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RELATIONAL COMPONENTS OF FORENSIC SERVICE USERS' EXPERIENCE OF RECOVERY

Section A: Interpersonal relationships as a component of forensic service users' recovery experience

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Section B: Understanding how the psychological and relational processes of a service user reflective group contribute to recovery on a medium secure ward

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Summary of Major Research Project

Section A

A literature review considering the role of interpersonal relationships in forensic service users' accounts of recovery. A systematic literature search identified twenty studies with qualitative descriptions of forensic service user recovery experience. These are critiqued and synthesised using an integrative review process. Results are presented under four resulting categories: relationships with staff, relationships with service user peers, relationships with family and friends and relationships with the wider community. Findings suggest that interpersonal relationships play an important role in recovery for forensic service users and highlight the relevance of a relational model in service provision. Clinical and research implications are discussed.

Section B

A qualitative study using Grounded Theory methodology to construct an understanding of the psychological and relational processes found within a forensic service user reflective group. Interviews were conducted with both service user and staff facilitator attendees of a reflective group run on a medium secure forensic ward. Results formed a flexible, cyclical model based around four key categories: 'Group Identity', 'Linking Self with Others', 'The Changing Self' and 'Living Visibly in a System'. Findings are presented as providing a solid rationale for the inclusion of service user reflective groups in forensic inpatient settings. Discussion of how this model contributes to and is complemented by existing theory is presented and clinical/research implications suggested.

Table of Contents

List of tables and figures

List of Appendices

Section A.

Interpersonal relationships as a component of forensic service users' accounts of recovery

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Abstract and Keywords

Whilst the importance of supportive social relationships in relation to recovery and recidivism is well evidenced, little research has focussed on the nature of these relationships within a forensic context. To contribute to the gap in research, this review will answer the following question: in what ways are interpersonal relationships included in forensic service users' accounts of recovery? A systematic search of electronic databases resulted in the identification of twenty research studies providing qualitative data on forensic service users' accounts of recovery. Studies were screened for methodological robustness and critiqued and synthesised using an integrative review process. Discussion of interpersonal relationships was found within service user accounts of recovery across all twenty studies. Findings are discussed in terms of four resulting categories: relationships with staff, relationships with service user peers, relationships with family and friends and relationships with the wider community. The results of this review suggest that considering the experience of recovery of forensic service users through a relational model is an important and necessary move for services. This and other clinical implications are discussed.

Keywords: mental health recovery, relationships, mental health service user, forensic

1. Introduction

This literature review addresses the following question; in what ways are interpersonal relationships included in forensic service users' accounts of recovery? Terms used in this review will include 'service users' to refer to people on the caseloads of forensic mental health services. In turn, the term 'forensic mental health services' (FMHS) will be used to define services provided for those with a "mental disorder (including neurodevelopmental disorders) who pose, or have posed, risks to others…where that risk is usually related to their mental disorder" (Joint Commissioning Panel for Mental Health [b] (JCPMH), 2013, p. 3). 'Recovery' as a term will be defined and discussed in the relevant contexts for this review in the introduction.

1.1. Recovery within a mental health context

Whilst definitions of recovery are plentiful, there is generally consensus in the literature of the surrounding conceptual ideas within a mental health context. Definitions tend to encompass holistic understandings of the impact of mental health difficulties, appreciating the effects on all areas of a person's life, including within that the impact of mental health difficulties on an individual's social connections, quality of life, hope, identity, working lives, self-esteem, relationships (Leamy, Bird, Le Boutillier, Williams & Slade, 2011; Turton et al., 2011). It is important however to remember where the recovery movement originated and to whom the experiences belong, in that highly individualised and nuanced descriptions of recovery experiences are based on just that, the experiences of individuals. Service user involvement in understandings of recovery is complex. Literature relies upon the input of service users to explore the meaning of recovery and service policies now reflect this (JCPMH [a], 2013). However, in adopting the model, services and professionals working within them have been seen to have appropriated the recovery model by some (Slade et al.,

2014), fostering a developing need to "recover 'recovery'" from its increasing professionalization" (Mental Health "Recovery" Study Working Group, 2009; p. 3). The service user collective 'Recovery in the Bin' (RITB) support this notion and point to a perceived focus within services on rebuilding a life without problems relating to mental health, rather than on rebuilding a meaningful life alongside any continuing experiences of mental ill health. They believe that a "co-opted 'recovery'" model serves to conceal the social and political circumstances which negatively impact and prevent service users from rebuilding their lives in a way that is meaningful to them, resulting in issues of coercion, disability denial, victim blaming and control (RITB, 2017). Bonney & Stickley (2008) point to the question of the interests of the different stakeholders within this picture, highlighting the potential benefits of a polarised model of wellness and illness to services, industries and policy makers. Slade et al. (2014) argue that it is only with wider societal changes that challenge stigma and transform services in order to promote human rights and social inclusion that truly person centred approaches will be reflected by services.

There is a wealth of research demonstrating the link between social support and recovery from mental ill health. For example, Corrigan and Phelan (2004) found that recovery was positively related to the size of a person's social network and their level of satisfaction with their network. Other studies have found that higher levels of social support facilitate recovery in mental health contexts (Davis & Brekke, 2014; Hendryx, Green & Perrin, 2009; Thomas, Muralidharan, Medoff & Drapalski, 2016). What mediates the relationship between social support and recovery has also been the focus of research. Findings include that self-efficacy, understood as an individual's perception of their ability to manage the experiences of their life, both internal and external, mediated all relationships between social support and recovery when measured both objectively and subjectively (Thomas et al., 2016).

1.2. Applying the concept of recovery within a forensic mental health context

Whether or not the concept of recovery can be applied to forensic mental health contexts is a topic of debate in the literature and the subject of various literature reviews (e.g. Bonney & Stickley, 2008; Clarke, Lumbard, Sambrook, & Kerr, 2016; Shepherd, Doyle, Sanders & Shaw, 2016). In the UK, detention under a section of the Mental Health Act (MHA, 2007) resulting in admission to FMHS most commonly applies to those who have committed crime or are at serious risk of committing crime and are assessed as posing a risk to themselves and/or those around them as a result of serious mental health illness (JCPMH [b], 2013; MHA, 2007). Inpatient FMHS are organised around risk level and vary through high, medium and low secure facilities. Community FMHS are in part populated by those discharged from inpatient care and offer support focussing on rehabilitation and community reintegration whilst continuing to monitor risk.

The argument exists that forensic service users have two issues by which they are stigmatised and from which to 'recover', their mental health difficulties and the consequences of their offence (Corlett & Miles, 2010; Turton et al., 2011). Analysing the elements of recovery as discussed above within the context of restrictions of liberty and autonomy highlights the potential difficulties faced by people detained in forensic settings. Consider for example the concept of 'hope and optimism for the future' from Leamy et al. (2011), rooted in themes of motivation to change, holding aspirations for the future, a belief in recovery and an ability to think positively about the ongoing processes and journey through mental health recovery. Applied to those in forensic settings, this concept gains another layer of complexity. This is particularly the case when considered alongside findings that the legal and systemic restrictions of FMHS can lead to feelings and experiences of hopelessness and

powerlessness (Nijdam-Jones, Livingston, Verdun-Jones & Brink, 2015), compounded by the uncertainty caused by the absence of time limited sentences (Yorston & Taylor, 2009).

The application of recovery principles within FMHS has been referred to by some as 'secure recovery' (Drennan & Alred, 2012). In the same way as found in non-forensic mental health literature, there is a call for systemic policy changes in order to facilitate application of a secure recovery model within FMHS (Clarke et al., 2016). However, legal restrictions and the management of increased risk may inhibit the ability of FMHS to adhere to organisational change in line with a recovery model, such as positive risk taking and increased choice for service users (Shepherd, Boardman & Burns, 2010; Shepherd et al., 2016). A shift to secure recovery is likely to incorporate compromise (Roberts, Dorkins, Wooldridge & Hewis, 2008) as the restrictions caused by the legal and safety measures of FMHS "limit opportunities for organisational change" (Clarke et al., 2016, p. 40).

When considering the role of social support in recovery in the context of FMHS, the constructs of related components and mediator relationships become more complex. Access to social support outside services such as family networks has been found to be important (Stanton & Simpson, 2006), but is also likely to be restricted (Barksy & West, 2007). Self-efficacy as a mediator of the relationship between social support and recovery also becomes more complex when considered in a forensic context. Measures of self-esteem, life satisfaction and mastery, cited as indicative of self-efficacy in the research by Thomas et al. (2016) are all reported to be lower in forensic mental health populations (Johnson, 2011; Lindstedt, Soderlund, Stalenheim & Sjoden, 2005; McMurran et al., 1998). In response to this contextual issue, research exploring the social support provided within FMHS has been carried out, showing that relationships with staff (Mezey, Kavuma, Turton, Demetriou & Wright, 2010) and others within the system can provide a sense of connection (Nijdam-Jones

et al., 2015), care and respect which helps to facilitate change, motivation and self discovery (Laithwaite & Gumley, 2007). As appears to be true for much of the research into FMHS, there is more published about rates of recidivism than that which focusses on recovery in relation to social support. It is however worth noting this research as it does demonstrate a protective relationship between social support and recidivism (Lindsay, Elliot & Astell, 2004; Ullrich & Coid, 2011).

1.3. Rationale for review

Whilst the importance of supportive social relationships in relation to recovery and recidivism is well evidenced, little research has focussed on the nature of these relationships within a forensic context. Social networks of those in FMHS may have been impacted by an offending history, whilst the individuals in services themselves are often restricted in some form from accessing the community. With a focus on reduction of length of stay in secure forensic beds and reintegration into communities, social relationships as a component of recovery are an increasingly important focus for research. To date, no review of the forensic recovery literature has been conducted with a focus on social relationships. To contribute to the gap in research, this review will answer the following question: in what ways are interpersonal relationships included in forensic service users' accounts of recovery?

2. Methodology

2.1. Literature search

A search of electronic databases was carried out in November 2019. Databases searched included 'PsycINFO', 'Web Of Science' and 'ASSIA'. Searches of the 'The Journal of Forensic Psychiatry & Psychology', 'The British Journal of Forensic Practice' and

'Google Scholar' were also conducted. An additional search of reference lists of selected papers was also included.

Search terms were kept intentionally broad and no time limit was applied in order to capture all relevant literature and were as follows: recover* AND (forensic* OR secure OR offend*) AND (mental* OR psych*). Articles identified by the database searches were screened, based on eligibility criteria for relevance, initially by title, then abstract and then full article. The details of the progression of the literature search are presented in *Figure 1*. Twenty studies were found to meet the eligibility criteria of this review and are summarised in *Table 1*.

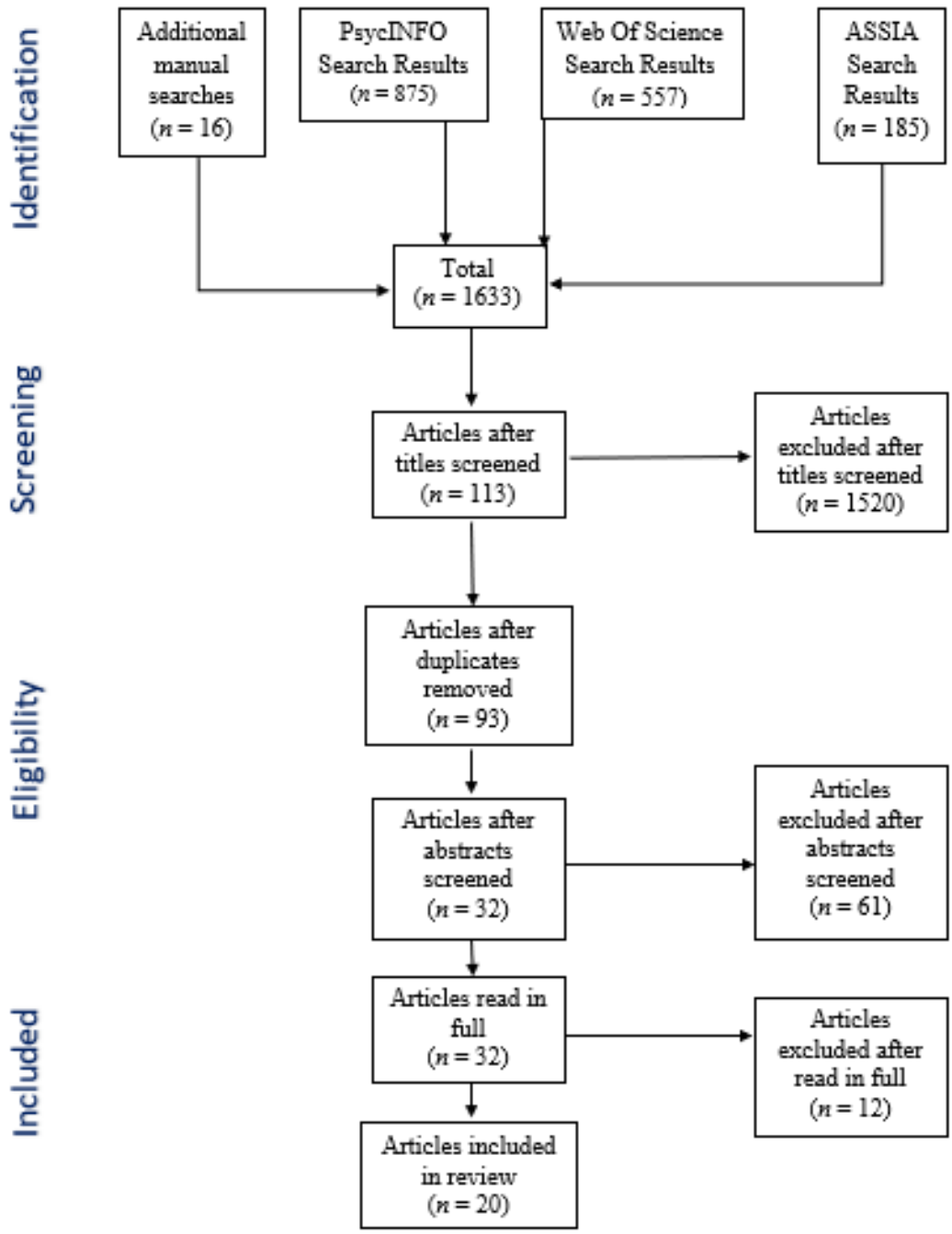

Figure 1. PRISMA Diagram to show progression of literature search

2.2. Eligibility criteria

Studies were included in the review if they were available to read in the English language and were published in a peer reviewed journal with access to the full text document. Inclusion criteria also included use of qualitative methodology with presentation or discussion of service users' experiences of recovery and that studies must have had samples of only the forensic adult population.

Studies were excluded from the review if they used only quantitative methodology, presented no discussion of service users' experience and were not peer reviewed documents (e.g. book chapters). Some research was found which considered only recovery from substance abuse; this was excluded as it was found not to be relevant to the research question. Research using mixed samples, or reporting the opinions/experiences of staff, friends or family were also excluded as service user accounts of recovery could not be adequately and clearly separated from the accounts of others after analyses had been conducted and presented.

Table 1. Summary of included studies

	Title and Authors	Location	Aim(s) and/or research question(s)	Design	Participants	Analysis	Key Reported Findings
Study 1	Recovery after homicide: Narrative shifts in therapy with homicide perpetrators. Adshead, Ferrito & Bose (2015)	UK, high secure inpatient hospital.	To explore how discussion of the index offense fits into recovery paradigms and how reflection on offender identity relates to recovery.	Qualitative. Material drawn from >400 data "sets", consisting of notes taken after therapy group sessions. Notes based on therapist recall, content agreed by 3 therapists.	Male perpetrators of homicide, *n* = 41.	Pragmatic approach based on thematic analysis.	Results presented under 3 themes; 'coming to terms with having offended: identity change', 'abnormal mental states and identity', 'therapist roles in facilitating narrative change'.
Study 2	"The waiting room": Narratives of recovery and departure in men leaving high secure psychiatric care. Adshead, Pyszora, Thomas, Gopie, Edwards & Tapp (2013)	UK, high secure inpatient hospital.	To examine the concept of recovery from the point of view of men who are assumed to be 'recovered' to some degree; but still feel disabled and anxious about the future.	Qualitative. Material drawn from process notes taken after reflective 'Leavers' group.	Male, *n* = 81.	Thematic analysis.	Results presented under 3 themes; 'where are they leaving?', 'where are they going?' and 'what are their challenges?'.
Study 3	A qualitative inquiry on recovery needs and resources of individuals with intellectual disabilities labelled not criminally responsible. Aga, Vander Laenen, Vandevelde & Vanderplasschen (2019)	Belgium, range of forensic/psychiatric settings.	To examine narratives of lived experiences to identify recovery needs and resources, as well as the impact of the judicial label on the recovery process as experienced by persons with intellectual disabilities labelled not criminally responsible.	Qualitative. Material generated by in-depth interviews using open-ended questions.	Sample of intellectual disability population labelled not criminally responsible, *n* = 26 (1 female, 25 male).	Thematic analysis.	Results of 17 key themes presented under 4 recovery dimensions; personal recovery, clinical recovery, social recovery and forensic recovery.

