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An exploration of the relationships between inpatients and clinical psychologists in forensic mental health services

SECTION A: The relationship between forensic mental health service users and psychologists; relationship, offender, therapist and environmental factors.

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SECTION B: An exploratory grounded theory of the relationship between inpatients in medium secure units and clinical psychologists.

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Acknowledgements

Summary of Major Research Project

Section A explores the theoretical and empirical literature related to engagement and the relationships between inpatients in Forensic mental health services and psychologists. The review considers the 'dual role' of clinical psychologists working in such settings of not only providing therapeutic intervention, but also expert risk assessment and how this may impact on the building of a trusting relationship. Further to this, offender, relationship and environmental characteristics are considered; to explore whether inpatients in such settings can realistically develop therapeutic relationships and engage successfully in such settings. The clinical and research implications of the review are then considered.

Section B presents an empirical study, which used a grounded theory approach employing semi-structured interviews to explore the relationships between inpatients and clinical psychologists within two medium secure units. It explores how relationships are formed, what therapeutic gains can be made and what the barriers are within these settings and presents this in a grounded theory model. The clinical and research implications as well as the limitations of the study are presented.

Section C offers a critical appraisal of the project in its entirety, focusing specifically on the skills and developments made by the researcher throughout the project. Reflections on areas for improvement are also offered before considering the implications for future clinical practice and possible further research arising from the project.

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Section A: Literature Review

Does the dual role of clinical psychologists in forensic mental

health settings impact on the therapeutic relationship?

Word Count: 4953

July 2013

Abstract

This review evaluates the literature exploring engagement and the relationships between inpatients and psychologists within forensic mental health services.

A small body of research within prison settings has identified a growing level of distrust of psychologists and the review considers how this may apply in forensic mental health services. The review begins with a consideration of the 'dual' role of clinical psychologists within such settings, of providing therapeutic intervention, as well as, risk assessment, which greatly limits confidentiality.

The review goes on to consider offenders and the characteristics, which may impact the development of a trusting and collaborative bond. The review then examines the existing literature pertaining to relationship factors between offenders and psychologists to aid understanding as to whether service users in forensic mental health settings can realistically engage and make treatment gains. Finally, the review considers the possible impact of environmental factors on service users in forensic mental health services.

Conclusions are drawn and suggestions for future research and the potential clinical implications drawn from the review are outlined.

1. Introduction

The number of offenders with mental health problems diverted from prison to forensic mental health services within the United Kingdom is growing. This review aims to explore and consolidate the theoretical and empirical literature pertinent to an understanding of the therapeutic relationship and treatment engagement in such settings.

1.1. Forensic mental health services

Forensic mental health services play an important role in the provision of treatment for those who have committed offences needing to be housed in a secure environment to receive specialist mental health treatment (Rutherford & Duggan, 2008). Today in the United Kingdom, forensic mental health services house more than 3,500 service users who have been diverted from the legal system, and admissions continue to rise with over 1000 a year reported (Ministry of Justice, 2010).

Forensic mental health services are provided both in the community and secure NHS settings. Their role has been described as facilitating a therapeutic environment, protecting society and maintaining security (Brunt & Rask, 2005). The patients accommodated by such services have offended, have a mental health disorder, have been sectioned under the Mental Health Act (1983, 2007) and are deemed to be a risk to themselves or others.

1.2. The dual role of clinical psychologists in forensic mental health services

Recent studies have identified the growing distrust in offenders of Psychologists (Crewe, 2009, Maruna, 2011). Research suggests that this distrust seems to have grown from the changing role of psychologists within forensic mental health services including prisons and forensic mental health services for mentally disordered offenders.

The number of psychologists in UK prisons and forensic mental health services (FMHS) expanded greatly during the late nineties, when offender programmes became increasingly popular (Towl, 2003). The chief focus of psychologists changed from one of providing relief of psychological distress to one of risk assessment, recommending appropriate interventions and providing reports for parole boards and other judicial bodies. The prior focus of prison psychologists tends to now be reserved for those with more severe mental health problems. It is argued that this new role of providing expert risk assessment is at odds with the function of providing a 'helping role' in prisons (Jeglic & Mercado, 2011).

Given this 'dual role' of clinical psychologists and its existence within forensic mental health settings as well as the growing distrust, the following review aims to outline the factors important to patient-therapist relationships. The existing empirical research regarding forensic mental health service users will then be explored to ascertain whether existing theory can be applied in this context.

1.3. Factors important to the patient - therapist relationship

Engagement and the collaborative nature of the alliance

Engagement is a well-researched area within the health care literature; however it is dominated by issues such as adhering to medication, treatment compliance and attendance of out-patient appointments (Mason & Adler, 2012). For the purpose of this review, engagement refers to the extent to which the client actively participates in the treatment offered, attends treatment sessions and willingly shares their thoughts, feelings and problems. In order to participate fully in treatment, clients must be able to develop effective working relationships with others, particularly their therapists (Hovarth & Greenberg, 1989). For psychotherapy to be effective, engagement is a key ingredient; those who are engaged with the process are more likely to have positive affective bonds with their

therapists, participate more readily, believe in therapy goals, stay in therapy longer and to report higher levels of satisfaction with their treatment (Thompson, Bender, Lantry & Flynn, 2007).

The therapeutic alliance, which will be referred to throughout this review, describes further the working relationship between the client and the therapist. The term will be used to refer to the quality of the interaction between the client and the therapist, the collaborative nature of the relationship as well as the personal bond between the client and therapist (Hovarth & Symmonds, 1991). Reviews of the early alliance literature has indicated that a collaborative nature to therapy and agreement on the tasks of therapy are closely related to engagement and positive outcomes in psychotherapy (Adler, 1988; Horvarth & Greenberg, 1989). It is likely that this sense of taking part in a collaborative endeavour improves a patient's sense of safety and contributes to their ability to build trust in their therapist enabling them to take part in the therapeutic journey (Hovarth & Luborsky, 1993).

Trust

An essential part of any therapeutic relationship is trust. A patient's trust in their therapist is crucial to form and maintain a therapeutic alliance (Pearson & Raeke, 2000). Minamisawa, Suzuki, Watanabe, Imasaka, Kimura, Takeuchi, Nakajima, Kashima & Uchida (2011) found that greater trust was correlated with a longer duration of treatment with their psychiatrist as well as the length of their psychiatrist's career (level of experience), although the authors acknowledged that they did not take into consideration the nature of the patients' diagnosis or level of medication and how this may have impacted upon the findings. Nevertheless, the implications are that it may be particularly pertinent to pay more attention to those new to treatment or working with less experienced clinicians in order to develop trust and a strong therapeutic alliance.

Satisfaction

It is known that low levels of satisfaction with services is likely to contribute to treatment failure and is a predictor of negative outcomes (Avis, Bond & Arthur, 1995). The interests of service user's should be considered when developing and evaluating existing and new services and is a recommended guideline in mental health provision (NICE, 2011). A recent review of service user's views of appropriate treatment was carried out by Hopkins, Loeb & Fick (2009) who identified three themes: safety, the quality of interpersonal relationships and the way in which services were structured.

1.4. Rationale and Aims

The evidence base informs us that the most common predictive factor of success of psychotherapeutic interventions is the therapeutic alliance (Hovarth & Symonds, 1991). However, this has not been investigated in forensic mental health services where clinical psychologists are in a unique position of providing not only relief from distress, but are responsible for reducing risk and providing assessment of the level of risk posed by their patients. There is a need to understand whether this unique position and the other constraints of a forensic mental health setting impact on the therapeutic relationship between clinical psychologists and patients. This review aims to explore whether patients in forensic mental health services can engage with the therapeutic process and make treatment gains in this unique context.

2. Method

2.1. Search strategy

See Appendix A.

2.2. Inclusion and exclusion criteria

The review was limited to papers published since 1990 since the introduction of the 'dual role' of clinical psychologists did not occur until this time (Crewe, 2009). Included papers were in English.

Papers were excluded if their focus was not relevant to the aims of this review or one of the following; the results were specific to child or adolescents, patients with a primary issue of substance abuse or dementia and could not be extrapolated to adults with long term mental health problems living in secure settings. Where a meta-analytic review was included, the individual papers within it were not examined to avoid repetition.

2.3. Identified articles

The literature search resulted in 15 relevant articles. The articles were organised by theme, the first of which explores relationship factors in forensic mental health services including three studies exploring engagement and its relationship to outcome in medium and high secure forensic mental health services (Long, Dolley & Hollin, 2013; Mason & Adler, 2012, McCarthy & Duggan, 2010), three papers examining perceived coercion in treatment (Donnelly et al, 2011; Parhar et al, 2008, Skelly, 1994) and one examining the risk of drop out amongst offenders (Nunes, Cortoni & Serin, 2010).

The second theme identified was of offender related factors (Ross & Prafflin, 2007; Levinson & Fonagy, 2004). The third theme examines psychologist related factors (Crewe, 2009;

Maruna, 2011) and the final theme, environmental factors, includes four papers exploring service user satisfaction in forensic mental health services (Long et al, 2012; Bressington et al, 2011; MacInness et al, 2010; Carlin et al, 2005).

3. Literature Review

3.1. Relationship Factors

Engagement

Where psychological treatment has been mandated for patients in forensic mental health services (for example, is expected by review tribunals, managers hearings and the Ministry of Justice) a failure to engage has been associated with a failure in the reduction of risk. It has been found that offenders who either drop out or are removed from psychological treatment are at higher risk for recidivism (Nunes, Cortoni & Serin, 2010). Confounding this problem further in forensic mental health services is the issue of a population who are often suffering from a severe mental health problem and a personality disorder as well as managing the impact of their offending history (Long, Dolley & Hollin, 2013).

The number of patients not completing treatment within forensic mental health services is alarming. McCarthy & Duggan (2010) found that three quarters of a male sample diagnosed with a personality disorder that were admitted to a medium secure unit also failed to complete treatment. They also reported that for those who did complete treatment, outcomes were more positive, including being referred from hospital, having lower levels of impulsivity and were less likely to have an unstable and antisocial lifestyle than those who failed to complete treatment over a two year programme. A further study by Long, Fulton, Fitzgerald & Hollin (2010) investigated engagement in psychological treatment (group cognitive behavioural therapy) in a womens medium secure unit (MSU) to assess the differences between high and low treatment attendees and to compare their progress

during the course of their stay in hospital. They classified the admissions of 60 patients into high and low attending treatment groups. Those in the high attending group had shorter hospital stays, demonstrated less disturbing behaviour and made the greatest improvements in terms of overall symptom reduction. They also reported that those in the low attending group were more likely to have a diagnosis of schizophrenia or schizoaffective disorder than a personality disorder. They concluded that attending group psychological treatment had clear benefits for patients and potential cost benefit implications for both the service and the community, but that for a small sub group of women attendance was particularly difficult, seemingly as a function of diagnosis.

Mason & Adler (2012) carried out a study of group-work therapeutic engagement in a high secure unit and investigated service user perspectives of the factors influencing engagement. The study involved an opportunistic sample of eleven male service users who took part in semi-structured interviews. The research was underpinned by the Health Belief Model (Rosenstock, 1974), which is based upon individual perceptions of illness, health values and the importance of health and consequences. The subsequent interview schedule related to the social and psychological factors associated with the health belief model including questions relating to individual understanding, cultural contexts, previous experiences and therapeutic rapport (McCormack Brown, 1999). The authors carried out an interpretative phenomenological analysis (IPA) and identified the pervasive nature of the environmental culture and the need to balance public protection with the therapeutic needs of the individuals it confines, and choice and agency, as their two main themes of influence. The participants gave a mixed account of positive and negative rapport with therapists and motivation to engage with the group based on past experience and expectancy of outcomes. Although participants also expressed value in having choice, they reported a lack of it, which they linked to an external locus of control. The authors concluded that most of the service

users in the study were unable to feel autonomous regarding engagement due to their perceptions of power and a sense of learned helplessness.

The study had several limitations. The authors excluded any personality-disordered patients on the basis that they considered these patients to have different treatment needs; they also excluded women as they felt they were unable to guarantee anonymity due to their smaller numbers in the hospital. Furthermore, and similar to the study by Long, Dolley & Hollin (2013), consideration was only given to engagement with group psychological therapy and thus these findings cannot be generalised to better understand factors associated with engagement in individual psychological therapy.

Trust

If trust is a key aspect of the therapeutic alliance, then the role requirements of clinical psychologists working within forensic mental health services, which considerably limit the level of confidentiality, must be damaging (Ross, Polaschek & Ward, 2008). Clinical psychologists in forensic mental health services are expected to help offenders make positive changes, at the same time they are expected to disclose information, which could ultimately lead to further punishment by the legal system in the case of new disclosed offences, or increased lengths of stay and further restrictions on activities due to disclosures related to risk.

At the time of this review, no studies were found regarding the relationship between trust and therapeutic alliance in forensic mental health services other than the prison environment.

Coercion in Forensic mental health services

Unlike in a traditional therapy setting, where a client enters therapy voluntarily and assumingly with motivation and an agenda of their own, entry to therapy in forensic mental health services is usually mandated or coerced-voluntary treatment (Ross, Polaschek & Ward, 2008).

In a meta-analysis of 139 studies, Parhar, Wormith, Derkzen & Beauregord (2008) found that where treatment was mandated or coerced in custodial settings there was no treatment effect; however, this was not the case where offenders entered treatment voluntarily. The findings indicate that caution should be taken in providing treatment within the criminal justice setting, which is either mandated, or with implications if the offender does not take the treatment.

Donelly, Lynch, Mohan & Kennedy (2011) examined the working alliance, interpersonal trust and perceived coercion in mental health review hearings in Ireland. The study aimed to see if positive or negative perceptions of mental health review hearings would impact on the therapeutic relationships experienced by inpatients. The authors found some evidence that where the reviews were negatively perceived there was a negative effect on therapeutic relationships, both in terms of trust and feeling coerced. A major limitation of the study was that mental state was not controlled for and it is possible that those who perceived hearings negatively and whose therapeutic relationships were negatively affected may also have been less well.

Skelly (1994) carried out semi-structured interviews with fourteen service users who had been transferred to a lower level of secure hospital. The findings indicated that the service users had not internalised the behaviours that the previous service had asked them to perform and they were unable to understand the rationale for these behaviours. They

reported that they had 'played the game' and complied with what they had been asked to do. The findings of the study must be considered with caution as Skelly's account failed to recognise the possible impact the researcher might have had.

3.2. Offender related factors

Research on attachment theory is particularly relevant for psychologists working in forensic mental health services as it provides an understanding of both normal and pathological interpersonal relationship formation (Fonagy, 1996). For the purpose of this review, an attachment style refers to working models held by individuals of their beliefs and expectations regarding themselves and their relationships. These are usually characterised by the early experiences that they had with their caregivers (Fraley & Shaver, 2000). Those with a secure attachment style generally report positive relationships and find it easy to build trusting and emotionally involved relationships. Those with an insecure attachment style are typically avoidant of developing such relationships or doubt their self worth and the likelihood of success of such relationships.

