent had been obtained, she would go via the responsible clinician for further information in regard to client records rather than accessing these directly.

The Committee accepted this response.

Suitability of supporting information

The Committee discussed the interview schedule and noted that the word "challenging" had been used on occasion which participants may find upsetting given that this population would often be labelled as "challenging". Members queried why the interview schedule did not contain questions relating to how participants spend their day; manage their budget and other related issues.

Ms McDonnaugh explained that there was no reason why these lines of questioning had not been included other than the interview would be semi-structured and the schedule provided would be the bare bones of the discussion which may extend into further questions. She iterated that the interviews would be very idiosyncratic. Ms McDonnaugh commented that it had been difficult to produce the correct language within the interview schedule and noted that there may be an alternative word to use as opposed to "challenging".

The Committee accepted this response.

Other general comments

The Committee discussed that the line of questioning would be highly sensitive and that researcher safety was very important given the population taking part and queried whether a lone worker policy would be followed.

Ms McDonnaugh explained that the study would be taking part in Barnet Enfield and Haringey Mental Health Trust therefore she would adhere to their lone worker policy. She detailed that the interviews would take place on site with other staff present and in working hours, and confirmed that alarms would also be used. Ms McDonnaugh furthered that interviews could also take place in the participants supported residence but that always staff would always be presented therefore she would be highly supported in the event of the first sign of disturbance.

The Committee accepted this response.

The Committee noted that there may be further issues raised in correspondence.

The applicant left the meeting

Please contact the REC Manager if you feel that the above summary is not an accurate reflection of the discussion at the meeting.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [UCL insurance confirmation letter]	1	25 April 2017
Interview schedules or topic guides for participants [Interview schedule]	1	06 March 2017
IRAS Application Form [IRAS_Form_26042017]		26 April 2017
Other [UCL Clinical Trial Policy]	1	11 July 2016
Other [218254_Initial_Assessment_Information_for_REC_form_Final]		09 May 2017
Participant consent form [Participant consent form]	1	15 February 2017
Participant information sheet (PIS) [PI sheet]	1	06 March 2017
Referee's report or other scientific critique report [Peer review]	1	01 March 2017
Research protocol or project proposal [authorised signed protocol]	1	03 April 2017

Summary CV for Chief Investigator (CI) [CI CV]	1	21 April 2017
Summary CV for student [Student CV]	1	21 April 2017
Summary CV for supervisor (student research) [Supervisor CV]	1	21 April 2017
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Flow chart of protocol]	1	03 April 2017

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

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

After ethical review

Reporting requirements

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

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

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

User Feedback

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

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

17/LO/0786	Please quote this number on all correspondence

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

Yours sincerely

pp

Mrs Rosie Glazebrook Chair

E-mail: nrescommittee.london-camdenandkingscross@nhs.net

Enclosures:	*List of names and professions of members who were present at the meeting and those who submitted written comments*
	"After ethical review – guidance for researchers"
Copy to:	*Miss Misha Ladva, Joint Research Office*
	Miss Tabitha Kavoi, University College London Hospitals NHS Foundation Trust

London - Camden & Kings Cross Research Ethics Committee

Attendance at Committee meeting on 22 May 2017

Committee Members:

Name	Profession	Present	Notes
Dr Emily Cadman	Senior Registrar	Yes	
Ms Heidi Chandler	Deputy Research Delivery Manager	Yes	
Mrs Julia Crenian	Volunteer with Home-Start	Yes	
Mrs Rosie Glazebrook	Consumer Marketing	Yes	
Ms Rosalind Jones	Retired Mental Health Nurse	Yes	
Mrs Elizabeth Landers	Tutor	Yes	
Dr Lorraine Ludman	Chartered Psychologist	Yes	
Dr Jacqueline Maxmin	Retired GP	Yes	
Dr Andy Petros	Consultant Paediatric Intensivist	No	
Ms Petra Shroff	Paediatric Nurse	Yes	
Mr Jonathan Simons	Investment Manager	No	

| Ms Eleni Yerolaki | Specialist Counsellor | Yes | |

Also in attendance:

Name	Position (or reason for attending)
Miss Courtney Bowen	MRes in clinical research student (observer)
Ms Jill Macpherson	Chlld and Adolescent Psychotherapist (observer)
Miss Christie Ord	REC Manager
Dr Gregor Scherzinger	Research Collaborator (observer)

Appendix C: Participant Information Sheet

Research Study

**'Service users' Experience of Discharge from
a Medium Secure Forensic Unit' (student study)**

Researchers: Tanya McDonnaugh

Information Sheet

You are being invited to take part in some research.