Study 4	Recovery of offenders formerly labelled as not criminally responsible: Uncovering the ambiguity from first-person narratives. Aga, Vander Laenen, Vandevelde, Vermeersch & Vanderplasschen (2017).	Belgium, range of forensic/psychiatric and informal settings.	To examine recovery based on first-person narratives of offenders formerly labelled as not criminally responsible of whom the judicial measure was abrogated and to identify resources for recovery in this population.	Qualitative. Material generated by in-depth interviews using open-ended questions.	Sample of offenders formerly labelled as not criminally responsible, *n* = 11 (1 female, 9 male).	Inductive thematic analysis.	Results presented under 5 themes: clinical recovery resources, functional recovery resources, social recovery resources, personal recovery resources and ambiguous role of the judicial measure.
Study 5	Secure settings and the scope for recovery: Service users' perspectives on a new tier of care. Barksy & West (2007).	UK, medium secure inpatient hospital.	To understand patient perspectives and to allow them to contribute to the current debate: namely, does the provision of long-stay, medium secure beds provide in-patients with a more therapeutic environment, and does this environment improve better rates of recovery than the traditional high-secure 'special' hospitals?	Qualitative. Material generated by semi-structured interviews.	Male, *n* = 6.	Thematic content analysis.	Results presented under 6 themes: 'activities', 'freedom on the ward', 'access off the wards and the security wall', 'atmosphere on the wards', 'staff' and 'positives of high-secure care: access to therapies'.
Study 6	Looking beyond the illness: Forensic service users' perceptions of rehabilitation. Barnao, Ward & Casey (2015).	New Zealand, range of inpatient forensic/psychiatric settings.	To understand the key issues regarding rehabilitation from the perspective of service users to inform service development.	Qualitative. Material generated by semi-structured interviews.	*N* = 20 (3 female, 17 male).	Thematic analysis.	Results presented under 7 themes: 'person-centred approach', 'nature of relationships with staff', 'consistency of care', 'awareness of rehabilitation pathway', 'self evaluation',

							'agency', 'coping strategies'.
Study 7	Recovery, turning points and forensics: Views from the ward in an English high secure facility. Chandley & Rouski (2014).	UK, high secure inpatient hospital.	To highlight how an individual account of recovery and the academic literature offer up related and important perspectives that have serious clinical utility.	Qualitative. Material generated by single case study, biographical account.	*N* = 1 (male)	N/A	Results presented under 9 themes: 'things that have happened on croft ward', 'relationships', 'qualities in others that have helped', 'turning points', 'hope and future plans', 'how I contribute', 'what recovery means to me', 'things I would change' and 'after here'.
Study 8	Recovery in a low secure service. Clarke, Sambrook, Lumbard, Kerr & Johnson (2017).	UK, low secure inpatient hospital.	To explore the lived experience of recovery for patients who were detained under the Mental Health Act in a low secure service.	Qualitative. Material generated by semi-structured interviews.	Male, *N* = 6.	Interpretative phenomenological analysis.	Results presented under 5 themes: 'it's a journey', 'we're vulnerable here', 'relationships with staff', 'loss' and 'hope'.
Study 9	A qualitative evaluation of recovery processes experienced by mentally disordered offenders following a group treatment program. Colquhoun, Lord & Bacon (2018).	UK, secure inpatient hospital.	To gain insight into the understanding and experience of recovery for the 'mentally disordered sex offenders'. To use this understanding to highlight some practical implications that can inform effective delivery of 'mentally disordered sex offender' treatment groups.	Qualitative. Material generated by semi-structured interviews.	Males who has completed the Sex Offenders Group, *N* = 5.	Interpretative phenomenological analysis.	Results presented under 9 themes: 'not being the person I was', 'gaining new perspectives', 'social relationships', 'the problem with groups', 'the goldfish bowl', 'barriers', 'poor memory', 'impression management' and 'disconnection'.
Study 10	Life after homicide: Accounts of recovery and redemption of offender patients in a	UK, high secure inpatient hospital.	To explore the processes of 'recovery' and redemption in the	Qualitative. Material generated by open-ended,	Male, *N* = 7.	Interpretative phenomenological analysis (IPA).	Results presented under 6 themes: 'the role of past experiences', 'impact on personal

	high security hospital – a qualitative study. Ferrito, Vetere, Adshead & Moore (2012).		narratives of a sub-group of homicide perpetrators who were admitted to a secure hospital for treatment.	non-leading interviews.			development', 'moments of "loss of grip on reality"', 'reframing: events via therapeutic interventions' and 'internal integration'.
Study 11	The development and initial validation of a service user led measure for recovery of mentally disordered offenders. Green, Batson & Gudjonsson (2011).	UK, medium secure inpatient hospital.	To develop a measure of recovery within forensic mental health services that had been led by service users' understanding of the concept. To develop a brief and simple questionnaire, the Recovery Journey Questionnaire (RJQ), to measure service users' experience of recovery over their in-patient journey that is reliable and feasible for use in forensic mental health services.	Mixed methods. Qualitative material generated by focus groups and in-depth interviews was used to develop the RJQ. Quantitative analysis of variance was used to investigate the internal consistency and factor structure and the feasibility for wide-scale use with a mentally-disordered in-patient population.	Focus groups: Male, *N* = 12 Interviews: Male, *N* = 4	Content analysis, alpha reliability, factor analysis, univariate analysis of variance.	Results presented under 5 themes: 'working together', 'support and preparation', 'empowering service users', 'providing good role models' and 'things to do'. RQJ has been successful in providing a service-user developed measure of recovery with good psychometric properties in terms of reliability and construct validity.
Study 12	Sense of self, adaptation and recovery in patients with psychosis in a forensic NHS setting. Laithwaite & Gumley (2007).	UK, high secure inpatient hospital.	To present service users' perspectives on being a patient in a high-security setting and the factors he/she considers important in his/her recovery.	Qualitative. Material generated by in-depth unstructured, open-ended interviews.	*N* = 13, (1 female, 12 male).	Grounded theory.	Results of 11 subcategories were presented under 3 themes: 'relationships and a changing sense of self', 'past experiences of adversity' and 'recovery in the context of being in hospital'.
Study 13	'I know what I need to recover': Patients' experiences and perceptions of forensic	Sweden, medium secure inpatient hospital.	To describe patients' experiences and perceptions of forensic	Qualitative. Material generated by semi-structured interviews.	Male, *n* = 11.	Content analysis.	Results of recurring theme 'I know what I need to recover', presented under 3 main

	psychiatric inpatient care. Marklund, Wahlroos, Looi & Gabrielsson (2019).		psychiatric inpatient care.				categories: 'a need for meaning in a meagre existence', 'a need to be a person in an impersonal context' and 'a need for empowerment in a restricted life'.
Study 14	Perceptions, experiences and meanings of recovery in forensic psychiatric patients. Mezey, Kavuma, Turton, Demetriou & Wright (2010).	UK, medium secure inpatient hospital.	To explore forensic psychiatric patients' perceptions and experiences of recovery and to identify whether they had different narratives and emphases from non-offender patients, that could inform service planning interventions.	Qualitative. Material generated by semi-structured interviews.	*N* = 10, (female = 2, male = 8)	Thematic analysis.	Results presented under 3 themes: 'definitions and understandings of recovery', 'what helps to bring about recovery' and 'impediments to recovery'. Suggests that some of the central concepts around recovery, i.e. hope, self-acceptance, self-management and having ones achievements recognised, may be particularly problematic for forensic psychiatric patients.
Study 15	Using social boding theory to examine 'recovery' in a forensic mental health hospital: A qualitative study. Nijdam-Jones, Livingston, Verdun-Jones & Brink (2015).	Canada, high secure inpatient hospital.	To understand the qualities of service identified by patients in a forensic hospital as being important and meaningful to recovery.	Qualitative. Material generated by semi-structured interviews.	*N* = 30.	Thematic analysis.	Results presented under 5 themes: 'involvement', 'belief in rules and social norms', 'attachment to supportive individuals', 'commitment' and 'concern about indeterminacy of stay'.
Study 16	Reaching a turning point – How patients in forensic care describe trajectories of	Sweden, high security inpatient hospital.	To explore how forensic patients who had decreased their assessed risk of	Qualitative. Material generated by semi-structured interviews.	*N* = 10, (female = 2, male = 8).	Inductive content analysis.	Results presented under 3 themes: 'the high risk phase: facing intense negative emotions and

	recovery. Olsson, Strand & Kristiansen (2014).		violence experienced their turn towards recovery.				feelings', 'the turning point phase: reflecting on and approaching oneself and life in a new way' and 'recovery phase: recognising, accepting and maturing'.
Study 17	It had only been a matter of time before I had relapsed into crime: Aspects of care and personal recovery in forensic mental health. Pollak, Palmstierna, Kald & Ekstrand (2018).	Sweden, forensic inpatient hospital.	To describe forensic psychiatric inpatients' own views on what aspects of care and personal recovery are important in reducing the risk of serious reoffending.	Qualitative. Material generated by semi-structured interviews.	*N* = 9, (female = 2, male = 9).	Inductive content analysis.	Results presented under 4 themes: 'time: opportunity for change', 'trust: creating a context with meaningful relations', 'hope: to reach a future goal' and 'toolbox: tools needed for recovery'.
Study 18	Seeking to understand lived experiences of personal recovery in personality disorder in community and forensic settings – a qualitative methods investigation. Shepherd, Sanders & Shaw (2017).	UK, range of forensic inpatient and community settings.	To explore the experience and personal meaning of recovery in relation to individuals receiving a personality disorder diagnosis and with experience of accessing care in either community or prison settings.	Qualitative. Material generated by semi-structured interviews.	*N* = 41, (female = 23, male = 18).	Thematic analysis.	Results presented under 4 themes: 'understanding early lived experiences as informing sense of self', 'developing emotional control', 'diagnosis as linking understanding and hope for change', and 'the role of mental health services'.
Study 19	The aftermath: Aspects of recovery described by perpetrators of maternal filicide committed in the context of severe mental illness. Stanton & Simpson (2006).	New Zealand, no further information provided.	To present the main themes the perpetrators described with respect to their recovery.	Qualitative. Material generated by semi-structured interviews.	Female, *n* = 6.	Thematic analysis.	Results presented under 6 themes: 'managing the horror of the memories', 'language used to describe the event', 'forgiving themselves', 'role as mother', 'support' and 'managing illness'.

Study 20	What are the barriers to recovery perceived by people discharged from a medium-secure forensic mental health unit? An interpretative phenomenological analysis. Stuart, Tansey & Quayle (2017).	UK, medium secure inpatient hospital.	To explore individual perceptions of recovery, in particular beliefs about barriers to its achievement, in people discharged from secure psychiatric care. To explore participants' values: i.e. what they perceived as their core values; to what extent these were congruent with their recovery; and to what extent participants perceived their values to be congruent with the values of wider society.	Qualitative. Material generated by semi-structured interviews.	*N* = 8, (female = 3, male = 5).	Interpretative phenomenological analysis (IPA).	Results presented under 5 superordinate themes: 'living in the shadow of the past', 'power imbalances', 'security and care', 'reconfigured relationships', and ''recovery' as a barrier to recovery'.

2.3. Structure and methodology of review

The following review attempts to critique and synthesise the findings of the literature included. An integrative approach to synthesis was used, allowing for cross-study integration, summaries, generalisations and the resulting clinical implications and recommendations (Noyes & Lewin, 2011 [a][b]; Pearson & Hannes, 2012). Guidelines were followed, designed by Whittemore and Knafl (2000) to provide uniformed protocol for integrative literature reviews. Results sections were analysed and all data which referenced relationships of any kind were extracted for further scrutiny. A combination of clustering, counting and constant comparison was used to analyse data, enabling the identification of patterns and themes within broader categories (Appendix A; Miles & Huberman, 1994). Findings are discussed in terms of four resulting categories: relationships with staff, relationships with service user peers, relationships with family and friends and relationships with the wider community. There was no outlying data which did not satisfy the characteristics of at least one of these categories.

2.4. Reflexivity of reviewer

As this literature review employed qualitative methods it is necessary to consider reflexivity of the reviewer. The integrative approach allows for summary of research in order to contribute to clinical practice and policy. It does not ask for the development of new meanings and therefore the scope of any reviewer bias is contained, impacting on the quality of the synthesis rather than its content (Broome, 1993; Whittemore & Knafl, 2005). Nevertheless, reviewer reflexivity was considered as an important factor. The reviewer had experience of conducting interview research in forensic mental health services and such knowledge could have created bias when reviewing similar articles. In order to mediate a

potential bias and enhance reflexivity, the following strategies were used; the use of a reflexive journal, supervision and memo-writing (Charmaz, 2014).

3. Critical Analysis

3.1. Summary of included studies

All the included studies used qualitative methodologies. Data collection strategies included interviews (*n* = 17), single case studies (*n* = 1), therapists' notes (*n* = 2) and focus groups (*n* = 1). Data analysis strategies included variations of thematic analysis (*n* = 11), content analysis (*n* = 5), Interpretative Phenomenological Analysis (IPA, *n* = 4) and Grounded Theory (GT, *n* = 1). Study 11 used a mixed methods design; quantitative data were not included in this review but were collected via questionnaires. Studies were conducted across five different countries; UK (*n* = 12), Belgium (*n* = 2), Sweden (*n* = 3), Canada (*n* = 1) and New Zealand (*n* = 2). FMHS context varied across studies including both inpatient and community settings. Service user populations tended not to be disorder or offence specific, there were exceptions to this i.e. perpetrators of homicide (*n* = 2), those with intellectual disabilities (ID) (*n* = 1), those with a personality disorder diagnosis (*n* = 1), those with symptoms related to psychosis (*n* = 1) and perpetrators of maternal filicide (*n* = 1).

3.2. Methodological issues

Studies were initially screened for methodological robustness using the Critical Appraisal Skills Programme (CASP; Singh, 2013; Appendix B.). The CASP allowed for assessment of the methodological design of qualitative research and is recommended for use by the Cochrane network (Noyes et al., 2019). All studies included a clear statement of aims and used appropriate design and methodology. Study 11 used a mixed methods design in order to construct a service user led measure of recovery. This review therefore focussed on

the qualitative methods by which the authors gathered information to inform the development of the measure.

The issues highlighted through CASP (Singh, 2013) screening were mostly in relation to four main areas; considerations of ethics, recruitment strategies described, reports of data analysis and the reflexivity of researchers.

Twenty percent of the studies reviewed (Studies 1, 5, 7 and 11) made no mention of ethical considerations in their write up, a major failing in any research but perhaps particularly so when working with a vulnerable population such as those in FMHS. Participant populations across the studies included those diagnosed with various complex conditions including ID, personality disorders and psychosis. It was possible for the interview process to be a challenging experience for respondents and ethical considerations of the potential for distress caused is therefore important. One would hope that the process of publication in a peer reviewed journal suggests ethical approval was gained for these studies and that in doing so, a broad spectrum of issues relating to consent, capacity and risk were considered. However, without an explicit statement outlining how ethical issues were considered the reader is left questioning the validity, reliability and generalisability of the findings.

The majority of studies used appropriate recruitment strategies in their designs. However, this review found issues with the recruitment methodology used in studies 7, 12 and 14. Studies 12 and 14 relied on clinical staff to identify participants for interview according to brief checklists including questions of capacity to engage or consent, diagnostic categorisation, and in Study 12 only, whether the individual was engaged in other research. This method of recruitment leaves both studies vulnerable to bias. Both studies stated that all participants identified by clinical staff agreed to take part, suggesting there may have been a

bias in the way those put forward were identified. This causes issues of reliability and generalisability. Study 7 provides no rationale to describe how the participant came to be recruited as the focus of a case study and requires additional discussion as the only single case study included in this review. The study provides a first hand account of a man's journey through forensic mental health hospital and includes discussion of how he understands the concept of recovery; for this reason, it has been included in this review. This does however create some complexity when comparisons are made with studies which have larger sample sizes (studies included in this review had a mean average participant number of $n = 17.3$). Attention has been paid to this disparity throughout this review and caution taken not to give weight to the findings of Study 7 if similar has not been reported by others, to increase generalisability of findings.

When considering data analyses the most frequent issue was one of methodological clarity and transparency of analysis. The majority of the studies gave adequate description of the data analysis methodology and presented exemplar quotes and themes to demonstrate how broader concepts were arrived at. Seventy-five percent of the studies also made statements to assure the reader of inter-rater reliability checks. However, studies 1, 11, 15, 16 and 19 failed to demonstrate inter-rater reliability leaving their results vulnerable to bias and creating issues in the reliability and validity of their findings.