Empirical findings have shown that the type of attachment style of offenders is mostly of the insecure style. Levinson & Fonagy, (2004) tested the prediction that an attachment style was more likely to be insecure and dismissive, once controlling for psychiatric illness, among a group of offenders. The study sample compared 22 prisoners, 22 matched psychiatric inpatients with a personality disorder and 22 healthy non-offending control group participants. The Adult Attachment Interview (AAI; George, Kaplin & Main, 1985) was given to all participants as a measure of early trauma and childhood attachment patterns, as well as the Reflective Function Scale (RF; Fonagy, Target, Steele, & Steele, 1998), a self-report

measure of an individual's capacity to reflect on mental states designed to accompany the Adult Attachment Inventory.

The authors found that the offenders group reported significantly more childhood abuse and trauma, had greater insecure attachment histories, were less likely to be able to mentalise and displayed less empathy. They concluded that the removal of the potential protective barrier, reflective functioning, may make offenders with such attachment histories more likely to offend. The authors did not comment on the types of offence for which the participants were incarcerated or the presence or absence of mental illness.

As secure attachment is a key factor in building trusting relationships and the offending group in this study had significantly higher levels of insecure attachment histories, it is possible that clinical psychologists are likely to experience more difficulties in building a therapeutic relationship with offenders.

Several studies have argued that patients often regard mental health professionals as attachment figures (Bowlby, 1988, Wilkinson, 2003). In particular psychiatric staff may function in an important role as providing a 'safe base' for the patients in their care. Furthermore, they may provide corrective experiences for those with an insecure attachment style, which may disconfirm their internal working models of attachment relationships (Ma, 2007). This would be increasingly likely when considering the relationship histories of offenders amongst other factors such as their detained status and how this may impact on building trust.

However, empirical research has not always supported these claims (Ma, 2007). It has been suggested that a therapeutic relationship only becomes an attachment relationship when the following criteria are fulfilled; if using the mental health professional as a secure base

would be characteristic of the patients previous relationships and would be apparent over an extended time period (Schuengel & Van lJzendoom, 2001).

A further study investigated the relationship between attachment styles, interpersonal problems and violent behaviour in German offenders compared with two non-violent groups living in the community (Ross & Pfafflin, 2007). The study sample included 31 violent male offenders detained in four German prisons; all had committed at least one violent offence and had to serve a minimum of three years prison sentence. There were two non-violent male comparison groups; a group of 22 prison officer trainees and a group of 21 males recruited from a Christian Choir, matched for age. Those who consented to take part completed self-report measures and a short interview. The Adult Attachment Prototype Rating Scale (EBPR; Straub & Lobo-Drost, 1999) was used to assess behavioural styles in attachment situations focusing upon both past and present relationships. The measure consists of an interview, self-report and prototype rating which corresponds to the Adult Attachment Inventory, secure, ambivalent, preoccupied and dismissing. The battery also included the Inventory of Interpersonal Problems (IIP-D; Horrowitz, Straub & Kordy, 1994) a self-report measure consisting of eight scales of interpersonal problems.

The authors reported that the offenders in the study were significantly more insecurely attached, reported more relationship instability, and had a greater desire for personal autonomy and less emotional attachment. Whilst they found the offenders to be more insecurely attached, they did comment on the fact that not all offenders were and that their results matched with any non-clinical socially disadvantaged group. Interestingly, they reported surprisingly similar levels of interpersonal problems between the offenders and the comparison groups, but did not offer any explanation of this, which warrants further investigation and limits interpretability.

It is highly likely that attachment patterns will be present when forming the therapeutic relationship (Bowlby, 1998, Dozier & Tyrrell, 1998, Slade, 1999). The evidence above suggests that it may be harder for offenders to engage in and complete therapy due to the insecure attachment patterns with which they often present. However, it has been suggested that psychotherapy can potentially be a reparative emotional experience for individuals who have insecure attachment histories, if the therapist can create a safe, secure base from which the individual can explore painful experiences and construct a more collected narrative of previously distressing and conflicting memories (Goldberg, 2000). The other factors below explore whether it may be possible to create such a space in a forensic inpatient setting.

3.3. Psychologist related factors

The changing role of Psychologists in Forensic mental health services has been theorised to impact on power relations between client and therapist. Crewe, (2009) carried out extensive interviews with offenders in English prisons. He posited that the shift in concern from prisoner welfare to public protection positioned almost all specialist staff as agents of an extensive and repressive network of disciplinary power. In a study of offenders at Wellingborough Prison, it was Psychologists who were held the most responsible for determining outcomes by the prisoners and who were therefore resented the most. Crewe, (2009) concluded that the force of 'psychological power' was found to lie the most in its perceived capacity to determine future plans and possibilities.

The recognition of this shift by prisoners has been studied and it has been argued that those who once perceived psychologists as there to help, now felt they were there to judge and manipulate (Crewe, 2009). The Wellingborough Prison study reported how prisoners

believed that Psychologists had the power to 'get you out or keep you in' (Crewe, 2009, p.149). One potential limitation of the study is the relationship that may have developed between the author and the participants, Crewe spent months on the landings of Wellingborough, was given keys and interacted freely with the prisoners. Whilst this may have fostered trust, it may also have influenced responses and Crewe makes no comment on this.

Maruna (2011) reviewed the limited research in prisons in the UK exploring beliefs regarding the role of psychologists. The author concluded that, for offenders to regard risk assessments as credible these must include a focus on the present and the progress that an individual has made, rather than the historical context. Furthermore, Maruna argues that for psychologists in prisons to lose their focus as helpers and to occupy this role seen as powerful in the eyes of many offenders in matters of their release, it is not surprising that a great level of distrust has arisen. The shift in the focus of prison psychologists from personal problems of the offender into the interests and risks for public protection reflect policy change over the last fifteen years and research is starting to grow on the damage that these changes may have created. To date, no research has been carried out in other forensic settings outside of the prison service to see if these findings extend to clinical psychologists in other forensic mental health settings who are placed in the dual role of providing therapeutic intervention as well as risk assessment.

3.4. Environmental factors

Given the secure nature of these settings and the long term nature of admissions, some consideration to the environment and service users satisfaction seems warranted. A study carried out five focus groups including 27 participants across three medium secure hospitals

to explore service user satisfaction and develop a suitable measurement tool (MacInnes, Beer, Keeble, Rees & Reid (2010). The participants were asked "what has been particularly helpful about the services you've received? What has been particularly unhelpful about the services you've received? How have the services you've received affected you"? The authors utilised a thematic analysis and identified the following themes as predictive of service-user satisfaction; staff interaction, rehabilitation, the physical appearance of the unit, communication, finance and personal safety. In particular the participants referred to the relationships with their therapists with positive and collaborative relationships indicating more satisfaction. Whilst the study authors reported good internal consistency as measured by Chronbach's alpha (above 0.7) for the first five themes, the latter themes of finance and personal safety were less reliable (above 0.5).

Carlin, Gudjonssen & Yates (2005) examined satisfaction within medium secure units using a structured questionnaire. The questionnaire focused on the admission process, the information that was given, awareness of the ward restrictions and rights and the assessment and treatment given. They found that only 42% of service users were satisfied that their treatment had been discussed with them at admission and only 44% felt involved in the initial assessment. This only increased to 53% at later care planning. This demonstrates a worrying level of service user involvement in treatment. The study is limited due to the use of the structured questionnaire, only 'yes' or 'no answers were possible and the scope of responses was limited to the topics included in the questionnaire.

A study by Bressington, Stewart, Beer & MacInnes (2011) investigated the levels of service user satisfaction of 44 inpatients across four medium and three low secure forensic mental health services in one National Health Service Trust. The authors used the measure developed by MacInnes, Beer, Keeble, Rees & Reid; 2010, a 60 item self-report survey of service user satisfaction (Forensic Satisfaction Scale), a 15-item five point Likert Scale to

assess the social climate of a forensic psychiatric ward (Essen Climate Evaluation Scale,

Schalast et al., 2008) as well as the Helping Alliances Scale (HAS, Priebe & Gruyters, 1993), to

see how satisfaction might be related to perceived therapeutic relationships. They found

that 55 % of service users were generally satisfied and that the variable which was most

predictive of satisfaction, was the perceived quality of therapeutic relationships with staff.

The authors reported that service users who perceived a positive social climate were more

likely to express positive views of the therapeutic alliance and to perceive higher levels of

treatment engagement. They also identified patient safety as related to treatment

satisfaction. The study has a number of limitations; factors which may have had an impact

on the findings such as a small sample size, diagnosis, medications and their side effects as

well as the level of security were not taken into consideration and warrant further

exploration. Despite these limitations, the findings indicate that both the perceived social

climate and therapeutic relationships are important indicators of service user satisfaction in

forensic mental health services.

4. Discussion

This paper aimed to review the available literature pertaining to an understanding of the

experience of therapeutic relationships formed between forensic service users and

psychologists. Within these settings is a further layer of complexity; the role of clinical

psychologists in providing therapeutic intervention, offender behaviour programmes and

risk assessment. This role has been argued to be conflictual in nature and at odds with the

traditional helping role assumed by psychologists (Jeglic & Mercado, 2011). It would

therefore seem that all of the three core components of the therapeutic alliance (the

affective bond, collaborative nature and agreement of tasks) are likely to be compromised

by the unique position held by clinical psychologists in forensic services and that exploratory

research into the nature of the alliance in this setting is required.

Whilst there is currently a lack of existing research regarding 'trust' in forensic mental health services, detailed interviews with offenders in UK prisons indicates the perception of a shift in the interests of psychologists from one of the well-being of the patient to that of a public protection agenda, and a subsequent growing distrust of prison psychologists (Crewe, 2009).

Those who find themselves within secure settings are likely to have experienced early trauma and empirical findings have shown that the attachment style of offenders are mostly of the insecure style (Levinson & Fonagy, 2004). Insecure attachment histories are likely to present a barrier to the development of a strong therapeutic alliance and the therapeutic alliance has been found to be the most consistent predictor of positive therapeutic outcomes and engagement in treatment across modalities (Taylor et al., 2009).

Further to this already complicated picture, patients mandated to treatment have been found to be less likely to engage with therapy and more likely to reoffend (Nunes et al, 2010). Within forensic mental health services, issues of engagement are further compounded by severe mental health problems (Long et al, 2013). Treatment drop out rates in forensic mental health services are alarmingly high, (McCarthy & Duggan, 2010). Where service users have attended, a range of positive outcomes have been reported in a women's medium secure unit, including greater symptom reduction, shorter stays and less disturbed behaviour (Long et al, 2013). Two key themes relating to engagement with therapy in a high secure unit have been identified; the need to balance public protection with responding to individual needs and the level of choice and agency perceived by service users. Where engagement has been lowest it is where service users have felt coerced and so have a lack of control over a perceived power imbalance regarding their treatment (Mason & Adler, 2012).

Finally, the scant existing literature of service user satisfaction in forensic mental health services was considered. The importance of the therapeutic relationship was again highlighted in this literature. Collaborative and positive relationships with psychologists were identified by inpatients across medium secure forensic mental health units, as the key predictors of satisfaction with services (Long, Fulton, Fitzgerald & Hollin; 2010; MacInnes, 2010). More worryingly, Carlin, Gudjonsson & Yates (2005) reported that only 42% of service users across three medium forensic mental health services were satisfied with the level of discussion regarding their treatment and their involvement in their assessment. Only a slightly higher level of service user satisfaction was reported by Long et al. (2010), with 55% of women on a medium secure unit reporting satisfaction with the quality of their relationships with therapists.

4.1. Implications for Research

There is a distinct lack of research carried out with service users in FMHS. This is likely due to the difficulties associated with accessing service users who would want to be involved as well as the practical difficulties associated such as confidentiality and observation levels (Faulkner & Morris, 2003).

The findings of this review highlight the need for exploratory research with service users in FMHS to gain an understanding of their experiences of taking part in psychological therapy. In depth qualitative studies are required to understand whether these individuals can develop a strong therapeutic alliance with their therapist, given the nature of the role that clinical psychologists hold in such settings and whether they can realistically make similar treatment gains to those in non-FMHS. If such gains are not possible, it is important to

investigate what adaptations could be made to facilitate such treatment gains within forensic mental health services.

4.2. Clinical Implications

It has been discussed in this review of the literature how the one constantly found predictor amongst all therapeutic paradigms of positive treatment outcome is the therapeutic alliance. Given the previous discussion of the levels of difficulties with trust likely experienced by inpatients within forensic mental health services and high levels of difficult attachment histories, and the coercive nature of mandated treatment, barriers to the formation of a strong therapeutic alliance and motivation to engage in treatment seem to be impossible to avoid.

It may be important to acknowledge these potential issues with engagement in training programmes for clinical psychologists intending to work in these settings, as being more mindful of how they may be perceived by service users may help them to shift these perceptions.

It seems especially pertinent to explore the therapeutic relationships in such settings as psychotherapy may provide a corrective emotional experience for those with insecure attachment histories (Goldberg, 2000). It may also be pertinent for those working in these settings to develop new approaches to intervention to take into account the number of factors, which may be present, and undermining the therapeutic alliance. Lastly, some consideration is indicated as to whether these roles of providing intervention and risk assessment need to be made more distinct or ultimately separated?

4.3. Conclusion

Given the high drop out rate of service users in these settings, it is important to identify more acceptable ways of providing psychological treatment as there is evidence that treatment completion leads to shorter hospital stays, improved mental health and reduced recidivism. This review has identified a number of potential barriers to the development of a strong therapeutic relationship in forensic mental health services including relationship factors such as trust and perceived coercion, offender related factors such as insecure attachment histories, psychologist related factors such as perceived distrust due to the unique 'dual' role that clinical psychologists hold in these settings and finally, environmental factors leading to dissatisfaction amongst forensic mental health users. To further explore these potential barriers to relationship formation and treatment gains, exploratory research with forensic mental health service users is vital.

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Section B: An article prepared for the Journal of Forensic Psychiatry and Psychology

A grounded theory exploration of the relationship between inpatients and clinical psychologists within Medium Secure Units

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An exploratory study of the relationship between in-patients and clinical psychologists within medium secure units

An exploratory study of the relationship between in-patients and clinical psychologists within medium secure units

Abstract

Recent studies with offenders have identified a growing distrust in psychologists and this may be due to the changing role of clinical psychologists working within these settings. In addition to the traditional role of alleviating psychological distress, psychologists in these settings also have the additional role of providing expert risk assessment. Clinical psychologists working in forensic mental health settings are also tasked with this 'dual role'. To date, there is no research exploring the impact of this dual role in forensic mental health services.

Semi-structured interviews were carried out with eight inpatients in two medium secure units. A grounded theory analysis produced a model of how trust was built and relationships developed.

Despite the 'dual role' held in these settings, with an approach that is transparent, open, collaborative, and patient-centred; service users are able to build trusting relationships. Furthermore, they report making positive therapeutic gains.

Where 'coercive' experiences were described, this appeared to be a representation of more distant times, with recent experiences being described as more satisfactory. Clinical psychologists also seem to be placed in a position of 'mediator' amongst the wider care team.

Further research is required to explore these findings and whether they apply in other secure settings.