Before you decide whether to take part, it is important for you to understand
Why the research is being done and what it will involve.

Please:
- Read the following information carefully
- Talk about it with others if you wish.

Ask us:
- If you don't understand anything
- If you would like more information.

You do not have to take part in this research. It is your choice.

What is this research about?

- We want to look at the experiences of service users when they are being discharged from a medium secure forensic hospital.

- Discharge can take a long time and the move to life in the community can sometimes be difficult.

- We think it is important to find out more about discharge from the patient's point of view.

- We hope that by hearing about the experience of patients during the discharge process we may be able to find out what parts are the most difficult and how this can be made easier.

- This study also forms part of a University College London Doctorate of Clinical Psychology research thesis by Tanya McDonnaugh (Trainee Clinical Psychologist) and is supervised and Dr Alan Underwood.

Why are we asking you?

- You have been invited to take part in this because you have recently been discharged from a medium secure hospital.

- You are getting support in the community from the Forensic Community Team.

UCL

What will it involve?

- You will be asked to sign a form to say that you have agreed to take part. This is called a consent form.

- The researcher will contact you to arrange a time and date for you to come to meet with them. You can also ask them questions about the meeting.

- Your responsible clinician will be told that you are taking part in the research.

When you come to meet with the researcher

- There will be just you and the researcher

- All interviews will be carried out on NHS clinical premises or staffed community accommodation during working hours.
- You will be asked questions about different parts of the discharge process and to talk about your experience of these.

- Your conversation with the researcher will be audio recorded.

- You can choose how much information you want to give.

- This should take between 1 hour and 1 hour 30 minutes.

- You will receive a £10 supermarket voucher for your time.

What happens next?

- The researcher will look at what you have said. They will try to understand your experiences and the experiences of the other people in the study.

- At a later time the researcher will write out what you have said. You can look at this and check that the researcher has understood you in the right way.

- All participants will be asked if they would like to be sent a summary of the research. Those who indicate their interest will be emailed/posted a summary after the study has ended.

UCL

What will happen to my information?

- All information collected about you during the course of the research will be kept private and confidential. It will be stored in a safe place at the university.

- Your name and contact details will be stored separately from the information you give the researcher at the meeting.

- All information will be kept securely according to the requirements of the Data Protection Act 1998.

- The results from this study will form part of the researcher's research thesis, which is part of the UCL Doctorate in Clinical Psychology. Information learned from the study will be written in a report. This might be published.

- No one will know anything about you or anyone else who has given information for the study.

- No names or any personal details about people who took part in the study will be put on any publication or report about this research.

- Your involvement will be kept private and confidential.

Are there any risks to me?

- There is very little risk in taking part in this study.

- The meeting will involve talking about your experience of your discharge. It might involve discussing difficult or challenging experiences so there may be times when you feel upset.
- However you can choose how much you would like to say for each question.

- This study has received ethical approval from Camden and Kings Cross Research Ethics Committee on 5th June 2017.

Are there any benefits to me?

- You will receive a £10 supermarket voucher for your participation; this will not be redeemable on tobacco or alcohol products.
- Although there is no direct benefit, you may find it helpful to talk and reflect on your experience of discharge into the community.

UCL

Do I have to take part?

- No

- It is up to you to decide whether or not to take part in this study. It is voluntary.

- If you do not take part you will still get the same support from the Forensic Integrated Community Service.

- If you do decide to take part and you change your mind you can stop at any time. You can ask for your information to be taken out of the study. You do not have to give a reason.

Your care during and after the study

- Your responsible clinician will continue to look after your care during and after the study. This will not change.

How this research may help others

- You will help professionals to understand better what it is like for a patient to be discharged from a medium secure forensic hospital into the community.

- You may help professionals to understand which parts of moving back into the community are the most difficult and how this can be helped.

