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Vikki Taylor BSc (Hons)

**AN EXPLORATION INTO SERVICE USERS' AND  
STAFF EXPERIENCES OF A MEDIUM SECURE  
SETTING**

Section A: Service users' experiences of secure hospitals and the  
associated factors related to quality of stay.

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Section B: A mixed-methods investigation into the relationship  
between compassion for others and work-related stress in a  
medium secure unit.

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

MAY 2016

SALOMONS  
CANTERBURY CHRIST CHURCH UNIVERSITY

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To my family and friends, thank you for your endless encouragement and support. Ruairidh, your infinite patience and unwavering love throughout this time has kept me on track. You have kept me going and reminded me of the light at the end of the tunnel

## SERVICE USER AND STAFF EXPERIENCES OF MEDIUM SECURE SETTINGS

### Overview of the Major Research Project

**Section A** explores service users' experiences of receiving treatment within secure hospitals. The factors which influence service users' quality of stay were also explored. A literature review, using a systemized narrative approach, was undertaken with 12 research studies. The implications of the results are considered, as well as suggestions made for future research. Further research investigating staff wellbeing, specifically compassion for others and work-related stress, in secure hospitals is recommended, alongside further exploration of service users' experiences.

**Section B** is an empirical research paper that aims to explore the relationship between compassion for others and work-related stress, as reported by staff in a medium secure unit. A mixed methods approach, including self-report questionnaires and individual interviews with 12 participants, was undertaken. The barriers to compassion, causes of work-related stress and factors that influence the relationship between compassion and work-related stress were considered. The findings are discussed in relation to practice and research implications.

**Table of Contents**

**Section A: A Literature Review**

<b>Abstract</b>	<b>9</b>
<b>Introduction</b>	<b>10</b>
Setting the Context	10
Challenges of Secure Hospitals	11
Therapeutic Relationships	12
Current Context	14
Rationale of Review	15
Aim of this Review	16
<b>Methodology</b>	<b>16</b>
Results	19
<b>Literature Review</b>	<b>29</b>
Relationships with Staff	35
Power and Control	37
Experiences of Care and Being Cared For	39
Satisfaction with Care	42
Transitions	45
Uncertainty	47
<b>Discussion</b>	<b>48</b>
Current State of the Literature and Limitations	51
Implications for Clinical Practice and Future Research	54
<b>Conclusion</b>	<b>57</b>
References	59

**Table of Contents**

**Section B: Empirical Paper**

<b>Abstract</b>	<b>69</b>
<b>Introduction</b>	<b>71</b>
Forensic Mental Health Services	72
Therapeutic Relationships	72
Compassion	74
Work-related Stress and Forensic Mental Health	75
Present Study	76
Research Questions	78
<b>Methodology</b>	<b>78</b>
Design	78
Research Setting and Recruitment	78
Participants	81
Measures	82
Procedure	84
Data Analysis	86
<b>Results</b>	<b>89</b>
Quantitative Phase	89
Qualitative Phase	97
<b>Discussion</b>	<b>106</b>
Limitations of Study	111
Practice and Research Implications	112
Conclusion	114
<b>References</b>	<b>115</b>

## List of Figures

<i>Figure 1: Flow Chart Diagram</i>	18
-------------------------------------	----

## List of Tables

<i>Table 1: Inclusion and exclusion criteria</i>	19
<i>Table 2: Summary of studies</i>	20
<i>Table 3: Comparison of quality of studies (CASP, 2014)</i>	30
<i>Table 4: Comparison of quality of studies (Adapted Strobe; von Elm et al., 2007)</i>	32
<i>Table 5: Contextual information for each ward gathered between July 2015 and December 2015</i>	80
<i>Table 6: Number of incidents, restraints and incidents of supervised confinement</i>	81
<i>Table 7: Pommier's (2011) definitions of compassion subscales</i>	83
<i>Table 8: Work-related stress subscale definitions (HSE, 2004)</i>	84
<i>Table 9: Mean and standard deviation scores for compassion and work-related stress responses</i>	90
<i>Table 10: Multiple Regression Results</i>	92
<i>Table 11: Ward 1 multiple regressions results</i>	93
<i>Table 12: Ward 2 multiple regression results</i>	94

<i>Table 13: Ward 3 multiple regression results</i>	95
---	----

<i>Table 14: Ward 4 multiple regression results</i>	96
---	----

### **Section C: List of Appendices**

<i>Appendix A: Contextual ward data between July and December 2015</i>	122
<i>Appendix B: The Compassion Scale</i>	123
<i>Appendix C: Health and Safety Executive MS Indicator Tool</i>	124
<i>Appendix D: Assumptions of parametric data</i>	129
<i>Appendix E: Multiple Regression (Full Table)</i>	131
<i>Appendix F: SPSS output example</i>	133
<i>Appendix G: Interview Schedule</i>	136
<i>Appendix H: Participant information sheets</i>	137
<i>Appendix I: Interview Transcript</i>	145
<i>Appendix J: Consent form</i>	171
<i>Appendix K: Excerpt from bracketing interview</i>	172
<i>Appendix L: Abridged research diary</i>	173
<i>Appendix M: Ethics approval letter</i>	174
<i>Appendix N: R&amp;D Approval</i>	175
<i>Appendix O: Letter to ethics committee and R&amp;D at the end of the study</i>	176
<i>Appendix P: Service and Participant Report and R&amp;D Summary</i>	177
<i>Appendix Q: Author guidelines for The Journal of Forensic Psychiatry and</i>	180

*Psychology*



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Major Research Project

Section A: Literature Review

Service users' experiences of secure hospitals and the associated factors  
related to quality of stay.

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## **Abstract**

The importance of service user perspectives is becoming increasingly significant in the development and provision of healthcare services. However, the lived experience of service users within secure hospitals has been largely under-researched in comparison to other areas of mental health. As a result, there is a lack of literature published in this area, leading to the present aim to conduct a systemised literature review. A search of the literature base including Psychinfo and EBSCOHost, using the terms (forensic mental health OR medium secure OR regional secure OR secure hospital) AND (patient OR service user) AND (experiences) yielded 12 papers. The studies were synthesised and discussed, using quality criteria. Findings suggest that a number of factors impact on the quality of patient stays within secure hospitals, including relationships with staff, satisfaction with care, transitions and feelings of uncertainty. Future research could explore staff experiences of working with this client group, given consistent findings that relationships with staff have a strong influence on the quality of stay within secure hospitals.

**Keywords:** forensic mental health, patient experiences, relationships, secure hospital

## **Introduction**

### *Setting the Context: Forensic Mental Health Services*

In 2009, the Bradley Report (2009) announced an increase in the number of individuals in prisons with both diagnosed and undiagnosed mental health difficulties. However, in the past 30 years there has also been a growing movement towards meeting the needs of those individuals who offend and who have mental health difficulties, such that they are to be supported by health and social care agencies in secure hospitals rather than within the criminal justice system (Badger, Vaughan, Woodward & Williams, 1999). Rutherford and Duggan (2008) argue the importance of offenders with mental health difficulties having access to the correct healthcare interventions in the correct environment. The authors advocate that offenders who have mental health difficulties should be given hospital orders rather than lengthy prison sentences, which could be detrimental to patients' mental health and prospects of recovery. This also comes at a time where there is increasing demand for secure forensic mental health (FMH) provisions, despite the cost of such services continuing to rise.

Medium secure units (MSUs), formally known as regional secure units, aim to provide patients with a safe and secure therapeutic environment, whilst maintaining custodial restrictions put in place by the criminal justice system (Kennedy, 2002). Patients are admitted to MSUs when a deterioration in mental health occurs alongside a perceived risk to self or others. Patients may also be admitted to an MSU with a history of offending and mental health difficulties (NHS Confederation, 2012).

Following the Butler Report (1975), which called for MSUs to function as ‘hubs’ for multiagency collaborative working, MSUs were initially tasked with providing treatment to offenders outside of prisons and enabling those with hospital orders to be admitted closer to their home (Wilson, James & Forrester, 2011). Despite this, the relationship between the criminal justice system and FMH provisions remains complex (Kurtz & Turner, 2007). For example, admissions to secure hospitals are time unlimited, unlike prison sentences. The implications of this have been discussed by Yorston and Taylor (2009) who found that patients’ feelings of uncertainty regarding the length of time they would remain in hospital had a negative impact on their stay, compared to time limited prison sentences. Alongside the increasing length of stay, there has also been much discussion in the literature regarding the challenges of providing treatments to patients in MSUs.

### *Challenges of Secure Hospitals*

The dual functionality of secure hospitals has been well considered within the literature. Kennedy (2002) discussed this and highlighted the need for forensic mental health services to remain grounded within healthcare values, rather than those of the criminal justice system. Yet, Wilson et al. (2011) argues that MSU’s have so far failed to meet these targets, with long waiting lists and a lack of treatment options being offered. Hörberg, Sjögren and Dahlberg (2012) acknowledged the complexity, from a patient perspective, of being cared for therapeutically whilst also being restricted by security measures.

From a professional perspective, Kennedy (2002) discussed the challenges of simultaneously balancing therapeutic care with the need to be secure and restrictive, given the perceived high risk believed to be associated with this population. The role of nursing staff in particular has been discussed in regards to the development and maintenance of therapeutic relationships whilst implementing custodial restraints (Martin & Street, 2003), due to spending the most amount of time with patients.

### *Therapeutic Relationships*

Several authors have discussed the relationship between patients and staff in secure hospitals (Kennedy, 2002; Jacob, Gagnon & Holmes, 2009; Weiskopf, 2005). Psychodynamic theory provides a useful framework for considering this relationship in respect to the conscious and unconscious processes present between staff and patients, which potentially impacts on the quality of patient care (Aiyegbusi & Clarke-Moore, 2008). Aiyegbusi and Kelly (2015) hypothesised that patients' unprocessed traumatic memories are triggered within the context of the nurse-patient relationship. Once triggered, the patients' emotional distress is projected on to the caregiver in the form of violent and aggressive behaviour, which then activates negative feelings for the caregiver. Consequently, Kurtz and Jeffcote (2011) suggest that staff may act in a defensive manner (e.g. limited emotional contact with patients) as a means of protecting themselves against the distress and suffering of their patients. It could be hypothesised that the emotional defences of which staff may engage in may hinder the quality of relationships between staff and patients.

Lyth-Menzies (1979) theorised that staff working within inpatient institutions are likely to experience internal conflict as patients' feelings of hopelessness and distress are likely to be projected on to and within staff teams. The author suggests that staff members are motivated by a wish to evoke therapeutic change for patients; however, this is met with feelings of hopelessness, which maintain the internal conflict. The consequence of this internal conflict and the influence this has on the nurse-patient relationship leads us to consider the experience of patients and their lived experience of being cared for.

Jacob and Holmes (2011) concluded that factors such as the nature of the crime committed by the patients (e.g. paedophilia) and a diagnosis of a "personality disorder" have a negative impact on the development of therapeutic relationships. For instance, staff may make efforts to emotionally detach themselves, as a defence, from the patients in order to protect themselves from any potential risks. This is an indication of the complex nature of secure hospitals, which is multi-faceted with complex relationships both between staff and patients and within patient groups (Adshead, 2002). Other factors that have been identified as having a negative impact on the development and maintenance of therapeutic relationships include feeling intimidated by patients (Jacob et al., 2009), restraining patients (Hinsby & Baker, 2004) and enforcing restrictions on patients (Kennedy, 2002).

Adshead (2002) applied Bowlby's (1988) attachment theory to understand the relationship between patients and nurses, and suggested one's ability to understand their own attachment styles, both inside and outside of the therapeutic relationship, can impact on one's ability to understand another's difficulties. From the patient perspective, one's attachment style and experiences of previous attachment

relationships are likely to influence their experience of being cared for by others whilst in hospital. The author argues that early experiences of attachment were unlikely to be safe or secure for patients in secure hospitals; therefore, given this poor early experience of care, links should be made as to how responsive such patients can be to care they receive from staff. Linking early experiences to the lived experiences of being in a secure hospital and the factors impacting on the quality of one's stay, it is important to consider the accounts of those who have had first hand experiences in secure settings.

### *Current Context of the NHS and Service User Perspectives*

Giving consideration to the lived experiences of patients within the mental health system is a developing process, with an increased emphasis on service users influencing policy and service development (Tambuyzer, Pieters & Van Audenhove, 2014). This comes at a time when the National Health Service (NHS) has come under scrutiny. The Francis Report (2013) described several failings of care delivered by Mid Staffordshire NHS Foundation Trust, which were deemed to have been directly caused by the 'culture' of the NHS. Davies and Mannion (2013) debate the usefulness of this idea, that 'culture' should be blamed, given the lack of uniformity between NHS services. Instead, the authors argue that the NHS is not defined or maintained by one 'culture', yet is organised by historical and complex differences between disciplines and services. This suggests that thinking about the culture of each service, rather than the NHS as a whole, may be more beneficial to improving the quality of patient care. However, important lessons can be drawn from considering the strengths and weaknesses of individual services in order to inform wider service developments within the NHS.

Hui and Stickley (2007) argue that service user involvement, especially in mental health services, remains a complex and challenging concept for services to authentically adopt despite the widespread acceptance of its utility. At the time of writing, the increasing use of service user involvement comes when the NHS is in a state of change and reorganisation following critical reports such as the Winterbourne View Report (Flynn, 2012). However, gaining the perspectives of service users in FMH services remains largely under-researched due to a perceived difficulty in gaining consent and recruitment restrictions (Spiers, Harney & Chilvers, 2005).

### **Rationale for Review**

This introduction has considered the development and formation of therapeutic relationships within MSUs. Whilst recently there has been an increased emphasis on the importance of service user perspectives across healthcare specialties, the experience of patients in secure hospital settings remains under-researched. A review of the available literature could investigate the link between patient experiences of being cared for by staff and the influence of such experiences on the development of therapeutic relationships. This link can then be better understood in the context of the relationship with patients being at the core of the caring role. A review of the literature specifically related to patients' experiences within secure hospitals was not found. There were a limited number of papers exploring patients' experiences of being cared for within secure settings, thus enabling a review of the available evidence to be carried out.



## **Aim of this Review**

The following questions will be addressed:

1. What are the experiences of inpatients<sup>1</sup> in forensic mental health settings?
2. In relation to the experiences found in Question 1, what factors contribute towards the reported quality of stay and treatment within forensic mental health settings?

## **Methodology**

This literature review will take a systematized approach, whilst undertaking a narrative synthesis of the studies (Grant & Booth, 2009). This approach to synthesising the studies will focus on describing the study, interpreting the findings, highlighting areas of ambiguity plus a discussion of the limitations of the studies. A literature search was carried out between August and December 2015 using the following databases: Medline (n=2), Psychinfo (n=4), EBSCOhost (n=4), PubMed (n=0) and Google Scholar (n=2), from the databases' inception. A final search was also completed in February 2016. The following Boolean terms were used:

(Forensic mental health OR medium secure OR regional secure OR secure hospital)

AND

(Patient OR service user) AND

---

<sup>1</sup> To reflect the terms used within the literature, the term 'patient' will be used throughout this paper. This is the common term used to refer to service users within such settings. The term 'participants' will be used when referring to patients in particular research studies.

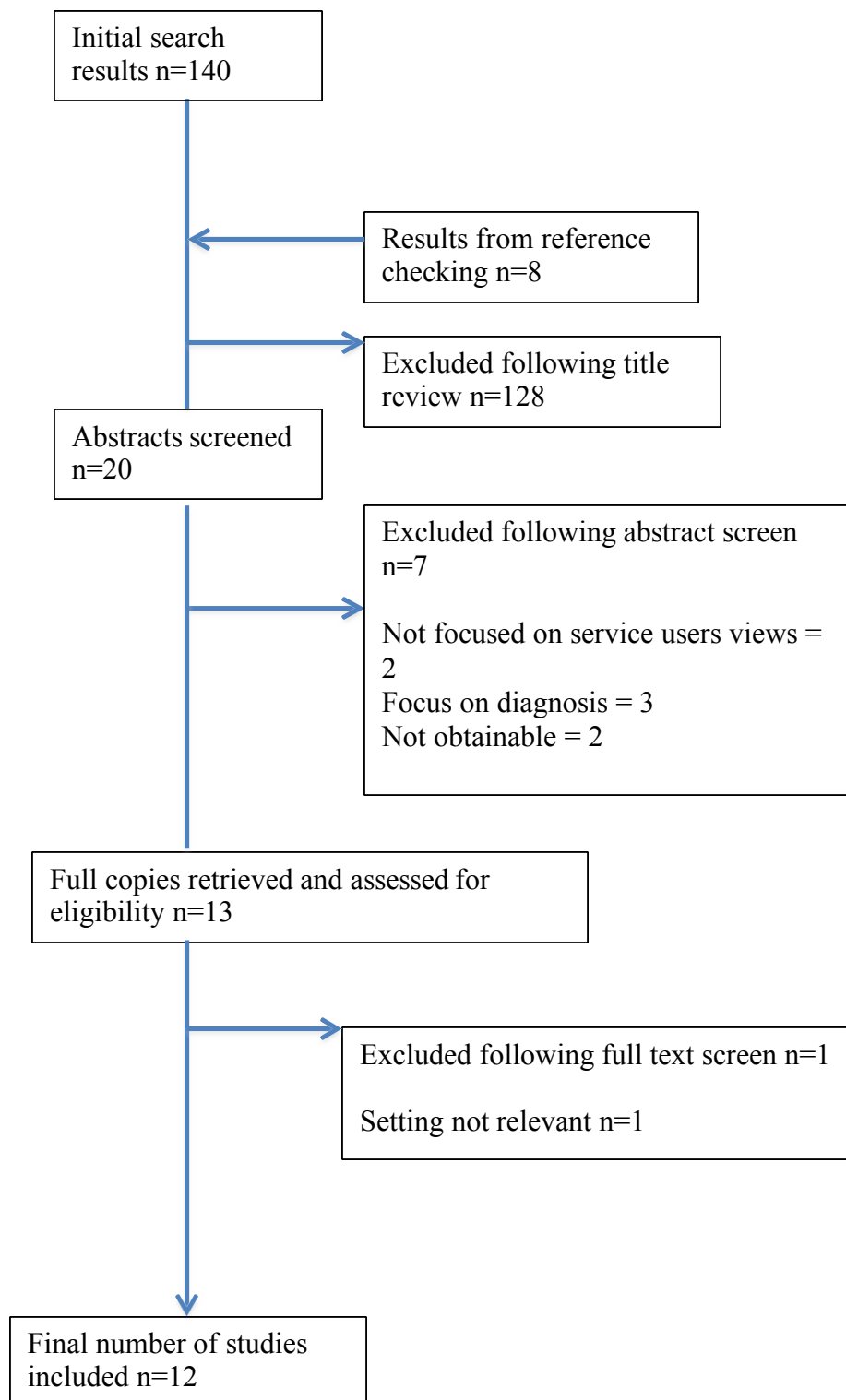
(Experiences).

In order to review studies for inclusion in the literature review not found using the database searches, reference lists of selected papers were checked and any relevant papers found at this stage were subjected to the same selection criteria included in the flow chart in Figure 1. International studies have also been included on the basis that the experience of being cared for is a universal experience and that there may be important aspects of caring from other healthcare systems which could be relevant to the development of the NHS system.

A time frame was not applied when searching for papers, as this would further limit the number of papers available to review given that this topic remains largely under-researched.

A flow chart diagram can be found in Figure 1, detailing the individual stages of the search process.

Figure 1: Literature Search Flow Chart Diagram



## SERVICE USER AND STAFF EXPERIENCES OF MEDIUM SECURE SETTINGS

Table 1 details the inclusion and exclusion criteria that were used to select papers.

*Table 1: Inclusion and exclusion criteria*

Inclusion	Exclusion
Patients within secure mental health hospitals of working age and above	Studies carried out within forensic settings other than medium or high secure settings e.g. therapeutic communities, prisons.
Studies that reported on service user's perspectives.	Studies carried out in inpatient settings that do not specialise in forensic mental health
Studies published in English	
Quantitative and qualitative methodologies	

### Results

Following a systematic search of the literature, 12 studies were identified. A summary of each of the studies included within this review can be found in Table 2.