1. Introduction

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1.1. The dual role of Clinical Psychologists working with mentally disordered offenders

The number of psychologists in UK prisons and forensic mental health services expanded greatly during the late nineties, when offender programmes became increasingly popular (Towl, 2003). Alongside this increase of psychological input, the focus of psychologists changed from one of providing relief and alleviation of psychological distress to one of risk assessment, recommending appropriate interventions and providing reports for parole boards and other judicial bodies. It is argued that this change in role to one of providing expert risk assessment is at odds with the function of providing a 'helping role' in prisons (Jeglic & Mercado, 2011). As well as working with offenders in prison settings, clinical psychologists also work with offenders in forensic mental health services, where it is also argued that they also occupy a dual role, which may be conflictual in nature; they not only provide care but have control over their patients (Skeem, Louden & Polaschek, 2007).

The patients accommodated by forensic mental health services have offended, have a mental health disorder, have been sectioned under the Mental Health Act (1983, 2007) and are deemed to be a risk to themselves or others. Forensic mental health services for offenders who have been in contact with the criminal justice system are offered at three levels of security, high, medium and low. Low secure units are provided under the Mental Health Act (1983) for those 'who pose a significant danger to themselves or others'. It is rare to be directed initially from the criminal justice setting to low secure units, which are used mostly for those who have spent considerable time in a medium secure unit before being 'stepped down', and also house voluntary patients. Medium secure units are provided for those 'who pose a serious danger to the public, whilst high secure units are reserved for those 'who pose a grave and immediate danger to the public' There are approximately 800 beds in high secure units and 3500 beds in medium secure units, where the vast majority of mentally disordered offenders are directed from the criminal justice setting (Rutherford

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& Duggan, 2007). The role of these services has been described as facilitating a therapeutic environment, protecting society and maintaining security (Brunt & Rask, 2005).

Clinical psychologists in forensic mental health services are expected to help offenders to make positive changes, but, at the same time, they are expected to disclose information which could ultimately lead to further punishment by the legal system in the case of new disclosed offences, or increased lengths of stay and further restrictions on activities due to disclosures related to risk.

Recent studies have identified the growing distrust in offenders of Psychologists (Crewe, 2009, Maruna, 2011). A study carried out at Wellingborough Prison reported how prisoners believed that Psychologists had the power to 'get you out or keep you in' (Crewe, 2009). The study employed in depth interviews with prisoners to explore their perceptions of psychologists, participants described a range of experiences and interventions. When asked how they felt about the role of the psychologist most prisoners reported having little objection to psychological insight but felt that when problems were identified, they were not given any support or intervention by the psychologists, which they reported, would have been welcomed. Instead it was felt that the identification of problems was just reported and used against them as demonstrated by the following quote:

> "They may isolate difficulties that you're having, but they don't help you with them. They will observe how you handle those difficulties, how you come to terms with them. You are given the opportunity to speak to a counsellor or somebody if you feel you're having problems, but it will all end up in a report." (George, as cited in Crewe, 2009, pg 18)

Crewe concluded that those who once perceived psychologists as there to help now felt they were there to judge and manipulate. A potential limitation of the study is the relationships that Crewe may have developed with the prisoners, Crewe spent many months at Wellingborough and

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interacted freely with the prisoners, whilst this may have helped to build rapport, this may also have influenced the responses of participants.

Maruna (2011) reviewed the narrow literature investigating the apparent loss of legitimacy of psychology as a profession within the UK prison system and also concluded that the stepping away from a 'helping' role and the emphasis on risk assessment over the last two decades was mostly responsible. He further concluded that, for psychology to become legitimate within the prison system again, risk assessments must focus more on the efforts made by prisoners in rebuilding their lives and less on the past, be less stigmatising and that the individual should be more involved with the assessment being transparent. He also highlighted that far from being a neutral environment, prisons are likely to be disruptive to psychological health and that these risks of imprisonment need to be recognised before those imprisoned may rebuild trust in the profession.

The research suggests that this distrust seems to have grown from the changing role of psychologists within prisons and is likely to extend to forensic mental health services for mentally disordered offenders given the similarity in role of the clinical psychologists in these settings. Whilst it is recognised that within forensic mental health services there is a focus on providing a therapeutic environment that does not exist within the prison system (with the rare exception of prisons with therapeutic communities attached), if trust is a key aspect of the therapeutic alliance, then the role requirements of clinical psychologists working within forensic mental health services, which considerably limit the level of confidentiality, must be largely damaging (Ross, Polaschek & Ward, 2008). At the time of this review, no studies were found regarding the relationship between trust and therapeutic alliance in forensic mental health services other than the prison environment. In turn, if, the ability to form a therapeutic relationship is limited by the nature of the role of clinical psychologists working within forensic mental health services, then engagement in treatment and the likelihood of any positive treatment gains is also likely to be compromised.

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1.2. Engagement

Where psychological treatment has been mandated for patients in forensic mental health services (for example, is expected by review tribunals, managers hearings and the Ministry of Justice) a failure to engage has been associated with a failure in the reduction of risk. It has been found that offenders who either drop out or are removed from psychological treatment are at higher risk for recidivism (Nunes, Cortoni & Serin, 2010).   Confounding this problem further in forensic mental health services is the issue of a population who are often suffering from a severe mental health problem and a personality disorder as well as managing the impact of their offending history (Long, Dolley & Hollin, 2013).

The number of patients not completing treatment within forensic mental health services is alarming. McCarthy & Duggan (2010) found that three quarters of a male sample diagnosed with a personality disorder that were admitted to a medium secure unit also failed to complete treatment. They also reported that of the sample who did complete treatment, outcomes were more positive, including being referred from hospital, having lower levels of impulsivity and were less likely to have an unstable and antisocial lifestyle than those who failed to complete treatment over a two year programme. The study also examined the reoffending rates of those who were discharged, comparing those who completed treatment with those who did not. Whilst the study results indicated a reduction in reoffending associated with completing treatment, the small sample size as a result of a naturalistic follow up, limited interpretation.

 A further study by Long, Dolley & Hollin (2013) investigated engagement in psychological treatment (group cognitive behavioural therapy) in a women's medium secure unit to assess the differences between high and low treatment attendee's and to compare their progress during the course of

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their stay in hospital. They classified the admissions of 60 patients into high and low attending treatment groups. Those in the high attending group had shorter hospital stays, demonstrated less disturbing behaviour and made the greatest improvements in terms of overall symptom reduction and a decrease in traumatic symptoms. They also reported that those in the low attending group were more likely to have a diagnosis of schizophrenia or schizoaffective disorder than a personality disorder. They concluded that attending group psychological treatment had clear benefits for patients and potential cost benefit implications for both the service and the community, but that for a small sub group of women attendance was particularly difficult and that this seemed to be a function of diagnosis. As the study focused on group therapy the findings cannot be extrapolated to individual therapy.

Mason & Adler (2012) carried out a study of group-work therapeutic engagement in a high secure unit and investigated service user perspectives of the factors influencing engagement. The study involved an opportunistic sample of eleven male service users who took part in semi-structured interviews. The research was underpinned by the Health Belief Model (Rosenstock, 1974), which is based upon individual perceptions of illness, health values and the importance of health and consequences. The subsequent interview schedule related to the social and psychological factors associated with the health belief model including questions relating to individual understanding, cultural contexts, previous experiences and therapeutic rapport (Mason & Adler, 2012). The authors carried out an interpretative phenomenological analysis (IPA) and identified the pervasive nature of the environmental culture and the need to balance public protection with the therapeutic needs of the individuals it confines, and choice and agency, as their two main themes of influence. The participants gave a mixed account of positive and negative rapport with therapists and motivation to engage with the group based on past experience and expectancy of outcomes. Although participants also expressed value in having choice, they reported a lack of it, which they linked to an external locus of control. The authors concluded that most of the service users in the study were

unable to feel autonomous regarding engagement due to their perceptions of power and a sense of learned helplessness.

The study had several limitations. The authors excluded any personality-disordered patients on the basis that they considered these patients to have different treatment needs; they also excluded women as they felt they were unable to guarantee anonymity due to their smaller numbers in the hospital. Furthermore, and similar to the study by Long, Dolley & Hollin (2013), consideration was only given to engagement with group psychological therapy and thus these findings cannot be generalised to better understand factors associated with engagement in individual psychological therapy.

There is a lack of detailed and rigorous studies investigating which factors contribute to engagement in psychological treatment within forensic mental health services, particularly with regard to individual psychotherapy.

1.3. Rationale and aims

The literature on engagement in forensic mental health services leaves us with three key messages; firstly, treatment drop out rates amongst this population are alarmingly high, two, that engagement is difficult, and finally, those that do engage make considerable therapeutic gains and are less likely to reoffend. It is therefore crucial to understand whether, within these settings, service users can develop a strong therapeutic relationship with their psychologist, given the nature of the role that clinical psychologists hold in such settings and whether they can realistically make similar treatment gains to those in non- forensic mental health services**.**

The findings of this review highlight the need for exploratory research with service users in forensic mental health services to gain an understanding of their experiences of taking part in psychological therapy. As the vast majority of mentally disordered offenders are directed to medium secure units

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the current study was carried out with service users accommodated in medium secure units. The

current study adopted a qualitative grounded theory approach using interviews with service users in

order to try to answer the following questions;

1) Does the dual role of clinical psychologists in FMHS impact on the development of a

therapeutic relationship?

2) Can service users in medium secure units trust clinical psychologists?

3) What do service user's in medium secure units perceive the role of the clinical psychologist to

be?

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2. Method

2.1. Participants

Eight participants were recruited from two National Health Service Medium Secure Units within the South East of England. The inclusion criteria for the study included that participants had committed an offence, had undertaken long term individual psychological therapy (as well as group in some cases) with a clinical psychologist during their current admission but that they were no longer engaged in the therapy. Participants' first language had to be English and they had to be deemed psychologically well enough by their responsible clinician in order to participate, as well as able to give informed consent. Of those who agreed, only one was excluded, as at the time of the scheduled interview, her mental health status had deteriorated. Written consent was obtained from all who agreed to take part by the researcher.

Table 1

Demographic details of participants

Participants	n=8
Gender	Males =5 Females = 3
Age	Range 28-50 years (Mean = 36 years)
Ethnicity	White British = 4 Black Afro-Carribean = 3 Asian = 1
Religious affiliation	No religious affiliation = 5 Christian = 2 Muslim = 1
Length of current admission	Range 2-10 years (Mean = 4 years)

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Ethical permission was granted by the local NHS Regional Ethics Committee (see appendix 6) and Research and Development approval was granted by the two relevant NHS Trusts (see appendix 7&8). The study adhered to the codes of ethics and conduct stipulated by both the Health Professionals Council (HCP) and the British Psychological Society (Health Professionals Council, 2009; British Psychological Society, 2006). Given that participants could place themselves at risk of further punitive sanctions and loss of privileges should they make a disclosure during the data collection, particular care was taken to ensure that all who were approached were fully informed and consented both at the time they were invited to take part and once again prior to interview.

Given the nature of FMHS, extra consideration was also given to the safety of participants, other residents and staff at the units as well as the research team. This was discussed in depth with the MDT at both units prior to data collection and local protective procedures were followed.

2.2. Design

The study adopted a qualitative, non-experimental grounded theory design including a focus group as well as semi-structured interviews.

2.3. Procedure

Those who were identified as meeting the inclusion criteria by the team psychologist were approached by a member of the nursing staff on the ward to ascertain initial consent for the researcher to arrange to meet with them to explain the study and ask for their consent to take part. Those identified were then approached on the ward at a time agreed by the researcher who explained the study protocol and went through the information sheet with them (see appendix 3). Participants were given the opportunity to ask any questions pertaining to taking part and those who agreed to participate were interviewed at least 24 hours later in order to give them time to

consider their participation. Written consent was obtained at the time of interview (see appendix 4).

Semi structured interviews based on the research aims and the literature review (see appendix 5 for interview schedule) were carried out face to face with each participant individually in a private and convenient area identified previously on their respective wards. Interviews lasted approximately one hour and were recorded digitally and transcribed. All transcribed interviews were anonymised. The lead researcher carried out all interviews.

Prior to carrying out the interviews, the lead researcher piloted the interview schedule in a focus group with three discharged patients to assess the appropriateness and relevance of the questions. The focus group participants agreed the questions were clear and appropriate based on their past experiences. The focus group participants also agreed that individual interviews would be more appropriate for data collection as participants may feel less restricted in what they can say, as they might in a group setting. As a result of the focus group two additional questions were added to the schedule (see appendix 5).   This is in line with grounded theory methodology, where questions are adapted as a response to emerging findings and was a continual process throughout the subsequent individual interviews (Corbin & Strauss, 2006).

Interviews at the first medium secure unit were carried out over a period of one month, at this point it was decided to obtain research and development approval from another Trust in order to carry out data collection within another medium secure unit to continue to strive for examples of difference within the participant group in order to expand and enrich emerging categories. The second rounds of interviews were carried out three months later, over a further period of one month at the second medium secure unit.

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2.4. Theoretical sampling

An important element of grounded theory is the use of theoretical sampling. Theoretical sampling is aimed at the development and generation of theoretical ideas rather than being representative of a select population or hypothesis testing. New research sites or participants are chosen to compare with ones that have already been studied to gain a deeper level of understanding and to facilitate the development of an analytical framework (Glaser & Strauss, 1967).

The focus group carried out was the first step in this process with participants who are no longer in-patients. Following the focus group it seemed that there may be a generation effect of those who experienced forensic mental health services during the eighties and nineties. It was decided to deliberately attempt to recruit younger service users for the interviews if possible. Further to this after the first three interviews were complete it was decided to recruit from another MSU to ensure the emerging categories reflected potential differences in culture across unit.

2.5. Data analysis

The interview data was analysed using a grounded theory approach (Glaser & Strauss, 1967). This method of analysis was chosen as it is designed to enable a process of discovery through the data, which may lead to the generation of a theory (Willig, 2001). The present study explored the experience of in-patients in medium secure units of engaging therapeutically with clinical psychologists; a complicated experience given the nature of the setting and the 'dual role' of clinical psychologists within forensic mental health services. Using a grounded theory approach was deemed appropriate to deconstruct such a complicated phenomenon (Glaser & Strauss, 1967). Furthermore the method seemed appropriate due to the lack of existing literature on the area of exploration (Eisenhardt, 1989).

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It was decided to adopt a positivist position (to search for an objective reality, rather than one's own prior opinions and knowledge) to working with the data, to pursue a generalisable theory about an objective reality through systematically applying a method by a neutral observer (Glaser, 1967). Glaser (1967) encourages researchers to achieve this neutrality and inductive nature of enquiry by being free of preconceived analytic frameworks and prior substantial knowledge of the area of enquiry prior to investigation.

The data was initially coded line-by-line and then instance-by-instance following each interview as outlined by Charmaz (2006) and Corbin and Strauss (2008). The first four interviews were coded line-by-line to enable a full understanding of the data (see appendix 10 for example of a fully coded transcript).

The next stage of the analysis was focused coding, to group the initial codes into broader codes which occurred most frequently and significantly in the data (Glaser, 1978). A method of continuous comparison was adopted in which all new data was compared to the previous data to evaluate any similarities and differences as more interviews were carried out (Glaser & Strauss, 1967). All codes were further explored and scrutinised in the following interviews to develop a deeper level of understanding of the emerging ideas.   This process continued until a point of relative saturation occurred where no further categories arose from the data. During the coding process, after each interview, memos regarding the content of the data and any pertinent ideas coming to the researcher were written to aid later theory development (Glaser, 1992).