Reflexivity is acknowledged by many as being a critical component of qualitative research, held as being integral to the quality of the findings (Ahmed, Hundt & Blackburn, 2011; Berger, 2015). It is also worth noting here findings which highlight the importance of reflexivity in research by those working in FMHS, who have been found to be vulnerable to bias (Neal & Brodsky, 2016) and to underestimate the impact of this bias on their practice (Faust & Ahern, 2012). Reflexivity was discussed by nine out of the 20 studies and therefore

reassured the reader that there was an awareness of researcher influence (studies 5, 6, 8, 9, 12, 14, 17, 18 and 20). The remaining 11 studies however made no explicit mention or consideration of reflexivity or the relationship between researcher and participant. Berger (2015) suggests that three practical components of research can be used to maintain awareness of the researcher's role and therefore facilitate reflexivity, one of which is peer consultation. With these guidelines, it could be argued that studies reporting inter-rater reliability have made a step towards reflexivity in their research. This would leave studies 1, 7, 11, 15, 16 and 19 as those without consideration of the issue and therefore most vulnerable to bias.

Although methodological issues were highlighted by this review, it is also important to recognise the strength of design and reporting of many of the studies. Using the CASP, 16 of the studies had only one or no issues highlighted. For this reason, all studies were considered to be robust enough for synthesis, although issues raised in this section should be held in mind throughout.

3.3. Relationships as an explicitly identified theme of recovery

It is important to begin by highlighting the fact that all studies included in this review referred to interpersonal relationships within service users' experiences and understandings of recovery in some way. Therefore, it was possible to extract data relating to relationships in the context of recovery from every study. In fact, the majority of the studies presented the discovery of at least one theme that explicitly identified relationships as a component of recovery within forensic service users' recovery experiences. In total, 17 of the 20 studies presented results including at least one theme entitled in order to demonstrate the relevance of relationships, with only studies 1, 2, and 16 not doing so. A comprehensive list of themes relating to relationships is provided in Appendix C.

Thematic identification of the relevance of relationships with staff was present in six of the studies included (Studies 3, 5, 6, 8, 18 and 20). Explicit thematic reference to relationships was made solely in the context of relationships with staff by Studies 5, 6 and 18, with other forms of relationships not reaching the same level of relevance within their analyses. Study 5 labelled the theme "Staff" (p. 9), Study 6 identified "nature of relationships with staff" (p. 1032) and Study 18 named "the role of mental health services" (p. 6). The remaining studies, 3, 8 and 20 presented findings of thematic relevance of relationships both with staff 'professional support' (Study 3, p. 6), 'relationships with staff' (Study 8, p. 68), 'security and care' (Study 20, p. 13), 'reconfigured relationships' (Study 20, p. 14) and within other social contexts.

Results relating to relationships within other social contexts i.e. familial relationships, friendships, relationships with service user peers or relationships with communities tended not to be presented under distinct themes in the same way as they were with staff. Most studies presented such findings under more general overarching themes, such as 'attachment to supportive individuals' (Study 15, p. 163) and 'social recovery resources' (Study 4, p. 926). It is however important to state that data relevant to the subject of relationships within a context of recovery was found by this review outside of the specific themes in thirteen out of the twenty studies included (Studies 3, 4, 5, 6, 7, 8, 12, 13, 14, 15, 17, 18 and 20). It is in this way that discussion of relationships was interwoven throughout the literature and is therefore an important focus for this review.

3.4. Recovery, forensic contexts and relationships with staff

Whether as a theme, or referred to within themes, relationships with staff were a present factor within the experience of recovery in all but Study 19. Study 19 had a specific,

index offence focus and therefore recovery was discussed in relation to this offence which may explain the lack of consideration of relationships with staff.

When considering relationships with staff it is important to bear in mind the service context and the pronounced way in which power imbalance is present within the relationships between service providers and service users whether or not it is explicitly acknowledged as being so (Pouncey & Lukens, 2010). It is perhaps unsurprising therefore that within accounts of relationships with staff, experiences which highlight this power imbalance are cited as detrimental to recovery. Nearly half of the studies contained examples of when service user experience has been one of lack of control within the FMHS system, illustrated and experienced through the behaviour of staff (Studies 1, 2, 3, 8, 13, 16, 17, 18 and 20). Examples of "enduring the appointments to be able to proceed in their judicial trajectory" (Study 3, p. 8), "staff held perspectives of their needs that differed from their own" (Study 8, p. 68), "I was just doing it, saying it so I wouldn't, didn't have to go under them" (Study 18, p. 6) and "professional management can represent a further disempowerment; an obstacle to recovery on their own terms" (Study 20, p. 11).

Relationships with staff, as described by Study 9 can provide essential learning for service users as they provide an opportunity for social interaction within hospital. This can help to develop social abilities and understanding of the importance of social links in terms of recovery and general wellbeing: "If I've got something that's bothering me, to tell the staff, to work with the staff so they can try and help me, um, I've learnt that a strong family support unit is important." (p. 360). All but studies 1 and 2, which contained minimal reference to staff relationships, included both positive and negative experiences of staff relationships as part of their accounts of recovery, with positive relationships in line with recovery and negative experiences felt to be detrimental to recovery.

Negative experiences of relationships with staff in relation to recovery tended to highlight the issue of power; be that in the experience of restrictive measures, poor communication or negative perceptions of staff motivations. Over half of the studies included (Studies 3, 5 6, 7, 8, 10, 13, 14, 15, 16, 17, 18 and 20) provided examples of negative accounts of relationships with staff as experienced by service users; "I think some of them don't even give a shit about us" (Study 10, p. 338). Poor communication from staff as experienced by service users was presented throughout negative accounts of relationships, described by some as curt (Study 3, p.8), antagonising (Study 5, p. 9; Study 10, p. 338) and belittling (Study 3, p.8). This often coincided with a negative perception of staff motivators, either that they were "here for the paycheque and not for the care of the patients" (Study 15, p. 163), or engaging in antagonistic behaviours to incite negative events, "pushing you that little bit further until you snap" (Study 5, p. 9).

Positive experiences of relationships with staff in relation to recovery were more frequently reported than those of negative experiences and were found in 17 of the 20 studies (Studies 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18 and 20.). However, one must bear in mind the possibility of researcher bias and the possible pressure to provide positive accounts felt by service users. Positive accounts of relationships with staff were reported when there was a sense of staff encouraging, "empowering" (Study 11, p. 257), caring about and supporting service users; "when I was unwell I never had any kind of, any support from anyone, I was totally alone… now I'm here it is important to have recognition and support by people because it helps you" (Study 14, p.690). Concepts in line with "being treated as a real person with feelings" (Study 6, p.1032) were mentioned in some way or other by several studies and with similar wording by studies 6, 12, 14. There was a sense that a trusting (studies 3, 4, 6, 7, 12, 16 and 17) consistent (studies 3, 6 and 7), emotionally (studies 3, 5, 6, 10, 12, 13, 20) and practically (studies 3, 4 and 11) supportive relationship with at least one

member of staff was enough for service users to feel as though the relationship was having a helpful impact on their recovery. Whilst 'staff' as a term was often used to describe the body of staff, there was also a pattern within the results which suggested that particular relationships with one member of staff, felt to be more personal in nature, were especially beneficial to experiences of recovery. These special relationships with staff members were referred to positively by service users in nearly half of studies; "With him, I can – and dare – to tell everything." (Study 3, p. 7), "if she asked me to do something on the ward, where I could do her favour with, then I did it" (Study 4, p. 925), "I believed them when they said they understood and those nurses in particular had great influence over me. They seemed genuine." (Study 7, p. 86), "when I look back now, I think he played a very important part in my recovery" (Study 7, p. 86). (Studies 3, 4, 6, 7, 12, 15, 16, 18 and 20).

3.5. Recovery, forensic contexts and relationships with service user peers

All but Study 6 included consideration of relationships with service user peers in some way as being part of the recovery experience in forensic populations. Most frequently, relationships with other service users were seen to benefit recovery through providing a chance to learn from one another. Thirteen of the studies included (studies 1, 4, 5, 7, 9, 10, 11, 12, 14, 15, 17, 18 and 20) presented results illustrating ways in which service user peer relationships were seen to have aided personal development; "I have buddies and such in here. You do activate yourself by being social with them and learning better socializing et cetera" (Study 17, p. 5), "being supportive reflects progress in life" (Study 4, p. 926), "we help each other by creating a little society you know where we all try and make it work" (Study 14, p. 691)"development of a normative attitude while communicating with others" (Study 4, p. 927), "a reciprocal relationship between learning about themselves and building relationships" (Study 12, p.313). Interestingly however only four studies (3, 4, 10 and 20)

found doing things for other service users to be integral to the recovery process; "I want to give back to mental health difficulties or give something to people" (Study 10, p. 337), "when you think about others the pain goes away. Forget me for a change, even if it's sharing a piece of cake with someone, a small thing like that makes a huge difference" (Study 10, p. 337), "providing good role models" (Study 11, p. 257). This suggests it is perhaps more important to learn from others through hearing stories and witnessing experiences than it is to intentionally fulfil this helping role for others bi-directionally. Perhaps it is the proximity to others which allows for developing understanding of the recovery process more generally i.e. it is possible, "I can't believe that person was a patient" (Study 20, p. 11), and it is changeable, "I can always mention that I don't feel well and they understand" (Study 4, p. 928). This could be seen as providing the learning which aids recovery, more so perhaps than the intentional helping or teaching to/from others. In fact, nine out of the 20 studies reviewed (studies 4, 5, 7, 9, 14, 15, 17 and 20) presented findings that there is something in the companionship and connectedness of being around others that contributes positively to recovery; "being part of a community to which they felt they were contributing" (Study 20, p. 13), "Well they're sort of always there when you need them. If you're thinking about something in particular, they're always there" (Study 17, p. 5), "the patients like me for who I am" (Study 15, p. 163). However, it is also important to acknowledge the findings of three of the studies reviewed (3, 4 and 14) which showed that a need for private space and distance from other service users was also a component of the recovery experience; "…little privacy…they express the aspiration for personal space and private time to reduce stress and to cope with the social climate" (Study 3, p. 6), "From time to time, I say: stop, I need rest. That's no problem." (Study 4, p. 928).

The sense of support created by the knowledge that other service users had shared similar experiences, problems and issues having a positive impact on recovery was apparent

in nine of the studies (studies 1, 4, 9, 10, 14, 15, 17, 18 and 20). All nine reported findings well illustrated by a quote from Study 18, "…made things a lot easier knowing that I was with like-minded people." (p. 6). However, this experience was not shared by all participants, with some rejecting other service users; "I don't want to be in a group with people like me" (Study 1, p. 76). Examples of the opposing view point tended not to be in the context of a positive experience of recovery.

Whilst results tended to suggest a positive relationship between service user peer relationships and recovery, there was of course evidence of difficulties within these relationships. These may have played a part in the experience of recovery but were not felt by service users to be facilitative. Results of studies 2, 8 and 9 suggested that comparisons made by service users as to their experiences within services was an aspect of relationships that could be experienced as challenging; "…you know people hear about you moving on, and they don't like that they're not, next thing you know, you're in a fight and you ain't going nowhere…" (Study 8, p. 67). With the statutory marker of discharge from a mandated placement or service representing the external recognition of "recovery" or symptom remission, the perceived progress of others perhaps presents a reminder of the system on which their future depends; "the men often compare how long they have been in the hospital; and how long they have been waiting for the next stage of transfer" (Study 2, p.12).

In the area of service user peer relationships, only one component was repeatedly reported in results to be detrimental to recovery and that was the presence and experience of violence within these relationships. Studies 5, 8 14 and 16 presented violence as being an inhibitor to recovery; "it was crammed and there's bound to be violence… we were all in each other's faces, you know it just didn't work, there was nowhere to go and get out of the way" (Study 5, p. 8), "It's all the violence, it's everywhere. You can't get away from it."

(Study 8, p. 67). It is also likely that respondents in other studies had similar experiences. Statistics of violence within FMHS in the UK show that 43% of service users had experienced violence directly during their admission, and 67% had witnessed violence (National Audit of Violence, 2005). The question perhaps therefore is about the potential bias illustrated by the lack of this theme across other studies. If researchers focus on recovery, they must also pay attention to the factors that detract from recovery as well as those which facilitate. It is possible that the mismatch between known statistics and these research findings are illustrative of a research bias.

3.6. Recovery, forensic contexts and relationships with friends and family

Seventy-five percent of the studies provided evidence that relationships with family and friends played a role within forensic service users experiences of recovery, with results of only studies 5, 6, 11, 17 and 18 not directly identifying these as a component of recovery. The most striking trends within these results were the acknowledgement of both contact with friends and family (Studies 3, 4, 7, 9, 12, 13, 14, 15, 16, 19 and 20) and support from friends and family (Studies 3, 4, 7, 9, 12, 14, 15, 16, 19 and 20) as being integral to recovery. "For all respondents, frequent contact with family and friends is significant to their wellbeing and to perceiving that their social network is strong" (Study 3, p. 7). This was strengthened by the complementary findings of studies 3, 12 and 15 which showed lack of contact with friends and family to have a detrimental effect on recovery; "Nothing. Not even by phone, or a card or letter, and that hurts" (Study 3, p. 7).

A process of rupture and repair was present throughout the results of the studies in terms of relationships with friends and family; "My relationships with all my nearest and dearest family and friends hit rock bottom. For the family that have stuck by me through this entire journey I will be forever grateful" (Study 7, p. 86). An acknowledgement of a change

or breakdown in relationships since the time of admission was present in the results of nine studies (Studies 1, 3, 7, 10, 12, 14, 15, 19 and 20). At times this was in relation to the service user's index offense "I am not really in touch with my mum's side…because obviously because of my offence. My mum and dad come up and support me quite a lot…I am building up more of a relationship with my family" (Study 12, p. 310). At other times this was more generally illustrative of the social networks' struggle to manage the impact of mental health difficulties; "but it is my family I feel more for. It's hard for them to deal with. They are wanting me oot, to get on with my life again" (Study 12, p. 312). The acknowledgement of these ruptures was frequently followed either by stories of contact or support with families as discussed above, or with findings of a sense that relationships were being rebuilt or repaired (studies 7, 9, 10, 12, 19 and 20). In line with the idea of rebuilding or repairing relationships were results around a sense of hope when discussing relationships with family and friends. These were present in a quarter of the studies (studies 2, 7, 10, 12 and 20); "Now I look forward to the future with hope with me now looking forward to a positive future has given my loved ones hope" (Study 7, p. 86).

An expressed desire to provide support to family and/or friends in the future was presented as a component of recovery in a quarter of the studies (studies 4, 7, 10, 12 and 20); "they would like to have more money to be able to support family and friends" (Study 4, p. 925), "I want to be out there for my wee brothers and stop them from getting into trouble, and give them a bit of guidance" (Study 12, p. 312). In particular, the children of service users were referred to within this motivating context in the results presented by studies 4, 7, 8, 9 and 10 "I have reached an equilibrium, a golden mean. But psychologically, I understand that I will not regain a healthy life, but I can stay alive for my children" (Study 4, p. 928). In particular studies 4, 7 and 8 presented findings that some service users are making efforts to recover for their children, "you want to look at who you are now, who you're gonna be, um,

you know, a good dad, a good son" (Study 8, p. 69). Alongside this ran results which demonstrated a desire to be near to family (studies 3, 5 and 10), either whilst admitted to hospital in order to facilitate visits, "geographical proximity of their social network is of utmost importance, as most of them currently experience practical difficulties related to physical proximity of meaningful others" (Study 3, p. 5), or in the future when discussing hopes for future housing placements. This illustrates the continuity of the importance of relationships with friends and family throughout the recovery journey. Not only were service users identifying the importance of their presence whilst in hospital but also when considering continuing recovery journeys outside of the hospital environment.

There was one example of a move away from past relationships with friends and family. This was within a group of results suggesting a necessary separation from social contacts who were seen to represent negative past experiences or potential bad influence. Results in line with this concept were found in Studies 4, 10, 19 and 20. "I've grew up at the wrong life, eh? … I've seen guys since I've been out …and I says I'm not giving you my number… because I'm wanting a, I'm, I'm doing my own thing now, eh?" (Study 20, p. 15)

3.7. Recovery, forensic contexts and relationships with community

Relationships to the wider community were a lesser discussed topic but were presented in the results of forty percent of the studies and were therefore found to be sufficiently significant for discussion (studies 1, 3, 4, 5, 7, 10, 11 and 20). The most frequent way in which relationship to wider communities was discussed within the accounts of recovery was as part of a desire for community involvement. Results in line with this were presented by studies 3, 5, 7, 11 and 20; "a quiet environment and contact with neighbours are also experienced as beneficial" (Study 3, p. 5), "there's this little old lady who catches the bus back with me and she always says 'oh I'm glad you're still here, it means the bus hasn't

gone yet' so it's something simple like that" (Study 5, p.8), "you see them conducting their everyday lives, and I get quite a buzz out of that" (Study 20, p. 16).