*Table 2: Summary of Studies*

Authors	Setting	Sample Size	Design	Research question/aim	Analysis	Summary of Results/ Themes
Tapp et al. (2013)	High secure forensic inpatient setting	12	Qualitative interviewing	To explore service users' experience of being cared for in a high secure hospital	Thematic analysis	Eight themes: 1. Suspension of responsibility 2. Collaboration with staff 3. Learning from others 4. Talking therapies 5. Supportive alliances 6. Living in non-toxic milieu 7. Medical treatment 8. Opportunities for work
Yorston and Taylor (2009)	High secure forensic inpatient setting	12	Qualitative interviewing	To examine the experiences and attitudes of patients aged 65 and over in a high security hospital	Unknown	Four Themes: 1. Quality of life 2. Vulnerability 3. Risk to others 4. External resources
Riordan and Humphreys (2007)	Secure psychiatric hospital	20	Qualitative interviewing	To explore patients' perceptions of medium secure care	Unknown	Issues of power/lack of power and diminished responsibility Good relationships with staff reported Unknown length of stay was reported as worst aspect of stay Most important factor related to quality of stay was positive relationships with staff.

## SERVICE USER AND STAFF EXPERIENCES OF MEDIUM SECURE SETTINGS

Horberg et al. (2012)	Forensic inpatient ward	11	Qualitative interviewing	To explore the patient's of their lived experiences of being cared for in forensic inpatient wards.	Reflective life-world research approach	Meanings of care: 1. Non-caring care 2. Pockets of good care 3. Strategies 4. Struggle against resignation 5. An existence characterised by tension 6. Longing
Vartiainen et al. (1995)	Maximum security hospital	225	Qualitative questionnaires	To explore the patients experiences of receiving treatment in a maximum security hospital	Unknown	Seven themes: 1. Liberties (97%) 2. Interactive treatment forms (97%) 3. Leisure activities (94%) 4. Occupational therapies (92%) 5. Community therapy and rehabilitation (88%) 6. Medication (77%) 7. Restrictions and Isolation (36%)
Parkes et al. (2015)	Medium secure hospital	Pre = 9 Post = 8	Qualitative interviewing	To explore the experiences and effects of change and transition in patients within a medium secure hospital	Thematic analysis	Three themes: 1. Information (subthemes = positive information sharing and consultation, lack of information and control and potential conflict. 2. Transition (subthemes = home and belonging, concerns and anxieties regarding environmental change, life change and opportunity). 3. Behaviour (subthemes = control and potential conflict, and life opportunity and control).

## SERVICE USER AND STAFF EXPERIENCES OF MEDIUM SECURE SETTINGS

Bressington et al. (2011)	Secure hospitals (4)	45	Cross sectional survey	To assess levels of service user satisfaction and to explore the relationship between therapeutic relationship and social climates of the ward with service user satisfaction	Correlational analysis	Participants indicated a general level of satisfaction with the service. “Rehabilitation” and “perceived safety” rated most positively and were positively correlated. Significant positive correlations between service user satisfaction and perceived social climate and service user satisfaction with nature of therapeutic relationships. Positive correlation also found between satisfaction and recovery rates.
Middelboe et al. (2001)	Secure hospital	101	Cross sectional survey	To investigate the relationship between the participants perception of the ward and service user satisfaction	Statistical analysis using paired and non- paired t tests, One way ANOVA, multiple step- wise linear regressions	Patient satisfaction rated moderate to high across locked and open wards. Participants rated higher levels of anger and aggression on locked wards, and attributed this to staff having higher levels of control. Anger and aggression subscale was negatively correlated with involvement on the ward, support, spontaneity, autonomy and practical orientation to the ward. Staff control was negatively correlated with support, spontaneity, practical orientation to the ward, order and organisation and programme clarity. Support was positively correlated with involvement on the ward.

## SERVICE USER AND STAFF EXPERIENCES OF MEDIUM SECURE SETTINGS

MacInnes et al. (2014)	Two medium secure units	77	Cross-sectional survey	To investigate the relationship between service user satisfaction and factors associated with therapeutic relationships	Correlational analysis	Overall general satisfaction and general ratings of positive therapeutic relationships. Positive correlation between overall satisfaction and feeling respected, positive beliefs about receiving the correct treatment and feeling understood.
Barnao et al. (2015)	Forensic inpatient hospital	20	Qualitative interviews	To explore the perspectives of service users on rehabilitations in a secure hospital	Thematic analysis	Themes identified:  External – person centred approach, the nature of relationships with staff, consistency of care and awareness of rehabilitation pathways. Internal – self evaluation, self agency and coping strategies
Skelly (1994)	High secure hospital/regional secure unit	14	Qualitative interviews	To explore patients experiences if being admitted to a secure unit	Grounded theory	Categories identified:  1. Getting out 2. Backward steps 3. Playing the game 4. Return commission and omission 5. Circumspection



## SERVICE USER AND STAFF EXPERIENCES OF MEDIUM SECURE SETTINGS

Carlin, Gudjonsson and Yates (2005)	Three medium secure units	57	Cross sectional survey	To investigate levels of service user satisfaction and effect of patient characteristics on service user satisfaction	Unknown	Patients generally indicated being satisfied with the service and their care however were least satisfied with the quality of food available in the hospital. Age had an effect on satisfaction levels such that younger patients were more likely to rate lower levels of satisfaction and older patients were more likely to rate higher levels of satisfaction.
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## **Structure of this Review**

The identified studies will be presented, discussed and critiqued. The studies will be considered under the following headings: relationships with staff, power and control, experiences of care and being cared for, satisfaction with care, transitions and uncertainty. The order of studies presented has been organised by the most frequent themes and have been named in order to reflect the most common themes reported throughout the papers. The quality of qualitative studies will be considered using the Critical Appraisal Skills Checklist (CASP) (2014). Quantitative studies will be critiqued using the STROBE Checklist (von Elm, 2007), both of which can be found in Table 3 and 4 respectively. The clinical and research implications will also be considered and suggestions for future research will be made.

## **Literature Review**

A total of 602 participants were included in the studies, across 18 medium or high secure hospitals (medium=14, high=4). Of the 602 participants, 297 were described as male, whilst 80 were described as female (the remaining participants' gender was not defined by Vartiainen, Vuorio, Halonon and Hakola (1995)). Eight of the 12 studies employed qualitative methods, whilst the remaining four studies adopted a quantitative method.

*Table 3: Comparison of quality of studies: CASP (2014) Checklist*

Author	Clear Aims	Appropriate methodology	Appropriate design	Recruitment appropriately described	Data collection described	Consideration of relationship	Ethical issues considered	Data analysis	Clear findings	Valuable research
Tapp et al. (2013)	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓
Yortston and Taylor (2009)	✓	✓	✓	✓	✓	✗	✗	✗	✓	✓
Riordan and Humphreys (2007)	✓	✓	✓	✗	✓	✓	✓	✗	✓	✓
Horberg at al. (2012)	✓	✓	✓	✗	✓	✗	✓	✓	✓	✓

# SERVICE USER AND STAFF EXPERIENCES OF MEDIUM SECURE SETTINGS

Vartiainen et al. (1995)	✓	x	✓	x	x	x	x	x	✓	✓
Parkes et al. (2015)	✓	✓	✓	✓	✓	x	x	✓	✓	✓
Barnao et al. (2015)	✓	✓	✓	✓	✓	✓	x	✓	✓	✓
Skelly (1994)	✓	✓	✓	x	✓	x	x	✓	✓	✓

## SERVICE USER AND STAFF EXPERIENCES OF MEDIUM SECURE SETTINGS

Table 4: Comparison of quality of studies – Adapted STROBE (2007) checklist

Author	Title and Abstract	Rationale & objectives	Methods	Results	Discussion	Other Information
Bressington et al. (2011)	<ul style="list-style-type: none"> <li>✓ Study design included</li> <li>✓ Abstract provides clear summary</li> </ul>	<ul style="list-style-type: none"> <li>✓ Aims and objectives clearly explained</li> </ul>	<ul style="list-style-type: none"> <li>✓ Key elements of design explained</li> <li>✗ Setting not clearly explained</li> <li>✓ Recruitment of participants explained well</li> <li>✓ Variables clearly defined and described</li> <li>✗ Potential biases not discussed</li> <li>✓ Data analysis described</li> </ul>	<ul style="list-style-type: none"> <li>✓ Number of participants reported</li> <li>✓ Reasons for non-participation given</li> <li>✓ Descriptive statistics given</li> <li>✓ Summary of results for each measure included</li> </ul>	<ul style="list-style-type: none"> <li>✗ Key results are not referenced using study objectives</li> <li>✓ Limitations of the study discussed and biases considered</li> <li>✓ Overall interpretation of the results are considered</li> <li>✗ Generalisability of results not discussed</li> </ul>	<ul style="list-style-type: none"> <li>✓ Source of funding and role of funders discussed</li> </ul>
MacInnes et al. (2014)	<ul style="list-style-type: none"> <li>✓ Study design included</li> <li>✓ Abstract provides clear</li> </ul>	<ul style="list-style-type: none"> <li>✓ Aims and objectives clearly explained</li> </ul>	<ul style="list-style-type: none"> <li>✓ Key elements of design explained</li> <li>✓ Setting clearly described</li> </ul>	<ul style="list-style-type: none"> <li>✓ Number of participants reported</li> <li>✗ Reasons for non participation not given</li> <li>✓ Descriptive</li> </ul>	<ul style="list-style-type: none"> <li>✗ Key results are not referenced using study objectives</li> <li>✓ Limitations of the study discussed and biases considered</li> </ul>	<ul style="list-style-type: none"> <li>✓ Source of funding and role of funders discussed</li> </ul>

# SERVICE USER AND STAFF EXPERIENCES OF MEDIUM SECURE SETTINGS

	summary		<ul style="list-style-type: none"> <li>✓ Recruitment of participants explained well</li> <li>✓ Variables clearly defined and described</li> <li>✗ Potential biases not discussed</li> <li>✓ Data analysis described</li> </ul>	<ul style="list-style-type: none"> <li>statistics given</li> <li>✓ Summary of results for each measure included</li> </ul>	<ul style="list-style-type: none"> <li>✓ Overall interpretation of the results are considered</li> <li>✓ Generalisability of results discussed</li> </ul>	
Middelboe et al. (2001)	<ul style="list-style-type: none"> <li>✓ Study design clearly described</li> <li>✓ Abstract provides a somewhat clear summary</li> </ul>	<ul style="list-style-type: none"> <li>✓ Aims and objectives clearly explained</li> </ul>	<ul style="list-style-type: none"> <li>✓ Key elements of the design explained</li> <li>✓ Setting clearly described</li> <li>✓ Recruitment of participants explained well</li> <li>✓ Variables clearly defined and described</li> <li>✓ Potential biases are discussed</li> <li>✓ Data analysis described</li> </ul>	<ul style="list-style-type: none"> <li>✓ Descriptive statistics given</li> <li>✓ Summary of results for each measure included</li> </ul>	<ul style="list-style-type: none"> <li>✓ Overall interpretation of the results are considered</li> <li>✓ Generalisability of results discussed</li> <li>✗ Limitations of the study not discussed and not biases considered</li> <li>✓ Generalisability of results discussed</li> </ul>	<ul style="list-style-type: none"> <li>✓ Source of funding discussed</li> </ul>

# SERVICE USER AND STAFF EXPERIENCES OF MEDIUM SECURE SETTINGS

Carlin, Gudjonsson & Yates (2005)	<ul style="list-style-type: none"> <li>✗ Study design not clearly described</li> <li>✓ Abstract provides a somewhat clear summary</li> </ul>	<ul style="list-style-type: none"> <li>✓ Aims and objectives clearly explained</li> </ul>	<ul style="list-style-type: none"> <li>✗ Key elements of the design not explained</li> <li>✓ Setting clearly described</li> <li>✓ Recruitment of participants explained well</li> <li>✓ Variables clearly defined and described</li> <li>✗ Potential biases not discussed</li> <li>✗ Data analysis not clearly described</li> </ul>	<ul style="list-style-type: none"> <li>✓ Descriptive statistics given</li> <li>✓ Summary of results for each measure included</li> </ul>	<ul style="list-style-type: none"> <li>✓ Overall interpretation of the results are considered</li> <li>✓ Limitations of the study discussed and biases considered</li> <li>✓ Overall interpretation of the results are considered</li> <li>✗ Generalisability of results not discussed</li> </ul>	<ul style="list-style-type: none"> <li>✗ Source of funding not discussed</li> </ul>
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### *Relationships with Staff*

Five of the 12 studies considered the therapeutic relationships between patients and staff. Riordan and Humphreys (2007) interviewed patients within a MSU on their experiences of their route into the hospital and explored their perceptions of their stay within the unit. The average length of stay for this sample of participants in this MSU was 18 months, which is significantly less than other participants included within this review. Twenty participants (19 males and 1 female) were interviewed during a one-year period. Participants commented on the role of staff members in facilitating the participants' transitions into the ward. One participant said:

*“Staff helped me to understand about the place... they have helped me a great deal... they're a good bunch and friendly...” (p. 22).*

A study by Yorston and Taylor (2009) focused on the experiences of patients over 65 years of age and found participants highlighted the importance of positive relationships with staff, especially in older age. The relationships with nurses were particularly important due to the prolonged period of time spent with nurses since being admitted. Participants commented on feeling detached from their responsible medical officers (who were usually consultant psychiatrists) and viewed them in a negative way, which was related to a lack of “knowing” the person or being able to develop a positive therapeutic relationship with them. The authors' commented on contradictory opinions of participants regarding the quality of relationships with staff within interviews, suggesting participants had a range of positive and negative experiences of the staff team.



Using a quantitative methodology, Bressington, Stewart, Beer and MacInnes (2011) reported that participants described an overall satisfaction in the context of their caregiver relationships and rated ‘feeling understood by staff’ as of most value to them. This linked with the study by Barnao, Ward and Casey (2015) where participants valued being put at the centre of their care and noted staff members’ ability to “look beyond their illness” had a positive impact of their therapeutic relationships.

MacInnes, Courtney, Flanagan, Bressington and Beer (2014) also used a quantitative approach and investigated the relationship between therapeutic alliance and service user satisfaction. Seventy-seven (65 males and 12 females) patients, across two MSUs, consented to take part in the study and completed the Forensic Satisfaction Scale (FSS; MacInnes, Beer, Keeble, Rees & Reid, 2010) and the Helping Alliance Scale (HAS; Priebe & Gruyters, 1993). Results from this study suggest no significant differences between the two hospitals for either measure. Additionally, a ‘reasonable level of overall satisfaction’ was recorded as well as an overall satisfaction with therapeutic relationships. Notably, a positive correlation was found between therapeutic alliance and satisfaction with care. This further highlights the potential influence of patients’ relationships with staff on levels of satisfaction and overall experience whilst in hospital. Further analysis using multiple regression indicated that all three subscales on the HAS measure (i.e. “feeling respected and well regarded”, “beliefs about receiving the right treatment” and “feeling understood by clinical staff”) were positively correlated with the FSS total score scale. Feeling respected and well regarded by staff was reportedly the most important variable for predicting service user satisfaction.

### ***Power and Control***

Power and control within nurse-patient relationships was discussed by Jacob et al. (2009) who suggested that staff are in a powerful position, which can lead to patients becoming marginalised and vulnerable whilst being cared for. Riordan and Humphreys (2007) reported that a number of participants commented on the perceived power imbalances between patients and professionals, specifically in relation to medication:

*“The doctor has a lot of power and it’s difficult to get in touch with the doctor about speaking about medication...they (the doctors) overpower the nurses in giving me medication.” (p. 22)*

In a later study, Tapp, Warren, Fife-Schaw, Perkins and Moore (2013) explored patients’ experiences by interviewing twelve participants following approval for discharge from a high security hospital in the UK. The authors aimed to gain a service user perspective of experiences of being cared for within a high security setting as well as exploring the care received from admission to being ready for discharge.

All participants were men who had extensive experience of being cared for within the forensic setting. The average age of the participants was 44 and the average length of stay within the hospital was 9.5 years. This is compared to the current British national average of 2.6 years (without a restriction order) and 8 years with a restriction order (Glorney et al., 2010). The most common index offences of the participants included within the study were homicide (n=4) and violence (n=4).

Using thematic analysis, the authors analysed the results and identified eight themes (“suspension of responsibility, collaboration in care, learning from others, talking therapies, supportive alliances, living in non-toxic milieu, medical treatments and opportunities for work”, p. 166). In reference to the “suspension of responsibility” theme, participants recognised that too little responsibility, in terms of choices of treatment, could lead to patients’ mental health being negatively affected.

From the participants’ perspective, a lack of choice or opportunities for collaborative care could increase the likelihood of violent incidents occurring. Participants attributed this to there being limited negative consequences possible as a result of becoming violent. For example, one participant reported:

*The way the doctors was talking they was just you carry on the way you are going nowhere ... well if you have got no hope of going out, what does, I had no worries with harming people, what was the point in um, keeping control instead of losing control ... you ain’t going nowhere. (p. 167).*

Barnao et al. (2015) explored patients’ perspectives of rehabilitation throughout their stay in a medium secure hospital. Using thematic analysis, seven overarching themes of the data (person centred approach, relationships with staff, consistency of care, awareness of rehabilitation pathway, self-evaluation, self-agency and coping strategies) were identified. Participants reported feeling powerless and oppressed by the treatment they had received. Inconsistencies with the care the participants received were also reported to link with confusion regarding the aim of rehabilitation and poor relationships with staff.

### *Experiences of Care and Being Cared For*

Bunkers (2004) wrote that being cared for “is a universal lived experience that relates to the human capacity for experiencing meaningful closeness with others” (p. 63), suggesting that one’s capacity to being cared for is dependent on capacity for meaningful closeness. This is especially important in the healthcare domain, specifically in FMH where ‘being cared for’ may be involuntary. Three studies looked at patients’ experiences of care and being cared for with a number of common themes reported across the studies.

“Supportive alliances” (Tapp et al., 2013) highlighted participants’ experiences of a high staff turnover and having numerous allocated workers during their stay. One participant commented on the difficulty of building trust with staff, given the constant change of relationships. In relation to supportive alliances within the environment, one participant said:

*“I have been bullied in the past, um, by patients and um been mistreated a little bit by staff, during another time period” (p. 169).*

Participants also highlighted a perceived increase in the focus of security within the hospital and a move away from the balancing of care with security towards an increased focus on security. This was a similar finding to Vartiainen et al. (1995) who explored patients’ opinions of receiving treatment. The results from this study are important to consider in relation to the wider context of patients’ experiences. Participants identified the negative influence of the perceived influential power of staff and the use of security restrictions placed upon them. This could suggest that

there has been a shift in clinical practice, especially for the role of FMH nurses, which traditionally emphasizes caring for patients rather than being responsible for the security of the ward environment.

Related to quality of life, Yorston and Taylor (2009) reported participants identified a number of perceived unmet needs. For example, participants identified that poor patient to staff ratios, as well as an increase in security restrictions within the hospital, negatively impacted on their quality of life:

*“There are never enough staff to go to the canteen because, whenever staff are needed for the hotspots, they are taken away”. (William, patient) (p. 60).*

This also related to the participants’ experiences of having increased restrictions placed upon them due to the non-compliance of ward rules by more recently admitted patients. This appeared to be associated with another theme, which was power and responsibility regarding choices of treatment and medication.

Yorston and Taylor (2009) interviewed patients who were admitted to Broadmoor Hospital (high secure hospital) and aimed to explore their experiences and attitudes towards being in Broadmoor. Twelve participants, comprising of eleven males and one female, were interviewed using an unstructured approach. The ages of the participants ranged from 60 to 88 with a median of 65, which is significantly older than the rest of the reviewed studies. The focus on older adults in this study was to enable an exploration of the experiences of this age group and, given that this is an under-represented group, to assess how well forensic services can meet this group’s needs.

The median time since admission at the time of interviewing was 17 years, which is also significantly higher than the British national average stay of 8 years (Glorney et al., 2010), suggesting that this sample of participants may represent a very small group of longer-term service users. Analysis of the interviews generated four main themes: quality of life, vulnerability, risk to others and external resources.

Hörberg et al. (2012) explored the experience of ‘being cared’ for with patients in a maximum-security hospital in Sweden. The authors aimed to explore the different elements of care, from the patient perspective. Eleven participants (six men and five women) took part in the study with an age range of 21 to 42 years old. The length of stay at the time of interviewing ranged from three months to six years. In order to analyse the data, the authors used a reflective life-world research approach.

Themes relating to insecurity, unreliability and uncertainty emerged from the data. “An almost constant desire to escape from the care” (p. 743) theme also arose. Participants reported a lack of care with only “pockets of good care” (p. 745) being available. For instance, participants identified an example of “good care” when they felt that staff members were treating them like friends and when staff could be open about themselves as humans.