The final stage of the analysis was theoretical coding (Glaser, 1992); during this stage the broader codes were related to each other in sub categories and finally into over arching categories in order to develop an explanatory model from the data.

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2.6. Quality assurance

A research diary (see appendix 9) and memos were used throughout the duration of the study to increase the researcher's awareness of assumptions and ideas forming throughout all stages of the study. A secondary function was to help the author avoid influencing the subsequent analysis and theory development. This is in line with taking a positivist position as a researcher in the quest for finding an objective reality within the data; this is fitting with the classic model of grounded theory. This model begins with the idea that facts about social reality are represented by the data, in which the meaning is inherent; it is the aim of the researcher to discover this meaning (Glaser, 1978). The use of a research diary and memo writing are key tools for the researcher to continuously refer to, during data collection and analysis, in order to facilitate neutrality. By referring to these tools, the researcher can increase awareness of their own subjectivity towards the data and be mindful to avoid influencing the subsequent analysis (Hallberg, 2006).

During all stages of coding, supervisors were consulted to discuss emergent codes and categories from the data. One transcript was analysed by another researcher and a peer supervision group carrying out grounded theory research was also used to ensure the quality of the analysis. The approach taken to the analysis was that of a 'critical realist' stance and this process enabled the incorporation of other coders perspectives to widen those of the author in order to get closer to an objective view of the data.

Direct quotations are used throughout the results to enhance the credibility of the model and ground the model firmly in the data.

3.   Results

The coding of the data resulted in 106 focused codes. Further analysis resulted in the development of four categories with 22 sub-categories (see appendix 11). For a table of categories, sub-categories

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and text examples from the transcripts see appendix 13, further to this an example of the development of a sub category can be found in appendix 12.

Figure 1 below shows a model formed from the emergent categories.

3.1. Model Summary

The data showed that it is possible for in-patients and clinical psychologists in MSU's to develop and engage in a therapeutic relationship within these settings, despite the dual role of clinical psychologists within these settings. The major categories identified included 'barriers to trust', 'building trust', 'arriving at a strong relationship' and 'dealing with things in a safer way'.

A description of each of the categories is presented with illustrating codes after Figure 1.

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Figure 1: A grounded theory model of the relationship between in-patients in a medium secure unit and clinical psychologists

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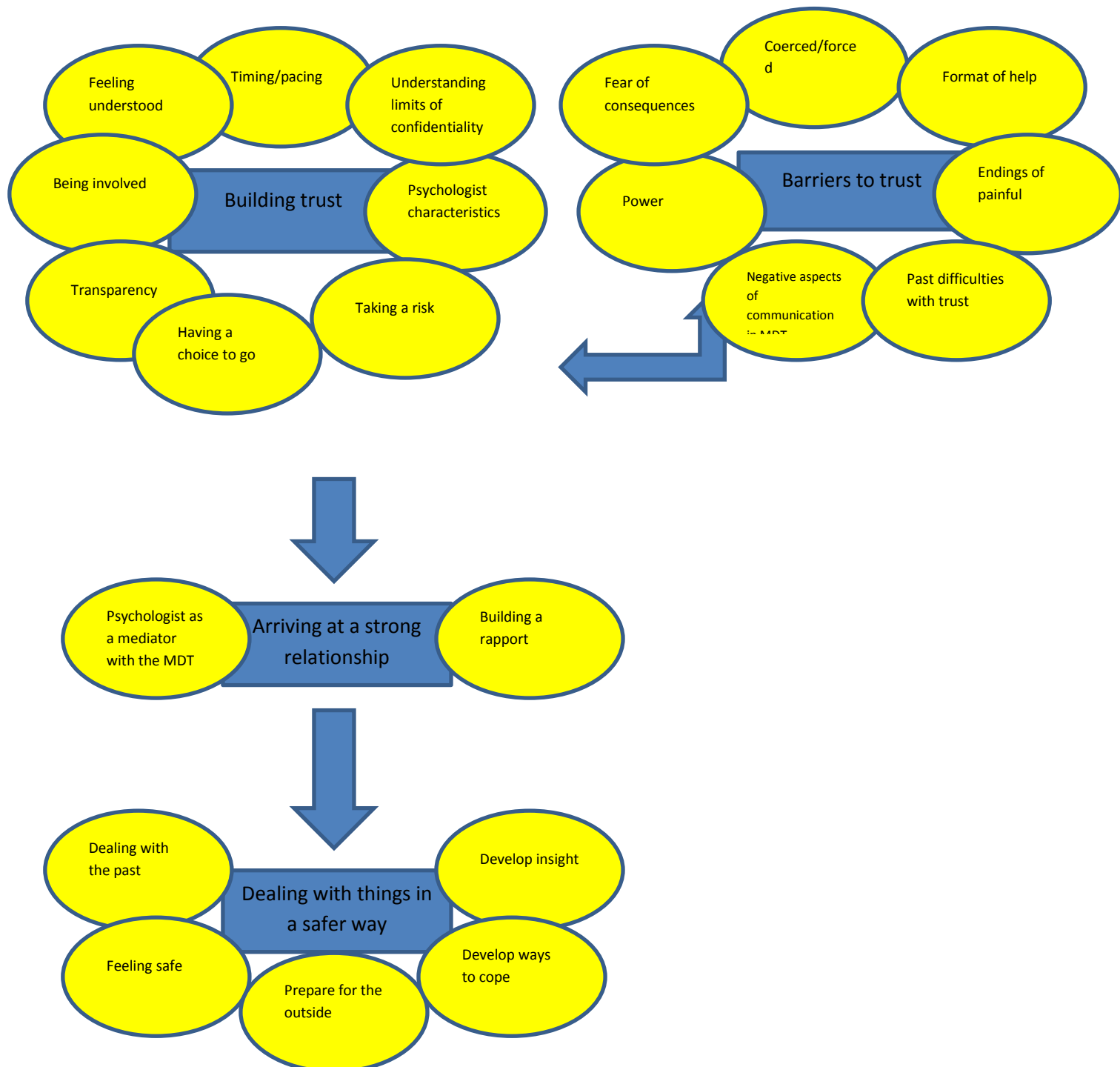
3.2. Barriers to trust

3.2.1. Fear of consequences

The majority of participants described being fearful of the potential consequences of disclosing information to clinical psychologists; including being fearful of legal consequences, such as being prosecuted for other offences not previously disclosed, increased hospital admissions or of further restrictions being placed on them. Further to this one of the participants who was particularly concerned about further legal consequences, described being equally concerned about being judged or believed to be 'stupid' by the psychologist if he opened up about his experiences prior to being admitted to hospital, despite still feeling distressed by these experiences:

> *"Erm, to tell the truth I didn't really bother with psychology more than a certain extent because they, erm they, they tell the Ministry of Justice, the psychologist, that I have been in situations like this or they don't, I mean I am not 100% sure it would be kept confidential."* (Participant 5, appendix 13, line 31)

They also expressed concern at being judged by the clinical psychologist:

> *"Some things I would just say let's leave this aside because it aint really all that important and it would just get me into a situation where I would be looked down upon." (Participant 4, appendix 13, line 1)*

3.2.2. Past difficult experiences in hospital

Previous difficult experiences within hospital were frequently reported by participants as making the development of a trusting relationship with clinical psychologists difficult;

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particularly previous difficult endings and feeling abandoned or rejected leading to the re-experiencing of previous difficult relationships:

> *"You think they are moving on because they don't like me, then you go back to*
>
> *blaming yourself again." (Participant , appendix 13, line 207)*

Some participants also described how it was difficult to form a trusting relationship with the

clinical psychologist when they were mentally unwell, as they were not sure if their trust

issues were real or a result of paranoia associated with their illness:

> *"You don't know when you are ill what is real, and what is not, has this person got a*
>
> *problem with you or are you just imagining it." (Participant 3)*

3.2.3. Coerced/forced

Several participants mentioned the difficulties of perceived coercion into treatment. Some

described being pushed or forced into meeting with a psychologist when they did not want

to, others described feeling that they had no choice due to potential consequences if they

did not attend or simply feeling harassed and giving in:

> *"I said to her I don't need to go to anger management, I shouldn't go there because*
>
> *I've got nothing on my chest and I don't feel angry right now but she was so*
>
> *persistent that I just went there." (Participant 5, appendix 13, line 55)*

3.2.4. Power

A further influence described by participants over their desire to engage was the perceived

power of the clinical psychologist, and the lack of control over whether they have attended

sessions or not:

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> *"Some have scared me and I have told them and they have said 'well you will have to put up with me'." (Participant 1, appendix 13, line 83)*

The main concerns of participants regarding power relations seemed to be directed at nursing staff rather than psychologists and to be particularly concerned with perceived misreporting of events and restrictions on leave and activities on the ward:

> *"The nursing staff, they are in it for the power trip I think and it is as simple as this, they can write whatever they want in their notes, and you may not know about it for months." (Participant 3, appendix 13, line 109)*

3.2.5. Negative aspects of communication within the wider care team

Several participants commented that they perceived members of the care team including nursing staff and psychiatrists as regularly misinterpreting events, which led to difficult situations for them, causing distress:

> *"They don't write things to insult me or nothing but it is not accurate descriptions of the things I do really, if they had done things correctly like how I would have done it then I wouldn't be here today." (Participant 5, appendix 13, line 185)*

However, it did not seem that concern with other members of staff negatively impacted the ability to engage with psychology – this is discussed further below in 'Building Trust'. Furthermore, where strong relationships were arrived at, it seemed that several participants placed the psychologist in the position of 'mediator' with the wider care team.

3.2.6. Format of help

A further barrier to engaging in a therapeutic relationship was the format that therapy was offered in. Several participants did not feel comfortable sharing experiences within a

therapy or offending behavior group and preferred to have a one to one format. The majority of participants reported that this enabled them to build a relationship with the psychologist and to be more open:

> *"I've never done group psychology, you are opening up yourself so the other people there will, you are showing your emotions and there are people there and I wouldn't want that." (Participant 6, appendix 13, line 130)*

Others felt that the clinical psychologist that they had one to one therapy with attempted to intellectualise too much and that this ignored the 'individual':

> *"Oh right, I just mean like er, they tend to say that this is schizophrenia or this is this element of schizophrenia, they have all their statistics, if I am right then psychology seems to be a bit soulless, do you know what I mean." (Participant 3, appendix 13, line 168)*

3.2.7. Endings are painful

Past experiences and in particular, past experiences of relationships ending suddenly in hospital were identified as being a barrier to forming new relationships and developing trust. Some participants reported that they had psychologists who did not even say goodbye, leaving them feeling abandoned and rejected and concerned about future relationships ending:

> *"You don't get the chance to say goodbye, that was really hard and that took me a while to trust somebody else because you think they are going to do that as well." (Participant 1, appendix 13, line 170)*

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Despite these considerable and numerous barriers to building a trusting relationship with clinical psychologists, all apart from one participant (this was the participant who was significantly worried about past offences coming to light) reported that they had managed to develop such a relationship. The mechanisms of how these relationships were built and the barriers overcome are discussed in the next category of the model 'how trust is built'.

3.3. Building Trust

Participants spoke of a number of ways in which trust is built.

3.3.1. Feeling understood

The majority of participants described the importance of feeling understood by somebody and that this person was usually the clinical psychologist. Participants reported that it was important to have someone understand who they were and how they were feeling:

> *"That's why I did the psychology sessions so someone knows what's going on in my head, the truth." (Participant 4, appendix 13, line 218)*

3.3.2. Timing/pacing

All of the participants mentioned the timing or pacing of therapy and this seemed particularly important in building trust. In order to be able to develop trust in the clinical psychologist, participants reported that they needed to be able to take things at their own pace and not to feel rushed into talking about their past experiences. Most participants (six of eight) described how the psychologists with whom they had worked had taken time to establish a relationship before probing too deeply about difficult aspects of their history. It

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was also widely commented on that if they (the patient) did not want to talk in a particular session that this was fine and they did not feel pressured:

> *"And then building up that rapport and then kind of nipping away at stuff, you know? Rather than going straight to the core of the problem, nipping away at stuff and also respecting my wishes." (Participant 2, appendix 13, line)*

The pacing of the ending of therapy was also mentioned, with the majority of participants feeling that endings were too sudden. In particular it seemed like a cost of getting closer to a psychologist was how painful it was when they left.

> *"Yes it needs to be a more gentle approach or descent rather than, ok three sessions time, it is just finished, done and dusted. Get on with it on your own." (Participant 2, appendix 13, line)*

3.3.3. Understanding the limits of confidentiality

For those participants who understood the limits of confidentiality that the clinical psychologist was able to offer them, trust seemed possible to achieve. The majority of participants were able to explain what kinds of information the psychologist would share with the team and what they may keep confidential. Most participants felt comfortable with the types of disclosures that psychologists were most likely to make with regard to risk and believed this was reasonable. When asked about the role that their psychologist played in risk assessments, this did not, for the majority of participants change their responses:

> *"If you have psychology with an individual they do respect privacy and they will only pass on what has to be passed on. The team don't have to know every detail you say to your psychologist, because sometimes it is between just you and them."*
> *(Participant 2, appendix 13, line 289)*

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3.3.4. Being involved

Being involved in their care and treatment plans was important to most participants and seemed to be central in developing a trusting relationship; responses indicated that most participants felt that they were working collaboratively with the clinical psychologist:

> *"What they are planning for me, keeping us in the loop, recently I have been more communicated to about what is next, about what people feel is the next best move, my treatment plan." (Participant 3, appendix 13, line 393)*

Further to this, being transparent and open about care plans, records and the aims of treatment was important to several participants. It was reported by several participants that there was information in reports about them, including diagnoses that had never been explained to them and the psychologist was the person who took the time to explain these things when asked:

> *"I showed her my care plan and I went through it with her, the Psychologist, because I was concerned and then it said something like I was suffering with schizophrenic blah, blah, blah and I was like; 'what the hell does that mean?!' and she said 'it's just something that is written in a book and that she will be able to show it to me and help me get the meaning of what has been written on my care plan'." (Participant 6, appendix 13, line 402)*

3.3.5. Psychologist characteristics

Participants reported that the personal characteristics of the psychologist played a large part in whether they would be able to trust and to develop a relationship with them. Frequently reported characteristics included being experienced, patient, caring, empathetic, non-judgmental and interested in the patient:

> *"I think it was her approach, her approach was excellent. She did not criticise me, she wasn't judgmental, she was just, she didn't take sides, she didn't say you were wrong, you were wrong and that helped me a lot."* (Participant 1, appendix 13, line)

3.3.6. Having a choice

Having a choice to meet with the clinical psychologist, as well as, what type of intervention they would like to engage and understanding the rationale for the intervention was described as important in building trust and most participants described having such choices:

> *"The only time I suppose I put my foot down really was about the family therapy because I did not think it would be helpful for my mum and dad to try to go through that."* (Participant 2, appendix 13, line 471)

3.3.7. Taking a risk

The final factor that the majority of participants described as being important in developing a trusting relationship with the clinical psychologist was taking a risk, even when fearful of the consequences, several of the participants described what sounded like taking 'a leap of faith' in order to engage with the psychologist, particularly those who described a history previous difficult attachment relationships.