Secondly within the context of relationship to wider communities, experiences relating to the stigma attached to being a forensic service user, their index offense or more generally having experiences of mental health difficulties were present in the results of Studies 1, 5 and 10. "You've done something violent and you are now seen as Mr. Violent." (Study 10, p. 338), "you're just a mental patient to the rest of the world" (Study 20, p. 11).

Additionally, interpersonal relationships related to recovery within the context of wider community in more practical senses in studies 3, 4 and 5. These presented findings of how service users considered the importance of social resources within their experiences of recovery. For example, Study 3 highlighted the importance of geographical location in relation to relationships and recovery, whilst studies 4 and 5 presented access to resources which facilitate social connection as part of the recovery picture i.e. internet and phone access (Study 4) and access to buses (Study 5).

4. Discussion

This review set out to explore the ways in which interpersonal relationships were included in forensic service users' accounts of recovery. The results of twenty qualitative studies were synthesised and presented under four main categories; relationships with staff, relationships with service user peers, relationships with family and friends and relationships with community. Broadly speaking, this review has found confirmatory evidence of the link between interpersonal relationships, psychological wellbeing and recovery from mental ill health (Chu, Saucier & Hafner, 2010; Corrigan & Phelan, 2004; Kaplan, Salzer & Brusilovskiy, 2012; Shor, Roelfs & Yogev, 2013; Stanton & Simpson, 2006). All studies reviewed presented findings which confirmed the relevance of interpersonal relationships to

forensic service users' experience of recovery. The important focus therefore becomes the nature of these links within a forensic mental health context.

Relationships with family and friends which pre-exist an admission to forensic services are likely to contribute to the life service users plan to return to once discharged and have been found to play a more important role in recovery than other relationships (Davies, Wakely, Morgan & Carson, 2012). Contact with supportive family members and friends was found to be beneficial to recovery, some finding these relationships, particularly with offspring, to be motivating factors for recovery. There are however restrictions to the frequency and nature of this contact within a forensic context. This creates a disparity between what is felt to facilitate recovery by service users and what is logistically possible within a secure hospital. There was however a theme of hope within findings relating to relationships with family and friends. Often having been preceded by a rupture within the relationship relating to circumstances around admission and/or offence, the hope for repair and for an ability to provide support to loved ones characterised the hope for the future. Hope is a recurrent theme in recovery literature (Leamy et al., 2011; Turton et al., 2011).

Relationships with staff were found to have a bi-directional link with recovery; those felt to be supportive, trusting and consistent seen as beneficial for recovery, and those felt to highlight imbalances of power through perceived poor communication for example seen as detrimental to recovery. What these relationships shared with service user peer relationships was a theme of social learning. This perhaps provided a base for rehearsal of interpersonal skills and for the development of understanding, both of others and of themselves through living with and hearing the experience of others. These findings are in line with social learning theory (Bandura, 1977), in that social skills are learned through the observation of and interaction with others. This theory has been applied to forensic contexts in order to

facilitate recovery with some success (Goodness & Renfro, 2002; Menditto, 2002; Newbill, Paul, Menditto, Springer & Mehta, 2011).

Relationships with wider community were a lesser discussed topic; however there were clear themes of a desire for resourceful community involvement, compounded by sense of stigma. Stigma carried by forensic service users, both projected by the wider community and self-stigmatising beliefs held by individuals themselves can be detrimental to recovery (Menditto, 2002; Thornicroft, 2006; Williams, Moore, Adshead, McDowell & Tapp, 2011). In a similar vein to the discussion above, there may be hope in the psycho-educational learning gained from other service users, found to decrease perceived stigma (Shin & Lukens, 2002).

4.1. Limitations

Limitations of this research begin with the researcher. This review was conducted by a single reviewer and although checked by supervising researchers, the singularity raises the possibility of bias. Efforts were made to reduce the impact of bias through enhanced reflexivity practices, although this possibility must still be held in mind.

Integrative review methodology has been criticised in the past for a perceived lack of rigour or uniformed protocol (O'Mathuna, 2000). As a result, this review followed the guidelines designed in response to this criticism by Whittemore and Knafl (2005).

In addition, methodological issues in the twenty studies highlighted by this review could impact the validity of the synthesised results. All studies were however found to be robust enough for inclusion.

4.2. Clinical Implications

The finding that interpersonal relationships of all kinds play a role in the experience of recovery for forensic service users suggests likely benefits to employing a relational model of care in FMHS. One possibility is a restorative approach which holds interpersonal processes at its core (Cook, 2019). This would bring the focus to the impact of behaviour on people, rather than on the legal or social rule structure which may have been broken, through open communication and acknowledgement of responsibilities (Ward, Gannon & Fortune, 2015; Zehr, 2015). Another possibility is to utilise the role of peer support workers, known to facilitate recovery (Baron, 2011) although this does present various challenges in implementation for forensic services (see Drennan & Wooldridge (2014) for discussion). Potentially more achievable in the short term, alterations to daily ward routines to include scaffolded opportunities to build relational skills, such as ward community meetings and reflective groups would contribute to the presence of a relational model within services (Drennan & Wooldridge, 2014). These are however yet to be to the focus of research.

Threatening environments can lead staff to rely on defensive practices in an attempt to contain and manage their own anxieties (Lyth, 1988) making the development of relationships found to benefit recovery between staff and service users a complex process, layered with imbalances of power, risk and uncertainty. It appears important however that staff are aware of the role they play in a service user's recovery and that they are enabled to be reflective about the nature of existing power dynamics and the ways in which they manage this imbalance through the provision of reflective practice (Johnson, Worthington, Gredecki & Wilks-Riley, 2016). Providing staff training in order to improve ward atmosphere and service user satisfaction has also been found to be effective (Nesset, Rossber, Almvik & Friis, 2009).

Considering the importance of relationships with friends and family, the provision of systemic family interventions in forensic settings becomes key (Geelan & Nickford, 1999) and complements the objective of forensic services to support the maintenance and re-establishment of relationships within families (JCPMH [b], 2013).

5. Conclusion

The results of this review are constructed around a central finding of the relevance of interpersonal relationships to recovery in forensic mental health services. A service users' journey through FMHS is inherently relational. Whether that be direct personal relationships with people or with the system itself, the felt experience is a relational one. Considering the experience of recovery of forensic service users through a relational model is an important and necessary move for services and some initial suggestions have been made as to how to implement this above.

6. References

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Section B.

Understanding how the psychological and relational processes of a service user reflective group contribute to recovery on a medium secure ward

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Abstract

The role of service user reflective groups in secure recovery has not been explored empirically to date, although they are a suggested intervention to enhance relational security within a secure recovery framework. This study aimed to fill this gap in research and understanding. It used a Grounded Theory methodology in order to understand how the perceived psychological processes within a service user reflective group may be instrumental in the perceived recovery process on a medium secure forensic ward. Qualitative data were collected using semi-structured interviews from 10 participants who had experience of an existing service user reflective group on a medium secure forensic ward. Results formed a flexible, cyclical model based around four key categories: 'Group Identity', 'Linking Self with Others', 'The Changing Self' and 'Living Visibly in a System'. Findings are presented as providing a solid rationale for the inclusion of service user reflective groups in forensic inpatient settings. Discussion of how this model contributes to and is complemented by existing theory is presented and clinical/research implications suggested.

Key words: forensic, reflective group, recovery, service user

1. Introduction

1.1. Recovery in forensic mental health settings

The aim of an admission to a forensic mental health service (FMHS) in the UK is to provide treatment to people assessed as posing a risk to others as a result of mental illness (Joint Commissioning Panel for Mental Health (JCPMH) 2013). Treatment pathways through FMHS should include access to interventions targeting social, mental and physical health care in line with National Institute for Health and Care Excellence (NICE) guidelines (2016). The goal of FMHS is to remain person centred and recovery orientated (JCPMH, 2013) and therefore interventions provided share this objective. The recovery movement called for the acknowledgement of the impact mental illness has on a person's life, beyond medically framed symptomology (Anthony, 1993). Recovery as a term has therefore come to include recognition of broader domains within which mental illness impacts an individual's life. Lloyd, Waghorn and Williams (2008) provide a frequently referenced conceptual framework of recovery represented by four domains: functional recovery, clinical recovery, personal recovery and social recovery. Whilst there is an abundance of literature in the area, providing subtly differing definitions of recovery, there is a general trend for appreciating each individual's personal process and their development of new goals, values, hope, connections and meanings as encompassing their recovery experience (Anthony, 1993; Turton et al., 2011).

The validity with which recovery principles can be applied within an environment of forensic detention, where autonomy and choice are restricted, has been called into question (Bonney & Stickley, 2008; Clarke, Lumbard, Sambrook & Kerr, 2016; Drennan & Alred, 2013; Shepherd, Doyle, Sanders & Shaw, 2016). The dissonance between recovery principles and the structures of FMHS is well described by Drennan and Alred (2012); "choice,

empowerment and an emphasis on strengths do not sit easily with the imperatives to prioritise risk assessment and offence-focussed interventions" (p. viii).

For those seen by FMHS, insecure attachment styles in childhood have been found to be prevalent (Pfäfflin & Adshead, 2004). With attachment framed as the didactic regulation of emotion (Sroufe, 1996), it is argued that unhelpful relational styles learned in childhood, are likely to replay throughout the lifespan (Bowlby, 1958). This necessitates attention to relational needs in the corresponding model of recovery (Drennan & Aldred, 2012).

It is within this arguably challenging environment, that those working in FMHS provide psychological treatments which aim to promote recovery (Vojt, Slesser, Marshall & Thomson, 2011).

1.2. Group interventions in forensic services

Group interventions allow space for new and therapeutic relational experiences which can challenge existing beliefs and expectations of the other. Yalom and Leszcz (2005) identify eleven factors of therapeutic change in group psychotherapy; instillation of hope, universality, imparting information, altruism, the corrective recapitulation of the primary family group, development of socialising techniques, imitative behaviour, interpersonal learning, group cohesiveness, catharsis and existential factors. Whilst the application of these principles to forensic settings was not discussed by the authors, literature linking theoretical understandings of group process with forensic cohorts has been published by other authors (Adshead, 2015; Ruszczynski, 2016; Welldon, 1993; Woods, 2014). Adshead (2015) argues that groups facilitate the rehearsal and development of pro-social processes through user-led narratives, exploration and reflection. As a result, interpersonal effectiveness and emotional intelligence can develop, highlighted by Long, Fulton and Dolley (2013) as being representative of skills which enable progression through services. It is here that the concept

of mentalisation also becomes relevant. Defined by Fonagy and Allison (2012) as the "ability to infer and represent other people's mental states" (p. 11), the development of the capacity to mentalise appears to provide a theoretical frame through which group processes might be understood in forensic services. It is recognised that the development of the ability to mentalise begins during childhood within the context of a secure attachment relationship (Fonagy, 1996). Service users in FMHS are therefore more likely to exhibit some deficits in their ability to mentalise due to their early experience of attachment relationships (Pfäfflin & Adshead, 2004).

Whilst the theoretical literature surrounding group interventions in forensic services provides thought provoking accounts from a psycho-analytic perspective, little has been done in the way of exploring the empirical validity of the suggestions made (Stein & Brown, 1991). In fact, literature published which tests group interventions tends not to include discussion of underlying psychological theory, focussing instead on efficacy and treatment outcomes. In a recent systematic review of 29 group interventions in FMHS, Sturgeon, Tyler and Gannon (2018) reported a notable trend for positive outcomes in structured groups such as skills based psychoeducational groups. The review highlighted fundamental methodological issues, called for more rigorous future research and did not discuss related psychological theories outside of confirmatory discussion of existing models on which the groups were designed e.g. cognitive behavioural model.

1.3. Rationale and aims

There appears to be a disconnect in the research between psychological theories of group process and studies of group efficacy. Structured or protocolled groups lend themselves to empirical research strategies, whereas reflective open groups, which allow space for the exploration of experience informed by group process theories, do less so. The role of service

user reflective groups in secure recovery has not been explored empirically to date, although they are a suggested intervention to enhance relational security within a secure recovery framework (Drennan & Wooldridge, 2014). The current study aims to fill this gap in research and understanding by exploring the experiences of both those attending and those facilitating a patient reflective group on a medium secure forensic inpatient ward. Whilst opinion is divided regarding the role of a group facilitator (David, 2016), it is arguably unavoidable that their presence be interpersonally influential (Ahlin, 2010). Staff facilitator participation in the research was therefore reflective of the group's process. It also allowed for the consideration of broader systemic and organisational constructs within a forensic inpatient context where issues of systemic power could hold relevance. In response to the apparent disconnect between theory and existing research, Grounded Theory (GT) will be used in order to construct a theoretical framework from which the group can be understood.

This study aims to understand how the perceived psychological processes within a service user reflective group may be instrumental in the perceived recovery process on a medium secure forensic ward.

2. Methods

This study used an exploratory qualitative design, gathering data using semi-structured interviews, based on a Constructivist GT approach as described by Charmaz (2014). Data were collected using semi-structured interviews which were transcribed and analysed through coding by the researcher. The approach allowed for the development of an explanatory theory which can be used to describe the active processes involved in the group (Chun Tie, Birks & Francis, 2019).

2.1. Setting

The study was conducted in relation to a reflective group run by psychologists for residents of an NHS Medium Secure ward in South England. Where service user participants were no longer residents of the ward, they were interviewed either on a nearby Low Secure ward, or in supported community accommodation. All service user participants included in this study had been residents of the Medium Secure ward within 18 months prior to interview and were therefore under the detention of the Mental Health Act (MHA, 2007).

The group was known by staff and service users as the 'Reflective Group' and ran once a week for one hour. The group was run on a rolling basis, with two staff facilitators present and an open-door policy for those on the ward who wished to attend. Staff facilitators were qualified clinical psychologists or psychotherapists who described their professional approaches as 'integrative' and all cited attachment theories as being influential in their practice.

2.2. Design

This study used GT to create a theoretical underpinning from which an understanding could be built of the relational and psychological processes influencing the experiences of those attending the reflective group. Alternative qualitative methodologies were considered, in particular, Interpretative Phenomenological Analysis (IPA) due to its focus on exploring personal experience and meaning (Smith, Flowers & Larkin, 2009). However, as the use of reflective groups within forensic contexts was a novel context for research, GT allowed for the development of a general model through which such groups could be understood. GT as described by Charmaz (2014) was used, allowing for the social constructionist consideration of the role of the researcher. In order to allow for the inclusion of a literature review, a position of 'theoretical agnosticism' was taken (Thornberg, 2012).

2.3. Ethics

Ethical approval was given by an NHS Research Ethics Committee (REC; Appendix D.), encompassing approval from the Health Research Authority (HRA) and Health and Care Research Wales (HCRW; Appendix E.). Approval was also gained from the Research and Development Department of the local NHS Trust (Appendix F.).

All participants were provided with an information sheet (Appendix G.) and given the opportunity to ask questions, following which they were able to provide informed consent for participation (Appendix H.). Confidentiality, and its limits, were explained in the information sheet provided and repeated verbally prior to interview.

Interview recordings were stored on an encrypted, password protected memory stick accessible only to the researcher. Interviews were anonymised during transcription and recordings deleted once transcribed.

Ethical consideration was given to the classification of service user participants as part of a vulnerable population. The researcher was separate from all treatment teams and this was made explicit, however consideration of power imbalance was necessary and included in the researcher's reflexive practice. Information relating to the potentially emotive nature of the interviews was provided (Appendix G.) and a plan was in place to take breaks or end the interview if distress was caused. As a result of the small sample population and the dissemination of results locally, to ensure confidentiality, demographic information other than gender was not reported.

2.4. Participants

A purposive sampling technique was used to identify both service user and staff participants, in line with inclusion and exclusion criteria presented in *Table 1.* In total 10

participants were interviewed for the purpose of this research: service user participants $n = 6$ (all residents of female ward), staff facilitator participants $n = 4$ (3 female, 1 male). It is notable that it was not compulsory for residents of the female ward to identify as female for the purpose of an admission.

In line with the transferability of findings to other clinical and research contexts, service user participants had been given a range of diagnoses to describe their mental health including personality disorders, bi-polar affective disorder, schizophrenia and a range of additional affective disorders. The prevalence of intellectual disability (ID) within the criminal justice system is unknown, however it is thought to be higher than in the general population (Royal College of Psychiatrists, 2014). The relevant ward was not ID specific, however it is possible some residents may have met criteria for ID. Offending profiles were varied and in line with the medium secure forensic context.

Table 1. Inclusion and exclusion criteria

Inclusion criteria	**Exclusion criteria**
Attendance to the group on at least one occasion within the last 18 months	Current and past residents of the ward who had been assessed by their treating team as being too unstable in their mental health to participate
Those with an adequate level of English language ability, allowing for full understanding of the information sheet	Current and past residents of the ward who had been assessed by their treating team as not having capacity to give informed consent to take part
	Current and past residents of the ward who had never attended the group
	Current and past residents of the ward who had attended the group more than 18 months prior to recruitment
	Staff facilitators no longer working for the NHS
	Staff facilitators who had attended the group more than 18 months prior to recruitment

All eligible residents of both the Medium Secure and partnered Low Secure ward were invited to take part in the study. Service user participants now living in the community were recruited via their community FMHS. Purposive sampling allowed for community staff to identify those eligible for participation and make initial enquiries as to their willingness to be contacted by the researcher. Staff facilitators of the group were opportunistically recruited dependant on exclusion and inclusion criteria.