In the largest study included in this review, Vartiainen et al. (1995) asked 225 patients about their experiences of being in a maximum security hospital in Finland and specifically asked questions regarding the participants’ opinion of the treatments offered to them whilst staying in the hospital. Approximately 77% of participants felt that medication was the most helpful part of their experience, followed by support from psychiatric nurses (26%). Occupational therapy was felt to be least useful (21%).

Participants highlighted walking, holidays and personal support from psychiatrists as other valuable forms of support. Additional unhelpful aspects of the participants' stay on the ward were related to feeling isolated and security restrictions.

Similar to participants in the Tapp et al. (2013) study, participants emphasised the importance of having trusting relationships with others, both staff and peers, which then positively impacted on their journey to being discharged. This, then, highlights the importance of forming positive alliances during one's time in forensic settings and the important elements of therapeutic relationships such as trust and continuity of care.

### *Satisfaction with Care*

Moving away from the experiences of being cared for, Pascoe et al. (1983) (as cited in Smith, Schussler-Fiorenza & Rockwood, 2006) defined satisfaction with care as "a healthcare recipient's reaction to salient aspects of his or her service experience" (p. 185). Other studies discussed in this review have considered singular aspects of care, however Bressington et al. (2011) used a quantitative methods approach to explore service users' overall satisfaction in secure settings. The authors aimed to measure the patients' experiences of staying in a forensic inpatient setting within one NHS Trust. A second aim focused on measuring the perceived impact of therapeutic relationships and the social climate of the ward on the participants' levels of satisfaction.

Using a cross-sectional questionnaire design, all patients who were staying on the ward at the time of the study were invited to take part. Only those deemed not able to complete the questionnaires by the staff were excluded from the study. The authors did not elaborate on the process of deciding which patients were unable to take part. Participants were also paid for their time in participating in the project.

Forty-five participants (out of a potential 110) consented to take part in the study. Forty percent of the participants were aged between 25 and 35 years old. Participants were asked to complete three questionnaires (Forensic Satisfaction Scale (FSS), (MacInnes et al., 2010), the Helping Alliance Scale (HAS), (Priebe & Gruyters, 1993) and Essen Climate Evaluation Scale (Schalast, Redies, Collins, Stacey, & Howells, 2008).

Fifty-five percent of participants reported a total satisfaction score that indicated an overall satisfaction with the service. Notably, participants were least satisfied with ‘communication’, although a significant positive correlation was found between communication and recovery, suggesting that participants who were satisfied with communication were also satisfied with their rehabilitation programme. ‘Rehabilitation’ and ‘safety’ scored the highest satisfaction level, indicating that participants were pleased with the interventions they were offered on the wards whilst feeling safe within the environment.

Results from the HAS questionnaire suggest that participants reported overall satisfaction with the helping relationships and rated ‘feeling understood by staff’ to be of the highest value (Bressington et al., 2011). However, as with all cross-sectional



studies included within this review, the use of correlational analyses means causality of satisfactions levels cannot be assumed.

One of the advantages of this study is the use of the FSS scale, which has been specifically designed for use in forensic settings. In the past, non-specific measures have been routinely used to measure service users satisfaction in this area (Bressington et al., 2011). However, this study measured satisfaction using a quantitative measure. Arguably, the constructs that the study aimed to explore (e.g. satisfaction and helping alliance) are difficult to capture using questionnaire data alone.

Similar to the previous study, Middelboe, Schjodt, Byrstring and Gjerris (2001) aimed to explore the relationship between patients' experience of being on the ward with the patients' satisfaction of being on the ward. Participants completed the Ward Atmosphere Scale (WAS: Moos, 1996), followed by an adapted version, which measures the participants 'ideal' ward atmosphere. Finally, participants completed a questionnaire measuring satisfaction (Good Milieu Index, adapted version), Friis (1986)). Results from this study suggest participants rated their satisfaction with their stay as 'moderate to high'. Participants reported higher levels of anger and aggression when receiving treatment on a locked ward compared to an open ward and felt that this was due to a higher level of staff control. This is supportive of the study by Tapp et al. (2013) who hypothesised that participants were more likely to feel increased aggression towards staff when there was a perceived lack of care or control of their care.

In the final study measuring service user satisfaction, Carlin, Gudjonsson and Yates (2005) asked 57 participants to rate their satisfaction of stay using the Bethlem and Maudsley NHS Trust In-Patient Satisfaction Survey (Smedley & Nesbitt, 2000). Results suggested that participants felt information related to their mental health diagnoses and treatment were given to them in a prescriptive manner, rather than discussed collaboratively. Furthermore, correlational analysis suggested a significant relationship between participant age and general satisfactions scores such that younger patients felt less satisfied with their care, compared to older patients.

### ***Transitions***

Schlossberg (1981) defined transitions as an ongoing developmental task that brings with it a change in behaviour, relationships and self-perceptions. Parkes, Pyer, Ward, Dyle and Dickens (2015) interviewed patients about their experiences of transitional change whilst in a medium secure hospital. The aim of the study was to explore the effects of the environment on patients' experience of care. This study was carried out before and after patients were transferred from one MSU to another. Nine participants took part in the interviews before the move, and eight of the nine (89%) participants took part in a subsequent follow-up interview six months after the move.

Using semi-structured interviews, the participants were asked about their experience and personal meaning of transition. Thematic analysis of the interviews indicted three overarching themes (information, transition and the behaviour) with a further five sub-themes (positive information sharing and consultation, lack of information, environmental change, control and potential conflict and life changing opportunities).

Related to "information sharing", participants reported a lack of adequate information when being admitted on to the ward, which led to experiencing the admission as stressful. Participants also reported feeling uninformed in terms of routines and of the staff expectations of patient behaviour. Finally, participants recognised a temporary period of adjustment to their new surroundings in which they felt unsettled, however once this period had ended, there were little reported changes in their behaviour compared with their previous surroundings.

In a second study exploring patients' experiences of transitions, Skelly (1994) interviewed 14 patients from high security hospitals on their admission to a medium secure hospital. Participants reflected on moving from a high secure environment, which was characterised by strict daily routines to a medium secure hospital, which allowed increased levels of freedom and fewer restrictions. It was interesting to note that participants reflected on the negative experience of this transition and the resultant readmission to the high security hospital. Two main themes ("backward step, (p.172) and "return commission and omission" (p. 175)) were found from analysis of 14 interviews. The majority of participants were unhappy with the reality of the medium secure setting, especially in relation to being subjected to undergoing an 'assessment' stage on the admission ward, despite having spent a prolonged period of time in the high secure hospital. Participants felt stigmatised by staff members, due to their history of being in a high secure hospital. Participants also felt the consequences of their behaviours (e.g. sexual assaults against staff) were more severe compared to patients who had never been admitted to a high security hospital.

### *Uncertainty*

In relation to uncertainty, Hörberg et al. (2012) found that participants described feeling misplaced within the hospital, yet acknowledged a lack of a secure base outside of the hospital. The authors understood the participants to have early experiences of care, which were unpredictable, unsafe and unreliable. This then, led participants to feel unsure of their future both within and outside of the hospital context and had a negative impact on their stay.

The authors highlighted the need for participants to adapt to the environment in which they find themselves in, yet the process of adaptation is driven by a fear of being punished by those in charge (e.g. staff members). The authors suggested that such experiences of unpredictable and irregular examples of early care result in an increased tension between patients and caregivers. Participants felt that the staff members tended to focus more on the security restrictions and regulations of the ward, rather than caring for patients.

Participants also commented on strategies they used in order to survive the environment. One participant said:

“I want to leave this place as soon as possible . . . The only thing that you can do is to cooperate . . . with the staff.” (p. 746).

The study concludes that the participants’ time in the hospital was mainly spent focusing on how to ‘escape’ from the care as opposed to focusing on treatment or recovery.

Participants in the Yorston and Taylor (2009) study commented extensively

on change and feelings of uncertainty they experienced as a result of an increased number of younger patients being admitted to the ward. Participants felt negatively towards the decreasing age of the patients (upon admission) coming on to the ward. Due to the influx of younger patients, participants noted an increase in security measures and unnecessary restrictions placed upon them. Participants considered the increased restrictions to be unnecessary for those patients who had been residing on the ward for a number of years.

### **Discussion**

This literature review has aimed to consider the experiences of patients in medium secure and high security hospitals. Further consideration has also been given to the factors of receiving care that have enabled transitions, recovery and discharge from secure settings, which contributed to the quality of stay. A summary of the findings of each study and the resultant themes can be found in table 2.

Riordan and Humpreys (2007) found patients' quality of relationships with staff impacted upon their experience of recovery. Positive experiences of care were evident throughout the literature and the idea of "caring care" could be seen throughout a number of the papers. Patients described feeling most cared for when staff members had the capacity to work within a person-centred model. For example, Barnao et al. (2015) found patients felt most connected to their experiences of rehabilitation when staff had the capacity to look beyond their illness and offences. This also links with Yorston and Taylor (2009) who found that positive relationships with staff were identified by patients as one of the most defining features of their treatment. The results considering patient experiences of being cared for can be

linked back to theoretical approaches to understanding the patient-professional relationship. For instance, this is consistent with Adshead's (2002) theory, which suggests a patient's experience of early attachments will influence the quality of attachments they make within future caring contexts.

Of note was the number of negative experiences of care patients described, which requires further discussion and exploration. This especially applied to the relationships patients reported having with staff members and the increased focus on security measures, rather than on care. This supports Kennedy (2002) who highlighted the difficulties for nurses in enforcing boundaries whilst remaining in a caring position. Issues of power and a perceived lack of responsibility are evident, with patients reporting a lack of choice regarding treatment options and a need to cooperate with staff in order to "survive". This may be consistent with psychodynamic theory which hypothesises that staff may act in a defensive manner, characterised by a lack of emotional contact, as a means of protecting themselves from the difficulties of being in this position (Kurtz & Jeffcote, 2011).

It could be argued that the themes discussed in the studies, for example relationships with staff and lack of treatment choices, would be expected given similar findings in other areas of mental health (Hui & Stickley, 2007). However, the relationship with staff and treatment choices are likely to be on a more intense level than those in outpatient services or non-forensic inpatient services. This is due to the increased and prolonged proximity between staff and patients, as well as increased risk associated with this client group and staff perceptions of offences.

Hörberg et al. (2012) found that participants were more focused on leaving the secure hospital than on the process of recovery. The authors argue that in order to maintain recovery on a long-term basis, and ultimately decrease offending behaviour and risk to the public, patients must be given a quality of care, which exceeds being subjected to security restrictions. This means that despite the security measures routinely placed upon patients within secure hospitals, the focus should largely be on care and recovery.

The emphasis on care has implications for mental health professionals in forensic settings. For example, Harris, Happell and Manias (2015) suggested that mental health professionals, specifically nurses, in forensic inpatient settings felt unprepared for the emotional impact of working with individuals who could potentially pose a risk, either suggested by their historical or current risks. From a psychodynamic perspective, Kurtz and Jeffcote (2011) suggested that caregivers in this context might act defensively, that is display a lack of emotional connectedness with patients in order to protect themselves from the emotional impact of working in this area. Feeling unprepared in managing the difficult emotions also links with Adshead (2002) who argued patients cannot be cared for in an authentic manner if staff themselves does not feel cared for. This highlights a need for staff members to feel supported in order to care for individuals in such settings.

Although both qualitative and quantitative studies have been included within this review, there are findings across both domains of research that appear to overlap. For example, Bressington et al. (2011) found evidence to suggest that service user satisfaction was highly correlated with positive therapeutic relationships within the

hospital whilst Vartiainen et al. (1995) found that participants' relationships with psychiatric nurses and doctors were the most valuable form of support.

### *Current state of the literature and limitations*

Historically, the views of service users within the FMH population have been largely under-represented. The studies presented within this review provide an initial understanding of service users' experiences of FMH hospitals. However, as the breadth of literature in this area remains limited, the utility of this review is restricted given the number of available studies.

The topic for this review was selected given the increasing focus on service user involvement in the design and development of services. However, developmentally, this area of research is still in its infancy compared to other areas of service user involvement in mental health services. The majority of studies included in this review have generally collected data from only one site, limiting the generalizability of results. Furthermore, as there are a limited number of papers published within this area, studies have been included which have taken place outside of the UK. For example, Hörberg et al. (2012) and Vartianen et al. (1995) conducted their studies in Sweden and Finland respectively and add to the current literature base regarding recovery and lived experience of those residing in secure hospitals. However, both studies should be read as supportive of the other studies rather than original research (in the context of this review) given that they were carried out in systems different to the NHS and are embedded within different cultures to that of the UK.

The Tapp et al. (2013) study excluded participants who were below 65 years



of age. Although the authors aimed to understand the experiences of this age group, it limits the potential of adding to the already restricted literature due to the possible developmental differences between participants in the later stages of their lives and the working age participants featured in the remaining studies. Similar to other studies included within this review, the small sample size limits the generalisability of results.

The use of quality checklists (e.g. the CASP checklist (2014) and the Strobe Checklist (2007)) has suggested that the studies included in this review have a varying degree of quality. For example, using the CASP checklist, Tapp et al. (2013) and Barnao et al. (2015) yielded the highest quality of research with the exception of failing to consider the ethical implications of the study. Vartiainen et al. (1995) was rated the least valuable qualitative paper given its failure to meet several of the CASP checklist criteria. Inclusion of poorer quality results in this review means conclusions should be read cautiously.

It could be argued that those patients who are interested in taking part in research related to their stay are motivated either by particularly poor examples or particularly positive examples of care rather than being representative examples of inpatient forensic experiences, which may be less extreme. The motivation of the participants may act as a confounding factor when considering the generalizability of results. Indeed, two of the studies paid participants for their contributions. Coolican (2004) suggested that paying participants to take part in studies might increase the likelihood of sampling biases. Particularly related to the qualitative studies included in this review, the small sample sizes highlight the difficulties associated with carrying out research within this type of setting.

Farnworth, Nikitin and Fossey (2004) commented on the lack of occupation of patients within secure hospitals, making it possible that participants were motivated to participate as a means of distraction. Although the author does not suggest this is a negative, it could attract participants to take part in research who may otherwise not have offered to take part. Further sampling biases may also be argued given the under representation of females included within the studies.

Throughout this review, there is a notable emphasis on the impact of nursing staff on patient experiences and less focus on other professionals such as psychiatrists, psychologists, social workers and healthcare assistants who typically form a large part of the staff groups within secure hospitals. This is indicative of the current state of the literature; however, the lack of diversity of professional groups considered in relation to the quality of patient stays needs addressing.

Finally, numerous themes throughout the studies appear to be overlapping suggesting that the limited evidence available is producing somewhat consistent results. Additionally, although this review is structured under headings (e.g. experiences of being cared for, transitions), it is important to highlight that these concepts do not exist in isolation, but rather are inter-related to each other. For example, experiences of being cared for and the concept of therapeutic relationships cannot be considered as singular entities, but rather as complex concepts, which require further exploration.

### **Implications for Research and Clinical Practice**

#### ***Clinical implications***

The reported importance of therapeutic relationships throughout the studies highlights the value of staff members' capacity to develop and maintain therapeutic relationships, which merits consideration to be given to staff wellbeing. Clinically, the wellbeing of staff working in such settings is vital. This is supported by Adshead (2002) who emphasised the need for staff members to feel contained and supported by the organisational structure and systems around them in order to successfully meet the needs of the individuals within the FMH system.

Participants in the MacInnes et al. (2013) study reported on the importance of feeling respected by staff members, whilst participants in the Hörberg et al. (2012) study talked about cooperating with staff as a means of coping within the hospital. Riordan and Humphreys (2007) gave examples of participants feeling 'powerless' in the context of their relationships with the doctors on the wards. This has implications for clinical practice in that the power imbalances seemed to be suggestive of participants finding it difficult to engage in therapeutic relationships or treatment options. This would imply that there were limited opportunities to feel powerful or hopeful, and highlights the importance of collaborative care between staff and patients.

The consistent findings related to relationships with staff throughout the studies emphasise the importance of clinical supervision in order for staff members to explore their feelings related to their role and their relationships with patients.

Providing clinicians with time and space to understand and formulate a patient's history, drawing on attachment and trauma frameworks, could increase clinicians' understanding of their patients behaviour and attachment style. The use of team formulations has been suggested to improve the quality of service provided to patients by increasing staff members' understanding of the patients difficulties (Berry, Barrowclough, & Wearden, 2009) and this is a possible area of future research, specifically in FMH settings.

Relating to Adshead's (2002) suggestion that the therapeutic relationship between staff members and patients will rely on the understanding of previous experiences of attachments, the results from the MacInnes et al.'s (2014) study highlight the need for staff to be suitably trained within attachment models. This could potentially increase the likelihood of staff being able to form and maintain positive relationships with patients.

In line with the increasing service user involvement within other areas of healthcare, the results would suggest that the number of opportunities that patients have to give feedback about their treatments and their experiences of being on the wards needs to be increased. This information could be used to improve service delivery, allowing a more tailored approach to this client group.

Considering the results of Skelly (1994) and Parkes et al. (2015), it could be hypothesised that feelings of uncertainty are likely to increase one's vulnerability to becoming distressed around times of transitions. Therefore the role of staff and professionals attracts higher importance in times of transition, as patients are likely to

require more support. Furthermore, positive relationships with staff appear to act as a protective factor against heightened distress during such times.

Related to the theme of “transitions” discussed within this review, it could be suggested that patients are given more information about the clinical context of the hospital in which they are admitted to. This information could also include communication related to the practicalities of transitions. This could potentially decrease the patients feeling of uncertainty and anxiety related to the process of transitions as described by Parkes et al. (2015).

### ***Research Implications***

The studies described in this paper focus on experiences of patients whilst being cared for. However, given the recurrent themes across the studies related to staff (e.g. importance of collaborative care) and the impact that staff can have on the patient experience within secure settings, further research is needed to understand the complex psychological processes involved in caring for others, given that therapeutic relationships are multifaceted and complex. Although there has been extensive research regarding the personal impact of working in mental health services, the impact of working in forensic mental health services remains largely under-researched by empirical methods (Harris et al., 2015).

Holberg et al. (2012) suggested that the lack of care received by the participants in their study was felt as a result of staff being unwilling or unable to acknowledge the patients’ own suffering, despite their crimes. This highlights an

important and under-researched area, which is the level of compassion that staff working within such environments report. Firth-Cozens and Cornwell (2009) suggest that staff experiences of stress and burnout are likely to impact directly on feelings of compassion towards patients. Given the current context in the NHS of increasing work demands, it would also be important to explore the relationship between self-reported compassion and work-related stress of staff working within secure environments. By considering the interactions between work-related stress, compassion and occupational demands, the present knowledge base can be added to. Furthermore, by exploring potential factors that influence the quality of compassionate care, compassion as a concept and its role in the experience of patient care can be better understood.

All of the papers included within this review adopt a single method approach to understanding the experience of patients within forensic inpatient services. Without mixed methods approaches, there is a risk that the lived experiences of service users and factors relating to quality of stay in secure hospitals will remain under-researched. Integrative approaches to research can build on the existing knowledge and can strive to understand the qualitative meanings behind quantitative concepts such as ‘service user satisfaction’.

### **Conclusion**

This literature review has examined service users’ experiences of medium and high secure hospitals using broad themes including experiences of being cared for, transitions and satisfaction with care. The review also aimed to determine the factors

that influence the quality of stay patients experience in such settings. The findings from the studies included within this review highlight that a variety of factors are responsible for differing qualities of stay. Individual accounts of the lived experience of such settings also vary in terms of therapeutic relationships, responsibility and control being discussed consistently. Adshead's (2002) theoretical understanding of the importance of attachment, as well as psychodynamic theory, and the influence this has on both patients and staff has been discussed throughout. Future research considering staff wellbeing and mental health professionals' understanding of their therapeutic relationships and understanding of patients' difficulties has been recommended.