> *"I felt that she would give up on me, nobody would like me, nobody would trust me. They would increase my medication, they would move me on, and everything that could possibly go wrong I thought would go wrong and it didn't. Because of that it has made it easier for me to talk to people and I told her things I hadn't told anyone for years, well I hadn't told anyone at all. And to tell her, I thought wow things aren't as bad as you think they are going to be."* (Participant 1, appendix 13, line)

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3.4. Arriving at a strong relationship

3.4.1. Building rapport

The majority of participants who had been able to build trust in or with their clinical psychologist described having developed strong relationships characterised by building a rapport, feeling supported and a sense of knowing the psychologist and where they stood:

> *"Yes you build up a relationship. You know how they are going to react and everything, which does help." (Participant 6, appendix 13, line 509)*

3.4.2. Psychologist as mediator to the wider care team

Several participants described that having a strong relationship with the psychologist meant that they felt like they had an ally to act as a mediator with the other members of the care team and to put across their side of the story when they felt things had been misreported by other members of the care team, in particular the nursing staff:

> *"Well the main reason why I do psychology sessions is to put across my point, because I know that they (nursing staff) write down things on *** (electronic database) and discuss things and I want to put across my point of view if anything happens. I just want them to tell the truth because I don't know what they are writing down on ***, so my point is the truth from my side. Their side is what they write down on ***, but I felt like that I need a voice, my own voice, and say this is what happened."   (Participant 6, appendix 13, line)*

It seemed that only after having arrived at this development of a strong relationship with the psychologist, were the participants able to engage in effective psychological work as described in the final category.

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3.5 Dealing with things in a safer way

All participants who described having had a strong relationship with their psychologist(s) also described a number of benefits or gains from having developed a trusting therapeutic relationship that helped them deal with things in a safer way and also to move on.

3.5.1. Dealing with the past

Addressing things that had happened in their past (some for the first time), in terms of their personal histories and the offences that they had committed was described as helpful in decreasing distress and allowing participants to move on:

> *"To help you deal with things in a much safer way and come to terms with it and not blame yourself." (Participant 1, appendix 13, line 549)*

3.5.2. Feeling safe

Several participants also described that they had felt safe through their engagement with the psychologist, this was particularly pertinent when it came to patients feeling like they might want to harm themselves. Two participants described how they could tell the psychologist who would then inform the ward staff and make sure that they were prevented from self harm and given additional support whilst they felt more vulnerable:

> *"You know they are there for you if you get stuck, you know they are there for you if you get desperate." (Participant 1, appendix 13, line 582)*

3.5.3. Prepare for the outside

Several of the participants were on pre-discharge wards and therefore knowing what to expect when they rejoined the community was a considerable concern. These participants described group and individual sessions in which they could discuss their concerns and

prepare for adjustment to life outside as hugely helpful and a source of relief with regards to their anxieties.

All participants described a number of ways in which, with their psychologist, they had been able to develop new approaches to coping with problems, which included reducing the amount of medication.

> *"They help you prepare for life outside, what to expect, how people will treat you and that makes them an important part of the team, the most important part apart from the doctors."* *(Participant 6, appendix 13, line 605)*

3.5.4. Develop ways to cope

In some way or other all of the participants described how, together with the psychologist they had developed ways to cope with a number of problems. In particular, several of the participants described how they had developed alternative ways of managing anxiety that reduced the amount of medication, restraints or extra restrictions that they had experienced in the past, as these anxieties had often been externalised in ways which appeared risky or aggressive:

> *"I used to get restrained so I could be physically held down and kept safe. The team would pass it on and then find other ways of dealing with it. So I would get out of the habit and into another habit….something more healthier!"* *(Participant 4, appendix 13, line 569)*

3.5.5. Develop insight

Finally, all participants described how they had developed insight to their own behaviours and past actions as well as to the experiences of others, in particular, how their actions had

affected their victims and their family members. Some participants also described how

groups were helpful, in that they discovered their feelings and experiences were shared:

> *"Well you can learn more about yourself and learn about other people as well, what*
>
> *their problems were." (Participant 7, appendix 13, line)*

Dealing with things in a safer way was important to participants, several of whom described

being ready to move on (both emotionally and physically), feeling 'well', no longer having

'incidents' on the ward and generally seeming to be functioning well.

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4. Discussion

The current study proposes an initial model to explain how inpatients in medium secure units develop trusting and gainful relationships with clinical psychologists, despite the many barriers present as a result of the dual role of clinical psychologists in forensic mental health services. The model is unique in considering both the barriers to, and the development of, a trusting and strong relationship and its potential outcomes and benefits for patients within FMHS. Whilst experiencing considerable barriers to building trust, the majority of service users were able to overcome these and build trust in clinical psychologists despite their 'dual role'. Whilst the dual role of clinical psychologists did bring extra barriers to developing a therapeutic relationship, it appeared these could be overcome through a combination of psychologist related factors (including being patient, non-judgmental, empathetic, transparent, collaborative and patient centered) and individual factors (taking a leap of faith). It would seem that service users in medium secure units perceived the main role of clinical psychologists to be of providing care rather than risk assessment, Whilst service users understood that providing risk assessment was part of the role of clinical psychologists, it would seem that this was acceptable to most service users where a strong relationship had been built. Furthermore, service users often placed the clinical psychologist in the role of 'mediator' between themselves and the wider care team

4.1. Links to previous research

4.1.1 The dual role of clinical psychologists in forensic mental health services

To date no studies have been carried out within forensic mental health services to explore the impact of the dual role held by clinical psychologists within these settings. Research from offender populations in the prison system has however painted a damning picture of

distrust (Jeglic & Mercado, 2011, Maruna, 2011, Crewe 2009). The current study offers a different perspective, the majority of service users were not concerned by the involvement of clinical psychologists in providing risk assessment, as long as this was transparent and explained to them. In relation to previous prison research, this may be explained by the considerable amount of psychological support and intervention offered by clinical psychologists in forensic mental health services rather than a dominant focus on identifying risk. This is supported by the findings of Crewe (2009) who concluded that in general, prisoners did not object to psychological insight but felt that when problems were identified they were not offered any support or intervention.

It has also been speculated that as the dual role of clinical psychologist working in forensic mental health services considerably limits the level of confidentiality that they can offer to their patients, that building trust must be significantly compromised and damaging to the building of a therapeutic relationship (Ross, Polaschek & Ward, 2008). Again this was the first study to explore this idea with service users in forensic mental health services and the findings were both surprising and encouraging. Whilst considerable barriers to building trust including worries over confidentiality certainly exist, the current study suggests that these may be overcome if service users understand the limits of confidentiality are informed of any disclosures and are involved in their care planning.

It has been assumed during this study that the building of therapeutic relationships between service users in forensic mental health settings and clinical psychologists will be more difficult where service users are of an insecure attachment style. This was based on the existing research positing such a notion (Bowlby, 1988; Wilkinson, 2003; Ma, 2007). However, some empirical research has found that not all therapeutic relationships can be equated to attachment relationships and that this only happens in certain circumstances

such as when the following criteria are fulfilled; if using the mental health professional as a secure base would be characteristic of the patients previous relationships and would be apparent over an extended time period (Schuengel & Van lJzendoom, 2001).

4.1.2. Engagement

The current study supports previous findings that engagement in psychological therapy in forensic mental health services has considerable benefits for both service users and the wider community as a whole (Long et al, 2013; McCarthy & Duggan, 2010). Whilst outcome measures and therapeutic gains were not measured in the current study, qualitative descriptions of a range of perceived benefits included developing insight into self and others, developing safer coping strategies, preparing for life back in the community and feeling well.

Previous studies have reported the value placed on having a choice in psychological intervention within forensic mental health services and that perceived choice is associated with higher levels of engagement (Mason & Adler, 2012). The current study provides further support to the importance in choice in forensic mental health settings, with perceived choice presenting both as a potential barrier if choice was restricted and a factor necessary in the building of trust. Where a lack of choice or perceived coercion were described in the current study, participants seemed to be referring to previous and much earlier admissions, with participants describing their current or recent experiences as much more collaborative.

4.1.3. Endings

The current study identified how the ending of relationships, if not managed sensitively and in a timely manner, could result in service users re-experiencing painful emotions associated with past rejections and abandonments. The literature on the attachment style of

offenders, tells us that they have likely experienced a difficult attachment history and to be of an 'insecure' style. This attachment style is characterised by mistrust of others and a self-view of being unworthy (Marshall & Marshall, 2000). If a patient manages to develop a strong attachment to a psychologist and this is then ended in a less than sensitive way, this is likely to cause further pain and impact on the development of future relationships

4.2. Clinical Implications

This study has a number of important implications for the provision of psychological intervention in forensic mental health services offered by clinical psychologists. All participants reported that they found it difficult to build a trusting relationship if they felt rushed, and that the building of trust could take months. The current study implies that the experience of service users regarding the pace of their interventions has been positive and allowed the building of trust. In the current economic environment, where 'payment by results' and institutional pressures on resources are major obstacles in the provision of services, this is a particularly pertinent issue. Whilst forensic mental health services may be in a more protected position they too will face increasing economic pressures. The findings of this study imply that it will be imperative that psychologists continue to be able to offer long term interventions to inpatients to allow the time and space for trust to be developed.

The current study also implies that the 'ending' of therapy relationships needs to be handled in a more sensitive manner. Whilst all of the service users were satisfied with the level of psychological intervention that they received, the pace and access to the clinical psychologist, almost all were equally dissatisfied with the ways in which therapy was ended. For most it felt too rushed and that after they had given their trust and worked for a significant period of time with the psychologist, therapy was abruptly ended. This was described as painful and a barrier to building future trusting relationships. To avoid

An exploratory study of the relationship between in-patients and clinical psychologists within medium secure units

repeating past relationship experiences or causing further pain, forensic mental health services need to find a way that better prepares its service users for the endings. The findings of this study imply that a more 'collaborative' approach to endings, with an agreed timeline between both parties would be helpful in reducing the distress associated with the ending.

The current study also identified an almost 'then and now' feel. It seemed that the majority of coercive and disempowered experiences were in relation to experiences far back in the past. When talking about more recent (over the last five years in particular), experiences, they were described as much more collaborative, involved and empowered. This may be a reflection of recent initiatives in medium secure units such as 'My Shared Pathway' with the aims of shifting services to a more outcome based approach, developing standardised pathways and reducing the lengths of stays for individuals. The principles of the Shared Pathway are to introduce a new way of working together, a way of sharing responsibility and choice, making recovery as important as security, helping individuals to reach their own goals and a way of thinking of each individual as different (Allen, 2012). The findings of the current study indicate that these initiatives are to be encouraged.

4.3. Research Implications

The current study suggests that a number of factors contribute to the building of trust which appears to be the decisive factor in whether inpatients in medium secure units can build a strong relationship with clinical psychologists and make therapeutic gains. It appeared that where there were more negative experiences, particularly those described as coercive, that this was a reflection of a past 'era'. It was not within the scope of the current study to investigate this in depth and further research could help to clarify whether indeed this is the case. Furthermore, the current study indicated that for some the clinical psychologist had

been placed as 'mediator' with the wider care team and this was an unexpected and interesting finding, indicating the need for further research on the team dynamics and the impact of other members of the care team on the experiences of inpatients. This may be particularly pertinent to relationships with nursing staff as this seemed to be the professional group with whom the issue of 'power' and misunderstanding arose.

4.4. Limitations

It was identified during the focus group that there may be an 'age' effect on the experiences of service users of clinical psychologists within forensic mental health services, specifically that services had much improved in the last decade. It was therefore decided to focus on younger service users, where possible, who were less likely to have experienced services from this time period. Due to the limited population available, this did not exclude any willing participants. However, it may have been more insightful to have identified all participants who had only experienced forensic mental health services within more recent years to develop this understanding.

It should be considered that the participants who were approached to take part in the current study were no longer receiving psychological intervention and considered psychologically well enough to take part in the study. Whilst this was a deliberate inclusion criterion to avoid interfering with any current intervention, this also narrowed the sample to predominantly those close to discharge. It would have been informative to have interviewed participants who had not had psychological interventions to ascertain their perspectives as well. The sample was self-selecting, only those interested in taking part, did so. This may indicate that the sample were likely to be well engaged with services and to thus bias their responses. It should also be considered that retrospective accounts may not

always be accurate. It would have been insightful to have ascertained the opinions and experiences of clinical psychologists working within these settings.

Finally, given that to some extent it was assumed during this research that the attachment style of most service users in forensic mental health settings would be of an insecure style and that this would likely cause difficulty in the formation of a therapeutic relationship, this warranted some investigation. However, neither attachment style or the nature of the attachments (if any) formed between service users and clinical psychologists was investigated. This was beyond the scope of this study.

4.5. Conclusion

This study identified how inpatients in medium secure units develop strong relationships with clinical psychologists despite the dual role that they hold. These relationships, where achieved, are centered on trust and associated with positive outcomes. Previous experiences, transparency, timing and inclusion as well as the approach of the psychologist are important elements of how trust is built in these settings. The findings suggest a positive change in the provision of psychological services may have taken place over recent years in forensic mental health services, possibly in relation to new initiatives such as 'My shared Pathway'. Further research is required to ascertain the mechanisms responsible for such changes as well as the influence of the wider care team.

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Section C: Critical Appraisal

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1. **What research skills have you learned and what research abilities have you developed from undertaking this project and what skills do you think need to be developed further?**

Prior to starting my clinical training I completed a PhD; therefore I had a background in participant recruitment, ethical applications and study planning. My research was almost entirely quantitative in nature, apart from carrying out several focus groups to inform the development of a questionnaire. It was therefore tempting to plan a study using the methodology with which I am most familiar. However, through the discovery of the limited literature on the area that I wished to research and the subsequent development of the aims of the current study, it became apparent that the necessary methodology was qualitative. Through reading the literature about qualitative methodology I began developing an understanding of how these methods are applied and the value that they lend, especially in areas where there is a gap in the literature (Elliot, Fisher & Rennie, 1999).

As there was no existing research on the experiences of service users in forensic mental health services in developing relationships with clinical psychologists and the potential challenges arising from the 'dual role' of providing therapeutic intervention as well as risk assessment held by these professionals, I needed to use a method that would let me build a model of how and if these relationships were built. My intentions were to develop a study that would capture, understand and represent the experiences of service users and to develop a model based on their perspectives, therefore using a grounded theory approach seemed the most appropriate method.

This was my first real experience of carrying out qualitative research and therefore despite having a background in research, I entered the current study feeling very much the novice and with considerable anxiety about getting the method 'right'. This was particularly difficult as there are no clear cut instructions on how a grounded theory should be completed. I spent a great deal of time researching and trying to find a concrete and agreed 'guide' on how to do grounded theory, this of course does not exist. I came across many differing versions of how to collect and manage data and this caused me a lot of anxiety about 'getting it wrong'. Eventually I came to accept this and that what one grounded theory researcher may consider as the right way to gather data, another may consider as forcing data into a preconceived framework (Glaser, 1998). These searches for the 'holy grail', did however, immerse me in the grounded theory literature and an understanding that I needed to follow the data, rather than it follow my interests and this was crucial in helping me to minimise my impact on the data and the subsequent model (Glaser, 1992).

The anxiety I experienced carrying out the research was also reduced by reading the literature regarding the quality assurance of qualitative studies such as Yardley, (2000). Through the experience of carrying out the project as well as this building my understanding of how to ascertain the quality of such studies, I have developed a confidence in evaluating other qualitative research and in using other qualitative approaches in my future career.