If you have worries, concerns or complaints due to the research project

- You can use National Health Service or UCL complaints services if you wish to complain, or have any concerns about any way you have been treated by members of staff due to taking part in the research.

Harm resulting from the project

- If you are harmed by taking part in this study, which is very unlikely, compensation may be available.

- First talk this through with the researcher.

- Then make the claim in writing to Dr Alan Underwood who is the Chief Investigator for the research and is based at: [add location name for Chief Investigator].

- The Chief Investigator will then pass the claim to the Sponsor's Insurers, via the Sponsor's office.

- You may have to pay the costs of any legal action initially, and you should speak to a lawyer about this.

UCL

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- You may have to pay the costs of any legal action initially, and you should speak to a

Next Steps

If you have read through this information sheet and are happy to take part then:
- Complete the consent form.
- Return it to your responsible clinician.

Contact details

- If you need any further information to help you decide whether to take part in the study or if there is anything you do not understand, please contact:

  Tanya McDonnaugh
  Department of Clinical, educational & Health Psychology
  University College London,
  1-19 Torrington Place,
  London WC17HB

- Dr Alan Underwood
  Department of Clinical, educational & Health Psychology
  University College London,
  1-19 Torrington Place,
  London WC17HB

- Further information can be obtained from the following:
  UCL Division of Psychology and Language Sciences
  Gower Street
  London
  WC1H 0AP

  Phone: 020 7679 2000

Appendix D: Consent Form

Patient Identification Number for this study:

CONSENT FORM

Service Users' Experience of Discharge from a Medium Secure Forensic Unit (student study)

Name of Researcher: Tanya McDonnaugh

Name of Chief Investigator: Dr Alan Underwood

Please initial all boxes

1. I confirm that I have read and understand the information sheet dated 12/06/17 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

3. I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from **UCL** regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

4. I understand that the information collected will form part of Tanya McDonnaugh's research and may be used by her in publications, reports and presentations – but I will not be identified in these.

5. I agree to my Responsible Clinician being informed of my participation in the study.

6. I agree to my interview being audio recorded, transcribed and verified.
.
7. I understand that all information will be kept securely according to the requirements of the Data Protection Act 1998.

8. I understand that confidentiality will be broken in the event that I disclose anything criminal that has not already been disclosed, or anything that may put myself or others at risk.

9. I agree to take part in the above study.

Name of Participant	Date	Signature

Name of Person taking consent.	Date	Signature

Appendix E: Interview Schedule

<u>Interview Schedule</u>

1. **Introductions**
- *Explain the purpose of the study and the type of questions that will be asked.*
- *Reminder that they should not feel pressured to disclose more than they wish to.*

2. **Demographic questions**
- "If it's ok with you I'm going to start by asking you some general questions to make sure I've got your information correct"
    - Age
    - Confirmation of medium secure
    - Time since discharge
    - Length of stay
    - Type of section
    - Current type of accommodation (e.g. low support)
    - CC

3. **Broad questions**
- "Overall how was the process of discharge?"
- "How well do you think you were prepared for discharge?"

4. **Leave**

- **(Main question): "tell me about your experience of having leave whilst an inpatient?"**

- *What do patients perceive as helpful and unhelpful*

    - "Where there any parts of the process you found challenging?"
    - "Was there anything you found particularly helpful through that challenge?"
    - "Was there anything you found particularly unhelpful through that

challenge?"

  o "Was there anything that was easier than you expected?"

- *The barriers and facilitators to enablement/independence*

  o "Can you tell me about your first unescorted leave into the community?"
  o "Is there anything you would like to have done more of?"
  o "Is there anything you would like to have done less of?"

5. **First contact with community/preparing to move out**

- **(Main Question): "tell me about what it was like for you preparing to move into the community?" (still living on the ward but visiting preparing to move)**

-

- *What do patients perceive as helpful and unhelpful*
  o "Where there any parts of the process you found challenging?"
  o "Was there anything you found particularly helpful through that challenge?"
  o "Was there anything you found particularly unhelpful through that challenge?"
  o "Was there anything that was easier than you expected?"

- *The barriers and facilitators to enablement/independence*
  o "How did you feel going to new places?"
  o "Did you feel at home on the ward?"