## References

- Adshead, G. (2002). Three degrees of security: Attachment and forensic institutions. *Criminal Behaviour and Mental Health*, 12, 31-45. DOI: 10.1002/cbm.2200120605
- Aiyegbusi, A., & Clarke-Moore, J. (2008). *Therapeutic relationships with offenders: An introduction to the psychodynamics of forensic mental health nursing*. London: Jessica Kingsley Publishers.
- Aiyegbusi, A., & Kelly, D. (2015). 'This is the pain I feel!' Projection and emotional pain in the nurse–patient relationship with people diagnosed with personality disorders in forensic and specialist personality disorder services: Findings from a mixed methods study. *Psychoanalytic Psychotherapy*, 29, 276-294. DOI:10.1080/02668734.2015.1025425
- Badger, D., Vaughan, P., Woodward, M., & Williams, P. (1999). Planning to meet the needs of offenders with mental disorders in the United Kingdom. *Psychiatric Services*, 50, 1624-1627. doi:10.1176/ps.50.12.1624
- Barnao, M., Ward, T., & Casey, S. (2015). Looking beyond the illness forensic service users' perceptions of rehabilitation. *Journal of Interpersonal Violence*, 30, 1025-1045. doi: 10.1177/0886260514539764
- Berry, K., Barrowclough, C. & Wearden, G. (2009). A pilot study investigating the use of psychological formulations to modify psychiatric staff perceptions of service users with psychosis. *Behavioural and Cognitive Psychotherapy*, 37, 39- 48. DOI: <http://dx.doi.org/10.1017/S1352465808005018>



Bowlby, J. (1988). Attachment, communication, and the therapeutic process. *A Secure Base: Parent-Child Attachment and Healthy Human Development*. New York: Basic Books.

Bradley, K. (2009). *The Bradley report. Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*. London: Department of Health.

Bressington, D., Stewart, B., Beer, D. & MacInnes, D. (2011). Levels of service user satisfaction in secure settings—A survey of the association between perceived social climate, perceived therapeutic relationship and satisfaction with forensic services. *International Journal of Nursing Studies*, 48, 1349-1356. doi:10.1016/j.ijnurstu.2011.05.011

Bunkers, S. S. (2004). The lived experience of feeling cared for: A human becoming perspective. *Nursing Science Quarterly*, 17, 63-71. doi:10.1177/0894318403260472

Carlin, P., Gudjonsson, G., & Yates, M. (2005). Patient satisfaction with services in medium secure units. *Journal of Forensic Psychiatry & Psychology*, 16, 714-728. DOI:10.1080/14789940500328245

Critical Appraisal Skills Programme (CASP) 2014. CASP Checklists. Oxford: CASP. Available at: [http://media.wix.com/ugd/dded87\\_29c5b002d99342f788c6ac670e49f274.pdf](http://media.wix.com/ugd/dded87_29c5b002d99342f788c6ac670e49f274.pdf)

Confederation, N. (2012). Defining mental health services: Promoting effective commissioning and supporting QIPP. *NHS Confederation*, Available at:

[www.Nhsconfed.org/~media/Confederation/Files/Publications/Documents](http://www.Nhsconfed.org/~media/Confederation/Files/Publications/Documents)

[/Defining mental health services.Pdf](#) (Accessed 24 February 2015),

Coolican, H. (2004). *Research methods and statistics in psychology* (4<sup>th</sup> ed.). London: Hodder & Stoughton.

Davies, H. T., & Mannion, R. (2013). Will prescriptions for cultural change improve the NHS? *British Medical Journal (Clinical Research Ed.)*, 346, 1-4. doi:10.1136/bmj.f1305

Farnworth, L., Nikitin, L., & Fossey, E. (2004). Being in a secure forensic psychiatric unit: Every day is the same, killing time or making the most of it. *The British Journal of Occupational Therapy*, 67, 430-438. doi: 10.1177/030802260406701003

Firth-Cozens, J., & Cornwell, J. (2009). *Enabling compassionate care in acute hospital settings*. London: The King's Fund.

Flynn, M. (2012). *Winterbourne view hospital: A serious case review*. South Gloucestershire Safeguarding Adults Board. <http://www.rcpsych.ac.uk/pdf/South%20Glos%20report.pdf> (accessed 11 April 2016)

Francis, R. (2013). *Robert Francis inquiry report into mid-Staffordshire NHS foundation trust*. London: The Stationery Office.

Friis, S. (1986). Characteristics of a good ward atmosphere. *Acta Psychiatrica Scandinavica*, 74, 469-473. DOI: 10.1111/j.1600-0447.1986.tb06270.x

- Glorney, E., Perkins, D., Adshead, G., McGauley, G., Murray, K., Noak, J., & Sichau, G. (2010). Domains of need in a high secure hospital setting: A model for streamlining care and reducing length of stay. *International Journal of Forensic Mental Health*, 9, 138-148. DOI:10.1080/14999013.2010.499552
- Grant, M. J., & Booth, A. (2009). A typology of reviews: An analysis of 14 review types and associated methodologies. *Health Information & Libraries Journal*, 26, 91-108. DOI: 10.1111/j.1471-1842.2009.00848.x
- Harris, D. M., Happell, B., & Manias, E. (2015). Working with people who have killed: The experience and attitudes of forensic mental health clinicians working with forensic patients. *International Journal of Mental Health Nursing*, 24, 130- 138. DOI: 10.1111/inm.12113
- Hinsby, K., & Baker, M. (2004). Patient and nurse accounts of violent incidents in a medium secure unit. *Journal of Psychiatric and Mental Health Nursing*, 11, 341-347. DOI: 10.1111/j.1365-2850.2004.00736.x
- Home Office & Department of Health and Social Security. (1975). Report of the Committee on Mentally Abnormal Offenders (Butler Report). Cmnd. 6422. London: HMSO.
- Hörberg, U., Sjögren, R., & Dahlberg, K. (2012). To be strategically struggling against resignation: The lived experience of being cared for in forensic psychiatric care. *Issues in Mental Health Nursing*, 33, 743-751. DOI:10.3109/01612840.2012.704623

Hui, A., & Stickley, T. (2007). Mental health policy and mental health service user perspectives on involvement: A discourse analysis. *Journal of Advanced Nursing*, 59, 416-426. doi:10.1111/j.1365-2648.2007.04341.x

Jacob, J. D., Gagnon, M., & Holmes, D. (2009). Nursing so-called monsters: On the importance of abjection and fear in forensic psychiatric nursing. *Journal of Forensic Nursing*, 5, 153-161. DOI: 10.1111/j.1939-3938.2009.01048.x

Jacob, J. D., & Holmes, D. (2011). Working under threat: Fear and nurse–patient interactions in a forensic psychiatric setting. *Journal of Forensic Nursing*, 7, 68-77. DOI: 10.1111/j.1939-3938.2011.01101.x

Kennedy, H. (2002). Therapeutic uses of security: Mapping forensic mental health services by stratifying risk. *Advances in Psychiatric Treatment*, 8, 433-443. DOI <http://dx.doi.org/10.1192/apt.8.6.433>

Kurtz, A., & Jeffcote, N. (2011). ‘Everything contradicts in your mind’: A qualitative study of experiences of forensic mental health staff in two contrasting services. *Criminal Behaviour and Mental Health*, 21, 245-258. DOI: 10.1002/cbm.796

Kurtz, A., & Turner, K. (2007). An exploratory study of the needs of staff who care for offenders with a diagnosis of personality disorder. *Psychology and Psychotherapy: Theory, Research and Practice*, 80, 421-435. DOI: 10.1348/147608306X171510

MacInnes, D., Beer, D., Keeble, P., Rees, D., & Reid, L. (2010). The development of a tool to measure service user satisfaction with in-patient forensic services: The

forensic satisfaction scale. *Journal of Mental Health*, 19, 272-281.  
DOI:10.3109/09638231003728133

MacInnes, D., Courtney, H., Flanagan, T., Bressington, D., & Beer, D. (2014). A cross sectional survey examining the association between therapeutic relationships and service user satisfaction in forensic mental health settings. *BMC Research Notes*, 7, 657. DOI: 10.1186/1756-0500-7-657

Martin, T., & Street, A. (2003). Exploring evidence of the therapeutic relationship in forensic psychiatric nursing. *Journal of Psychiatric and Mental Health Nursing*, 10, 543-551. DOI: 10.1046/j.1365-2850.2003.00656.x

Menzies Lyth, I. (1979). Staff support systems: Task and anti-task in adolescent institutions. *Containing Anxiety in Institutions: Selected Essays*. London: Free Association Books.

Middelboe, T., Schjødt, T., Byrting, K., & Gjerris, A. (2001). Ward atmosphere in acute psychiatric in-patient care: Patients' perceptions, ideals and satisfaction. *Acta Psychiatrica Scandinavica*, 103, 212-219.  
DOI: 10.1034/j.1600-0447.2001.00102.x

Moos, R. H. (1996). *Ward atmosphere scale manual (2<sup>nd</sup> Ed)*. Palo Alto: Consulting Psychologists Press.

Parkes, J. H., Pyer, M., Ward, A., Doyle, C., & Dickens, G. L. (2015). 'Going into the unknown': Experiences of male patients in secure settings during environmental transition. *International Journal of Mental Health Nursing*, 24, 2-10.  
DOI: 10.1111/inm.12088

- Priebe, S., & Gruyters, T. (1993). The role of the helping alliance in psychiatric community care: A prospective study. *The Journal of Nervous and Mental Disease, 181*, 552-557.
- Riordan, S., & Humphreys, M. (2007). Patient perceptions of medium secure care. *Medicine, Science and the Law, 47*, 20-26. doi: 10.1258/rsmmsl.47.1.20
- Rutherford, M., & Duggan, S. (2008). Forensic mental health services: Facts and figures on current provision. *British Journal of Forensic Practice, 10*, 4-10. doi:10.1108/14636646200800020
- Schalast, N., Redies, M., Collins, M., Stacey, J., & Howells, K. (2008). EssenCES, a short questionnaire for assessing the social climate of forensic psychiatric wards. *Criminal Behaviour and Mental Health, 18*, 49-58. DOI: 10.1002/cbm.677
- Schlossberg, N. K. (1981). A model for analyzing human adaptation to transition. *The Counselling Psychologist, 9*, 2-18. doi:10.1177/001100008100900202
- Skelly, C. (1994). From special hospital to regional secure unit: A qualitative study of the problems experienced by patients. *Journal of Advanced Nursing, 20*, 1056-1063. DOI: 10.1046/j.1365-2648.1994.20061056.x
- Smedley, N., & Nesbitt, S. (2000). Measuring in-patient satisfaction: A survey of satisfactory service provision for psychiatric inpatients. *Journal of Clinical Excellence, 1*, 235-242.
- Smith, M. A., Schüssler-Fiorenza, C., & Rockwood, T. (2006). Satisfaction with care. *Understanding Health Care Outcomes Research*. Boston: Jones & Bartlett.

Spiers, S., Harney, K., & Chilvers, C. (2005). Service user involvement in forensic mental health: Can it work? *The Journal of Forensic Psychiatry & Psychology*, 16, 211-220. DOI:10.1080/14789940500098137

Tambuyzer, E., Pieters, G., & Van Audenhove, C. (2014). Patient involvement in mental health care: One size does not fit all. *Health Expectations*, 17, 138-150. doi:10.1111/j.1369-7625.2011.00743.x

Tapp, J., Warren, F., Fife-Schaw, C., Perkins, D., & Moore, E. (2013). What do the experts by experience tell us about 'what works' in high secure forensic inpatient hospital services? *The Journal of Forensic Psychiatry & Psychology*, 24, 160- 178. DOI:10.1080/14789949.2012.760642

Vartiainen, H., Vuorio, O., Halonen, P., & Hakola, P. (1995). The patients' opinions about curative factors in involuntary treatment. *Acta Psychiatrica Scandinavica*, 91, 163-166. DOI: 10.1111/j.1600-0447.1995.tb09760.x

von Elm., Altman, DG., Egger, M., Pocock, S.J., Gøtzsche. P.C., & Vandenbroucke, J .P. (2007) STROBE Initiative. The Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) statement: guidelines for reporting observational studies. *The Lancet*, 370, 1453-1457. doi:10.1016/S0140-6736(07)61602-X

Weiskopf, C. S. (2005). Nurses' experience of caring for inmate patients. *Journal of Advanced Nursing*, 49, 336-343. DOI: 10.1111/j.1365-2648.2004.03297.x

Wilson, S., James, D., & Forrester, A. (2011). The medium-secure project and criminal justice mental health. *The Lancet*, 378, 110-111.  
doi:[http://dx.doi.org/10.1016/S0140-6736\(10\)62268-4](http://dx.doi.org/10.1016/S0140-6736(10)62268-4)

Yorston, G., & Taylor, P. J. (2009). Older patients in an english high security hospital: A qualitative study of the experiences and attitudes of patients aged 60 and over and their care staff in Broadmoor hospital. *The Journal of Forensic Psychiatry & Psychology*, 20, 255-267. DOI:10.1080/14789940802327259



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Major Research Project

Section B: Empirical Paper

A mixed-methods investigation into the relationship between compassion for others and work-related stress in a medium secure unit.

Word Count: 7998 (8538)

APRIL 2016

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**Abstract**

Despite a growing literature base related to both compassionate care and work-related stress in healthcare settings, there is a lack of empirical studies investigating the relationship between these concepts, particularly in medium secure settings.

This mixed methods study explored the relationship between compassion (The Compassion Scale) and work-related stress (The HSE Management Standards Toolkit) from the self-report of 51 members of staff in a medium secure setting, including semi-structured interviews with 12 participants.

Quantitatively, the relationship between self-reported compassion and work-related stress was found to be statistically non-significant. However, elements of compassion were found to significantly predict subscales of work-related stress, such that high levels of elements of compassion were found to predict higher levels of subscales of work-related stress.

Participants constructed several meanings in relation to compassion and its role in the care of the patients. Several consequences of occupational demands were cited including an increase in work-related stress and less time to build therapeutic relationships or to develop compassion towards patients.

The findings of this study can be used to inform the development of staff interventions. Increased consistency of staff groups, increased debriefing opportunities and a review of paperwork responsibilities within staff teams have also been recommended.

## SERVICE USER AND STAFF EXPERIENCES OF MEDIUM SECURE SETTINGS

**Key words:** work-related stress, compassion, staff, discourse analysis, medium secure unit

### **Introduction**

The wellbeing of staff working within the National Health Service (NHS) and its link to the quality of care patients receive has recently been the focus of increased attention. In 2016, the British Psychological Society (BPS) found that 70% of staff working with patients in a psychological capacity reported high levels of stress (BPS, 2016), whilst Cooke and Watts (2016) argued that increased organisational demands were a cause of distress for healthcare professionals. Specific to forensic mental health (FMH), Coffey (1999) found that 44.3% of a sample of forensic community mental health nurses reported high levels of burnout.

In response to the Francis Report (2013), which recognised a number of failures in healthcare provided by the NHS, policies and interventions have been changed, in order to prevent further deficiencies. For example, the Francis Report cited poor staffing levels as a contributing factor to shortcomings of care. Meanwhile, Firth-Cozens and Cornwell (2009) advocated for decreasing staffing levels to be addressed in order to increase the quality of compassionate care delivered within healthcare settings.

The quality of patient care is not only influenced by individual staff members' approach to caring itself, but also by wider systemic factors (Johnson & Webb, 1995). Maben, Adams, Peccei, Murrells and Robert (2012) suggested that numerous factors such as ward climate, organisational influences and service-based dynamics are likely to influence the quality of patient care, as well as staff members' capacity to provide high quality care. This links with research in FMH settings by Kurtz and Jeffcote (2011) who found that staff working in medium secure hospitals are likely to attribute

stress to occupational demands, rather than as a result of caring for individual patients.

### ***Forensic Mental Health Services***

In the UK, FMH services are provided in high, medium and low secure hospitals for individuals with mental health difficulties who have a history of offending behaviour or are at risk of offending (Rutherford & Duggan, 2008). Rutherford and Duggan (2008) estimated that over 85% of the population within secure hospitals are male and that a similar percentage accounts for the population of working age adults. Length of stay tends to be longer than stays within psychiatric hospitals, with approximately 65% of admissions being longer than two years (Rutherford & Duggan, 2008). Moreover, secure hospitals differ from non-forensic psychiatric hospitals in terms of increased security restrictions, longer admission rates and higher rates of violent incidents towards staff and other patients (Hinsby & Baker, 2004).

### ***Therapeutic Relationships***

When considering the concept of compassion and work-related stress in healthcare settings, it is important to consider the theoretical underpinnings of the therapeutic relationship. Watson and Woodward (2010) theorised that caring is a part of the human condition which involves enabling another individual to feel harmonious. In nursing relationships, the theory suggests that the process of caring occurs as a result of relational interactions between the nurse and the patient. This links with Kurtz and Jeffcote (2011) who offered a psychoanalytic approach to

conceptualising the experiences of FMH staff working in secure hospitals. The authors suggest that staff, both individual and groups, may re-enact certain characteristics of the patient's inner world, which leads to anxiety and fear.

Using grounded theory to explore the influence of fear in therapeutic relationships, Jacob and Holmes (2011) found that the process of "othering" occurred between nurses and patients. "Othering" refers to the process of defining oneself in relation to, and in comparison with others, which can lead to marginalisation of patients and maintain hierarchical positions of difference between staff and patients (Johnson et al., 2004). The need to maintain a safe environment, alongside the knowledge of crimes committed by patients, reinforced the fear nurses experienced towards patients. Consequently, participants made attempts to create an emotional distance in order to position themselves as "different" from the patients as a means of decreasing the likelihood of emotionally identifying with patients and the crimes they had committed.

Empirical studies have investigated the development and maintenance of therapeutic relationships within FMH services. Evans, Murray, Jellico-Jones and Smith (2012) reported on the formation of therapeutic relationships between staff and patients in a medium secure unit (MSU). Qualitative interviews with staff found key themes related to the development of therapeutic relationships including engaging in activities, spending time with patients and maintaining boundaries. The results also suggested that staff had an awareness of their own biases and preconceptions of mental health difficulties and patients' behaviours, which they felt had a negative impact on the development of their therapeutic relationships.

### *Compassion*

Cole-King and Gilbert (2011) define compassion as “sensitivity to the distress of self and others with a commitment to try and do something about it and prevent it” (p. 30). As highlighted by the authors, complex psychological processes are needed in order to be compassionate towards others, including the ability to hold another’s suffering in mind and act accordingly. Drawing upon attachment theory, Cole-King and Gilbert (2011) suggest being compassionate towards others allows one to engage in the distress of another individual whilst being able to make sense of the distress and be motivated to care for that individual. Regarding barriers to compassion, Cole-King and Gilbert (2011) cite time demands and increased paperwork as examples of organisational limitations in providing compassionate care.

In 2013, The NHS Constitution document positioned “compassion” as central to the delivery of care within the NHS and listed compassion as one of its six core values. The document states that compassion for patients will be demonstrated through actions of “humanity” and “kindness” (NHS Constitution, 2013 (pg. 5)). Nonetheless, Paley (2013) argues that the well documented failures of the NHS have been attributed to “a lack of compassion”.

To date there has been little research looking into the barriers and facilitators of compassionate care within inpatient settings. However, in a large-scale mixed- methods study, Maben et al. (2012) considered the role of staff experiences in the quality of health care provided to patients and its link to compassionate care in an older adults setting. The authors found that high levels of staff wellbeing highly correlated with good quality of care given to patients, whereas low levels of staff

wellbeing resulted in poor levels of patients care. Results also suggested that staff made efforts to counteract poor examples of care and sought job satisfaction through seeking ‘favourite’ patients to whom they felt more able to give both better quality of care to and higher levels of compassionate care.

### ***Work-related stress and forensic mental health***

Despite a growing literature base and media coverage discussing the personal impact of working in mental health services, the wellbeing of staff working in FMH services remains under-researched by empirical methods (Harris, Happell & Manias, 2015). The World Health Organisation defines work-related stress as:

“the response people may have when presented with work demands and pressures that are not matched to their knowledge and abilities and which challenge their ability to cope” (WHO, para. 3, 2016).

Theoretically, Lazarus and Folkman’s (1984) transactional model of stress can be applied to the concept of work-related stress. The authors suggest that individual and group differences in abilities to cope with certain situations will depend on their vulnerability and sensitivity to triggering events. In organisational terms, this suggests that both individuals within the system, and the systems within the wider organisation, may respond differently to stressful events. The stress reaction by the individual or system is therefore a product of the interaction with the environment in which the event occurs.



The model of transactional stress can be applied to a study by Harris et al. (2015), who explored the experiences and attitudes of FMH staff. Participants reported feeling unsupported by colleagues in terms of their own reactions to working with patients who had committed crimes. Additionally, participants struggled with feelings of horror and fear when they became aware of the nature of the crimes patients had committed. This was particularly evident for participants who were engaged in long-term therapeutic relationships with patients, suggesting that investing in longer-term relationships can be more difficult in this particular context.