A further skill that I developed during this project was that of carrying out semi-structured interviews. The carrying out of the focus group was particularly helpful in developing an appropriate interview schedule and in making me consider directions that had not occurred to me, key to grounded theory. It felt like this was a good lesson to learn before starting the

interviews. In terms of the actual interviews, I was conscious that in the earlier interviews I

asked more closed questions, by using the grounded theory approach of transcribing and

coding interviews sequentially to inform the following interview, I was made aware of this

early and able to address it in subsequent interviews. This awareness and ability to reflect

independently and with my supervisors during the gathering of the data both developed my

interview skills and improved the quality of the data.

Perhaps the most difficult learning experience for me during this project was trying to avoid

influencing the responses of the participants and in trying to avoid my own preconceived

ideas influencing my coding and development of the model. I was particularly cautious in

the interpretation of the data, having worked in the prison service, I was very aware of the

existing 'distrust' in psychologists there, as I had experienced it on the landings myself, and

to some extent I assumed it would be a similar situation in forensic mental health services.

This only really came out in one interview and I had to be aware not to add extra importance

to the transcript that seemed to build on my preconceived idea. I think this made me try

even harder to avoid any pre-conceptions impacting on my interpretation, this made the

data analysis a very time consuming process. Eventually through discussions with my

supervisor and further reading around grounded theory methodology, I started to accept

that you cannot be completely free of such pre-conceptions influencing the data (Thomas &

James, 2006). In particular, my supervisor encouraged me to use the line-by-line coding

method, taking an analytic stance whilst keeping close to the data (Glaser, 1978).

Initially, I had considered using Interpretative Phenomenological Analysis (IPA) to explore

how participants made sense of their relationships with clinical psychologists, this type of

analysis would have also allowed more consideration of the researcher's own conceptions and consideration of things that were not implicitly said in the data. This method may have led to gaining a sense of processes which participants themselves may not be fully aware of. This may have added an interesting dimension to the research, but I also felt as a novice researcher this may be a step I lacked the experience to fully grasp. I also decided to use a grounded theory approach for the study to enable an understanding of the experience of the participants as well as developing a model of how the relationships developed in these settings. In terms of further learning, this is the start of using such methods and I envision using them in the future, developing this foundation and exploring other qualitative approaches.

2. If you were able to do the project again, what would you do differently and why?

After the focus group I was aware of a possible 'then and now' theme to experiences described by service users. Whilst I attempted to explore this by seeking participants to take part in the interviews who had more recent experiences of psychological intervention, this was not a clear inclusion criteria and so a mixed range of experiences were captured. This was in itself a very interesting part of the research, but if I was to carry out the research again then I would have this as an inclusion criteria in order to be clear on what were current experiences as it does seem that there has been a considerable shift in experiences and this would help to clarify this. I think I should have made this decision prior to beginning the recruitment for participation.

Due to time constraints, it was not possible to return to the study participants and present the analysis for their scrutiny and to validate the analysis. Whilst this is not considered a

compulsory step, this would have added credibility to the analysis (Williams & Morrow, 2009). This would have also been particularly difficult with the current study as two of the participants had been discharged to lower secure settings by the study completion and accessing at least one of who would have required research and development approval from a further trust.

Whilst participants described qualitatively, experiences of positive outcomes from the development of relationships with clinical psychologists, it may have been helpful to have included a more explicit outcome measure as well. Early in the study development, it was decided not to enquire about any diagnosis that participants had been given, this was to avoid having any preconceived ideas about their experiences as a function of their diagnosis. However, in reflection, whilst no inclusion criteria around diagnosis were given, it may have been equally valid to have obtained this information. The few existing studies critiqued in the literature excluded those with personality disorders; it would have been interesting to see if diagnosis had an impact in the current study.

3. **Clinically, as a consequence of this study, would you do anything differently and why?**

This study highlighted the many barriers to building a trusting therapeutic relationship faced by service users in these settings. What was encouraging was that these barriers could be overcome and helpful relationships were described. I was greatly touched by some of the more difficult experiences described by service users and how despite this, they had often taken 'a leap of faith' in placing trust in a clinical psychologist. Clinically, I would be particularly aware of the difficulty and distress experienced by service users in these settings

around the 'ending' of therapy. I would try to make this as collaborative and gradual as possible to reduce the level of distress experienced by the service user. This also led me to consider how other members of the care team may be involved in supporting the service user through such a transition, to avoid the feeling of 'abandonment' described by several of the participants in this study.

The study also highlighted that where service users are clear about the limits of confidentiality and what we as psychologists need to share with the care team and others with regards to risk, they are mostly accepting of. In my own practice, I have felt uncomfortable when working in forensic settings about the level of information I would share with colleagues, particularly where risk was disclosed, as I feared this would compromise any therapeutic relationship. Whilst I disclosed what was necessary and informed my clients, I felt very uncomfortable, and I wonder how much my anxiety was transferred to the client. In future, I would feel more confident that my own transparency could be protective of the relationship, rather than destructive.

4. **If you were to undertake further research in this area, what would that research project seek to answer and how would you go about doing it?**

Whilst undertaking this research, an interesting finding was that not only are clinical psychologists not held in a position of 'distrust' due to their role in risk assessment, but are often seen as an ally, and a mediator with the wider care team. Service users described how they 'used' their psychology sessions to get their side of the story and their point of view across; particularly where incidents on the ward had occurred which they felt had been

misinterpreted by nursing staff. This warrants further exploration, the majority of service users interviewed in the current study had experienced positive relationships with clinical psychologists. Further to this, their participation was voluntary which may be a reflection of a wider positive engagement with services. To further clarify this positioning of the psychologist, as well as other findings from the research, the views of more participants who have not engaged with clinical psychologists are needed.

In addition to this, the views and experiences of clinical psychologists, as well as, other members of the wider care team, are needed to grasp a full picture. It had been the initial intention that this research would include interviews with clinical psychologists working in forensic mental health services, however, as the study progressed, it was clear that this was beyond the scope of this project. Whilst service users may be able to negotiate the 'dual role' of clinical psychologists in forensic mental health services, it is possible that this positioning may be a cause of internal conflict for those undertaking such a role.

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Section D: Supporting Appendices

July 2013

A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church University for the degree of Doctor of Clinical Psychology.

Appendix 1: Literature review search strategy

Computer based searches of the following electronic databases were used to identify the relevant literature:

Medline: 1990-2013

PsycInfo: 1990-2013

Ebscohost: 1990-2013

Psycharticles: 1990:2013

Additional articles were identified through Google Scholar.

Search terms

The following terms were searched; offenders and therapeutic alliance, inpatients and therapeutic alliance, therapeutic alliance and secure units, therapeutic alliance and forensic settings, therapeutic alliance and medium secure units, psychological therapy, dual roles, therapist roles in secure units, therapeutic relationships in secure units, coercion and offenders, coercion and secure units, working alliance, working alliance and secure units, working alliance and offenders, power and therapeutic alliance, engagement and offenders, engagement and secure units, offenders and psychotherapy, psychotherapy and secure units, trust and the therapeutic alliance, affective bonds, collaborative nature, satisfaction, satisfaction and secure settings, satisfaction and in-patients, satisfaction and secure units, attachment, attachment theory and psychopathology, attachment theory and offenders.

Selection of articles

The search identified 180 peer-reviewed journals, after cross checking for duplicates, 75 articles were identified. The abstracts of the remaining journals were then examined to check for relevance, of those only those written in English were included, of these 15 met the inclusion and quality criteria. Dissertations and unpublished manuscripts were excluded where the full article could not be obtained.

The quality of qualitative articles was assessed using the quality assurance guidance set out by Yardley (2000).

Appendix 2: Selected study characteristics

Table of identified articles for Section A literature review

Theme	Study	Participants	Design
Therapeutic Alliance	Taylor et al, 2009.	Psychiatric In-patients with long term mental health problems	Meta-analysis – Critical interpretative synthesis of 110 peer reviewed articles including 77 quantitative papers, 24 systematic reviews or meta-analyses and 19 descriptive reviews.
Trust/Power	Crewe 2009 (UK)	Male offenders in Wellingborough Prison	Opportunistic/qualitative Interviews
Attachment	Ross & Pfafflin. 2007 (Germany)	31 male offenders 22 male prison service trainees from 4 prisons & 21 male members of a Christian group	Cross sectional/survey
Attachment	Levinson & Fonagy 2004 (UK)	22 male offenders 22 personality disordered inpatients 22 healthy controls	Cross sectional/survey and Semi structured interview
Engagement	Long et al. 2013 (UK)	60 female offenders MSU	Cross sectional/ descriptive and survey
Engagement	Mason & Adler. 2012 (UK)	11 male offenders HSU	Opportunistic/semi structured interviews/IPA
Engagement	McCarthy & Duggan 2010 (UK)	MSU 22 male offenders	Cross sectional/survey
Engagement	Nunes et al 2010 (UK)	53 male offenders MSU	Cross sectional/survey and descriptive
Engagement	Donnelly et al. 2011 (Ireland)	75 offenders MSU & HSU	Cross sec/Survey
Engagement	Skelly et al. 1994 (UK)	14 offenders LSU	SSI/GT
Engagement	Parhar et al. 2008	Offenders (prisons)	Meta analysis:139 studies
Satisfaction	Long et al. 2012 (UK)	19 female offenders MSU	Theoretical sample/focus

			group/thematic analysis
Satisfaction	Bressington et al. 2011 (UK)	44 offenders 4 MSU's and 3 LSU's	Cross sectional/survey
Satisfaction	MacInnes et al. 2010 (UK)	27 3 MSU's	Cross sectional/focus groups/thematic analysis
Satisfaction	Carlin et al. 2005	57 3 MSU's	Cross sectional/survey

INFORMATION FOR PARTICIPANTS

Patient perceptions of Psychologists in secure Settings

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read and listen to the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for listening to this.

Purpose of the Research Study:

Why have I been asked to take part?

We are asking in-patients in the ************ on xx.xx.xx to take part.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will get this information sheet to keep and you will be asked to sign a consent form. If you decide to take part you can still withdraw at any time without giving a reason. If you decide to not take part or to withdraw at any stage it will not affect your individual life in the unit. It will not affect any board reviews or be recorded in any reports about you. Interviews will be arranged at a time that suits you and does not interfere with any other activities you may have planned.

What will happen to me if I take part?

You will take part in an interview with the researcher who will ask your opinions about your experiences of psychology as an in-patient. This will take around 45

minutes, but there is no set time limit. The researcher will record these responses with your permission. This will not however be played outside of the research team or to any staff at the unit or within the service. It is purely for the purpose of the researcher being able to capture all of your views to present anonymously later.

Will my taking part in this study be kept confidential?

- All tape recordings and interview data will be kept in a safe and secure location. Direct quotations that you make may be used in the written report of the study but they will be anonymous and no identifying information will be included.

- If you take part in the study, a copy of the consent form will be placed in your clinical records so that your care team know you have taken part. This note will not include any information other than noting your participation. This is to make sure that if you have any problems and talk to care staff they are aware of the study. Your Responsible Clinician will be made aware of your participation.

- No note will be placed in any of your offence related records about taking part in the study.

However, if at any time (either during the assessments or the workshops) you tell us something which suggests that you are at risk of harming yourself or someone else, we have to share this information with the care team by talking to them and in writing. This is to make sure you and other people are safe. If you tell us anything which suggests that security is at risk, or about breaches of ward rules including the use of drugs, we also have to share this information with the care team by talking to them and in writing.

What are the possible disadvantages and risks of taking part?

The interview questionnaires cover questions which may deal with quite sensitive material about your experiences of Psychology whilst an in-patient. People who find that the interview raises difficult feelings can ask for support through the usual ways in which this is available on the ward. They will also be able to ask a member of the care team to contact the research team if at any point they would like to discuss or withdraw their participation.

What are the possible benefits of taking part?

Taking part in this study will not lead to direct changes in your care or experiences with Psychology currently but we hope that it will enable us to develop a service which is helpful and approachable by building on its strengths and addressing its weaknesses.

What if something goes wrong?

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated in the course of this study, the normal National Health Service complaints mechanisms are available to you.

What will happen to the results of the research study?

When the research is finished, the results of the research will be used to write research thesis for a doctoral dissertation. Articles may also be published in mental health research journals. However, anything which is published will have no names or other information which could identify you or anyone else.

Who is organising and funding the research?

The research is being organised by Salomons, Canterbury Christchurch University and ****************. The research is funded by the University. The researchers are not receiving any payment for conducting the research because it forms part of their standard work duties.

Contact point for further information:

If you would like any further information about the research study, please don't hesitate to contact ****** (Trainee Clinical Psychologist and Lead researcher), via the care team at your unit.   ****** can be contacted via writing at Canterbury Christ Church University, Department of applied psychology, Broomhill Road, Tunbridge Wells, Kent, TN3 0TG or by leaving a message on 01892 507661 or by email ***************.

If you would like to make a complaint about this research you can do so by contacting ********* at the above address or at *******************.

Who has reviewed the study?

(To be confirmed)

<u>Thank you</u>

Thank you for taking the time to listen to and read this information sheet.

*********   Clinical Psychologist and supervisor of the research

**********   Trainee Clinical Psychologist and Lead Researcher.

Participant Code Number for this Study: ………
………………………………………………………………

CONSENT FORM

Title of Project:
Patient perceptions of Psychologists in Secure Settings

Please initial box

1)   I confirm that I have read/had read to me and understood
the information sheet dated xx.xx.xx for the above
study and have had the opportunity to ask questions.

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

3)   I agree to take part in the above study. I understand only
information relevant to the study will be collected, and will be
made anonymous before transfer to the central database.

4)   I understand that if I disclose information that suggests that I
am a risk to myself or others the research team must inform the
care team on the ward. If I tell the research team anything that
suggests security is at risk or about breaches of ward rules, the
research team will also need to inform ward staff in writing.

5)   I agree that my interview may be recorded and that the
recording will be destroyed after the data has been transcribed.
Quotes from my interview may be used anonymously. All data will
be kept in a secure place on an encrypted data stick and with no
identifying information for 10 years after which it will be destroyed.

6)   I agree that my Responsible Clinician will be informed of my
participation.

Name of Participant   Date   Signature
_____   _____   _____
Name of Researcher   Date   Signature

9

Appendix 5: Initial Interview Schedule & progressive questions

What do you think the main aims of your time spent with the clinical psychologist(s) was?

What do you think the main role of the psychologist that you were working with was?

Prompts: What (if any) have been the good things about working with your psychologist?

What (if anything) made working with your psychologist difficult?

What can you say about being able to trust your psychologist?

Prompts: Have you had worries about confidentiality? How have you trusted them? Why? Why not?

Has the issue of risk assessment and your psychologist being involved impacted on your ability to trust them?

Can you describe any experiences with your psychologist where you have felt you had to agree with something when you did not?

Prompts: In case of negative consequences, losing leave, longer stay in hospital, legal consequences?

 Questions added later after initial coding

How do you think the psychologist fits in with the rest of your care team?

How does this impact on you?

Do you think that you could achieve the same goals of group therapy in one to one therapy?

Can you tell me how the endings have been with your psychologists?