Service user participants included both current and past residents of the Medium Secure ward. Past residents had been relocated either to a nearby Low Secure ward or to supported community accommodation. All interviews were conducted in private rooms in the participants place of residence. A total of 6 service user participants were recruited.

Staff facilitator participants included both current and past facilitators of the group. All interviews were conducted in private rooms in NHS settings; this included both offices and hospitals. A total of 4 staff facilitator participants were recruited for this research.

2.5. Procedure

The researcher spent time on both the Medium Secure and Low Secure wards building rapport with residents and staff and joining ward community meetings. Information about the study was provided verbally at these meetings and information sheets given to those who expressed an interest in taking part. Following an expression of interest, staff in that services user's care team were informed and questions of capacity and suitability were answered, in line with the Mental Health Act (2007). The researcher then met with the identified participant to answer any questions in relation to the study/information sheet, following which informed consent was sought.

Service user participants living in supported community accommodation were identified via their clinical teams. Once an expression of interest had been confirmed, the researcher made contact with the potential participant to arrange an interview. Information sheets were available both via clinical teams and prior to the interview, when questions were answered and informed consent sought.

Staff facilitator participants were contacted via email with information sheets attached. Following an expression of interest, interviews were arranged. Questions were answered and informed consent sought prior to commencing the interview.

All participants were asked whether they would like to be contacted with the results of the study.

2.6. Interviews

Interviews were semi-structured and conducted in a conversational, exploratory style in line with the guidance of Charmaz (2014). A draft interview guide was created with the study's research question in mind. This draft was then developed with the help of a service user, resident on the Low Secure ward but ineligible for inclusion in the research due to the length of time that had elapsed since she attended the group. Alterations were made according to her suggestions (Appendix I.). In line with GT methodology (Charmaz, 2014), questions asked in later interviews were designed to develop emerging focussed codes (Appendix J.).

Interviews, which ranged in duration from 14 to 88 minutes, were audio recorded and transcribed by the researcher. Initial codes, focussed codes and the development of categories were produced without use of computer analysis software input.

2.7. Data Analysis

Analysis of data followed the guidance of Charmaz (2014) and was conducted alongside data collection using opportunistic sampling. Initially, three interviews were analysed using line-by-line coding with gerunds, staying close to the action of the data, whilst moving towards defining their meaning (Appendix P.). Following initial coding, the "most significant and/or frequent" (p. 138, Charmaz, 2014) codes were advanced and developed through the use of focussed coding, allowing for the beginnings of analytic understanding of data through synthesis and conceptualisation. Additional interviews were then conducted with amended questions informed by emerging focussed codes where appropriate (Appendix J.). This iterative process continued throughout the period of data collection aided by theoretical sorting, clustering and diagramming (Appendix K.), until emerging categories were found to have reached theoretical sufficiency (Dey, 1999). Memo-writing throughout allowed for the researcher's engagement with critical reflexivity and constant comparisons between data, initial codes, focussed codes and categories (Appendix L. for examples). Inter-rater reliability checks were conducted by a university based clinical psychologist supervising this research who had no prior knowledge of interview data. A mixed sample of initial codes, focussed codes and associated raw interview data were provided with no additional information. These were then matched by the second researcher; a concordance rate of 100% was found (Appendix M.).

2.8. Reflexivity

The impact of the researcher on the data and analysis was acknowledged fully and emerging theory viewed as having been created through a process of shared meaning-making and experience (Charmaz, 2014). The constructivist position allows for the acknowledgement of researcher influence by recognising an unavoidable awareness of surrounding theory and literature. This necessitates a reflective and reflexive stance, examining researcher bias and

assumptions whilst also acknowledging wider societal structures within which theory evolves (Charmaz, 2014). Various strategies were used to enhance reflexivity and included a reflexive journal (Appendix N.), supervision and memo-writing (Appendix L.). Additional strategies to mitigate potential researcher bias such as inter-rater reliability checks were also considered to have strengthened reflexivity (Berger, 2015).

3. Results

Analysis of interview data led to the development of a model through which the processes of the group can be understood. The model is shown diagramatically in *Figure 1.* Its components are described in detail in the subsequent discussion of results. Direct quotations to illustrate categories and codes are provided, labelled as 'F' and 'SU' to identify faciltator and service user participants respectively. Tables to show codes within sub-categories are also included (*Tables 2, 3, 4* and *5*).

The model is made up of three central categories; 'Group Identity', 'Linking Self with Others' and 'The Changing Self'. These categories interact within the context of an environment, represented by the fourth category 'Living Visibly in a System'. The results of this GT analysis suggest that the development of a shared group identity, with the safety and structure it provided, allowed group members to begin to see themselves in relation to other people. This linking of the self with others then enabled growth and development of each individual. As individual understandings of the self shifted, the processes within the 'Group Idenitity' and 'Linking Self with Others' were enriched. This cycle was fluid and flexible but importantly existed within a wider systemic context; 'Living Visibly in a System' as a category represented this context and the vulnerability it created in the group. The components of the model will be discussed under the headings of the four identified categories.

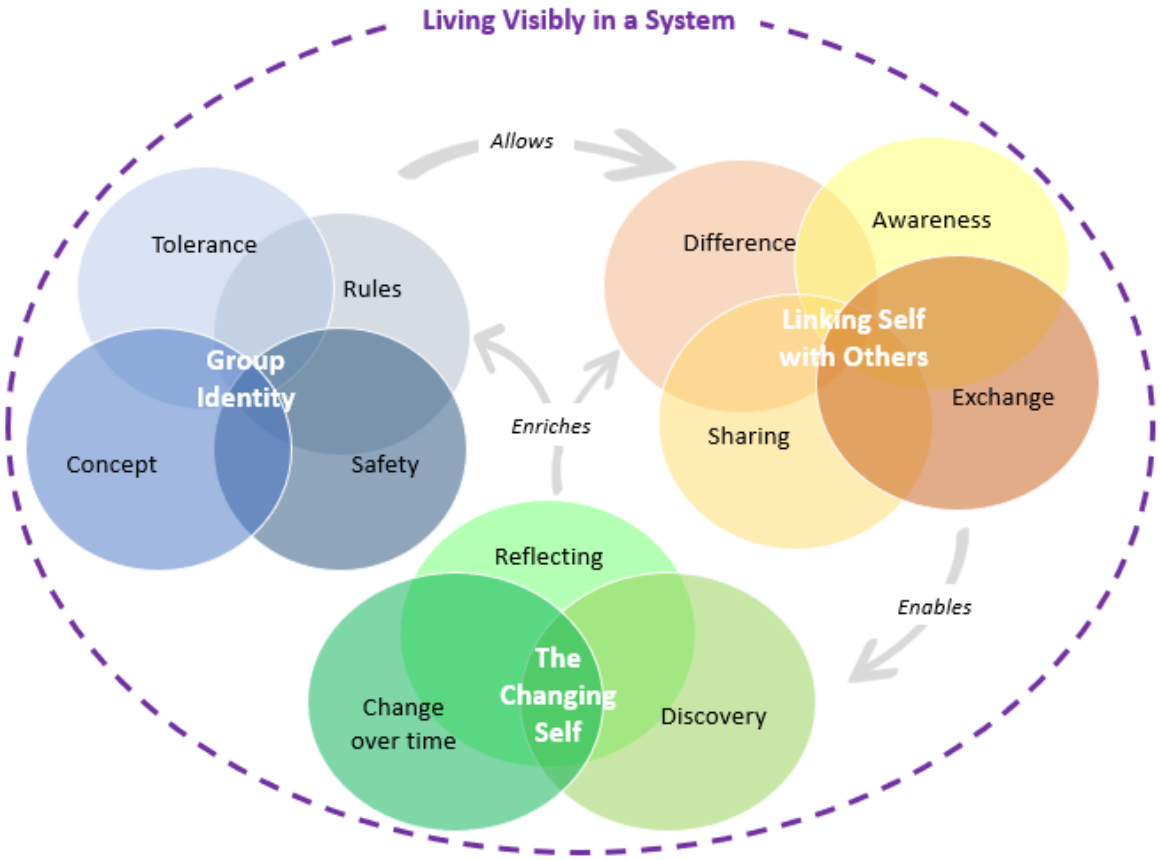

Figure 1. A Grounded Theory model representing the experiences of a service user reflective group on a medium secure ward

3.1. Group Identity | "Coming Together"

'Group Identity' as a category had four contributing subcategories; concept, rules, safety and tolerance. These are described and discussed below (*Table 2.*).

Table 2. Summary of 'Group Identity' category

Category	**Sub-Categories**	**Focussed Code Samples**
Group Identity	Concept	Differentiating ward from group
		Coming together
		Forming
		Valuing group
		Forgetting specifics
		Holding group in mind
		Positioning group as good
	Rules	Compulsory attendance
		Recognising group rules
		Identifying rules
		Getting your turn
		Defining group
		External intrusion
	Safety	Safe enough to share
		Being vulnerable
		Creating safety
		Maintaining safety
		Struggling to find safety
		Exposing vulnerable self
		Needing consistency
		Facilitators as containing
		Requesting protection
		Seeking safety from staff
	Tolerance	Tolerating uncertainty
		Coming from different angles
		Accepting difference
		Learning to accept difference
		Tolerating vulnerability
		Living with unpredictability

Concept

All participants were able to articulate a sense of the group in a manner that differentiated it from the ward and other activities.

> *"Because, being in there, you, there is quite a lot of stress of being locked up all the time… And it's, to me it was a horrible place to be. So um, having a group and having someone to talk to you were able to get rid of some of the stress."* P8 (SU)

> *"If we could have a space and kind of go, look things are really hard at the moment, um… what's this bringing up for people because it's pretty stressful."* P7 (F)

Quite often service user participants could not recall specific events or examples of the group, but instead were carrying a concept of the group in mind.

> *"Yeah, well they walk out the door, and, you've had those conversations and things don't necessarily change immediately, but over time I think they did. And it was in people's heads what they had talked about, in their awareness."* P2 (F)

> *"I think it was helpful, but I can't remember what was said."* P1 (SU)

> *"They all feel similar."* P5 (SU)

The group self-identified as "good", at times in denial of any "bad". The group did this to further distinguish itself from the ward, positioning the two in polarised positions in order to protect itself within the context of a threatening environment.

> *"It's medium secure… there's a lot of fight and emotions are high."* P1 (SU)

> *"It is good, nothing bad about that group"* P9 (SU)

> *"I think it's a fantastic group. Um, everybody should go to it really."* P3 (SU)

"There was only, if I remember there was only about a once a week session. If I remember rightly, um, but more sessions should be available." P8 (SU)

Rules

A shared understanding of group rules ran throughout the interviews. At times these were explicitly stated and agreed, such as confidentiality and no direct discussion of people who were not present.

"But what's said in the room, you don't, don't tell anybody else on the outside, outside you know the other patients…Mmhmm. It doesn't go outside that room, that's the rule." P3 (SU)

"They had their points like that you had to abide by the rules but they were broken like quite a lot of the time there. A lot of bitching." P1 (SU)

Other rules were less about restrictions and more about giving permission to group members to use the time differently from time spent outside of the group, e.g. speaking honestly about experiences in an environment where each person is allowed the space to do so.

"But in that group, it's really good because one person will talk and then someone else will talk and it just goes around nicely." P9 (SU)

"We would discuss what issues we had on the ward and that and how it affected us" P1 (SU)

The concept of rules included an acknowledgement of a wider system with its own regulations and structures. The group worked within the development of its identity to distinguish itself from this external system, although the latter intruded upon the group in various ways. The question of compulsory attendance signified this tension.

> *"…how far, do you engage in treatment freely because it's helpful to you, and how far do we push you because it's part of what you have to do here. And it's, you know, it's a little bit of both."* P6 (F)

> *"There's a real sense of um, external intrusion in in the group space and… there's so many fac – there's some real er concrete examples of that like the cleaners tend to turn up…"* P7 (F)

> *"You weren't allowed out until reflective group was finished."* P4 (SU)

Safety

The containing structure of a safe space was an explicit aim of facilitators but was also contributed to by group members and their understandings of components of all other 'Group Identity' sub-categories.

> *"But, um, I think especially when like, the ward is very unsettled and people are unwell or something and you know having incidents and that, it's nice to get together, and sit in a room with somebody that's trained to like do, reflect, help us reflect on things, um, and people get to voice their opinion and it's in a safe, kind of way."* P5(SU)

The group was frequently described as providing a level of safety not experienced on the wider ward. The processes active in 'Linking Self with Others' and 'The Changing Self' necessitated a space within which it was safe enough to allow vulnerability.

> *"It was safer than being on the ward."* P8 (SU)

> *"Just people um… voicing their opinion in a safe environment."* P5 (SU)

"…because you don't, you can't tell what other people are thinking or feeling because they don't open up until the group." P9 (SU)

Safety in the group was created in part by the role of the facilitators. Group members sought safety through protection by facilitators who shared an understanding that their role included the provision of containment.

"I s'pose in the broad sense that the you know one of the overarching points of the group is to help people to feel safe with their, if you like say with their vulnerabilities." P6 (F)

"And staff just sat back and listened and I'm thinking, interrupt!" P1 (SU)

Tolerance

Tolerance formed part of the shared 'Group Identity' in various ways. They were in the position of living with people whom they had not chosen as housemates/associates, often for periods of years, and the group was a place where this community was encouraged to come together. Group members had to tolerate the vulnerability of their position, diversity of group members and each other's differing motivations for attending.

"… other patients identified her as very odd, very different, and that activated all their kind of fear and arousal" P10 (F)

Tolerating difference in others took various forms, most strikingly, difference as in diversity between group members, whether that took the form of individual identities, characters or even diverse motivations for attendance to the group.

"I think sometimes people attend because they think they ought to attend. Sometimes people attend because they're a bit bored and there's nothing else to do kind of thing. Um… sometimes it seems that people have got a bit of an agenda." P6 (F)

"I'd never really been around gay people before…there are quite a number of people that are locked up that are gay… Made me realise that there are different people and it doesn't matter. You know." P8(SU)

"But unfortunately not everybody has them skills so some people may not feel confident to be able to voice their opinion." P5 (SU)

3.2. Linking Self with Others | "Not the Only One"

The development of a group identity allowed for the components of the category 'Linking Self with Others' to activate. This had four contributing subcategories; awareness, difference, exchange and sharing. These are described and discussed below (*Table 3.*).

Awareness

Group members spoke about an increasing awareness of the experience of others in relation to the self. This was discussed as a discovery of the impact of the self on other people; an awareness that was formed, or sharpened as a result of the group.

"It just made you sit back and thought of others… and just made me think OK this is not a good thing I'm doing and I need to think of others as well not just myself." P1 (SU)

"Yeah it changes because you've gotta realise how it affects everyone else on the ward." P9 (SU)

It is possible that the apparent disconnect between the self and the other before the group was born of early experiences in a forensic cohort.

"I think… it's like I said, you should think of others before you act and relationships grow stronger then because you have better consideration for each other." P1 (SU)

"She brought it to the group, and she explained why. And again they were able to be like oh ok like so she's not just doing it to annoy us all she is doing it because she's struggling with something, which is a nice moment for them to kind of realise. And I think then when she left people said that really helped to understand what's going on." P2 (F)

Table 3. Summary of 'Linking Self with Others' category

Category	**Sub-Categories**	**Focussed Code Samples**
Linking Self with Others	Awareness	Discovering impact of self on others
		Thinking of others
		Impact of others on self
	Difference	Positioning self as different
		Disconnection
		Differentiating self from others
		Keeping to myself
		Competing by comparing
		Anticipating judgement
		Being evaluated
		Scapegoating
		Managing conflict
		Tolerating non-violent conflict
		Navigating difference
	Exchange	Receiving advice
		Listening and being listened to
		Opening up
		Being heard
		Receiving support
		Mentoring
		Getting things off your chest
		Letting off steam
		Problem solving
		Advising
		Questioning authenticity of relationships
	Sharing	Sharing safely
		Sharing experiences
		Sharing my issues
		Sharing emotional experience
		Sharing wisdom
		Sharing part of my life
		Understanding through sharing
		Shared understandings

Difference

'Difference' represented an allowance of the other, in line with the sub-category 'Tolerance'.

> *"Um, and um, but but he was a very nice person you know um and um it just made me realise that, despite the package, inside, could be a lot different you know."* P8 (SU)

However, it was also an acknowledgement of the need to differentiate the self from others in some way. Various group members differentiated themselves from other group members, some positioning themselves as more capable:

> *"Erm and I've learned communication styles, how to be assertive and voice my opinion rather than get angry and stuff… I think I'm quite a strong character so whether I'm in a group or not I always voice my opinions."* P5 (SU)

Others positioning themselves as being further on in terms of their recovery status, at times seeing the group as no longer necessary when they perceived themselves as well and nearing discharge.