Moving away from transactional stress, the concept of burnout amongst professionals working in FMH settings has been associated with a decreased quality of patient care (Coffey, 1999). “Burnout” relates to an emotional state characterised by emotional fatigue, feelings of depersonalisation and decreased feelings of accomplishment (Terry, 2014). Terry (2014) suggested that high levels of burnout are likely to be associated with a reduced capacity to engage in reflective practice and a decreased quality of therapeutic relationships between staff and patients. This has potential implications for the current study and highlights the possible consequences of high levels of burnout on therapeutic relationships.

### ***Present Study***

The research discussed in this introduction provides a base on which to explore the relationship between staff wellbeing and quality of care provided to patients. Increased occupational demands, lengthy admissions and working with a vulnerable client group who may have severe and enduring mental illness, as well potential historic offences within MSUs, could suggest that there may be challenges

in staff members' capacity to show and remain compassionate towards patients. With this in mind, further research is needed to understand the complexity of psychological processes involved in the development and maintenance of therapeutic relationships within the FMH field. More specifically, the interaction between work-related stress and compassionate care requires further investigation, given the present lack of knowledge available.

To address this gap, a mixed-methods approach will be used. The use of quantitative and qualitative methodologies within the same study poses questions regarding the philosophical compatibility (Franz, Worrell & Vogeley, 2013) of methodologies. Previous authors have commented on the lack of mixed methods studies including discourse analysis (DA) due to the difficulty integrating the social constructionist epistemology of DA with quantitative data (Bryman, 2006). However, the lack of current research requires a deeper understanding than the data that would be available from a single approach would support. The positivist epistemological stance of quantitative data provides a measurable, "realist" perspective of compassion and work related stress, whilst the qualitative data offers an alternative dimension to understanding the context and complexity of discourses. In this sense, the two sets of data will be conceptually and theoretically different however each will provide an exploration of a previously unknown relationship between compassion and work-related stress.

This study firstly aimed to investigate the relationship between compassion and work-related stress, including the specific elements of compassion and work-related stress, as reported by staff working in a MSU. Secondly, this study aimed to

explore how the discourses related to compassion and work-related stress connects with each other, and make sense of the relationship between the concepts.

### **Research Questions**

The following research questions will be explored:

1. What is the relationship between self-reported compassion for others and self-reported work-related stress by staff in a medium secure unit?
2. What are the differences in self-reported compassion for others and self-reported work-related stress across wards of varying levels of acuity?
3. How do staff discourses make a connection between work-related stress and compassion towards patients?

### **Methodology**

#### ***Design***

This mixed methods study used a triangulation design. Quantitative and qualitative data were collated in parallel and were drawn together in a way which focused on the strengths, whilst counterbalancing the limitations, of each approach (Johnson & Onwuegbuzie, 2004) and providing a multilevel perspective of the data. The relationship between compassion and work-related stress was measured quantitatively, whilst qualitative data were gathered in order to explore the discourses related to the relationship between them.

#### ***Research setting and recruitment***

Participants were recruited from a NHS funded MSU in the South East of England, using convenience sampling. The MSU consisted of six wards, five of which

are for males. The average stay on each ward across the unit was 204 days (6.7 months). However, patients often transitioned between wards and therefore this does not reflect average total lengths of stay within the hospital. Nationally, the average stay in MSU's is 18 – 24 months (NHS Confederation, 2012). Referrals to the service are made from community and inpatient mental health teams, prisons and high secure hospitals. Eligibility criterion to the service states that patients must have a diagnosis of “psychosis” or “personality disorder”, with a current or historical risk to themselves or others.

Four of the six wards were identified as suitable for the study on the basis that the four wards included a range of acuity of patients' needs and were for male patients only. The remaining wards were not included in order to decrease the number of confounding variables between wards; one was a female ward and the other was a low secure ward.

An email was sent out to all staff members on the identified wards, including details about the project and a participant information sheet. The researcher then attended staff and handover meetings and gave potential participants further information about the project. If staff members wanted to take part at that stage, consent was sought and questionnaires were given out. Participants who wanted to complete the electronic version of the questionnaire were provided with the Survey Monkey link. Participants who agreed to take part in the qualitative interviews then arranged a time and date to meet with the researcher.

***Ward Information****Table 5: Contextual information for wards gathered between July and December 2015*

	Ward 1	Ward 2	Ward 3	Ward 4
Ward description	Acute admissions	Acute ward	Rehabilitation ward	Rehabilitation Ward
Number of beds	12	15	16	16
Staff per early shift	6	5	4	4
Staff per late shift	6	5	4	4
Staff per night shift	5	4	3	3
Average hours of patient observations per month <sup>2</sup>	1729	81	81	62.4
Average hours of patient escorts per month	19.7	77.75	77.75	121.4

Contextual data were gathered between July and December 2015 to account for the time period in which participant recruitment was taking place. The wards have been presented in terms of decreasing acuity where Ward 1 is the most acute ward and Ward 4 is the least acute ward in relation to patient needs.

<sup>2</sup> This refers to the amount of hours staff spend carrying out 1:1 observations of patients.

*Table 6: Number of incidents, restraints and incidents of supervised confinement per ward*

	Ward 1	Ward 2	Ward 3	Ward 4
Incidents	89	64	32	40
Supervised confinement	23	5	1	1
Restraints	28	5	0	1

According to the ward data, Ward 1 had the highest number of reported incidents of supervised confinement, restraints and recorded incidents whilst Ward 3 had the (see Appendix A for a full breakdown of number of observations and escorting patients on leave per month).

### ***Participants***

A g-power calculation estimated that 49 participants were needed for a large effect size to be detected in the quantitative data. Fifty-one participants took part including 17 nurses, 15 support workers and 19 ‘other’ including assistant psychologists and occupational therapists. Eighteen participants had been in their role for less than one year, 14 for 1 to 5 years, six had been working in their current role for 5 to 10 years and the remaining 13 had been in the role for more than 10 years.

Twelve participants (4 males, 8 females) took part in the interviews. Three participants took part from Ward 1, two participants from Ward 2, four from Ward 3

and the remaining three were from Ward 4. The length of time participants had been in their current role ranged from 1 to 13 years. The sample included three senior support workers, two support workers, five nurses and two senior nurses.

### ***Measures***

The Compassion Scale (Pommier, 2011) (Appendix B) is a 24 item self-report questionnaire measuring compassion for others using a 5-point Likert scale ranging from “Almost Never” to “Almost Always”. Responses to each subscale are added up and mean scores are computed, ranging from 1 to 5. This measure has 6 subscales including kindness, indifference, common humanity, separation, mindfulness and disengagement (Table 7). Total scores are then computed by adding up the mean subscales scores (maximum=30). Higher scores are related to higher levels of compassion. This is a relatively new measure therefore there is no data available on standardised scores, however the measure has been found to have good reliability and validity (Pommier, 2011).

*Table 7: Pommier's (2011) definitions of compassion subscales*

Subscale	Definition
Kindness	“being warm and understanding to others as opposed to being harshly critical or judgemental” (p. 2)
Indifference	“cold, uncaring and dismissive (towards others)” (p. 100)
Common Humanity	“the recognition of a shared human experience that allows for a sense of connection to others” (p. 2-3)
Separation	“a sense of separation from others, particularly in instances where others are suffering” (p. 26)
Mindfulness	“an emotional balance that prevents over-identification or disengagement from the pain of others” (p. 3)
Disengagement	“(to) deny or disengage from the pain and suffering others” (p. 28)

The Health and Safety Executive Management Standards Indicator Tool (The HSE MS Indicator Tool) (HSE, 2004) (Appendix C) is a self-report questionnaire measuring work-related stress and consists of 35 items and 6 subscales (demands, control, role, support, relationships and change (Table 8)). All items are measured on a 5-point Likert scale ranging from “Never” to “Always”. Scores between 4 and 5, which are high scores, indicate lower levels of stress associated with that subscale whereas scores between 1-2 indicate higher levels of stress. The total maximum score is 175 whilst responses to each subscale are added up and mean scores are computed, ranging from 1 to 5.

This measure has been shown to have good reliability and validity (Edwards, Webster, Van Laar & Easton, 2008).



*Table 8: Definitions of the subscales of work-related stress (Edwards et al. 2008)*

Subscale	Definition
Demands	“workload, work patterns and the work environment” (p. 99)
Control	“how much say a person has in the way they do their work” (p. 99)
Role	“(how an individual) understand their job role and whether their employer ensures they do not have conflicting roles” (p. 99)
Support	“colleague encouragement and support at work” (p. 99)
Relationships	“positive working to avoid conflict and dealing with unacceptable behaviour” (p. 99)
Change	“how organisational change is managed and communicated at work” (p. 101)

### ***Interview Schedule***

The interview schedule (Appendix G) adopted a semi-structured approach to allow for as much information related to compassion and work-related stress as possible to be gathered, whilst allowing participants to draw upon their own subjective experiences. Semi-structured interviews also lend themselves well to a discourse analysis approach (Willig, 2008).

### ***Procedure***

#### ***Quantitative Phase***

Participants were recruited through convenience sampling and via a snow-

balling effect of participants informing other staff members who may be interested in the project. Participants were initially invited to take part via an email sent to all staff members on the identified wards. The researcher then attended staff and shift handover meetings to discuss the project. Potential participants were given a participant information sheet (Appendix H) for both parts of the study. Staff members were eligible to take part if they were in a NHS-funded role and were fluent in English. Participants were given the link to complete the questionnaires electronically, which included a consent form, via SurveyMonkey. In order to increase the accessibility of the questionnaire, participants were also given paper versions of the questionnaires. Paper questionnaires were returned anonymously to a designated post box in a locked reception room.

Questionnaires were then excluded if the respondent had not indicated the ward they worked, on or if staff members from non-participating wards had completed the questionnaires. This is likely to have occurred if staff had been working as bank or agency members of staff on the participating wards at the time of recruitment. Two sets of questionnaires were excluded as participants had not fully completed the compassion measure and did not complete the work-related stress measure.

### *Qualitative Phase*

Participants were interviewed individually within the MSU building and were audio-recorded using a Dictaphone. Before recording started, participants were informed of the aims of the project, the purpose of interviewing and confidentiality guidelines. Once participants had been given the opportunity to ask questions, written consent was obtained. The mean length of interview was 25 minutes, ranging from 14

to 36 minutes.

A pilot interview was carried out with the first participant. The experience and process of conducting the interview was discussed and reviewed by a member of the supervising research team in order to identify potential weaknesses of the interview schedule. No changes were made to the interview schedule following this discussion.

### ***Data Analysis***

#### *Quantitative Phase*

The responses to the questionnaires were inputted into SPSS (Version 22) and ANOVA, correlational and standard multiple regression tests were carried out using ward numbers as the independent variable and total compassion, work-related stress and the subscales of each measure as dependent variables. Multiple regression analysis was used to predict the value of each subscale, for each ward, on self-reported compassion and work-related stress levels. The Bonferroni correction was also applied ( $0.05/6=0.0083$ ) in order to reduce the likelihood of a type one error.

#### *Qualitative Phase*

Discourse analysis (DA) is based on the assumption that the language used in relation to a certain topic is responsible for the construction of the meaning of the topic on a societal level (Willig, 2008). Different perspectives can allow for a deeper understanding and thus increase the knowledge known about a particular topic (Jorgensen & Phillips, 2002). Using this approach allowed for a deeper understanding of the language, and therefore the meanings of compassion and work-related stress, and finally the dominant discourses present within the MSU.

The DA approach as outlined by Willig (2008) was used to analyse the interviews (see below). Examples of each stage can be found in the interview transcript in Appendix I.

1. *Discursive constructs* – references to the chosen discourse objects (e.g. compassion and work-related stress) were identified. Interviews were read several times and implicit and explicit mentions of the objects were highlighted. The discursive objects were ‘compassion’ and ‘work-related stress’.
2. *Discourses* – differences between the object’s construction were identified. For example, similarities and differences between the participants’ discussion of compassion and work-related stress were considered in relation to the wider societal constructs of the concepts.
3. *Action orientation* – the function of the discourses used by participants was then considered in relation to the wider societal discourses related to the objects. For example, who are the participants representing in the interviews and what is being accomplished by representing themselves or others in this way?
4. *Positioning* – the functioning of positioning in which participants located themselves was studied. Particularly important was how participants positioned themselves in relation to both the patients and the wider systems they were working in.
5. *Practice* – this stage involved looking at the relationship between the identified discourses and how those relate in clinical practice. For example, how do the discourses related to compassion and work-related stress impact on participants’ clinical practice?

6. *Subjectivity* - finally, the relationship between the subjectivity of the participant, the identified discourses and the consequences of the subjectivity were explored. For example, how do participants' subjective experiences fit with the dominant and non-dominant discourses and what are implications of this for the individual if they have alternative discourses?

### *Qualitative Validity*

A bracketing interview was conducted between the researcher and a fellow researcher before DA commenced (Appendix K). Bracketing interviews allow the researcher to identify their own assumptions and personal experience related to the research topic, which could influence the way in which the data are analysed (Fischer, 2009). Additionally, interview transcripts were read by a fellow researcher and were checked for similarities and differences in analysis. Assumptions and motivations for undertaking the project, as well as the ongoing experiences whilst recruiting participants, were also discussed regularly with members of the supervising research team. A research diary was also kept and excerpts from this can be found in Appendix L.

### *Ethical Considerations*

As service users were not directly involved in the project, ethical approval was given by Canterbury Christ Church Salomons Ethics Panel (Appendix M). Participant information sheets were made available to the staff team and informed participants that all identifiable information would be removed from interview transcripts. The impact of staff members talking about difficult experiences and their relationships with patients was taken into account and debriefing opportunities were offered to each

participant. A summary report (Appendix P) was sent to participants once data analysis had finished. Consideration was given to the reporting of unethical practice should this have occurred during interviews. It was agreed that the researcher would inform a member of the supervising research team to discuss the concerns and a plan for escalating the concerns further would be made.

### **Results**

#### ***Question 1: What is the relationship between compassion and work-related stress?***

Results in Table 9 suggest participants in Ward 1 scored higher than 50% of the population sampled by Edwards et al. (2008). Ward 2 scored higher than 90% of the sample, Ward 3 scored 10% higher whilst Ward 4 scored 75% higher than the sample percentiles in the Edwards et al. (2008) study.

Parametric testing was used once the data were established to be normally distributed. Carrying out Kurtosis, skewness and Shapiro-Wilks tests was used to assess this, alongside examining histograms and scatterplots. Parametric assumptions were checked using z-scores (Appendix D).

# SERVICE USER AND STAFF EXPERIENCES OF MEDIUM SECURE SETTINGS

*Table 9: Mean and standard deviation scores for compassion and work-related stress responses*

	Ward 1	Ward 2	Ward 3	Ward 4
<b>Compassion</b>	<b>25.08 (2.23)</b>	<b>25.72 (2.37)</b>	<b>24.22 (2.52)</b>	<b>24.72 (2.68)</b>
<b>Total</b>				
Kindness	4.53 (0.53)	4.55 (0.52)	4.59 (0.56)	4.52 (0.41)
Indifference	4.03 (0.6)	4.22 (0.65)	3.89 (0.80)	3.97 (0.72)
Common Humanity	4.25 (0.33)	4.25 (0.67)	4.09 (0.51)	4.13 (0.65)
Separation	4.13 (0.71)	4.32 (0.81)	3.61 (0.81)	3.92 (0.75)
Mindfulness	4.12 (0.33)	3.84 (0.94)	4.17 (0.51)	4.23 (0.53)
Disengagement	4.22 (0.63)	4.59 (0.54)	4.08 (1.06)	3.98 (0.78)
<b>Stress Total</b>	<b>124.5 (10.07)</b>	<b>116.0 (16.66)</b>	<b>129.9 (14.65)</b>	<b>123.07 (19.82)</b>
Demands	3.27 (0.93)	3.19 (0.55)	3.33 (0.35)	3.26 (0.78)
Control	3.19 (0.43)	2.94 (0.63)	3.60 (0.47)	3.18 (0.64)
Support	3.85 (0.47)	3.53 (0.77)	3.94 (0.69)	3.77 (0.67)
Relationships	3.74 (0.45)	3.51 (0.61)	3.88 (0.69)	3.81 (0.69)
Role	4.33 (0.34)	4.15 (0.68)	4.25 (0.52)	4.16 (0.57)
Change	3.29 (0.65)	2.79 (0.85)	3.37 (0.75)	3.22 (0.87)

A two-tailed Pearson's product-moment correlation coefficient was computed

to determine the relationship between overall compassion and work-related stress, to fit with the non-directional research question. The relationship was found to be non-significant,  $r = 0.09$ ,  $N=51$ ,  $p=0.95$ .

Multiple regression analyses were carried out in order to test the predictability of each subscale of compassion against each subscale of work-related stress (see Table 10). A full table of results can be found in Appendix E. The corrected alpha level was 0.001 in order to account for the large number of individual tests. Significant p-scores have been highlighted in bold.

‘Separation’ significantly predicted levels of ‘Demand’ (beta=.52,  $p=.01$ ) ‘Control’ (beta=.38,  $p=.01$ ), ‘Support’ (beta=.42,  $p=.03$ ) and ‘Change’ (beta=.54,  $p=.00$ ).

‘Indifference’ contributed significantly to the prediction of levels of ‘Support’ (beta=.4,  $p=.04$ ) whilst ‘Mindfulness’ contributed significantly to the predictor of levels of ‘Role’ (beta=.36,  $p=.02$ ).



*Table 10: Multiple regression analyses for each subscale variable*

Dependent variable	Independent Variable						
	Constant	Kindness	Indifference	Common Humanity	Separation	Mindfulness	Disengagement
Demands	b=3.14, p=.00	b=.13, p=.5	b=.15, p=.41	b=.15, p=.38	b=-.42, <b>p=.01**</b>	b=.05, p=.71	b=.04, p=.82
Support	b=1.71, p=.06	b=.18, p=.40	b=.39, <b>p=.04*</b>	b=.14, p=.42	b=-.35, <b>p=.03*</b>	b=.18, p=.24	b=-.05, p=.77
Relationships	b=1.61, p=.16	b=.18, p=.40	b=.24, p=.131	b=.11, p=.14	b=-.26, p=.09	b=.19, p=.21	b=.04, p=.84
Role	b=2.43, p=.01**	b=.12, p=.50	b=.10, p=.57	b=-.10, p=.95	b=-.12, p=.34	b=.32, <b>p=.02*</b>	b=.02, p=.88
Change	b=3.31, <b>p=.02*</b>	b=-.02, p=.94	b=.22, p=.33	b=.03, p=.88	b=-.55, <b>p=.00***</b>	b=.28, p=.12	b=.00, p=.99
Control	b=2.64, p=.01	b=.08, p=.67	b=.09, p=.59	b=.28, p=.07	b=-.38, <b>p=.01**</b>	b=.07, p=.61	b=-.01, p=.96

\* Significant at the 0.05 level, \*\* significant at the 0.01 level \*\*\*significant at the Bonferroni adjusted value

***Question 2: What are the differences in self-reported compassion for others and self-reported work-related stress across wards of varying levels of acuity?***

There were no significant differences between levels of self-reported compassion across the wards as calculated by a one-way ANOVA ( $F(3, 48) = 0.84$ ,  $p$

## SERVICE USER AND STAFF EXPERIENCES OF MEDIUM SECURE SETTINGS

= 0.48). There were no significant differences between levels of work-related stress across the wards using a one-way ANOVA ( $F(3, 48) = 1.60, p=0.20$ ).

Multiple regression analysis was carried out in order to test the relationship between the compassion subscales and work-related stress subscales for each ward. There were no significant results in Ward 1 and 2.