6. **Living in the community**

- **(Main Question): "tell me what it was like for you when you first moved into the community?"**

- *What do patients perceive as helpful and unhelpful*
    - "Where there any parts of the process you found challenging?"
    - "Was there anything you found particularly helpful through that challenge?"
    - "Was there anything you found particularly unhelpful through that challenge?"
    - "Was there anything that was easier than you expected?"

- *The barriers and facilitators to enablement/independence*
    - "How do you spend your time?/ tell me about a typical week for you?"
    - "Was there anything that was challenging after leaving hospital and living in the community?"
    - "Was there anything that was easier than you expected about moving back into the community?"
    - "Do you feel at home in the community?"
    - "If so when did you start to feel this way?"
    - "Do you feel part of the community? Have you ever felt part of the community?"
    - "When did you start feeling this way?"
    - "Is there anything that made it harder to integrate back into the community?"
    - "How connected do you feel with people you spend time with?"
    - "Some people who are discharged from a secure hospital talk about their relationships with friends and family and how this can change, how was this for you when you were discharged?"
    - "How is it now?"
    - "Do you feel discharge prepared you to manage these things?"

7. **Relationships with professionals throughout the process**

- **(Main Question): "tell me about the professionals who have worked with you throughout the process?"**

    - "Tell me a bit about the professionals involved in your care at present."

- o "What are those relationships like?"
- o "Has the level of support changed overtime from being an impatient to now?"
- o "What has this been like?"
- o "Is there anything that staff have done that was particularly helpful during this time?"
- o "Is there anything staff have done that was unhelpful during this time?"

8. **Identity, control and responsibility throughout the discharge process**

- o "Do you still feel like a patient/identify as a patient?"
- o "When did you stop feeling like a patient/do you think you will ever stop feeling like a patient?"
- o "Was there a change in the amount of responsibility you had as an inpatient compared to the community?"
- o "Was this a gradual change?"
- o "How did you cope with this change?"
- o "When did you start to feel you had more control over your daily life?"
- o "What was this like going from not having control to decided more things yourself?"
- o "How much choice do you think you had?"

9. **Ending questions**

- o **"How do you feel now looking back on the whole process of discharge?"**

Appendix F: Sample Interview Transcription

I = Interviewer, P = Participant, (…) = pause greater than three seconds.

I: Ok and I just want to ask you about the time when you actually moved out into the community and what that was like; about transitioning to live in the community, what was that like for you?

P: I think it was ok, because I had overnight stays for a little while

I: How long for?

P: Erm (…) I think it was three months

I: Ok, so was that enough time for you to adjust?

P: Yeah, probably a bit too long for my liking

P: Alright, and can you remember your first week of actually living in the community, do you want to tell me a bit about that?

P: Yeah I do actually yeah. Well I had a lot of support from the team, so they came to visit me quite a bit so that was good. I think erm (…) cooking for myself again was a good experience.

I: Did you find that easy, or did it take a bit of getting used to?

P: I think it took a bit of getting used to actually. I think.

P: And did you feel ready and prepared to move out into the community when you did?

P: I did feel ready yes, I'd been building up to it for a long time.

I: Was there anything you think could have helped you feel more prepared or were you as prepared as you could have been?

P: It's a difficult question because therapy, psychology in particular, is leading up to discharge, but nothing's guaranteed. So my first concern when I was in hospital with the possibility of discharge was actually to get out of hospital. So I couldn't actually plan and say "I'm gonna get out this date" or that date until I actually go to that tribunal and they say "you've got your discharge" and even then it's a drawn out process afterwards. So a lot of mind is concentrating on the therapy and consolidating the information that the psychologist has given me so (…) I didn't have much time to think about how I would get out, the main thing was to get out.

I: It sounds like that was a bit of an unknown in terms of firm timeframes, so it sounds like you were focusing on something you did have a bit more control over time frame wise, does that sound right?

P: Well (...) yeah erm (…). Well I was working on getting out and the psychology to receive the doctors consent to go to the tribunal and let him give his consent to my discharge, so that's a big struggle. It's a constant struggle in fact when you're in hospital so you're constantly working toward that goal but it's not set out in stone for you, it's a bit of an unknown. They only let you know when you've actually go to that tribunal; and you're never actually out till you've left the door.

I: Ok, so it sounds like it's a case of taking things one step at a time, that's interesting.

P: It is yeah.