> *"And then in the end I just told staff I can't handle this anymore. I'm well I don't need to be here, so I just did my own little thing"* P1 (SU)

> *"It made me feel better, but it also made me want to um, move on more quickly because er, um, I didn't, I didn't feel I had too many issues, you know."* P8 (SU)

Within 'Difference' there was also a sense of competition and comparison between group members.

> *"It's hard in these services because some people don't like the attention on others. And I was the focus."* P1(SU)

> *"And that in itself creates a difficult dynamic if someone comes into the group and says oh I'm off."* P6 (F)

It is in this way that 'Difference' as a sub-category encompasses conflict. Navigating conflict within the group required group members to clear the air in a non-violent way, aided by the understanding and acknowledgement of the experience of others.

> *"Yeah, rather than just keeping it balled up and then you might go to that person that's annoying you and then maybe an incident so it definitely probably reduces violence and stuff like that."* P5 (SU)

> *"If somebody had been… quite difficult on the ward, to be able to sit in the group and for them to say look this is what's going on for me, and this is why I'm behaving like this. Um… and people then understood and were more forgiving and weren't as angry with each other so."* P2 (F)

Exchange

Whilst 'Linking Self with Others' was a relational process, for many it had a transactional underpinning.

> *"It was a time for people to talk and the other people would listen."* P8 (SU)

There was an amount of disconnect within this sub-category which led to its classification as one of 'Exchange'. This signified a sense that group members got something from going to the group, sharing experiences, receiving advice and problem solving, but that these processes did not necessarily lead to connection between group members.

> *"I dunno just listen to our complaints and how we're feeling and that... It makes you feel better in a way, yeah. Getting it off your chest."* P3(SU)

> *"Just to be able to sit there and just vent, how you're feeling and what you're thinking. And then afterwards like when you come out you do feel like a bit of relief like."* P5 (SU)

> *"Good at helping solve the issues and that."* P9 (SU)

There were links here with a noted disparity between those who attended the group, and social groups which formed on the ward. Facilitators also questioned the authenticity of some relationships within the group.

> *"I built relationships but that was before the reflective group, do you know what I mean?"* P4 (SU)

> *"There was a one one girl there I was quite close to, she had quite a few issues herself um… but to be honest the rest of the group I never really associated with."* P8 (SU)

> *"… and um, supportive of each other… and sometimes that feels completely real. Sometimes it feels a little bit like that's what you say in those circumstances, but… not not always it does feel genuine sometimes you know."* P6 (F)

There was an apparent acknowledgement of the benefits of being on both the receiving and providing ends of these exchanges, alongside a relational distance between some group members.

Sharing

Firstly it is important to note the connection between 'Safety' as a sub-category of 'Group Identity' and 'Sharing'. Coded as 'safe enough to share' (*see Table 2.*), the group needed a space which allowed them to show vulnerability through sharing.

> *"So like, I never normally talk to people and I talk in that and it makes me feel better because I've actually finally opened up to someone. Yeah, coz sometimes I bottle up and then I go bang and end up self-harming or something I got restrained and put in seclusion or whatever it is. But there you just know how it's solved quite easily quite calmly."* P9 (SU)

Sharing related to various processes, exemplified by their related codes. There was at times a sense of shared storytelling, accounting for their experiences and allowing others to hear how they survived. Sharing was a relational process through which understanding of the other grew.

> *"I think I was going through what the other patient was going through so we connected a bit."* P1 (SU)

> *"And even just hearing an experience that someone had four years ago, and how they dealt with it. A lot of people would be like oh, maybe I could try that."* P2 (F)

> *"…give me insight to how other people were coping."* P1 (SU)

> *"And it's nice to listen to other patients' views and comments as well because you understand what they're going through. So you're not the only one that's going through some stuff."* P9 (SU)

3.3. The Changing Self | "I'm Getting Somewhere"

'The Changing Self' represented a more independent process through which group members progressed, informed by their experiences with others, but with more distance from direct relational processes. 'The Changing Self' as a category had three contributing subcategories; change over time, reflecting and discovery. These are to be described and discussed below (*Table 4.*).

Table 4. Summary of 'The Changing Self' category

Category	Sub-Categories	Focussed Code Samples
The Changing Self	Change over time	Increasing in confidence Changing over time Increasing self-awareness Struggling with progression The threat of recovery Coping with silence
	Reflecting	Understanding emotions De-emotionalising Realising and understanding Reflecting on incidents Explaining Realising Learning to be reflective Reflecting over problem solving Processing ward incidents
	Discovery	Learning from others Communicating differently Putting words to experience Voicing disapproval Learning how to survive Learning to accept difference Learning to cope Knowing what others need Recognising small achievements

Change over time

A sense of time passing and the changes that this brought included comments and conversation about recovery.

"*I dunno it just makes me feel different. I think it helps with recovery. Yeah it does… I don't know but it does. It makes me feel like I'm getting somewhere."* P3 (SU)

"It was hard because they bang on about stuff that didn't really make sense and it was quite upsetting because you knew that you were like that at the beginning." P1 (SU)

There was however a threat associated with recovery for some group members, related to the loss of support and containment provided by the system.

"I think they have a sense that if they do too much of that or they look too kind of… that someone might forget that their distress is still there" P7 (F)

Silence in the group was felt to be threatening or un-containing by some, leading at times to the rejection of the group.

"Nothing its boring. People don't, don't really talk. So it's like a awkward silence" P4 (SU)

However, an ability to tolerate this silence and the vulnerability that it signified tended to improve over time and was discussed as representative of progress.

"Well when I first went there, it was quiet, I felt really really nervous and scared… But um, I went there, I've been going there and I feel, quite relaxed and… and easy." P3 (SU)

"Like it was an open space and they felt vulnerable there. Which, I can kind of understand because when I first went to the group that's how I felt." P2 (F)

Through the processes of 'The Changing Self' an understanding and tolerance of the group's silence developed. This occurred alongside a parallel invitation to speak, breaking a pattern of silence in group members' lives.

"I speak for women in our service who I think who have had experiences of a living environment whereby terrible things happen, and they're not spoken about, and they're not acknowledged … the group is a sphere to kind of, do something different to that." P7 (F)

Reflecting

As the group was referred to as "the reflective group" the concept of reflection was familiar to all. As a sub-category, however, 'Reflecting' encompassed a range of internal thoughtful processes contributing to personal growth and change within 'The Changing Self'. Group members talked of an increasing self-awareness and confidence within their experience.

> *"Well when I first went there I felt really really nervous and scared… will they judge me and that you know…. But um, I went there, I've been going there and I feel, quite relaxed and… and easy Yeah, yeah, I don't feel like that now."* P3 (SU)

> *"It's helped me get where I am now… bit of support, bit of help, bit of understanding."* P1 (SU)

Reflecting aided understanding and encouraged realisations about the self and others. It was used to explore not only internal processes but also wider systemic issues and incidents on the ward.

> *"Help you solve issues by maintaining being calm instead of aggressive and shouting."* P9 (SU)

> *"A chance to reflect on what's going on on the ward, a chance to reflect on um… how they're feeling about themselves."* P6 (F)

> "*Obviously if there's something major happening people want to reflect on it. It's a space to allow them to do that."* P2 (F)

Discovery

Discovery encompasses the learning processes involved in 'The Changing Self'. The group allowed learning about the self and others in a way which is difficult to pick apart. Discovering how to live, cope and survive in the world was a key process of developing and changing as an individual over time.

> *"Learning how to kind of, take that really frightening step of putting words to that of of kind of exploring that, of sharing it with other people."* P7 (F)

> *"Umm, yeah… it, it teaches you things you know like, um, getting on with somebody, really well and um, that's all I can think of."* P3 (SU)

> *"That's what we tried to do, we tried to say, you know… you were here once, you know and they'd give each other advice or they'd tell each other, how they'd done it."* P2 (F)

> *"You just don't go without feeling accomplished like you've achieved something."* P9 (SU)

Whilst these processes were important and meaningful, they were often spoken about as slow, with small progressive steps. Facilitators tended to acknowledge achievements which in other spheres may have seemed small.

> *"And they'll sit there and go, oh I feel like shit. And maybe that's all they'll say. But I kind of in my mind I'm like, that's an achievement."* P7 (F)

Group members were supported by the group process to develop their communicative style in order to support the changes within them, for example putting words to experiences which before they had been unable to verbalise. A necessity for honesty within group discussions was taken seriously and allowed for the development of the self through

communication, both positive and negative. To learn different responses was key to changing self.

> *"I mean I was a bit more confident going through the time I was there with the group."* P8 (SU)

> *"Coz, on the out you're always going to have situations, there's always going to be that person that you don't like and it's about being mature, being an adult about it."* P5 (SU)

3.4. Living Visibly in a System | "What's going on on the ward"

'Living Visibly in a System' as a category represented the environment within which the group existed. The ward atmosphere was key and the experience of the group unequivocally linked to the wider system (*Table 5*.).

> *"Sometimes you'd have a settled ward and there wouldn't be that much that people wanted to bring to the table but…"* P2 (F)

> *"I guess it's just a place to… realise the impact of living together as well."* P2 (F)

Table 5. Summary of 'Living Visibly in a System' category

Category	**Focussed Code Samples**
Living Visibly in a System	Living alongside mental illness Feeling vulnerable in threatening environment Living with unpredictability Living on an unsettled ward Challenging environment Feeling attacked External intrusions An attack on thinking Living visibly Living together in a system Reflecting on the self within its environment Desiring discharge Moving forwards Flying the nest Recovering for discharge Escape Navigating discharge

The contribution of systemic power was felt in the group in various ways, linking with the felt vulnerability of the group members and contributing to the need for creating safety. The system was unpredictable, unsettled and challenging, leaving residents feeling vulnerable. There was also a sense of attack; the threat of physical attack for some, but the attack of such an environment on thinking and on the attempts to protect the group.

"Yeah the ward is tense mainly all the time and you're sick of it." P9 (SU)

"The attack on thinking, on that ward at times can be really profound." P7 (F)

"Well at first when I was first in it was scary, you know um… when people were screaming" P8 (SU)

Group members were visible by the nature of their environment. A fight for privacy therefore clashed with the need to allow one's own vulnerability to emerge in order to progress and engage fully with the helpful processes in the group.

"I mean I was there for three years and it seemed like forever at the time and all I wanted to do was just move on quickly you know um… and to, I didn't want to bottle everything up, you know. Um, and so the reflective group helped with that." P8 (SU)

Living alongside mental illness was also a component of the environment felt by group members. This brought with it some challenges; however it also contributed to the learning of the experience.

"Yeah an awful lot of different issues there um… it made me realise that… um… there's a lot of people that need help." P8(SU)

"Um… and although I get annoyed with somebody I always like, make up with them because you can't help having a mental health problem." P5 (SU)

Alongside power inequalities, living in a system one has not explicitly chosen brings with it the desire for an ending. The concept of discharge from the ward was threaded throughout various interviews.

"I just got myself well and got out" P1(SU)

"I like to participate in things because it looks good for you when you attend the groups" P1(SU)

"That's what I call it here it's like a nest and then when you're ready to move on you're flying away" P9 (SU)

4. Discussion

This study aimed to use a GT methodology to build an understanding of how the perceived psychological processes within a service user reflective group may be instrumental in the perceived recovery process on a medium secure forensic ward. A model was constructed in response to this aim which describes how a flexible and fluid cycle between the development of a shared group identity, an understanding of the self as being linked with others and changes within the self all serve to contribute to recovery principles within the constructs of a forensic system.

The bottom-up methodological design of this study means that results are unique. There are, however, useful comparisons to be drawn with existing theory. Within an unpredictable and threatening environment, the predictability of a shared understanding of the group's identity created a sense of safety and belonging for group members. This is potentially comparable with attachment theory (Bowlby, 1958) and the establishment of a secure base from which to explore (Ainsworth & Bell, 1970). Once established, this shared construction of a safe base allowed group members to explore interactions with others, develop a sense of themselves in relation to others and grow as individuals. This suggests that in order to feel secure enough to engage with recovery processes, such as developing connections and making meaning of experiences (Turton et al., 2011), a boundaried and containing group to which one can belong and form attachment is beneficial. Providing those in FMHS with a safe and reliable structure from which they are able to test out relational processes, such as those present in the model above, provides service users with a different experience of attachment to that with which they are familiar (Pfäfflin & Adshead, 2004). Whilst the attachments made were meaningful in this way, relationships between group members could not necessarily be categorised as 'friendships'. Illustrated most clearly by the sub-category of

'Exchange', this finding may provide a useful insight for facilitators of therapeutic groups of this kind.

With its roots in attachment, mentalisation theory (Fonagy, 1989) can also be linked with the findings of this research. The aim of interventions in Mentalisation Based Therapy (MBT) are to provide an environment which encourages the stabilisation of expressed affect and increase capacity to mentalise (Bateman & Fonagy, 2010). It is likely that these processes are present in the reflective group. The environment created by the development of the 'Group Identity' provides boundaries within which controlled expressions of emotion are invited. Processes identified as part of the categories 'Linking Self with Others' and 'The Changing Self' are therefore enabled, some of which could be understood as mentalisation based: increasing self-awareness, understanding emotions, knowing what others need, discovering impact of self on others, understanding through sharing. Bateman and Fonagy (2010) suggest that it is not the design of the intervention which holds the utmost importance in MBT, but rather its aim and outcome. It is possible therefore that the reflective group could in some ways, be understood through the lens of MBT.

The eleven therapeutic processes of a group cited in the introduction (Yalom & Leszcz, 2005) also provide grounds for comparison with the results of this study. Parallels between the processes described within both theoretical frameworks can be found throughout. Mirrored by 'Group Identity', the process of 'cohesion' (Yalom & Leszcz, 2005) produces a sense of belonging and acceptance (Marogna & Caccamo, 2014). As 'Group Identity' allowed for the 'Linking [of the] Self with Others', it is argued that it is through cohesion that all additional ten group processes flow (Marogna & Caccamo, 2014; Yalom & Leszcz, 2005). Consider also the example of the concepts in the 'Linking Self with Others' category in the current study. These are arguably comparable with Yalom's universality (e.g. recognising

shared experience), altruism (e.g. advising), development of socialising techniques (e.g. listening and being listened to), catharsis (e.g. venting) and existential factors (e.g. discovering impact of self on others). The complementary relationship between the findings of the current study and existing theory strengthens the validity of the results and suggests potential transferability of the theory.

Recovery is referred to in mental health literature as a developing process, a process of change (Repper & Perkins, 2003), of personal discovery (Turner, 2002; Kelly & Gamble, 2005), of learning and growth (Whitehill, 2003) and of healing (Fisher, 2000; Repper & Perkins, 2003), to cite some but by no means all of the differing explanations. 'The Changing Self' represented a progression through time, marked by an increasing reflective understanding of the self and of how to communicate emotion and experience. The group allowed its members to learn how to cope and survive in an environment of threat, unlikely to be dissimilar to that which they were used to outside the hospital (Pfäfflin & Adshead, 2004). It is in this way that the model becomes representative of recovery. The processes of developing a shared group identity and the ability to link the self with others enable recovery processes within this cyclical model.

4.1. Limitations

There were limitations to this study, beginning with the relatively small sample size. As a result it is possible, for example, that the process of attending to the "most significant and/or frequent" (p. 138, Charmaz, 2014) codes may have left the findings vulnerable in comparison to a study with more participants. However, the aim of the study and the requirement of GT as described by Charmaz (2014) was for the satisfaction of theoretical sufficiency (Dey, 1999), achievable with a minimum of six participants according to surrounding literature (Guest, Bunce & Johnson, 2006). In order to support the aim of

theoretical sufficiency and the requirements of sampling for GT research, the purposive sampling technique used could have left room for recruitment bias. Ethical procedures undertaken to ensure capacity to consent involved liaison with staff. There was therefore potential for bias in staff to impact their decision making about a service user's ability to engage with an interview. Recruitment from the wards involved no instances whereby a staff member prevented a service user from participating when they had expressed a desire to do so and therefore bias was unlikely. Recruitment from the community, however, left more room for potential bias in that staff were asked to identify those eligible for participation. It is therefore a possibility that the generalisability of the findings to a wider forensic community may not be fully reliable.

There was also a potential bias in analysis as a result of having only one researcher. In line with its constructivist methodology, to mitigate this, the current study attempted to manage researcher bias with reflexivity practices, including the writing of a reflexive journal, supervision, memo-writing and inter-rater reliability checks (Berger, 2015; Charmaz, 2014). It is possible, however, that the findings of this research could have been strengthened by introducing a more robust test of the validity of coding, in addition to checks of reliability. If resources had allowed, it would have been beneficial to have an external researcher code samples of the data independently to allow for comparative checks of validity.