What would you say to a new patient who was going to start seeing a clinical psychologist, what advice would you give them?

The following appendices have been removed:

Appendix 6   NHS ethics committee approval letter

Appendix 7   Research and development approval letter Trust one

Appendix 8   Research and development approval letter Trust two

Appendix 9: Abridged research diary

Summer 2011, lit searches, found papers on offenders and psychologists but not patients in FMHS – thinking about exploratory research, so needs to be qualitative. I have only ever carried out thematic analysis before, so quite excited to try something new! Anne Sheeran has also agreed to supervise (external) and Yvonne has agreed to supervise internally.

September 2011 – Met with Anne Sheeran to discuss the plan for the project. We agreed a grounded theory approach seemed appropriate due to the lack of research on inpatient relationships with psychologists.

Anne also suggested asking Leigh Curtis if he would co-supervise as he worked in an MSU with the clients I was interested in doing research with and may bring a lot to the project. Leigh agreed.

October 2011 – MRP proposal meeting with Fergal and John, they agreed that a grounded theory approach and interviews with patients in an MSU would be an appropriate way to explore how the 'dual role' of psychologists in these settings impacts on the therapeutic relationship.

November 2011 – Applied to local REC after completing IRAS.

December 2011 – Approached the service lead at ****** MSU to ask for her support in recruiting from the unit, she agreed. Told me to fill out R&D forms and send them off whilst waiting to hear from the REC.

February 2012 - REC ethics panel, was asked a couple of questions about whether I thought it may be too much taking on interviewing both psychologists and patients. But was left that I could consider this. After speaking to Anne and Leigh, thinking they may be right, the

analysis may be too big for the scope of this project. Shame though as I really would have liked to get both perspectives.

Mar 2012 – Provisional favourable opinion from REC, they wanted me to change a few things on the consent form and to confirm how participants would be supported should the need arise, that the care teams agreed. I have clarified this and sent off changes, so should be good news.

May 2012 – Favourable opinion through from REC, just waiting in R&D now. Planning a focus group with ex-patients from an MSU to get ideas for the interview schedule, but need the R&D approval. Leigh has helped me to contact a supported living residential home in the community that have suitable participants.

July 2012 – R&D approval! I have now arranged the focus group for next week with 3 ex patients, who I visited today to explain what I am hoping to do and how I would like to know their experiences to guide my questioning and the legitimacy of the method.

July 2012 - focus group complete, was great, got some really helpful information. They have made me think about trying to capture patients of a certain age, as it seemed like a kind of generation affect may have been coming through in the interviews.   The trust thing may not be as doom and gloom as suggested by the prison research. They felt that one to one interviews would be helpful as people could speak more freely.

September 2012 – approached service lead at another trust to ask for support in recruiting from an MSU in that trust. Waiting to hear back. I have also arranged to visit the other MSU to talk to the identified patients that are suitable to take part about the project.

October 2012 – I have arranged 4 interviews over the next month. Helen Caird has also taken over as my internal supervisor now as Yvonne had left. This is great, as she seems to be really familiar with grounded theory.

I carried out the first interview and it has definitely got me thinking about this 'then and now' description of the way psychologists work in MSU's. The next participant is quite young and only ever been admitted once, will be interesting to see if they respond differently.

Carried out two more interviews, transcribed and started an initial coding process which we will talk about in supervision. The 4th patient was not well and we decided to leave it.

November 2012 – the other trust has agreed, now starting the R&D process.

December 2012 - met with Anne and Leigh to go through the initial coding, we decided to add a few questions to the next interviews about the MDT and group versus one to one therapy. Still nothing from the other trust, getting a bit worried as time is of the essence, have chased them up.

January 2013 – they lost the R&D forms, but have promised to prioritise them.

Have almost finished writing section A.

February 2013 – R&D from the second trust, going to the MSU next week to identify potential participants.

Met with Brian and approached patients on the ward to explain the project, 5 agreed to take part. There are still some more who I have not been able to reach today who may be able to take part.

March 2013 – Carried out the remaining interviews, transcripts and coding. Picture is building up of the importance of trust and how it is developed, seems it can be despite the conflict over risk assessment.

April 2013 – Meeting with Helen to discuss the next steps of the analysis, started the focused coding.

Supervision with Anne and Leigh to talk about the coding and make decisions where we have differing ideas. Start to build the categories, trust is definitely an emergent theme, with transparency about communication key. Also interestingly the patients are placing the psychologist into the role of mediator with the MDT, had not expected that! We think this is strong enough to be a sub-category.

May 2013 - Finished the coding and agreed all codes with Leigh and Anne. Meeting with Helen to check she is in agreement with the methods (and also methods section for section B).

Helen gave me some advice on how to present the coding and how to make sure the sub categories definitely reflected the focused codes, came up with some better names that more reflected the patient experiences. Started to write Section B up now.

June 2013 – had a few meetings with Helen to go over the category development and finished the final model, it fits with some of the lit from Section B but contradicts some of the research with offenders in prison, which is really interesting. Have a meeting with Anne to discuss this further and what this may imply.

Anne and I met, we discussed how some of the 'then and now' stuff may be a reflection of more patient centred initiatives such as 'my shared pathway'. I am going to read up further for the discussion section.

July 2013 – final meeting with Helen to go over the model and get feedback on Section B before writing final version.

Have written an end of study letter to the REC and will forward the report to both R&D departments.

The following appendix has been removed:

Appendix 10   Example of an interview transcript with initial codes and
memos

Appendix 11: Table of categories, sub-categories and focused codes

Category	Sub category	Focused codes
Barriers to trust	**Fear of consequences**	Worries about confidentiality Worries about legal consequences Worries about restrictions Worries about increased admission time Fear of being judged
	Coerced/forced	Having no control Feeling powerless Being scared into doing things Feeling threatened Having to go when I don't think I need it Having to take medication that I do not want
	Format of help	Group/individual therapy Repetitive groups
	Power	Being scared by the psychologist Psychologist acting threateningly Psychologist sticking to their agenda Psychologist knowing your history before you even meet Holding the ace cards
	Endings are painful	Ending abruptly Feeling rejected

	Feeling abandoned Reliving past rejections Gentler endings High staff turn over
Negative aspects of communication by the wider care team	Being misrepresented or misunderstood Not being listened to, just seeing the illness Not working together
Past difficulties in hospital	Disclosing has affected my progress Being ill Moving hospitals Lack of consistency in psychologist approaches Past relationship difficulties with trust Psychologist not doing enough Psychologist not understanding me Misreporting (electronic records) Ignoring my complaints Not agreeing with care pathway Being scared by psychologists If I do not trust I do not give information I think they can harm me with Psychologists are looking for problems Psychologist not interested

Building Trust	Feeling understood	Patient focused not fitting to a model About me Treating me as a person not an illness
	Timing/Pacing	Gradual pace Takes time to build trust Timing of the ending
	Being involved	Collaborating on risk assessment HCR-20 Access to information Being kept in the loop Knowing what the team plans for me Understanding rationale for treatment
	Transparency	Explaining care plans Explaining risk assessments Explaining diagnosis MDT working together
	Having a choice to go	Choice in type of therapy Choice in psychologist Not going every week Having some control
	Understanding the limits of confidentiality	Being told from the beginning Not worried about

		confidentiality
		Knowing when information is shared
		Psychologists only disclose when risk involved
		Psychologists disclose less than other members of the care team
		If I don't want something to be known I do not disclose it
	Psychologist characteristics	Being upfront
		Warmth, empathy
		Being interested
		Being there to help me
		Being patient
		Being respectful
		Being experienced
		Not being judgemental
	Taking a risk	Taking a chance
		Following your instincts about who you can trust
Arriving at a strong relationship		
	Building a rapport	Building a therapy relationship
		Two way street
		They know me
		Feeling supported
	Psychologist as mediator to the MDT	Put my side across to the MDT and others
		Needing a voice
		Using the psychologist to pass things on
		The psychologist

		can help other team members understand me Communicating with MDT
Dealing with things in a safer way	**Dealing with the past**	Turning point Coming to terms with the past Different techniques to talk How therapy worked Ways to express yourself Sharing for the first time Not feeling guilty
	Feeling safe	Not being scared Being kept safe Reduced distress Psychologist as protector
	Prepare for the outside	Moving on What to expect
	Develop ways to cope	Talking about ways to cope Avoid being restrained Develop healthier habits Develop tools to overcome problems Reducing 'incidents'
	Develop insight	Learning how others think Having a better understanding of yourself Understanding others motivation

Appendix 12: Example of the development of a sub category (fear of consequences) was developed

Sub Category	Focused codes	Initial codes	Example text from transcripts	Memos
Fear of consequences	Worries about confidentiality	Worry my family will find things out	"Oh my god what if they accidently slip something out in front of my mum or something' and that is quite nerve racking".	This same participant said they were not worried about confidentiality with the psychologist, so this was a bit of a contradiction, though seemed more worried something would come out by accident. Also worried about family rather than staff knowing?
		Don't tell if it can harm me	"Well I have to be able to trust them, and if I feel like I cannot trust them then I don't give out the information that I think they can erm…harm me".	It seems that most participants were aware of the boundaries of confidentiality and those that were worried knew what types of disclosures may harm them – e.g past offences, or beliefs/feelings/desires

				etc that may impact their progress in hospital?
	Worries about legal consequences	Finding out other offences from my past	"So that's the kind of things that I want to not make him (psychologist) know about things that make you look stupid, I am in here for like criminal offences and during my teenage years there were someone doing criminal activity around me that no one even noticed and that so I don't want to go to personal, too deep".	This participant was very wary about engaging with psychologists; unlike the others he was more worried about confidentiality. It seemed from what he was saying that there were several offences that are not known about and that he is aware that a disclosure will lead to possible further legal action.
		They might tell the MoJ	"Erm, to tell the truth I didn't really bother with psychology more than a certain extent because they, erm they, they tell the Ministry of justice, the psychologist, that I have been in situations like this".	I wonder if more of the participants had past undisclosed offences whether they would be more likely to be worried about engaging in case of consequences.

Also seemed like he wanted me to like him, |

				not to be seen in a 'bad light'.
	Worries about restrictions	Keeping quiet or losing leave	"You can't have arguments with them (nurses) anymore they say you are abusing them and they say it's an incident because you have abused them, you lose your leave".	This came up only once (explicitly) and in relation to nursing staff rather than psychologists. Participants were more concerned with how nurses perceptions or reports would impact their status on the ward – having worked on forensic wards I think this made me think about how it is the nurses who are there all of the time and how psychologists only 'pop' in and out. This comes up later in other contexts as well, such as having the psychologist explain 'their' side of things to the rest of the MDT and get their side across – something

				about these positions maybe placing the psychologist as an ally?
	Worries about increased admission time	Feeling threatened so complying	"He said that if I refused to take the med he would section me, so I took the med but he really scared me".	This was in reference to experiences in a different hospital over 10 years ago and seemed to reflect a different era, I thought they may be confusing the psychologist with the psychiatrist but when I asked the participant was sure it was the psychologist. This was similar to what had been said in the focus group I carried out, all of the participants were ex-patients in the group and were also referring to experiences that dated back at least 10 years ago, in some cases longer.
	Fear of being judged	Getting looked down on	"Something's I would just say let's leave this aside, because it aint	In particular this guy really seemed to want to come across well to

			really all that important and it would just get me into a situation where I would be looked down upon".	me so I can imagine this extends to others he has worked with and that he would see regularly as he knew he would only see me once.
		Thinking I am stupid	"I don't talk about it because it just shows that, that, that, it doesn't show me as a person, it just shows the certain people I move about with, they could probably think I was stupid".	I guess social desirability and wanting to be liked/respected may make things really difficult to talk about experiences that people may be ashamed of or want to keep in their past even if there would be no consequences in terms of their hospital progress or legal status?
		Looking bad	"It wouldn't look good on me would it if I was to tell him I used to hang with a group of guys that used to do all this stupid things, because like killing is against the law and murder is against the law".	

Appendix 13: Table of categories, sub-categories and text examples from the transcripts

Category	Sub Category	No of participants	Example text and line number
Barriers to trust	Fear of consequences	5	1 "Something's I would just 2 say let's leave this aside, 3 because it aint really all 4 that important and it 5 would just get me into a 6 situation where I would be 7 looked down upon". 8 "It wouldn't look good on 9 me would it if I was to tell 10 him I used to hang with 11 a group of guys that used 12 to do all this stupid 13 things, because like 14 killing is against the law 15 and murder is against the 16 law". 17 "So that's the kind of 18

			things that I want to not 19 make him (psychologist) 20 know about things that 21 make you look stupid, I 22 am in here for like 23 criminal offences and 24 during my teenage years 25 there were someone 26 doing criminal activity 27 around me that no one 28 even noticed and that so 29 I don't want to go to 30 personal, too deep".
			31 "Erm, to tell the truth 32 didn't really bother with 33 psychology more than a 34 certain extent because 35 they, erm they, they tell 36 the Ministry of justice, 37 the psychologist, that I 38 have been in situations 39 ike this or they don't, I 40 mean I am not 100 % 41 sure it would be kept 42

			confidential". 43 "Well I have to be able 44 to trust them, and if I 45 feel like I cannot trust 46 them then I don't give 47 out the information that 48 I think they can 49 erm…harm me".
	Coerced/forced	4	50 "He said that if I refused 51 to take the med he 52 would section me, so I 53 took the med but he 54 really scared me". 55 "I said to her I don't 56 need to go to anger 57 management, I shouldn't 58 go there because I've got 59 nothing on my chest and 60 I don't feel angry right 61 now but she was so 62

			persistent that I just 63 went there".
			64 "I don't really suffer 65 from illnesses really 66 much, I said to myself I 67 shouldn't really like 68 erm, like follow it 69 through because as I said 70 it doesn't really apply to 71 me"
			72 "Erm, it is just 73 something that I didn't 74 really need. I thought I 75 didn't need to do these 76 things or know about 77 these things cos I am 78 like a patient that that, 79 that like go's into 80 hospital and there ain't 81 really things that are 82 wrong with me"

	Power	4	83 "Some that have scared 84 me and I have told them 85 and they have said 'well 86 you will have to put up 87 with me'". 88 "But I wasn't saying 89 anything and I had a 90 member of the children's home with me and it was all quiet and he wacked his hand on the table' 91 "Errm, it is like doing a 92 jigsaw puzzle. You start 93 at one end and then you 94 go wherever he 95 (psychologist) wants to 96 take it to". 97 "The only advice I 98 would give them is just 99 go through it but you 100 don't let the 101

			psychologist, you know 102 take all the ace cards".
			103 "Well definitely a 104 problem that every 105 patient in any hospital 106 has had is dealing with 107 certain narratives 108 (nursing staff), they are 109 in it for the power trip 110 I think and it is as 111 simple as this, they can 112 write whatever they 113 want in their notes, and 114 you may not know 115 about it for a number 116 of months".
			117 "See you do get nurses 118 like that who are in a 119 position of power when 120 they shouldn't be and 121 they use it. When you 122 are down, there isn't 123 anything you can do, 124 because you are 125

			'schizophrenic'".
	Format of help	5	126 "Erm, I just felt bored 127 of it and it was just too 128 long so I stopped doing 129 it".
			130 "I've never done group 131 psychology, you are 132 opening up yourself so 133 the other people there 134 will, you are showing 135 your emotions and 136 there are other people 137 there and I wouldn't 138 want that really".
			139 "Yeah, you always 140 want don't to answer 141 when you are in a group".
			142 "Some of them were 143 not good, too wrapped 145 up in numbers and 146 statistics, and you 147 know

34

			theories".
	Endings are painful		148 "Some I have had for 149 2/3 years, some I've 150 had 2/3 weeks so it 151 does…and when you 152 have had someone you 153 have trusted and they 154 move on, sometimes 155 it's harder to trust 156 somebody else because 157 you think they are 158 moving on because 159 they don't like me, 160 then you go back to 161 blaming yourself again".
			162 "Yes it can get quite 163 emotional when you 164 have done a lot of hard 165 work and you have to 166 say goodbye to them. 167 Sometimes I have had 168 psychologist leave and 169

			not tell me".
			170 "You don't get the 171 chance to say goodbye, 172 that was really hard and 173 that took me a while to 174 trust somebody else 175 because you think they are going to do that as 176 well".
	Negative aspects of communication by wider the care team	4	177 "If they (nursing staff * psychiatrist) hear of 179 something they spiral 180 it into a big debate and 181 there are things that 182 have been written 183about me which aint 184 correct".
			185 "They don't write 186 nothing to insult me or 187 nothing but its not 188 accurate description of 189 the things I get up to 190 or the things I do 191 really, if they had done 192 things

			correctly like 193 how I would have done 194 it then I wouldn't be 195 here today".
	Past difficulties in hospital	3	196 "I have a lot of issues 197 with trust, to literally 198 learn how you can trust 199 someone, cos you trust 200 different people in 201 different ways I think". "When you have had someone you have trusted and they move on, sometimes it's harder to trust somebody else because you think they are moving on because they don't like me, then you go back to 210 blaming yourself again".
How trust is built	Feeling understood	5	"It's like little things like that that I need the psychology sessions for and other things obviously just to show how I'm feeling, you know".