*Table 11: Multiple regression analyses for each subscale variable for Ward 1*

Dependent variable	Independent Variable						
	Constant	Kindness	Indifference	Common Humanity	Separation	Mindfulness	Disengagement
Demands	b=-7.79, p=.46	b=-.03, p=.96	b=-.76, p=.48	b=.87, p=.61	b=-6.17, p=.19	b=3.40, p=.27	b=5.22, p=.20
Support	b=4.12, p=.32	b=-.50, p=.20	b=.43, p=.32	b=1.68, p=.15	b=-.27, p=.74	b=-.82, p=.34	b=-.56, p=.51
Relationships	b=10.23, p=.25	b=-.45, p=.38	b=.01, p=.99	b=-1.67, p=.27	b=1.83, p=.36	b=.26, p=.83	b=-1.42, p=.41
Role	b=4.14, p=.55	b=.53, p=.37	b=.07, p=.92	b=-.33, p=.77	b=.54, p=.75	b=-.35, p=.79	b=-.44, p=.78
Change	b=10.07, p=.24	b=.22, p=.58	b=.65, p=.36	b=.98, p=.40	b=1.46, p=.40	b=-2.9, p=.18	b=-2.05, p=.29
Control	b=5.85, p=.20	b=-.44, p=.19	b=.37, p=.33	b=-.29, p=.54	b=.75, p=.38	b=.49, p=.26	b=-1.39, p=.21

# SERVICE USER AND STAFF EXPERIENCES OF MEDIUM SECURE SETTINGS

\* Significant at the 0.05 level, \*\* significant at the 0.01 level \*\*\*significant at the Bonferroni adjusted value

*Table 12: multiple regression analyses for each subscale variable for Ward 2*

Dependent variable	Independent Variable						
	Constant	Kindness	Indifference	Common Humanity	Separation	Mindfulness	Disengagement
Demands	b=2.78, p=.23	b=.69, p=.53	b=-.51, p=.27	b=-.27, p=.67	b=-.16, p=.54	b=-.25, p=.36	b=.49, p=.50
Support	b=-1.33, p=.67	b=.09, p=.96	b=.11, p=.87	b=.44, p=.64	b=-.13, p=.75	b=.17, p=.68	b=.44, p=.68
Relationships	b=.87, p=.77	b=.32, p=.83	b=-.03, p=.98	b=.20, p=.82	b=-.07, p=.85	b=.06, p=.87	b=.11, p=.92
Role	b=1.93, p=.56	b=-.52, p=.76	b=-.02, p=.98	b=.11, p=.91	b=-.11, p=.78	b=.24, p=.57	b=.81, p=.48
Change	b=2.14, p=.54	b=-.59, p=.74	b=.33, p=.65	b=.35, p=.73	b=-.66, p=.17	b=.35, p=.43	b=.42, p=.72
Control	b=1.91, p=.43	b=-.08, p=.95	b=-1.19, p=.70	b=.65, p=.37	b=-.26, p=.37	b=.00, p=.99	b=-.13, p=.87

\* Significant at the 0.05 level, \*\* significant at the 0.01 level \*\*\*significant at the Bonferroni adjusted value

# SERVICE USER AND STAFF EXPERIENCES OF MEDIUM SECURE SETTINGS

Table 13: Multiple regression analyses for each subscale variable for Ward 3

Dependent variable	Independent Variable						
	Constant	Kindness	Indifference	Common Humanity	Separation	Mindfulness	Disengagement
Demands	b=3.34, p=.03	b=.36, <b>p=.03*</b>	b=.47, <b>p=.02*</b>	b=-.01, p=.94	b=.13, p=.47	b=-.29, p=.08	b=-.66, <b>p=.01**</b>
Support	b=2.54, p=.41	b=.55, p=.14	b=.71, p=.09	b=.16, p=.67	b=-.57, p=.19	b=-.34, p=.36	b=-.25, p=.59
Relationships	b=-3.68, p=.14	b=.37, p=.38	b=.29, p=.34	b=.96, <b>p=.01**</b>	b=-.94, <b>p=.01**</b>	b=.59, p=.06	b=.42, p=.26
Role	b=2.58, p=.43	b=-.12, p=.75	b=-.20, p=.63	b=.22, p=.58	b=-.27, p=.54	b=.48, p=.23	b=.26, p=.60
Change	b=2.97, p=.49	b=.11, p=.82	b=.40, p=.48	b=.23, p=.65	b=-.45, p=.45	b=.04, p=.94	b=-.29, p=.66
Control	b=1.37, p=.57	b=.24, p=.38	b=.34, p=.28	b=.38, p=.25	b=-.45, p=.20	b=.01, p=.98	b=-.02, p=.97

\* Significant at the 0.05 level, \*\* significant at the 0.01 level \*\*\*significant at the Bonferroni adjusted value

A standard multiple regression was carried out with ‘Demands’ as the dependent variable and the compassion subscales as independent variables for Ward 3. The results of the regression indicated that three predictors (‘Kindness’, ‘Indifference’ and ‘Disengagement’) accounted for 56.3% of the variance ( $R^2=0.74$ ,  $F(6, 9) = 4.22$ ,  $p=0.03$ ). ‘Kindness’ (beta=0.57,  $p=0.02$ ), ‘Indifference’ (beta=1.07,  $p=0.02$ ) and ‘Disengagement’ (beta=1.98,  $p=0.01$ ) contributed significantly to the

# SERVICE USER AND STAFF EXPERIENCES OF MEDIUM SECURE SETTINGS

prediction of levels of ‘Demands’.

Two predictors (‘Common Humanity’ and ‘Separation’) accounted for 63% of the variance ( $R^2=0.78$ ,  $F(6, 9) = 5.23$ ,  $p=0.01$ ) of levels of ‘Relationships’. ‘Common humanity’ ( $\beta=0.70$ ,  $p=0.01$ ) and ‘Separation’ ( $\beta=1.09$ ,  $p=0.01$ ) contributed significantly to the prediction of levels of ‘Relationships’.

*Table 14: Multiple Regression Analyses for each subscale variable for Ward 4*

				Independent Variable			
Dependent variable	Constant	Kindness	Indifference	Common Humanity	Separation	Mindfulness	Disengagement
Demands	b=1.79, p=.59	b=.01, p=.99	b=.30, p=.67	b=.30, p=.53	b=-.56, p=.26	b=.10, p=.85	b=.19, p=.78
Support	b=4.34, p=.10	b=-.30, p=.67	b=1.19, <b>p=.04*</b>	b=-.23, p=.51	b=-.41, p=.25	b=.10, p=.80	b=-.45, p=.68
Relationships	b=3.97, p=.20	b=-.02, p=.98	b=.62, p=.33	b=-.15, p=.73	b=-.19, p=.82	b=-.31, p=.52	b=.03, p=.95
Role	b=2.36, p=.36	b=.11, p=.87	b=.43, p=.42	b=.01, p=.99	b=-.21, p=.57	b=.22, p=.58	b=-.15, p=.78
Change	b=6.09, p=.13	b=-.10, p=.36	b=.50, p=.54	b=-.12, p=.58	b=-.52, p=.35	b=.27, p=.66	b=.27, p=.72
Control	b=4.27, p=.17	b=-.15, p=.86	b=.07, p=.92	b=.23, p=.07	b=-.09, p=.82	b=-.25, p=.60	b=-.05, p=.93

\* Significant at the 0.05 level, \*\* significant at the 0.01 level \*\*\*significant at the

Bonferroni adjusted value

Multiple regression analysis indicated that one predictor ('Indifference') accounted for 7% of the variance ( $R^2 = 0.47$ ,  $F(6, 8) = 1.18$ ,  $p = 0.40$ ) in Ward 4. 'Indifference' ( $\beta = 2.71$ ,  $p = 0.04$ ) contributed significantly to the prediction of levels of 'Support'.

***Question 3: How do staff discourses make a connection between work-related stress and compassion towards patients?***

***Compassion***

Participants constructed a number of different meanings related to compassion although most related compassion to the role of caring for others in a nursing capacity:

1<sup>3</sup>. *"I think nursing is compassion first and foremost...it's about trying to care for people, it's as simple as that"* (Participant 5)

2. *"my job centres on providing compassionate care...we always focus on care and compassion for the patient"* (Participant 7)

A number of participants suggested each individual, regardless of position, has the capacity to be compassionate. In this sense, compassion was observed as being part of the human condition:

3. *"we are human beings whether patients or not patients...compassion...it*

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<sup>3</sup> Quotes are numbered to allow for cross-referencing in the discussion section.

*comes natural...even if you cannot do anything but show that you really care and you would have done something to help if it was in your capacity to solve the problem” (Participant 9)*

Participants referred to the process of caregiving as “giving them (patients) the quality of care they need according to their care plan” (Participant 1), which appeared to be informed by a “professional” discourse. Another participant (2) said “consistent care delivery” when asked about the elements needed to have a positive relationship with patients. This approach to care delivery and consistency suggested a somewhat prescriptive approach to caring for patients, which is pre-planned and within the power of the person or team delivering the care.

### ***Barriers to Compassion***

There appeared to be a discourse related to the “expectations” of patients and the role of mental health difficulties within this. One participant said *“I respect my patients and I expect them to respect me in return”* (Participant 9), however further commented:

4. *“you are being disrespected...we get that all the time...they are disrespectful but what can you do you still have to work with them and you still got to deliver your care to the optimum level irrespective”.*

In terms of discourse, this quote suggests that staff located being disrespectful as the patient (“they are disrespectful”) rather than experiencing it as a behaviour of the patient.

Others commented on the mental health of the patient as being a barrier to forming positive relationships and understanding the patient:

5. *“When they are not happy or when they are emotionally distressed or when their mental state is not stable” (Participant 6)*

6. *“they are very unpredictable especially when you know they are unwell there is nothing you can do...you have to work around it but when he comes around then the relationship continues” (Participant 12)*

An alternative to the negativity of the mental health discourse was given by one participant who commented on the role of the service in patients’ recovery:

7. *“We see people at their worst and we able to make them walk out of there which is nice” (Participant 2)*

A number of participants alluded to the difficulty in balancing ‘displaying actions of compassion’ and ‘maintaining boundaries’. Enforcing boundaries was a barrier to having or displaying too much compassion and participants identified that there was a perceived danger of getting “too close” to patients.

There was a powerful discourse related to the level of care patients needed and the ways in which compassion was displayed towards patients. Some participants identified particular patients or patient groups they found harder to be compassionate towards. This seemed to relate to a discourse around patients who had committed sexual offences being “difficult to understand”:

8. *“I think it depends also on how...your attitude towards some of the patients...they are not very nice characters when they want to be...and their offences...there are a certain type of people...or index offence...that I won’t tolerate and I will probably avoid that person if I can” (Participant 4)*



One participant located barriers to understanding the patients in their behaviour and separated this from their mental health. This also seemed to relate to the “expectations” of the patient:

9. *“It’s got nothing to do with their mental state it’s just behaviour it’s so hard for you to understand” (Participant 12)*

A number of participants commented on the risk of being “too compassionate” and the associated personal consequences of this. Participants tended to position themselves in a dual role when talking about risk highlighting the struggle between balancing compassion and risk, and the difficulty in holding both positions.

10. *“It’s very hard to find a middle point...the right point between the risk taking and being a compassionate person” (Participant 4)*

Participants talked about the idea of “revolving door patients” and the difficulty in remaining hopeful for the patient’s future. This was also linked to the wider perceptions and attitudes toward the recovery of patients:

11. *“some people will see it as the revolving door they are gonna come back anyway” (Participant 3)*

12. *“Its kind of a revolving door...they tell me by the time you know it these people are well enough to go you see them back either on (Ward 1) or (Ward 2) which kind of demoralises you” (Participant 9)*

### **Work-related Stress**

Discourses related to “hierarchy” and “power” both within staff groups and between staff and patients were identified. The construction of participant

professional identities were seemingly made in relation to their hierarchical difference to other members of the staff team, which came with varying levels of work-related stress. Participants used the discourses in order to distinguish their own roles, compared to others.

*13. “well I am a band 4...so what are they called now...senior forensic support worker...which is basically a healthcare assistant...and so I basically help the nurses...the trained nurses” (Participant 1)*

Comparisons were also made in regards to the time pressures between trained and non-trained staff and certain privileges and limitations associated with being a non-trained staff member:

*14. “I suppose...being a healthcare assistant compared to a nurse is you actually get to spend a lot of time with patients you actually get to take them out and do things with them...they feel you are there more often” (Participant 1)*

*15. “I’m relatively new and...I would be seen as the one who doesn’t know it or hasn’t seen it all...(like) I need firmer boundaries” (Participant 4)*

Participants made attempts to position themselves away from the wider systems in which they worked in and identified a lack of control as a source of stress:

*16. “...sometimes in this environment there is a lot of pressure put on people...there is a lot of red tape, a lot of things have been taken away”(Participant 7)*

Linked to a lack of control, participants recognised ongoing issues within the

ward (e.g. difficulty accessing certain areas of the hospital and an increase in serious incidents), which had remained unresolved and participants commented on a perceived lack of attempt to resolve the issues.

*17. “we have had...a succession of serious incidents where people have been injured and...have actually felt unsafe coming onto ward and managing those anxieties and letting staff know that you are there to support them but them seeing that things aren’t really changing is hard” (Participant 2)*

There were conflicting subjective experiences related to the “usefulness” of staff interventions on the wards such as reflective practice groups. Some participants identified the groups and peer support as a means of coping with the pressures of their job and a protective factor against burnout.

*18. “if you really ...want to be compassionate and if you care at all then you’ve got an opportunity to have a better understanding of what is going on” (Participant 4)*

*19. “I think it is really important to prevent burnout (in reference to reflective groups)” (Participant 4)*

However, other participants associated the reflective groups with the perceived lack of change (*“reflective practice wasn’t working for me just because they come and listen we talk about all these issues and then you never get any feedback...the situation is not improved”*) (Participant 6).

When asked about the more demanding elements of the role, participants identified a number of systemic influences on levels of stress such as staff shortages,

shift coordination<sup>4</sup> and a perceived lack of shared responsibilities.

20. *“it’s kind of a worry when we are short staffed it’s kind of a worry”*

*(Participant 8)*

21. *“if everyone done their job like they are meant to then it would be so much easier and at the moment I don’t think that will ever happen” (Participant 11)*

### ***Relationship between compassion and work-related stress***

The identification of external influences continued whilst thinking about the relationship between compassion and work-related stress. When discussing both concepts, participants most frequently discussed feelings of frustration and a lack of control over time and job roles as having a negative impact on their capacity to remain compassionate.

In particular, the impact of time pressures was reflected upon by a number of participants:

22. *“sometimes you just don’t have the time or the imagination to understand why a patient is behaving the way they behave” (Participant 11)*

The participants’ expectations of themselves as professionals and the barriers to developing relationships with patients were also highlighted. This suggested a discourse related to the patients being “too unwell”, which seemed to prevent possible opportunities for job satisfaction and compassionate care:

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<sup>4</sup> Shift coordination refers to a designated role in which one member of the team will be responsible for the running of the shift, allocation of workload and responsibilities and ensuring the overall safety of patients.

23. *“sometimes maybe the patient is not well enough to develop a proper relationship it can be very difficult because you don’t see the job satisfaction”*  
(Participant 8)

One participant had an alternative understanding of the relationship between stress and compassion and said (24) *“I’m not going to relate the stress with compassion...whatever it is stressing me out...it will not impact on my care or my patients...so I’m not going to put stress in the concept of compassion”* (Participant 6). Although this was not a frequently reported assertion within the sample, it does appear to support the results of the quantitative data.

### ***Security and Relationships***

“Security” and the role of enforcing security whilst also in a caring role appeared to create conflict for participants. Participants described being put in difficult positions of holding conflicting perspectives of care and security and reflected on the impact of this on the therapeutic relationship.

25. *“we’re the people that enforce the security...enforce the medication compliance but we are also the people that they need to trust so I think that does affect our relationship”* (Participant 2)

26. *“...however much I’m going in there with the intention of helping people...to the patients, I suspect I am simply part of the people who are locking them up...when they don’t want to be locked up”* (Participant 10)

There was a strong discourse related to threat and the perceived dangers of the client group (*“you always have to be aware of the risk and perhaps what someone is capable of in this environment”* (Participant 5)). This also related to the discourse of

“risk” and the danger of having “too much compassion”. Participants frequently identified choosing not to read patient histories as a means of avoiding making judgments or preconceptions about that individual, suggesting that it may be easier to remain compassionate if the patient’s history is unknown:

27. *“sometimes you feel like you are absolutely terrified...I try really hard to avoid preconceptions I think as well when they first come in” (Participant 10)*

28. *“I’ve become desensitised to it...I don’t look at people’s offences...if I let that bother me I wouldn’t treat them the way they need to be treated” (Participant 2)*

29. *“...as a rule, I don’t tend to read case histories too much...but it sticks in your mind and it creates...it can create that barrier so sometimes I think I prefer not to at times...sometimes you can’t help it...you hear things...people say things” (Participant 10)*

The discourse related to “risk” was also linked to external influences such as public protection and the difficulty in allowing patients to have leave (*“sometimes it’s very difficult we have the public to protect as well because if they are very unwell and you allow them to go out...then something might happen” (Participant 12)*). One participant commented that the need to minimise risk appeared to be at the expense of care (*“...risk is taken extremely seriously and it is not in balance with care” (Participant 4)*)).

Internal sources of stress were also apparent and appeared to impact on compassionate care. For example, five participants commented on the impact of assaults on colleagues:

30. *“you have to work in a professional manner especially when I see that one of the patients has assaulted a colleague initially it is difficult for me to have compassion” (Participant 8)*

31. *“I’ve had to look after someone who has assaulted one of my colleagues quite badly and its been quite difficult you know to be professional with them” (Participant 3)*

## **Discussion**

This study had two aims; to explore the relationship between self-reported compassion for others and work-related stress quantitatively, and to identify the discourses related to compassion and work-related stress in a MSU setting. The mixed-methods approach and the philosophical differences between qualitative and quantitative data means that the results in this study should be considered within the context that this is an exploratory study within a new area of research. Both methodologies provide a unique understanding of the concepts of compassion and work-related stress. By adopting both methodologies, both the individual and social meanings of compassion and work-related stress in this context can be considered. Whilst the quantitative results provide a level of objectivity, the results from the qualitative data remain the subjective observations of the researcher.

Results from the quantitative phase proposed that the relationship between compassion and work-related stress was non-significant, suggesting that compassion and work-related stress were not related to each other. This was also the case when compassion and work-related stress were compared across wards of varying levels of acuity, suggesting that high levels of compassion and moderate levels of work-related

stress are consistent within the unit. However, multiple regression analysis suggested that certain elements of compassion influenced levels of work-related stress. For instance, ‘Separation’ (emotional separation from others’ suffering) most commonly predicted levels of ‘Demands’ (e.g. “workload, work patterns and environment” (Edwards et al., 2008: p. 99) and ‘Control’ (“how much say a person has in their role” (Edwards et al., 2008: p. 99). This could suggest that when participants felt overwhelmed by their workloads (demands) and experienced a perceived lack of control, participants were most likely to feel ‘separated’ from patients. Furthermore, in Ward 3, which had the lowest number of restraints and incident, levels of ‘Demand’ were predicted by ‘Kindness’ (warmth and understanding towards others), ‘Indifference’ (“cold, uncaring and dismissive” (Pommier, 2011: p.100)) and ‘Disengagement’ (disengaged from others’ suffering). Finally, in Ward 4, which had the highest number of hours escorting patients on leave and the least number of patient observations, levels of ‘Support’ (feeling encouraged and supported) were predicted most by levels of ‘Indifference’.

Discourses (“mental illness”, “security and relationships”) related to the barriers to compassion, the constructions of meanings of compassion, demands of the role, risk and threat were observed in qualitative interviews. A barrier to compassion was found to relate to mental health difficulties and the participants’ ability to develop and maintain therapeutic relationships when patients are in a phase of being unwell (quote 12) such that it was suggested to be difficult to form relationships when patients appeared to lack ‘insight’ into their difficulties. The need to maintain boundaries alongside knowledge of patients offending history emerged and was suggested to impact on showing compassion towards patients.



A number of participants commented on the influence of work-related stress on their ability to remain compassionate. Causes of work-related stress were observed to be linked to occupational demands such as shift coordination, following policies and procedures (“red tape”), and increasing amounts of paperwork, all of which were suggested as barriers to spending time with patients and their capacity to remain compassionate. Participants identified a lack of time and increasing role demands as factors, which influence the amount of available time to spend with patients, which in turn decreased participants’ capacity to “understand the patients” (quote 22).

The analysis also presented an “us and them” discourse in which participants found it difficult to continue to work with patients if they had physically attacked staff members within their team or committed sexual offences. This process of “othering” is consistent with Peternelj-Taylor’s (2004) idea that individuals who are mentally unwell or in the role of the “patient” are vulnerable to being designated the “other”. The author suggested that nurses are vulnerable to engaging in the process of “othering” as a means of socially separating themselves from patients and the associated stigma of being in the patient role.

“Othering” occurred between patients and staff and also within the staff groups. For example, a discourse was observed which related to “qualified and non-qualified” staff such that non-trained participants positioned themselves in relation to being able to spend more time with patients, and consequently develop better relationships, compared to nurses who have less time. This links to the process of “othering” but also highlights possible frustrations related to sharing responsibility of

tasks. Participants appeared to make attempts to separate themselves from the wider system by identifying demands placed upon them from senior management teams as a possible reason for work-related stress and deficits in compassion, rather than locating triggers of stress or deficits in compassion internally.