Findings of this research incorporated the experiences of service user and staff participants. One could therefore have expected there to be disparity within the results, particularly when considering the differential in power between the two cohorts. Instead, this study presented findings which suggested a shared understanding of the group held by both staff and service user participants. Systemic power impacted the group. However, the

awareness of power disparity, and a willingness to name and discuss related concepts, appeared to have created a united understanding of the group experience.

An additional limitation was the use of a sample centred on a female ward, as this may have impacted the generalisability of results to reflective groups run on male wards. Whilst there is validity to this concern, as it was not compulsory for residents of the female ward to identify as female, it was important to respect the fluidity of gender identity regardless of the ward's categorisation of residents. It would however be useful for future research in the area to explore the generalisability of findings to other reflective groups in similar settings.

4.2. Clinical and research implications

The model presented in this study provides a framework within which the psychological processes involved in forensic service user reflective groups can be understood. Similarities between the model and existing theory discussed above provides some evidence for their relevance within forensic contexts. The focus in psychological research on evidence-based intervention is necessary, but lends itself with more ease to skills-based groups underpinned by cognitive behavioural theories (Sturgeon et al., 2018). The current study provides evidence of the importance of a less structured group than those previously evidenced; one in which the focus is on the relational processes and development of understanding of the self in relation to others in line with mentalisation theory (Bateman & Fonagy, 2010). The model provides a solid rationale for the presence of reflective groups on forensic wards and validates the application of complementary existing theory to forensic settings. There is, however, a reliance on quantitative research when attempting to impact clinical practice within the NHS. Future research focussing on measurable outcomes of the reflective group would therefore be useful in terms of influencing real change in treatment programmes.

Further research into the model could be conducted under two broad streams. The first could drill down into the detail of contributing components of the model; for example, the concept of safety. Qualitative research which looks with more detail at how safety was created by the group in a way which allowed for a different type of interaction from those on the wider ward. Unpicking the processes in order to inform future group design and intervention would be a useful direction for further research. The second stream of research could be framed as 'zooming out'; potentially testing the validity of the model when applied to a larger sample size or different reflective group. Alternatively, longitudinal studies looking into the progression of the model over time, how it applies to understandings carried into community living or perhaps those service users who chose not to attend the group during their time on the ward.

5. Conclusion

This study provides a model with which the psychological and relational processes of a forensic service user reflective group can be understood in relation to recovery principles. The model provides a theoretical basis for the group and a rationale for the inclusion of service user reflective groups in interventions provided by forensic wards. Whilst the research has some limitations, it provides the groundwork for further research and a basis from which existing reflective groups can be understood and their benefits further evidenced in the future. Suggestions have been made for this further research which would benefit from a quantitative stance, from which evidence can be gathered to suit current evidential constructs within the NHS.

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Section C.

Appendices

Appendix A. Summary of thematic analysis

Appendix A: Summary of thematic analysis
*Numbers relate to studies, see *Table 1*.

Category 1: Relationships with staff

Themes	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Informal contact			X	X	X		X													
Being treated as a person						X						X		X						
Consistency of staff			X			X	X													
Practical support			X	X							X									
Special relationship			X	X		X	X					X			X	X		X		X
Poor communication			X		X					X				X						
Lack of control	X	X	X					X					X			X	X	X		X
Positive relationships			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X
Negative relationships			X		X	X	X	X		X			X	X	X	X	X	X		X
Trust			X	X		X	X					X				X	X			
Emotional support			X		X	X				X		X	X							X

Category 2: Relationships with service user peers

Themes	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**
Personal development	X			X	X		X		X	X	X	X		X	X		X	X		X
Connectedness				X	X		X		X					X	X		X			X
Shared experience	X			X					X	X				X	X		X	X		X
Helping others			X	X						X										X
Need for space			X	X										X						
Comparison		X						X	X											
Violence					X			X						X		X				

Category 3: Relationships with friends and family

Themes	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**
Recovery aid	X	X	X	X			X	X	X	X		X	X	X	X	X			X	X
Contact			X	X			X		X			X	X	X	X	X			X	X
Support			X	X			X		X			X		X	X	X			X	X
Change/ Rupture	X		X				X			X		X		X	X				X	X
Desire to support				X			X			X		X								X
Rebuilding/ Repair							X		X	X		X							X	X
Separating from negative influence				X						X									X	X
Hope		X					X			X		X								X
Children as motivator				X			X	X	X	X										

Category 4: Relationships with community

Themes	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**
Desire for involvement			X		X		X				X									X
Social resource			X	X	X															
Stigma	X				X					X										

Appendix B. Table of CASP findings

Appendix B. Table of CASP findings

	CASP – Qualitative Research									
	Clear statement of aims?	Appropriate methodology?	Appropriate design?	Appropriate recruitment strategy?	Appropriate data collection method?	Adequate consideration of researcher – participant relationship?	Consideration of ethical issues?	Rigorous data analysis?	Clear statement of findings?	How valuable is the research?
Study 1	Yes	Yes	Yes	Yes	Yes	No	No	Can't tell	Yes	Valuable contribution to existing knowledge clearly discussed.
Study 2	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Valuable contribution to narratives of recovery in mental health clearly discussed.

Study 3	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Valuable contribution to under researched area of recovery of those with intellectual disabilities in forensic services.
Study 4	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Valuable contribution to existing knowledge clearly discussed.
Study 5	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Valuable contribution to existing knowledge clearly discussed.
Study 6	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable contribution to existing knowledge clearly discussed and new areas for future research identified.

Study 7	Yes	Yes	Yes	Can't tell	Can't tell	No	No	N/A	Yes	Valuable as first co-produced paper on recovery in high-secure care.
Study 8	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable contribution to current practice clearly discussed.
Study 9	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable discussion of practical implications of findings.
Study 10	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Valuable contribution to existing knowledge clearly discussed.
Study 11	Yes	Yes	Yes	Yes	Yes	No	No	Can't tell	Yes	Valuable contribution in development of new measure.
Study 12	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes	Yes	Valuable discussion of implications for clinical practice and

										areas for further research presented.
Study 13	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Valuable contribution to existing knowledge clearly discussed and implications for clinical practice presented.
Study 14	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes	Yes	Valuable contribution to existing knowledge clearly discussed.
Study 15	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Valuable contribution to future evaluation of forensic mental health services clearly presented.
Study 16	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Valuable contribution to clinical practice

										clearly discussed.
Study 17	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable contribution to existing knowledge and areas for further research clearly discussed.
Study 18	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable contribution to existing knowledge and areas for further research clearly discussed.
Study 19	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Valuable contribution to existing knowledge and clinical practice clearly discussed.
Study 20	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable consideration of clinical implications and directions for further

research clearly discussed.

Appendix C. Summary of reported themes relevant to relationships

Appendix C. Summary of reported themes relevant to relationships

	Themes relevant to relationships	Relationships referenced in additional themes?		Themes relevant to relationships	Relationships referenced in additional themes?
Study 1	None	Yes	**Study 11**	▪ 'Working Together' ▪ 'Support and Preparation' ▪ 'Providing Good Role Models'	Can't tell
Study 2	None	Yes	**Study 12**	▪ 'Relationships and a Changing Sense of Self' (with subthemes: 'Parental Break Down and Loss', 'Relationships with Significant Others', 'Feeling Rejected and Worthless', 'The Importance of Relationships' and 'Development of Trust'	Yes
Study 3	▪ 'Professional Support' (subtheme of 'Clinical Recovery') ▪ 'Social Recovery' (with subthemes: 'Social Network' and 'Being Significant to Others')	Yes	**Study 13**	▪ 'A Need To Be A Person In An Impersonal Context' (Subtheme of 'I Know What I Need to Recover')	Yes
Study 4	▪ 'Social Recovery Resources' (with subthemes: 'Helping Others', 'Social Network' and 'A Sense of Belonging')	Yes	**Study 14**	▪ 'Positive Relationships and Attachments' (Subtheme of 'What Helps to Bring About Recovery') ▪ 'Negative Relationships and Interactions' (Subtheme of 'Impediments to Recovery')	Yes
Study 5	▪ 'Staff'	Yes	**Study 15**	▪ 'Attached to Supportive Individuals: Staff, Friends and Family'	No

				▪ 'Involvement' ▪ 'Belief and Adherence to Social Norms and Rules' ▪ 'Commitment	
Study 6	▪ 'Nature of Relationships with Staff'	Yes	**Study 16**	None	Yes
Study 7	▪ 'Relationships' ▪ 'Qualities in Others That Have Helped'	Yes	**Study 17**	▪ 'Trust: Creating a Context with Meaningful Relations'	Yes
Study 8	▪ 'Relationships with Staff'	Yes	**Study 18**	▪ 'The Role of Mental Health Services'	Yes
Study 9	▪ 'The Goldfish Bowl' ▪ 'Social Relationships' ▪ 'The Problem with Groups'	No	**Study 19**	▪ 'Role as a Mother' ▪ 'Support'	No
Study 10	▪ 'Social Isolation' (subtheme of 'Impact on Personal Development')	Yes	**Study 20**	▪ 'Security and Care' with Subthemes: 'Wanting to Feel Safe and Secure' and 'Wanting to Care' ▪ 'Reconfigured Relationships' with Subthemes: 'Relationships with Others Are Different Now', 'Relationships with Others Are More Difficult Now' and 'Building New Relationships with Others (and Myself)'	Yes

Appendix D. NHS Research Ethics Committee (REC) approval

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Appendix E. Health Research Authority (HRA) approval

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Appendix F. Research and Development Department approval

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Appendix G. Information sheet

Information Sheet

Project Title: Understanding a service user reflective group as part of secure recovery on a medium secure ward.

My name is Anna Woodcock and I am a trainee clinical psychologist at Canterbury & Christ Church University. As part of my studies for a Doctorate in Clinical Psychology I am running a research study and I would like to invite you to take part.

The following information has been written to help explain the purpose of this study and what it would involve if you decide to take part. Please take your time and read the following information carefully. You are welcome to ask questions or discuss it with others if you wish.

Purpose of the study

The aim of this study is to help to understand the role that a reflective group plays in the process of recovery in a medium secure ward. The reflective group we are interested in is the one which has been running on [redacted] as part of the treatment there. We are interested in finding out about your experience of the group, in what ways you feel that it impacts on recovery and how you think it might do this. We are hoping to hear from people with a range of different experiences of the group to help us get a real sense of what it is like to be part of.

Why have I been chosen?

You have been chosen to take part in this project for one of two reasons. Either you have experience of the reflective group because you have attended as part of your treatment on the ward. Or, you have experience of the reflective group because you have been involved as a facilitator.

Do I have to take part?

No. Taking part in this project is entirely voluntary and therefore it is up to you whether you wish to be involved. If you choose not to take part this will not impact you in any way.

If you do decide to take part then I will ask you to sign a consent form. If you change your mind, you are free to withdraw from the project at any time, without giving a reason. If you decide to withdraw from the project, we will keep the information that we have already obtained. Please see "**What happens to my information?**" section for more details.

What would taking part involve?

Taking part in this project means agreeing to be interviewed by me. You will only be interviewed on one occasion and this could take anything up to 1 hours depending on how much you would like to share. The interviews will be audio recorded and stored safely on an encrypted memory stick before they are copied out into text (transcribed). Recordings will only be identifiable by number, not with your name and write-ups will also be made anonymous. Quotes from your interview may be included in the write-up of the research but these will also be anonymised and will not contain any identifiable information (e.g. names, locations).

Location of the interviews will be arranged on an individual basis. If you are currently a resident of the ward I will interview you there. If you are not currently a resident of a ward, I

will make arrangements to interview you in a place which is easy for you to access such as your local team base.

Are there possible disadvantages and/or risks in taking part?

If you have found being part of the reflective group challenging for any reason, then talking about it in an interview may bring up some difficult emotions or memories for you. In this situation you would be welcome to take a break or end the interview at any time.

If you need to travel to the location of your interview, a possible disadvantage of this could be the cost of travel. Each person who takes part is entitled to up to £10 to cover travel costs and I will try to make sure you do not have to go far.

What are the possible benefits of taking part?

The results of this project will hopefully help to increase understanding of how the reflective group is/isn't helpful in terms of recovery. By taking part you will be contributing to this understanding and any changes that happen as a result of the findings.

Will my involvement in this project be kept confidential?

Yes. All of the information gathered as part of this project will be kept strictly confidential. We will follow ethical and legal practice guidelines and all information about you will be handled in confidence.

In some rare situations something might come up during an interview which would mean I need to break confidentiality. This would only happen if I became aware that either you or someone else is in serious direct risk of harm. In this rare situation, this information would have to be shared. This would be done in line with NHS policy and guidelines.

What will happen to the results of the research project?

Results of this project will be used in four different ways.

1) The project will be submitted to be published in an academic journal and therefore people will be able to access this through their library if they wish to do so.
2) The results of the project will be shared with the team working in [redacted]
3) The project will be submitted to Canterbury & Christ Church University as part of my qualification to become a Clinical Psychologist.
4) A summary of the research and findings will be given to everybody who has taken part. This summary will also be available to residents of the ward and their carers if they wish to see it.

Who is organising and funding the research?

The research is being funded and organised by Canterbury & Christ Church University, in partnership with [redacted].

Ethics

This project has received NHS ethics approval.

What happens to my information?

Canterbury & Christ Church University is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your

information and using it properly. Canterbury & Christ Church University will keep information about your interview for 10 years after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information by contacting Dr. Fergal Jones, Research Director, Salomons Institute for Applied Psychology, Canterbury Christ Church University fergal.jones@canterbury.ac.uk.

NHS will collect information from you for this research study in accordance with our instructions. NHS will keep your name and contact details confidential and will not pass this information to Canterbury & Christ Church University. NHS will use this information as needed, to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. Certain individuals from Canterbury & Christ Church University and regulatory organisations may look at your research records to check the accuracy of the research study. Canterbury & Christ Church University will only receive information without any identifying information. The people who analyse the information will not be able to identify you and will not be able to find out your name or contact details.

What if there is a problem or you have a complaint?

If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to address your concerns. You can contact me by leaving a message on the 24-hour voicemail phone number 01227 927070. Please leave a contact number and say that the message is for me (Anna Woodcock) and I will get back to you as soon as possible. If you remain unhappy and wish to complain formally, you can do this by contacting Dr. Fergal Jones, Research Director, Salomons Institute for Applied Psychology, Canterbury Christ Church University fergal.jones@canterbury.ac.uk.

Contact

If you would like to speak to me and find out more about the study or have questions about it answered, you can leave a message for me on a 24 hour voicemail phone line at 01227 927070. Please say that the message is for me (Anna Woodcock) and leave a contact number so that I can get back to you.

Appendix H. Consent form

Consent Form

Title of project: Understanding a service user reflective group as part of secure recovery on a medium secure ward.

Name of Researcher: Anna Woodcock

Please read the following and initial the box to the right of each statement if you agree. There is space for you to sign and date below.

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to discuss the information, ask questions and have had these answered satisfactorily.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason without my medical care or legal rights being affected.	
3. I agree that the anonymous quotes from my interview may be used in published reports of the study findings.	
4. I agree that my anonymous data can be used in future research. (You will still be able to take part in this study if you do not agree to this.)	
5. I agree to take part in the above study.	

Name of participant: _____

Date: _____

Signature: _____

Name of person taking consent: _____

Date: _____

Signature: _____

Appendix I. Initial interview guide

Service Users	Staff
1. When did you attend the group? (If not current)	1. When were you involved with the group? (if not current)
2. Approximately how many groups did/have you attend(ed)?	2. Approximately how many groups did/have you attend(ed)?
3. Did/do you attend regularly?	3. Are/were you involved regularly?
4. When you think about the times you have attended the group, what first comes to mind?	4. When you think about the times you have attended the group, what first comes to mind?
5. What did you hope that the group could do for you?	5. What did you hope that the group could do for its members?
6. Is there a particular time in the group that stands out for you? • What happened? • What was said next? • What did the facilitator say? • What did you say? • What happened next? • What did the other group members say/do? • What feelings/emotions does that bring up for you?	6. Is there a particular time in the group that stands out for you? • What happened? • What was said next? • What did the facilitator say? • What did you say? • What happened next? • What did the other group members say/do? • What feelings/emotions does that bring up for you?
7. Can you tell me about your experience of relationships with other group members? • Can you tell me about a positive experience of a relationship within the group? (Doesn't have to be one that you are/were involved in, could be one that you have witnessed.) • Can you tell me about a negative experience of a relationship within the group? (Doesn't have to be one that you are/were involved in, could be one that you have witnessed.) • Did you learn anything about relationships as a result of the group?	7. Can you tell me what you have noticed about relationships between group members? • Can you tell me about a positive experience of a relationship within the group? • Can you tell me about a negative experience of a relationship within the group? • Can you tell me about a relationship in the group which has changed over time?
8. Did/has your experience of the group change(d) over time? • In what ways?	8. Did/do you notice a change in the ways group members engage(d) in the group over time? • What have you noticed when people first join the group?