			"That's why I did the psychology sessions so 220 someone knows what's going on in my head, the truth".
	Timing/Pacing	8	"You don't want to be rushed, be rushing to answer questions. It is too much to take.

"Initially when psychologists were talking to me I was not 230 forthcoming. I was thinking I don't want any psychologist in my life, the thing is I was surprised that she was able to still go along and not get angry, she patiently waited for me to change my mind, and then start talking about myself, about my children, my   240 offence. So I think it takes |

			time".
			"So they have got to have the right approach, which like I say they have up till now, in my experience. By talking about things but not too intensely to start with".
			"After about two and a half 250 months I was able to settle down into doing the therapy".
			"Depends who it was but the person I trusted the most, it took a good 6 – 7 months to you know get to really trust that person".
			"My only comment would be

| | | | that at times you could 260 feel a bit 'psychology'ed' out, could feel a bit overload".

"Thinking about it the only possible one bad experience with one to one stuff would be that after three sessions, that is it. When you have had so much input from the psychology department on 270 one side it is good because you have done all that you can do, on the other hand you can think 'well hang on a minute, the amount of stuff that I have done with the psychology department, you should not be stopped – like that".

"But at the beginning they 280 had the right approach, |
|---|---|---|---|

			so if they could put that into practice at the ending".
	Understanding limits of confidentiality	8	"No I wouldn't be worried about confidentiality because they always said they would tell me if they were going to pass information on". "They do respect privacy 290 and they will only pass on what has to be passed on. The team don't have to know every detail you say to your psychologist, because sometimes it is between just you and them. But that's quite important because if you can't build the trust, then it isn't going 300 to work".

			"I have had psychologists in the past and I know the way that they work and they don't discuss your problem with another person, I mean they have their own record but its not like if I see somebody else apart from them, they go 310 on the RIO and everyone can read it, but the psychologists are not like that, they put details about the session but not the full report, I think that it is very good". "Yes if you tell them someone 'I'm going to hit someone', they have to 320 pass it on, or if you say 'I'm going to kill myself', they have to pass it on. Anything that she feels is at risk, they

			have to pass it on really".
			"At first I was worried but he just said it was confidential and its only for his benefit to help me out, 330 there are some things he did, without going into detail, in my CPA meeting, he gave out enough to say how far we had gone".
			"Yeah they will tell you init, if they wanna share it or if they don't want to share it anyone they will tell you".
			340 "They have always said to me that they will 'discuss this in the team'. But I think this is a good thing to discuss it in the team, because that is part of the MDT in my

			experience anyway. Then everyone can sit down, have an all-round case conference and 350 CPA. Discussing as a team and working out what is the best next plan for us".
			"No I was not concerned, she actually told me how things would work from the beginning, just like you explained to me, she explained to me, everything is confidential unless she 360 has to tell them or something".
			"Psychologists are known for the way that they work, because they don't share much information, it is confidentiality which matters, but I think they get along well with the rest of

			staff even if information 370 is not shared fully, you understand. But if they come they will come to the staff and let them know "I have just seen *** and she is doing well and there is no problem", but if there is a problem they will say "I am worried about *** that she has expressed suicidal 380 ideation or thoughts of self-harm" and stuff like that".
	Being involved	6	"But they always inform you on what they do, they go through your care plan, your psychology care plan". "Yes we sign it to say that we agree. It's pointless having a care plan if no 390 one's going to stick by it"!

			"No we have a say what goes in our care plans". "Yes. What they are planning for me, keeping us in the loop, recently I have been more communicated to about what is next, about what people feel is the next 400 best move, my treatment plan".
	Transparency	5	"I showed her my care plan and I went through it with her, the Psychologist, because I was concerned and then it said something like I was suffering with schizophrenic blah, blah, blah and I was like; 'what 410 the hell does that mean?!' and she said 'it's

			just something that is written in a book and that she will be able to show it to me and help me get the meaning of what has been written on my care plan".
	Psychologist characteristics	8	"They requested for me to see the trainee Psychologist 420 but I refused because I wanted to see the Senior Psychologist because I'm not keen on keep seeing the trainee psychologist". "So I like my psychologist to have a duty of care and to be sincere and to want to help you, psychologists help people don't they and 430 I want my psychologist to help me and all of them have care and want to help me and to have the experience of knowing how to help – that's

			why I am not keen on Junior Psychologists".
			"The Senior one has already worked in these 440 establishments for years, and has already given psychology to plenty and plenty of people. So she's had the experience and knowledge of learning about people's mental illness and how they feel with their 450 mental illness if you get me?"
			"I strongly believe that the right initial approach, depending on the individual, should show that the person is warming and caring. If you do not show that you are caring initially then it will not

			work".
	Having a choice to go	5	460 "I have been asked to do psychology sessions and I only do them if I want to".
			"I have done six closed groups since I have been here and I was asked to do a seventh one but I said no, my rationale for that and in fairness they seemed to 470 listen to my rationale".
			"The only time I suppose put my foot down really was about the family therapy because also I did not think it would be helpful for my mum and dad to try and go through that".
	Taking a risk	3	"But sometimes you have to just get it out and that's 480

			the only way you can do it". "I trusted my last psychologist before I came here an awful lot and I was so scared to tell them something because it had a bad affect. But it didn't and it was a risk I took".
			" I told her things I hadn't told anyone for years, well I 490 hadn't told anyone at all. And to tell her, I thought wow things aren't as bad as you think they are going to be".
			"Well you have got to trust someone, laughs, Promises it is going to be confidential but you have to trust".
			"The way they present

			500 themselves to you, erh, theres not, nothing, its just talking, if you agree with what they are talking about then you just have to trust them".
Arriving at a strong relationship			
	Building a rapport	3	"You tell them a bit about you and they tell you a bit about them". "Yes you build up a 510 relationship. You know how they are going to react and everything, which does help". "I know that in the past

			when I was at XXX and XXX psychologists there have said to me a couple of times 'what's up with you today?' and I say 'nothing' 520 and they say 'yes there is', and they know what is wrong before we even start".
	Psychologist as mediator with the MDT	3	"I used the psychology to voice my concerns". "Definitely, definitely I need someone that is not on the nursing side to voice my opinions on what's been 530 happening". "I told them that cause I want them to do this'. You feel I have told them this, so I want them to pass this on".

| Dealing with things in a safer way			
	Dealing with the past/Moving on	7	"We did a lot of DBT to help deal with past issues, lot of talking about my past".
			540 "What I mean, is, like, ok so we were discussing about my offence and I have never discussed it like that before with anybody, so she gave me a relaxing atmosphere in order to discuss it with her which was very helpful".
			"Just to help you deal with 550 things in a much safer way and come to terms with it and not blame yourself and yes that's it really". "We did a lot of DBT to help deal with past issues, lot of

			talking about my past".
			"I've recovered and I feel very well and happy now".
			560 "It has been helpful, the, you can bring things up, you know, that I wasn't able to do before".
	Develop insight	4	"I don't know, I don't know, it's like sometimes I used to get restrained and I used to talk to the psychologist about these reasons, I used to get 570 restrained so I could be physically held down and kept safe. The team would pass it on and then find other ways of dealing with it. So I would get out of the habit and into

			another habit….something more healthier".
			"We were all in to discuss 570 our offence and able to sympathise with the victims".
			"like teaching you how other people might think. And that's quite interesting in psychology".
	Feeling safe	3	"Here I'm not scared of anything here and I feel really safe here and that's 580 with the help of psychology as well".
			"You know they are there for you if you get stuck, you know they are there for you if you get desperate".

			"We would talk about ways to cope. She would say 'I will see you in your session' and that really made it a lot 590 easier to trust psychologists". "Sometimes after psychology I feel, I go to my room, self-harming but if I tell them that they will tell staff and then you will be kept safe and sometimes some places don't do that but here they do".
	Prepare for the outside	2	600 "There was a coping group where you anticipate what will be happening in the community when you leave, will they accept you when you leave or not". "They help you prepare for

			life outside, what to expect, how people will treat you and that makes them an 610 important part of the team, the most important part, apart from the doctors".
	Develop ways to cope	5	"That's when I really started trusting someone, I could be having a crap night, and they would threaten to sedate me and I would say I am just going to 620 ring my therapist and I would ring her and we would talk about ways to cope. She would say 'I will see you in your session' and that really made it a lot easier to trust psychologists". "I suppose the whole point of psychology is to develop the tools you need in order 630 to overcome and deal with your problems".

Appendix 14: Instructions for publication in the Journal of Forensic Psychiatry and Psychology
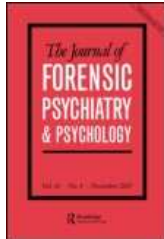
For all manuscripts non-discriminatory language is mandatory. Sexist or racist terms should not be used.

The manuscript

Submissions should be in English, double spaced with wide margins. Pages must be numbered.

Articles should normally be no more than 5,000 words in length (excluding references) and be preceded by an abstract of no more than 150 words.

Review papers (eg systematic reviews, meta-analyses, law reviews) and some empirical studies may require greater length and the Editors are happy to receive longer papers. We encourage brevity in reporting research.

A word count should be provided.

Style guidelines

Description of the Journal's article style

American Psychological Association (APA) referencing style should be used

APA references style guide

Any consistent spelling style is acceptable. Use single quotation marks with double within if needed.

Three levels of heading are suggested:

First level

Second level

Third level.

For direct quotations of 40 words or more, which will be printed as prose extracts, page numbers are required. Always use the minimum number of figures in page numbers, dates etc., e.g. pp. 24-4, 105-6 (but using 112-13 for 'teen numbers) and 1968-9.

If you have any questions about references or formatting your article, please contact authorqueries@tandf.co.uk (please mention the journal title in your email).

Word templates

Word templates are available for this journal. If you are not able to use the template via the links or if you have any other template queries, please contact authortemplate@tandf.co.uk

Figures

It is in the author's interest to provide the highest quality figure format possible. Please be sure that all imported scanned material is scanned at the appropriate resolution: 1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour.

Figures must be saved separate to text. Please do not embed figures in the paper file.

Files should be saved as one of the following formats: TIFF (tagged image file format), PostScript or EPS (encapsulated PostScript), and should contain all the necessary font information and the source file of the application (e.g. CorelDraw/Mac, CorelDraw/PC).

All figures must be numbered in the order in which they appear in the paper (e.g. Figure 1, Figure 2). In multi-part figures, each part should be labelled (e.g. Figure 1(a), Figure 1(b)).

Figure captions must be saved separately, as part of the file containing the complete text of the paper, and numbered correspondingly.

The filename for a graphic should be descriptive of the graphic, e.g. Figure1, Figure2a.

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NHS

Health Research Authority

DECLARATION OF THE END OF A STUDY
(For all studies except clinical trials of investigational medicinal products)

To be completed in typescript by the Chief Investigator and submitted to the Research Ethics Committee that gave a favourable opinion of the research ("the main REC") within 90 days of the conclusion of the study or within 15 days of early termination. For questions with Yes/No options please indicate answer in bold type.

1. Details of Chief Investigator

Name:	Kate Ellis
Address:	
Telephone:	
Email:	
Fax:	

2. Details of study

Full title of study:	Developing a model of the relationship between inpatients and clinical psychologists in secure settings
Research sponsor:	Canterbury Christ Church University
Name of main REC:	Kent
Main REC reference number:	12/LO/0304

3. Study duration

Date study commenced:	01/07/2012
Date study ended:	01/05/2013
Did this study terminate prematurely?	**No** *If yes please complete sections 4, 5 & 6, if no please go direct to section 7.*

4. Circumstances of early termination

What is the justification for this early termination?	

5. Temporary halt

Is this a temporary halt to the study?	Yes / No
If yes, what is the justification for temporarily halting the study? When do you expect the study to re-start?	e.g. Safety, difficulties recruiting participants, trial has not commenced, other reasons.

6. Potential implications for research participants

Are there any potential implications for research participants as a result of terminating/halting the study prematurely? Please describe the steps taken to address them.	

7. Final report on the research

Is a summary of the final report on the research enclosed with this form?	Yes
	If no, please forward within 12 months of the end of the study.

8. Declaration

Signature of Chief Investigator:	
Print name:	Dr Kate Ellis
Date of submission:	26/07/13

End of study report

The study is now completed. The study began with a focus group with ex-inpatients now living in the community. The focus group was a chance to ask what service users felt about the relationships they had with clinical psychologists in the past. From the focus group and an extensive literature review an interview schedule was developed which focused on the following;

1) How relationships are developed in these settings given the 'dual role' held by clinical psychologists of providing therapeutic intervention as well as risk assessment

2) Can trust be developed given the limits of confidentiality?

3) What do service users perceive as the role of clinical psychologists in these settings?

Eight Participants were recruited from 2 MSU's and consented to take part in a semi-structured interview. A grounded theory analysis produced a model of how trust was built and relationships developed.

Despite the 'dual role' held in these settings, with an approach that is transparent, open, collaborative, and patient-centred; service users are able to build trusting relationships. Furthermore, they report making positive therapeutic gains such as developing insight into the impact of their offences on others, their own risky situations, managing anxiety, feeling well and preparing for living in the community.

Where 'coercive' experiences were described, this appeared to be a representation of more distant times, with recent experiences being described as more satisfactory. Clinical psychologists also seem to be placed in a position of 'mediator' amongst the wider care team.

Further research is required to explore these findings and whether they apply in other secure settings.