Although the quantitative part of this study failed to find a significant relationship between compassion and work-related stress, observations from the qualitative analysis suggest that work-related stress has a negative impact on compassion. Given the increased attention that “compassion” and “compassionate care” has received in the public media and the literature base, it is possible that participants were aware of this and the potential consequences (e.g. increased work pressures) if questionnaires appeared to deem participants as “lacking in compassion”. It could also be argued that this may have influenced the participants’ responses in the qualitative interviews such that participants’ answers may have been influenced by the same effect. The differences could be explained by participants’ self-reporting high levels of compassion for others when thinking in general terms (as is measured in the questionnaires) but this differs qualitatively when recalling difficult or stressful working conditions.

The influence of wider systemic factors such as increasing demands, a perceived lack of organisational change and feelings of powerlessness reported by participants in this study support the results of Maben et al. (2012). Maben et al. (2012) found that patients’ quality of care varied based on service dynamics and organisational culture. The similarity of results to the current project suggests the systemic pressures influencing staff members, and consequently patient care, are not

unique to a particular setting but rather are applicable across a number of healthcare settings.

Linking back to the theory of compassion and Cole-King and Gilbert's (2011) idea that compassion for others involves an active choice in trying to reduce distress, the results from this study could highlight important dilemmas for staff. Participants alluded to "the revolving door patient" and the sense of hopelessness that this idea brings. This, paired with the likelihood that some patients may remain in the service for a prolonged period of time, could exacerbate feelings of helplessness held by staff. It could be hypothesised that identifying occupational demands and systemic pressures as a source of work-related stress could be easier than acknowledging the painful realisation of the limitations of being compassionate or showing compassion towards patients, in terms of their recovery.

In terms of social positioning, it could be hypothesised that this is an example of participants attempting to counteract feelings of hopelessness and powerlessness, in terms of their capacity to "fix" patients, by attributing the responsibility solely on the patients and their mental health. The discourses related to compassion and stress appeared to be externally driven, such that deficits in compassion are explained by the deficits in the system. Similarly, in the case of work-related stress, participants drew upon discourses related to lack of resources and time pressures. However, when participants considered the behaviours of patients, this appeared to be internally driven such that the behaviour of patients was located within the patient rather than an example of the patients' distress.

### *Limitations of Study*

This study has several limitations related to its study design and the generalisability of results. Data collection was carried out within one service only, meaning that sample sizes are limited. Despite it being possible to compare responses across the four wards, the hospital is run by the same management team and therefore arguably may conform to the same cultural values (Davies & Mannion, 2013).

The definition of compassion is constructed in different ways between individuals. Therefore, it is possible that the compassion measure did not capture the idiosyncratic elements of compassion personally for each participant. Similarly, the social constructionist epistemology of DA means there is a high degree of subjectivity when analysing the data (Willig 1999). Therefore the researchers own subjective experiences of compassion and work-related stress are likely to impact on the analysis.

There is a lack of normative data available for the compassion measure, meaning it is difficult to compare results to other populations. Furthermore, by measuring work-related stress, rather than a general measure of stress, it suggests that work-related stress and personal stress could be separated. However, this is unlikely to be the case; therefore, it is not possible to predict how much the higher or lower levels of stress reported in the questionnaires can account for the actual levels of work-related stress experienced by the participants.

### *Practice Implications*

Staff experiences of compassion for others and work-related stress can be better understood in the context of wider organisational demands. Firstly, a number of participants discussed the negative reactions they can experience whilst working in this environment. Similarly, participants commented on the impact of physical assaults against members of their team. When this occurred, it seemed as though participants experienced feelings of fear and stress, which in turn led to disengaging with patients. Linking back to psychodynamic theory, disengagement from patients could be conceptualised as a defence in order to protect oneself from re-experiencing fear and stress in the future, instead focusing on organisational pressures. This highlights the importance of having a space to reflect and discuss the assaults with other team members, through debriefing opportunities and supervision. This is a role in which clinical psychology can take an active part in facilitating.

In regards to compassion, results from this study could be used to inform future staff interventions which aim to increase the levels of compassion towards patients in FMH settings. Staff interventions such as the Schwartz Rounds (Lown & Manning, 2010) are currently being piloted throughout the UK. Schwartz rounds are based on the idea that providing a space for staff to discuss individual experiences of working with a particular patient can increase and maintain staff wellbeing (Goodrich, 2012). This intervention remains in its infancy within the NHS. However, in a study by Goodrich (2012), staff members reported feeling a stronger sense of support after attending Schwartz Rounds. Participants also agreed that Schwartz Rounds have the

potential to affect organisational culture within services. This could be introduced and adapted specifically for staff working within the FMH field.

Participants within the study reflected on the value of having peer support and many identified this as a protective factor against increased levels of work-related stress. However, a number of participants also commented on the lack of consistency within the staff groups, as the number of agency staff members on each shift seemed to be increasing. Having an increased level of stability amongst staff groups could allow for stronger relationships to develop amongst teams and help staff feel more supported within their roles.

Finally, several participants identified that large amounts of paperwork and organisational demands associated with their role had a negative impact on the amount of time they could spend with patients. This could be addressed by encouraging team leaders to reflect on the balance between administrative tasks and time spent with patients. This could also be addressed by introducing more freedom and flexibility for staff members in how they engage and spend time with patients.

### ***Future Research***

The discourses that emerged from this study largely focused on the barriers to compassion and the causes of work-related stress. As a result, the understanding of the factors that enable compassion and reduce work-related stress remains less clear. Therefore, future research could aim to consider these ideas in more detail.

This study included a relatively small sample size; consequently the lack of relationship found may be specific to the research site used in this study. Future research could repeat the study on a larger scale and across multiple sites. The gaps in the knowledge base regarding the specific constructs of compassion and work-related stress could also be addressed.

### **Conclusion**

This study explored the quantitative relationship between compassion and work-related stress from a staff perspective in a MSU. The discourses related to compassion and work-related stress were also explored. The results found in this study show no significant relationship between compassion and work-related stress, inclusive of wards with varying levels of acuity. However, elements of compassion and work-related stress were found to significantly correlate with each other. The qualitative discourses related to compassion and work-related stress suggests dominant dialogues related to time pressures, a perceived lack of recovery from mental illness, hierarchical positions between staff and patients, and patient histories as contributing factors towards differences in compassion and work-related stress.

## References

- British Psychological Society (2016). Psychological therapies staff in the NHS report alarming levels of depression and stress – their own (Press Release). Retrieved from [http://www.bps.org.uk/system/files/Public%20files/Comms-media/press\\_release\\_and\\_charter.pdf](http://www.bps.org.uk/system/files/Public%20files/Comms-media/press_release_and_charter.pdf)
- Bryman, A. (2006). Integrating quantitative and qualitative research: how is it done? *Qualitative Research*, 6, 97-114.
- Coffey, M. (1999). Stress and burnout in forensic community mental health nurses: An investigation of its causes and effects. *Journal of Psychiatric and Mental Health Nursing*, 6, 433-443. DOI: 10.1046/j.1365-2850.1999.00243.x
- Cole-King, A., & Gilbert, P. (2011). Compassionate care: The theory and the reality. *Journal of Holistic Healthcare*, 8, 29-37.
- Confederation, N. (2012). Defining mental health services: Promoting effective commissioning and supporting QIPP. *NHS Confederation*, Available at: [Www.Nhsconfed.org/~media/Confederation/Files/Publications/Documents/Defining\\_mental\\_health\\_services.Pdf](http://www.Nhsconfed.org/~media/Confederation/Files/Publications/Documents/Defining_mental_health_services.Pdf) (Accessed 24 February 2015),
- Cooke, A. & Watts, J. (2016, February 17). We're not surprised half our psychologist colleagues are depressed. *The Guardian*. Retrieved from <http://www.theguardian.com/healthcare-network/2016/feb/17/were-not-surprised-half-our-psychologist-colleagues-are-depressed>



Davies, H. T. O., & Mannion, R. (2013). Will prescriptions for cultural change improve the NHS? *British Medical Journal*, 364, 1-4. DOI: <http://dx.doi.org/10.1136/bmj.f1305>

Department of Health. (2013). *The NHS Constitution. The NHS belongs to us all*. London: Author

Edwards, J. A., Webster, S., Van Laar, D., & Easton, S. (2008). Psychometric analysis of the UK health and safety executive's management standards work-related stress indicator tool. *Work & Stress*, 22, 96-107. DOI:10.1080/02678370802166599

Evans, K., Murray, C. D., Jellicoe-Jones, L., & Smith, I. (2012). Support staffs' experiences of relationship formation and development in secure mental health services. *The British Journal of Forensic Practice*, 14, 104-115. DOI: <http://dx.doi.org/10.1108/14636641211223666>

Firth-Cozens, J., & Cornwell, J. (2009). *Enabling compassionate care in acute hospital settings*. London: The King's Fund.

Fischer, C. T. (2009). Bracketing in qualitative research: Conceptual and practical matters. *Psychotherapy Research*, 19, 583-590. DOI:10.1080/10503300902798375

Francis, R. (2013). *Robert Francis inquiry report into mid-Staffordshire NHS foundation trust*. London: The Stationery Office.

Franz, A., Worrell, M. & Vogeles, C. (2013). Integrating mixed method data in psychological research: Combining Q methodology and questionnaires in a study

investigating cultural and psychological influences on adolescent sexual behaviour. *Journal of Mixed Methods Research*, 7, 370-389.

Goodrich, J. (2012). Supporting hospital staff to provide compassionate care: Do Schwartz centre rounds work in English hospitals? *Journal of the Royal Society of Medicine*, 105, 117-122. doi:10.1258/jrsm.2011.110183

Harris, D. M., Happell, B., & Manias, E. (2015). Working with people who have killed: The experience and attitudes of forensic mental health clinicians working with forensic patients. *International Journal of Mental Health Nursing*, 24, 130- 138. DOI: 10.1111/inm.12113

Health & Safety Executive [HSE] (2004). *Psychosocial working conditions in Great Britain in 2004*. <http://www.hse.gov.uk/stress/standards/pdfs/indicatortool.pdf> (retrieved April 1, 2016)

Hinsby, K., & Baker, M. (2004). Patient and nurse accounts of violent incidents in a medium secure unit. *Journal of Psychiatric and Mental Health Nursing*, 11, 341-347. DOI: 10.1111/j.1365-2850.2004.00736.x

Jacob, J. D., & Holmes, D. (2011). Working under threat: Fear and nurse–patient interactions in a forensic psychiatric setting. *Journal of Forensic Nursing*, 7, 68-77. DOI: 10.1111/j.1939-3938.2011.01101.x

Johnson, J. L., Bottorff, J. L., Browne, A. J., Grewal, S., Hilton, B. A., & Clarke, H. (2004). Othering and being othered in the context of health care services. *Health Communication*, 16, 255-271. DOI:10.1207/S15327027HC1602\_7

- Johnson, M., & Webb, C. (1995). Rediscovering unpopular patients: The concept of social judgement. *Journal of Advanced Nursing*, 21, 466-475. DOI: 10.1111/j.1365-2648.1995.tb02729.x
- Johnson, R. B., & Onwuegbuzie, A. J. (2004). Mixed methods research: A research paradigm whose time has come. *Educational Researcher*, 33, 14-26. doi: 10.3102/0013189X033007014
- Jørgensen, M. W., & Phillips, L. J. (2002). *Discourse analysis as theory and method*. London: Sage Publications.
- Kennedy, H. (2002). Therapeutic uses of security: Mapping forensic mental health services by stratifying risk. *Advances in Psychiatric Treatment*, 8, 433-443. DOI: 10.1192/apt.8.6.433
- Kurtz, A., & Jeffcote, N. (2011). 'Everything contradicts in your mind': A qualitative study of experiences of forensic mental health staff in two contrasting services. *Criminal Behaviour and Mental Health*, 21, 245-258. DOI: 10.1002/cbm.796
- Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York: Springer publishing company.
- Lown, B. A., & Manning, C. F. (2010). The schwartz center rounds: Evaluation of an interdisciplinary approach to enhancing patient-centered communication, teamwork, and provider support. *Academic Medicine : Journal of the Association of American Medical Colleges*, 85, 1073-1081. doi:10.1097/ACM.0b013e3181dbf741

- Maben, J., Adams, M., Peccei, R., Murrells, T., & Robert, G. (2012). 'Poppets and parcels': The links between staff experience of work and acutely ill older peoples' experience of hospital care. *International Journal of Older People Nursing*, 7, 83-94. DOI: 10.1111/j.1748-3743.2012.00326.x
- Maben, J., Peccei, R., Adams, M., Robert, G., Richardson, A., Murrells, T., & Morrow, E. (2012). Exploring the relationship between patients' experiences of care and the influence of staff motivation, affect and wellbeing. *Final Report. Southampton: NIHR Service Delivery and Organization Programme*,
- Paley, J. (2013). Social psychology and the compassion deficit. *Nurse Education Today*, 33, 1451-1452. doi:10.1016/j.nedt.2013.05.011
- Peternelj-Taylor, C. (2004). An exploration of othering in forensic psychiatric and correctional nursing. *Canadian Journal of Nursing Research*, 36, 130-146.
- Pommier, E. A. (2011). The compassion scale. *Dissertation Abstracts International Section A: Humanities and Social Sciences*, 72, 1174.
- Rutherford, M., & Duggan, S. (2008). Forensic mental health services: Facts and figures on current provision. *The British Journal of Forensic Practice*, 10, 4-10. DOI: <http://dx.doi.org/10.1108/14636646200800020>
- Tambuyzer, E., Pieters, G., & Van Audenhove, C. (2014). Patient involvement in mental health care: One size does not fit all. *Health Expectations*, 17, 138-150. doi:10.1111/j.1369-7625.2011.00743.x
- Terry, S. W. (2014). Reducing burnout in nurses and care workers in secure settings. *Nursing Standard*, 28, 37-45.

Watson, J., & Woodward, T. (2010). Jean Watson's theory of human caring. *Nursing Theories and Nursing Practice*, 3, 351-369.

Willig, C. (1999). *Applied discourse analysis: social and psychological interventions*. Buckingham: Open Press University.

Willig, C. (2008). *Introducing qualitative research methods in psychology*. Maidenhead: McGraw Hill.

World Health Organisation (2016) [http://www.who.int/occupational\\_health/topics/stressatwork/en/](http://www.who.int/occupational_health/topics/stressatwork/en/)

Vikki Taylor BSc (Hons)

Major Research Project

Section C: Appendices

**APRIL 2016**

**SALOMONS  
CANTERBURY CHRIST CHURCH UNIVERSITY**

# SERVICE USER AND STAFF EXPERIENCES OF MEDIUM SECURE SETTINGS

## Appendix A: Contextual ward data between July and December 2015

		Observation Hours	Escort Hours	Total
Ward 1	July	2581	2	2583
	August	1568	11	1568
	September	1235	7	1242
	October	N/A	N/A	N/A
	November	2026	2	2028
	December	1235	76.5	1311.5
Ward 2	July	N/A*	N/A	N/A
	August	958	21	993
	September	350	23	373
	October	746	100.5	846.5
	November	734	55.5	789.5
	December	1235	76.5	1311.5
Ward 3	July	184	118.5	302.5
	August	0	112	112
	September	88	170.5	258.5
	October	N/A	N/A	N/A
	November	40	116	156
	December	0	90	90
Ward 4	July	163	82	245
	August	0	61.5	61.5
	September	104	101	205
	October	182	66	248
	November	5	78	83
	December	32	78	110

**Appendix B: This has been removed from the electronic copy**



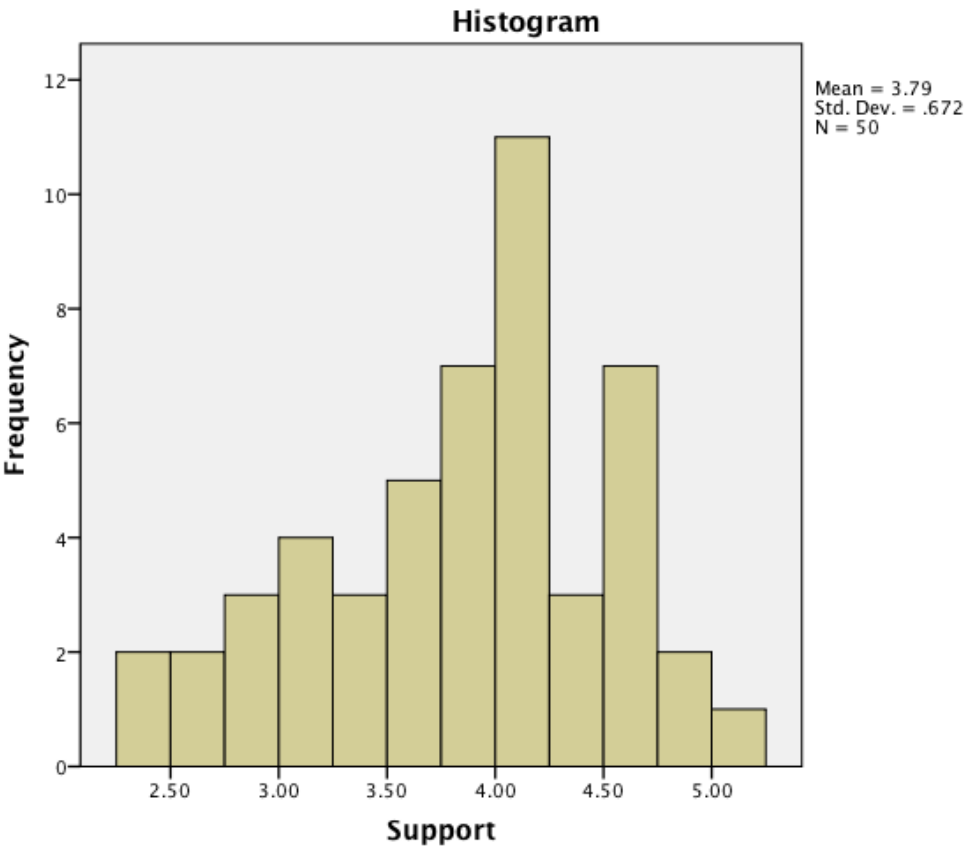
**Appendix C: This has been removed from the electronic copy.**





**Appendix D: Assumptions of Parametric Data**

Variable Name	Skewness z-value (Statistic/SE)	Kurtosis z-value (Statistic/SE)	Shapiro-Wilk p- value
Compassion Total	0.001	0.92	0.72
Kindness	-3.312	1.17	0.00
Indifference	-1.45	-0.19	0.32
Common Humanity	-1.44	0.01	0.23
Separation	-1.72	0.00	0.20
Mindfulness	-3.26	3.08	0.23
Disengagement	-4.36	4.82	0.00
Stress Total	-1.93	1.89	0.27
Demands	-0.91	0.63	0.46
Control	-1.46	0.41	0.43
Role	-1.19	-0.95	0.16
Support	-1.14	-0.71	0.69
Relationships	0.04	0.39	0.05
Change	-1.04	0.55	0.36



# SERVICE USER AND STAFF EXPERIENCES OF MEDIUM SECURE SETTINGS

## Appendix E: Multiple Regression (Full Table)

Dependent Variable	Independent Variable	b	SE b	$\beta$	<i>df</i>	F	<i>p</i>
Demands	Constant	3.14	1.09		6, 43	1.82	0.00
	Kindness	0.13	0.21	0.10			0.5
	Indifference	0.15	0.18	0.17			0.41
	Common	0.15	0.17	0.13			0.38
	Humanity						
	<b>Separation</b>	<b>-0.42</b>	<b>0.15</b>	<b>-0.52</b>			<b>0.01</b>
	Mindfulness	-0.05	0.14	-0.05			0.71
	Disengagement	0.04	0.17	0.05			0.82
Support	Constant	1.71	1.13		6,43	2.22	0.06
	Kindness	0.18	0.21	0.13			0.40
	<b>Indifference</b>	<b>0.39</b>	<b>0.19</b>	<b>0.40</b>			<b>0.04</b>
	Common	0.14	0.18	0.12			0.42
	Humanity						
	<b>Separation</b>	<b>-0.35</b>	<b>0.15</b>	<b>-0.42</b>			<b>0.03</b>
	Mindfulness	0.18	0.15	0.16			0.24
	Disengagement	-0.05	0.18	-0.07			0.77
Relationships	Constant	1.61	1.12		6,43	1.52	0.16
	Kindness	0.18	0.21	0.14			0.40
	Indifference	0.24	0.19	0.27			1.31
	Common	0.11	0.17	0.10			0.14
	Humanity						
	Separation	-0.26	0.15	-.032			0.09
	Mindfulness	0.19	0.15	0.18			0.21
	Disengagement	0.04	0.18	0.05			0.84
Role	Constant	2.43	0.95		6, 43	1.54	0.01
	Kindness	0.12	1.88	0.11			0.50

# SERVICE USER AND STAFF EXPERIENCES OF MEDIUM SECURE SETTINGS

	Indifference	0.10	0.16	0.12			0.57
	Common	-0.10	0.15	-0.01			0.95
	Humanity						
	Separation	-0.12	0.13	-0.18			0.34
	<b>Mindfulness</b>	<b>0.32</b>	<b>0.12</b>	<b>0.36</b>			<b>0.02</b>
	Disengagement	0.02	0.15	0.03			0.88
Change	Constant	3.31	1.32		6, 43	2.73	0.02
	Kindness	-0.02	0.25	-0.01			0.94
	Indifference	0.22	0.22	0.19			0.33
	Common	0.03	0.21	0.02			0.88
	Humanity						
	<b>Separation</b>	<b>-0.55</b>	<b>0.18</b>	<b>-0.54</b>			<b>0.00</b>
	Mindfulness	0.28	0.17	0.21			0.12
	Disengagement	0.00	0.21	0.00			0.99

**Appendix F: SPSS Output Example****Variables Entered/Removed<sup>a</sup>**

Model	Variables Entered	Variables Removed	Method
1	Disengagement, Mindfulness , Common_Humanity, Kindness, Separation, Indifference <sup>b</sup>	.	Enter

a. Dependent Variable: Demands

b. All requested variables entered.

**Model Summary<sup>b</sup>**

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
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# SERVICE USER AND STAFF EXPERIENCES OF MEDIUM SECURE SETTINGS

1	.450 <sup>a</sup>	.203	.091	.60389	1.753
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a. Predictors: (Constant), Disengagement, Mindfulness, Common\_Humanity, Kindness, Separation, Indifference

b. Dependent Variable: Demands

## ANOVA<sup>a</sup>

Model		Sum of Squares	df	Mean Square	F
1	Regression	3.986	6	.664	1.822
	Residual	15.681	43	.365	
	Total	19.667	49		

a. Dependent Variable: Demands

b. Predictors: (Constant), Disengagement, Mindfulness, Common\_Humanity, Kindness, Separation, Indifference

SERVICE USER AND STAFF EXPERIENCES OF MEDIUM SECURE SETTINGS

**Coefficients<sup>a</sup>**

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Correlations			Collinearity Statistics	
	B	Std. Error	Beta			Zero-order	Partial	Part	Tolerance	VIF
(Constant)	3.116	1.102		2.828	.007					
Kindness	.140	.198	.108	.709	.482	.159	.107	.097	.794	1.260
Indifference	.158	.180	.174	.881	.383	-.033	.133	.120	.475	2.106
Common_Humanity	.149	.167	.131	.888	.379	.073	.134	.121	.851	1.176
Separation	-.413	.144	-.515	-2.864	.006	-.359	-.400	-.390	.573	1.744
Mindfulness	-.055	.145	-.053	-.380	.706	.001	-.058	-.052	.958	1.044
Disengagement	.027	.163	.035	.163	.871	-.083	.025	.022	.400	2.502

. Dependent Variable: Demands

### **Appendix G: Interview Schedule**

1. Introduce myself and the project
  2. Explain purpose of the interviews (including length of interviews, audio recording and interview structure)
  3. Discuss confidentiality and process of raising concerns
  4. Participant questions
  5. Check consent form has been completed
- 
1. Thank you for agreeing to take part in this study. I recently asked staff to complete some questionnaires. How did you find the questionnaires? (prompts; do you feel they covered all the aspects of your job, was there anything not included)
  2. I wondered if we could start by you telling me a little bit about your role here? (Prompts; how long have you worked here, what kind of tasks does your job involve)
  2. The first part of this study asked staff within XXXX to complete questionnaires exploring compassion and work related stress (if participant took part) how did you find the questionnaires?
  3. I am interested in the relationship you have with service users you work with, how do you understand the relationship with service users) (Prompts; what do you see as the good parts of the relationships, are there times when this can be difficult, is there anything that helps the relationship)
  4. In terms of your job, what are your favourite parts of your job? (Prompts; what helps to make your job possible, are there times when this is more difficult)

End of questions and debrief

That is the end of the questions I wanted to ask, is there anything else you would like to add or talk about that we haven't covered?

How did you find the interview?

Give details of how the interview data will be used and when the report will be available to staff.

Give contact details for any future questions or withdrawal

## Appendix H: Participant Information Sheets



Salomons Centre for Applied  
Psychology

### Participant Information Sheet

**Project Title:** A comparative study of work related stress and compassionate care in a medium secure setting.

Hello. My name is Vikki Taylor and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide it is important that you understand why the research is being done and what it would involve for you.

Talk to others about the study if you wish.

(Part 1 tells you the purpose of this study and what will happen to you if you take part.

Part 2 gives you more detailed information about the conduct of the study).

**This research is being carried out as part of the Doctorate in Clinical Psychology programme at Canterbury Christ Church University.**

### What is the purpose of this study?

More information is needed to understand the relationship between staff well being and showing compassion towards patients. This study will provide more information about examples of compassionate care and the role staff well being plays in this. The aim of this project is to examine the relationship between work-related stress and experiences of giving compassionate care in medium secure settings.

### Why am I being asked to take part?

I am looking for nursing staff, of all grades, to take part in this study. I would like to invite as many nursing staff working within XXXX as possible to take part.

### What will the research involve?

Taking part in this study is voluntary and you can withdraw at any time without giving any explanation. If you agree to take part I will provide you with a link to the

website 'Survey Monkey', which will ask you to sign a consent form to take part. You will be asked to complete two questionnaires measuring work related stress and compassion. Completing these questionnaires will take approximately 20 minutes and you can choose to leave the questionnaire at any time.

### **What will happen with my answers?**

Your anonymised answers will be collated to provide data in order to examine the relationship between work related stress and compassion. Information about the ward you work in, such as the staff to service user ratio and number of incidents on the ward will also be used in the statistical analysis.

Your name will not appear on any documents and no information, which could identify either staff or patients, will be used in this project. Any data collected will be destroyed following the completion of the project.

The results of the study will also be reported back to you at the end of the research project in the form of a written summary of the results and access to the full research paper.

### **What are the possible disadvantages of taking part in this study?**

The questionnaires used in this study ask participants to think about work related stress and compassion towards others. It is possible that the questions may cause some discomfort in answers however all questions are voluntary and you can miss out questions should you wish to do so.

### **What are the advantages of taking part in this study?**

Although the results of this study may not directly benefit yourself or any individuals you work with, you will be helping to provide more information about the relationship between work-related stress and compassionate care giving. The results from this study may highlight important factors, related to your job, which are important to providing compassionate care.

### **Will my taking part in the study be kept confidential?**

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

### **This completes part 1.**

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

## **Part 2 of the information sheet**

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

As stated above, you have the right to withdraw from the study at any time. If you withdraw from the study, we would like to use the data collected up to your withdrawal. If you would like to withdraw all your data collected up until your withdrawal then please let us know.

### **What if there is a problem?**

In the first instance, you could discuss any problems you may have with myself, Vikki Taylor at [v.taylor50@canterbury.ac.uk](mailto:v.taylor50@canterbury.ac.uk). Alternatively, you may also speak to my Lead Supervisor, Margie Callanan by email: [Margie.Callanan@canterbury.ac.uk](mailto:Margie.Callanan@canterbury.ac.uk)

### **Complaints?**

If you remain unhappy and wish to complain formally, you can do this by contacting XXXXXX Trust Complaints Department.

Contact details: Complaints Department, XXXXX Telephone: XXXXX Email: [Complaints@XXXX.nhs.uk](mailto:Complaints@XXXX.nhs.uk)

You can also contact Professor Paul Camic, Research Director, Salomons Centre for Applied Psychology. Telephone: 03330 117 114.

### **Will my taking part in this study be kept confidential?**

Your data will be collected in an electronic format via Survey Monkey. Only the researcher and main supervisors will have access to the data. The data will also be entered onto a password-protected encrypted database, which will be stored on an NHS secure computer server. If the data needs to be moved at any point this will be done on a secure encrypted Trust-approved memory stick. The only people who will have access to the electronic data will be authorised persons including the main researchers and potentially the Research and Development department should there be any call for the data to be audited.

After the study has finished the data will be stored securely for up to 10 years at Canterbury Christ Church University. This is in line with the regulations of the university and the clinical psychology training programme. After this the data will be disposed of securely.

Participants have the right to check the accuracy of data held about them and correct any errors.

### **What will happen to the results of the research study?**

When this study is completed the results will be written up and hopefully published in a psychology journal. This means that other researchers will be able to find out about the study and it will hopefully help increase the current knowledge base we have about the relationship between work related stress and compassionate care.

A summary of the results will also be made available to both staff and service users at XXXXX.

As data is anonymised you will not be identified in any report. Anonymised quotes may be included in the final paper.

### **Who is organising and funding the research?**

Canterbury Christ Church University XXXXX NHS Trust are organising this research study. The study is being conducted in partial fulfilment of the requirements of the Doctorate in Clinical Psychology Training Programme at Canterbury Christ Church University.

### **Who has reviewed the study?**

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by Canterbury Christ Church University (Salomons Campus) Research Ethics Committee.

### **Further information and contact details**

#### **1. General information about research.**

If you would like to speak to me and find out more about the study or have questions about it answered, you can email me on [v.taylor50@canterbury.ac.uk](mailto:v.taylor50@canterbury.ac.uk) and we can arrange to discuss your questions via telephone if required.

#### **2. Any concerns about the clients whom you care for.**

If any concerns about any individuals whom you care for arise during your time in the study then we will endeavour to help you speak to the appropriate person, be that someone in the clients care team.

#### **3. Risk.**

If we became concerned about risk of harm to you or anyone else during your participation in this study then we would be obliged to let someone know. We would discuss this with you first and ensure that you were aware of the necessary steps to take and support available.



Salomons Centre for Applied  
Psychology

## **Participant Information Sheet**

**Project Title:** A comparative study of work related stress and compassionate care in a medium secure setting.

Hello. My name is Vikki Taylor and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide it is important that you understand why the research is being done and what it would involve for you.

Talk to others about the study if you wish.

(Part 1 tells you the purpose of this study and what will happen to you if you take part.

Part 2 gives you more detailed information about the conduct of the study).

**This research is being carried out as part of the Doctorate in Clinical Psychology programme at Canterbury Christ Church University.**

### **What is the purpose of this study?**

More information is needed to understand the relationship between staff well being and showing compassion towards patients. This study will provide more information about examples of compassionate care and the role staff well being plays in this. The aim of this project is to examine the relationship between work-related stress and experiences of giving compassionate care in medium secure ward settings.

### **Why am I being asked to take part?**

I am looking for nursing staff, of all grades, to take part in this study. I would like to invite as many nursing staff working as XXXX as possible to take part.

### **What will the research involve?**

Taking part in this study is voluntary and you can withdraw at any time without giving any explanation. If you agree to take part, we will arrange to meet at a time most convenient for you. The interview will last approximately one hour and talk about your relationships related to your job.



**What will happen with my answers?**

All interviews will be recorded using a digital recorder. The recording will then be transcribed into word documents to analyse the responses collected.

Your name will not appear on any documents and no information, which could identify either staff or patients, will be used in this project. Quotations from your interview may be used however this will be fully anonymised and will not include identifiable information. Any data collected will be destroyed following the completion of the project.

The results of the study will also be reported back to you at the end of the research project in the form of a written summary of the results and access to the full research paper.

**What are the possible disadvantages of taking part in this study?**

It is possible that the interviews may cause some discomfort in answers however all questions are voluntary and you can refuse to answer any questions asked of you should you wish to do so. We can also arrange to have a debriefing session at any time.

**What are the advantages of taking part in this study?**

Although the results of this study may not directly benefit yourself or any individuals you work with, you will be helping to provide more information about the relationship between work related stress and compassionate care giving. The results from this study may highlight important factors, related to your job, which is important to providing compassionate care.

**Will my taking part in the study be kept confidential?**

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

**This completes part 1.**

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

**Part 2 of the information sheet**

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

As stated above, you have the right to withdraw from the study at any time. If you withdraw from the study, we would like to use the data collected up to your

withdrawal. If you would like to withdraw all your data collected up until your withdrawal then please let us know.

### **What if there is a problem?**

In the first instance, you could discuss any problems you may have with myself, Vikki Taylor at [v.taylor50@canterbury.ac.uk](mailto:v.taylor50@canterbury.ac.uk). Alternatively, you may also speak to my Lead Supervisor, Margie Callanan by email: [Margie.Callanan@canterbury.ac.uk](mailto:Margie.Callanan@canterbury.ac.uk)

### **Complaints?**

If you remain unhappy and wish to complain formally, you can do this by contacting XXXX NHS Trust Complaints Department.

Contact details: Complaints Department, XXXX. Telephone: XXXX. Email: [Complaints@XXXX.nhs.uk](mailto:Complaints@XXXX.nhs.uk)

You can also contact Professor Paul Camic, Research Director, Salomons Centre for Applied Psychology. Telephone: 03330 117 114.

### **Will my taking part in this study be kept confidential?**

Your data will be recorded using a digital recorder and then will be transcribed onto a word document. Only the researcher and main supervisors will have access to the interview transcripts. The transcripts will also be entered onto a password-protected encrypted device. If the data needs to be moved at any point this will be done on a secure encrypted Trust-approved memory stick. The only people who will have access to the electronic data will be authorised persons including the main researchers and potentially the Research and Development department should there be any call for the data to be audited.

After the study has finished the data will be stored securely for up to 10 years at Canterbury Christ Church University. This is in line with the regulations of the university and the clinical psychology-training programme. After this the data will be disposed of securely.

Participants have the right to check the accuracy of data held about them and correct any errors.

### **What will happen to the results of the research study?**

When this study is completed the results will be written up and hopefully published in a psychology journal. This means that other researchers will be able to find out about the study and it will hopefully help increase the current knowledge base we have about the relationship between work related stress and compassionate care.

A summary of the results will also be made available to both staff and service users at XXXX.

As data is anonymised you will not be identified in any report. Anonymised quotes and examples of compassionate care may be included in the final paper.

### **Who is organising and funding the research?**

Canterbury Christ Church University and XXXX NHS Trust.

Trust are organising this research study. The study is being conducted in partial fulfilment of the requirements of the Doctorate in Clinical Psychology Training Programme at Canterbury Christ Church University.

### **Who has reviewed the study?**

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by Canterbury Christ Church University (Salomons Campus) Research Ethics Committee.

### **Further information and contact details**

#### **1. General information about research.**

If you would like to speak to me and find out more about the study or have questions about it answered, you can email me on [v.taylor50@canterbury.ac.uk](mailto:v.taylor50@canterbury.ac.uk) and we can arrange to discuss your questions via telephone if required.

#### **2. Any concerns about the clients whom you care for.**

If any concerns about any individuals whom you care for arise during your time in the study then we will endeavour to help you speak to the appropriate person, be that someone in the clients care team.

#### **3. Risk.**

If we became concerned about risk of harm to you or anyone else during your participation in this study then we would be obliged to let someone know. We would discuss this with you first and ensure that you were aware of the necessary steps to take and support available.

**Appendix I: This has been removed from the electronic copy.**

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I

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**Appendix J: Consent Form**



Salomons Centre for Applied  
Psychology

Consent Form: Staff Questionnaires and Interviews

Title of Project: A comparative study of work related stress and compassionate care in a medium secure setting.

**Name of Researcher: Vikki Taylor**

Please initial box

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

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

**3. I agree that anonymous quotes from my questionnaire may be used in published reports of the study findings [if applicable]**

**4. I agree to take part in the above study.**

Name of Participant\_\_\_\_\_Date\_\_\_\_\_

Signature \_\_\_\_\_

Name of Person taking consent\_\_\_\_\_Date\_\_\_\_\_

Signature \_\_\_\_\_

**Appendix K: This has been removed from the electronic copy**



**Appendix L: This has been  
removed from the electronic  
copy**

**Appendix M: This has been removed from the electronic copy**

**Appendix N: This has been removed from the electronic copy**

SERVICE USER AND STAFF EXPERIENCES OF MEDIUM SECURE SETTINGS  
**Appendix O: End of study letter for ethics committee and R&D department**

**Dear.....,**

I am writing to update on the progress of my research study (“A mixed-methods investigation into the relationship between compassion for others and work-related stress in a medium secure unit.”).

The recruitment and analysis phase is now complete. In total, 51 participants took part in the quantitative stage whilst 12 participants were interviewed individually. The results will be disseminated by submitted to a peer-reviewed journal. I will also be revisiting the research site to present the finding of the project.

If you would like to receive a final copy of the paper, please do let me know. Please feel free to contact me if you have any questions regarding the project.

Yours sincerely,

Vikki Taylor

Trainee Clinical Psychologist

**Appendix P: This has been removed from the electronic copy**



## Appendix Q: Author Guidelines for The Journal of Forensic Psychiatry and Psychology

### Instructions for authors

Thank you for choosing to submit your paper to us. These instructions will ensure we have everything required so your paper can move through peer review, production and publication smoothly. Please take the time to read them and follow the instructions as closely as possible.



Should you have any queries, please visit our [Author Services website](#) or contact us at [authorqueries@tandf.co.uk](mailto:authorqueries@tandf.co.uk).

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## **Contents List**

### **Manuscript preparation**

1. General guidelines

2. Style guidelines

3. Figures

4. Publication charges

*Submission fee*

*Page charges*

*Colour charges*

5. Reproduction of copyright material

6. Supplemental online material

### **Manuscript submission**

### **Copyright and authors' rights**

### **Free article access**

### **Reprints and journal copies**

### **Open access**

## **Manuscript preparation**

### **1. General guidelines**

↑

| Manuscripts are accepted only in English. Any consistent spelling style may be used. Please use single quotation marks, except where 'a quotation is "within" a quotation'. Long quotations of 40 words or more should be indented without quotation marks. 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.

| A typical manuscript will not exceed 5,000 words not including references. Manuscripts that greatly exceed this will be critically reviewed with respect to length. Authors should include a word count with their manuscript. Review papers (e.g. 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. Brief reports should be no more than 2,000 words in length, including references. Normally, there should be a maximum of one table.

- | Manuscripts should be compiled in the following order: title page (including Acknowledgements as well as Funding and grant-awarding bodies); abstract; keywords; main text; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figure caption(s) (as a list).
- | Please supply all details required by any funding and grant-awarding bodies as an acknowledgement in a separate Funding paragraph as follows:

*For single agency grants*

This work was supported by the <Funding Agency> under Grant <number xxxx>.

*For multiple agency grants*

This work was supported by the <Funding Agency #1> under Grant <number xxxx>; <Funding Agency #2> under Grant <number xxxx>; and <Funding Agency #3> under Grant <number xxxx>.

- | [Abstracts](#) of 150 words are required for all manuscripts submitted.
- | Each manuscript should have 3 to 6 [keywords](#) .
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- | Section headings should be concise.
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- | Books for review should be sent to the Book Review Editor, Dr Mary Whittle, John Howard Centre, 12 Kenworthy Road, London, E9 5TD, UK.
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## 2. Style guidelines

↑

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- | Description of the Journal's [reference style](#).
- | [Guide to using mathematical symbols and equations](#) .
- | [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](mailto:authortemplate@tandf.co.uk) .

## 3. Figures

↑

- | Please 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 manuscript 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 manuscript (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 manuscript, and numbered correspondingly.
- | The filename for a graphic should be descriptive of the graphic, e.g. Figure1, Figure2a.

#### 4. Publication charges



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## **6. Supplemental online material**



Authors are encouraged to submit animations, movie files, sound files or any additional information for online publication.

[Information about supplemental online material](#)

## **Manuscript submission**



All submissions should be made online at *The Journal of Forensic Psychiatry and Psychology* [ScholarOne Manuscripts site](#). New users should first create an account. Once logged on to the site, submissions should be made via the Author Centre. Online user guides and access to a helpdesk are available on this website.

Manuscripts may be submitted in any standard format, including Word and EndNote. These files will be automatically converted into a PDF file for the review process.

Click here for [information regarding anonymous peer review](#).

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