• Tell me a bit about what it was like when you first started going? • Tell me a bit about what it was like near the end/now?	• What have you noticed when people are nearing the end of their involvement with the group?
9. What was helpful about the group?	9. What is your understanding of why people attend the group? • What do you think people find helpful about the group?
10. What was unhelpful about the group?	10. What do you think that people find unhelpful about the group?
11. Did/does the group impact the way you are/were feeling? • In what ways?	
12. Did/does the group impact the way you were/are thinking? • In what ways?	
13. Do you think the group relates(d) to your journey to recovery? • In what ways?	13. In what ways do you think the group relates to recovery? • Can you tell me about one person in the group, whose journey towards recovery stands out for you?
14. How do you think your experience of the group could be/ could have been improved?	14. How do you think the group could be improved?
15. Is there anything you would like to say about your experience of the group that you haven't already had a chance to share?	15. Is there anything you would like to say about the group that you haven't already had a chance to share?

Appendix J. Example of developed interview guide

Did you or other people use the group to get things off your chest?

- What does it mean to get things off your chest?
- What are the benefits of getting things off your chest?
- What was it like to sit and listen to other people as they got things off their chests?

Did you or other people use the group to share their experiences?

- Did you learn anything from listening to other people?
- Do you remember anyone saying anything helpful to you in the group?

Can you tell me about you experience of relationships with other group members?

- A positive experience?
- A negative experience?
- Did you learn anything about relationships as a result of the group?

Were you impacted by the behaviour/emotions of other people in the group?

- Did you feel as though your behaviour/emotions impacted other people?
- Did you discuss how the behaviour/emotions of one person can impact others?

Can you tell me about an experience of conflict you had in the group (either involving you or that you witnessed)?

- What did you feel like at the time?

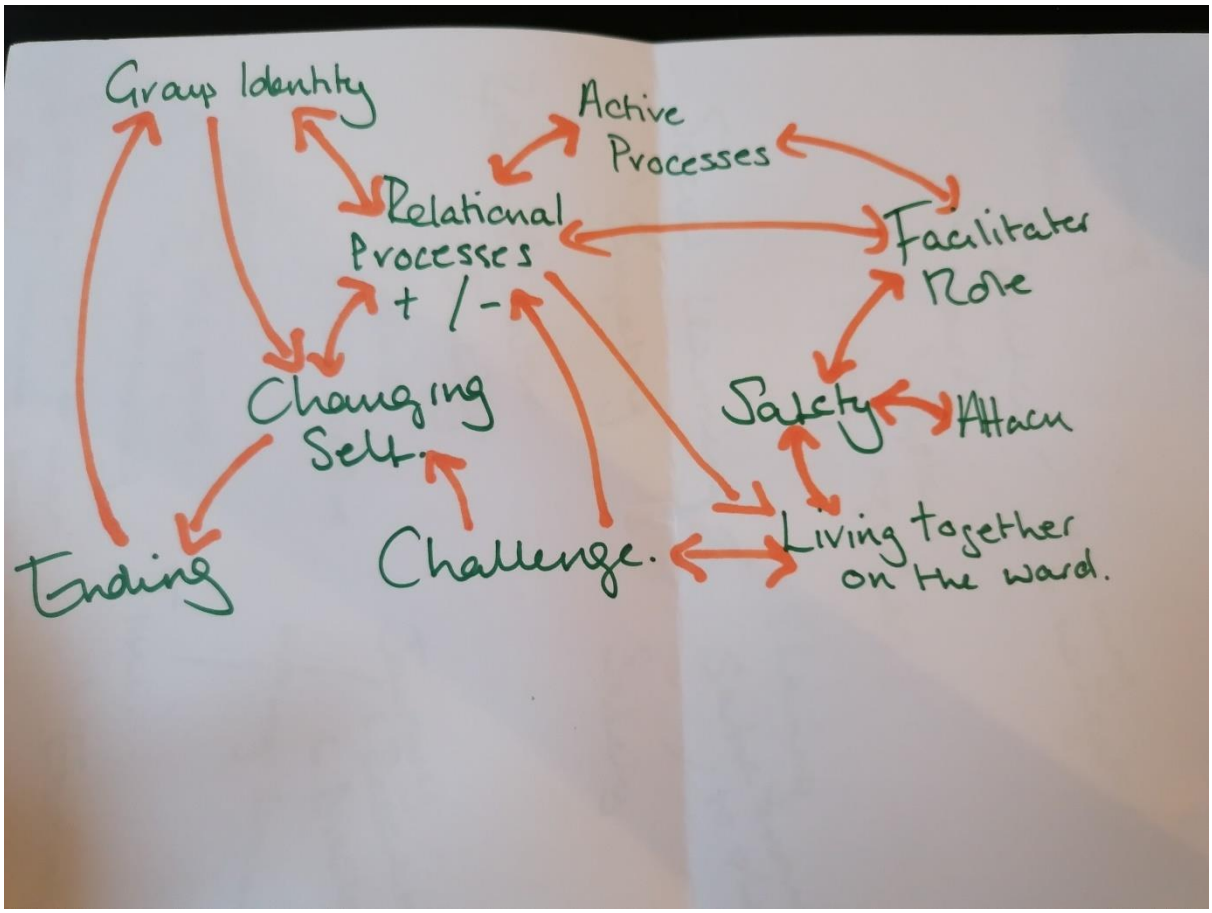
Did you feel there was a difference between the environment in the group & the environment in the ward?

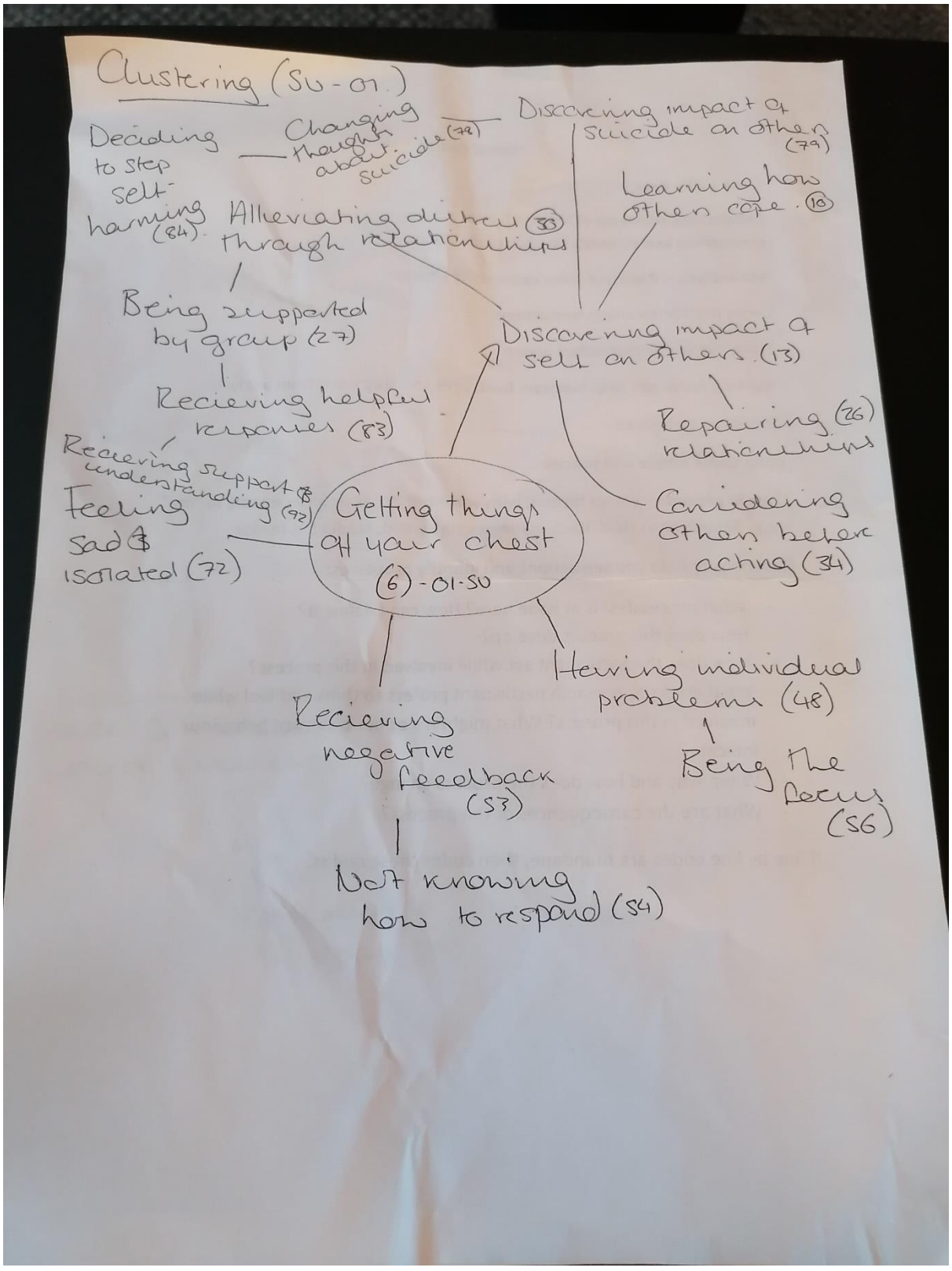
- Did you feel safe?
- Did you feel vulnerable?
- Did you feel attacked (physically or verbally)?

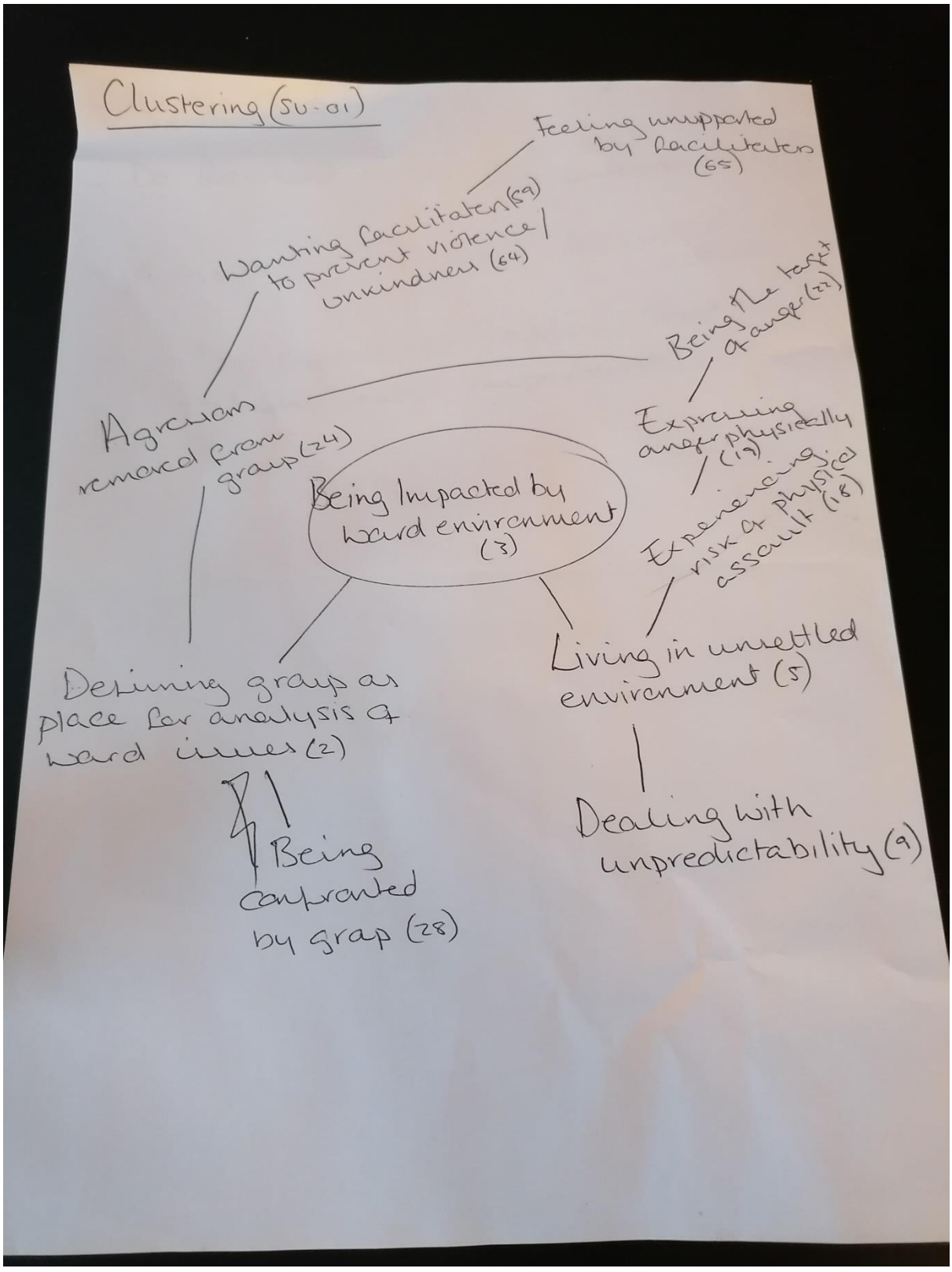
Did you experience any competition within the group?

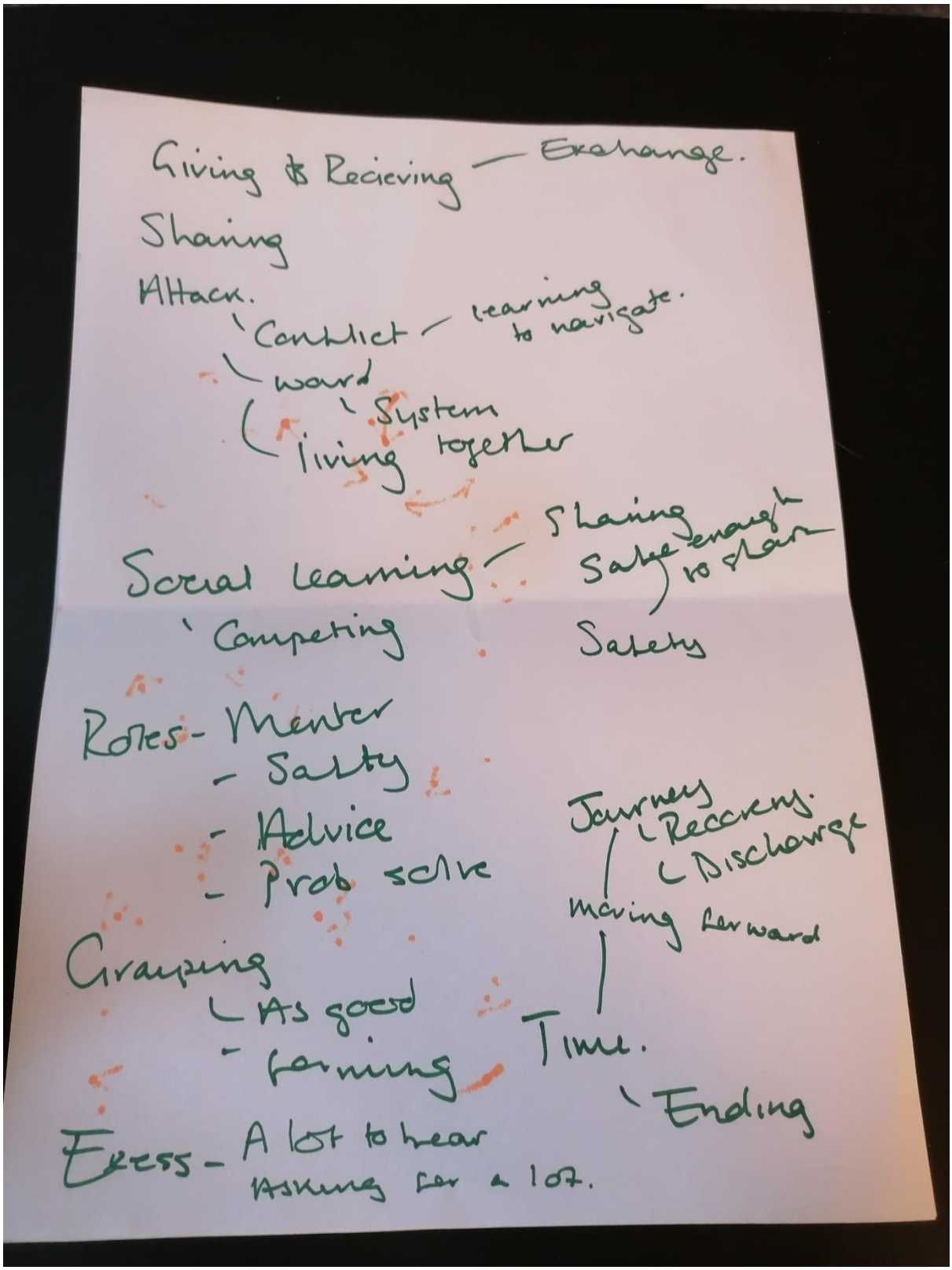
- When people were discharged?
- In relation to treatment?

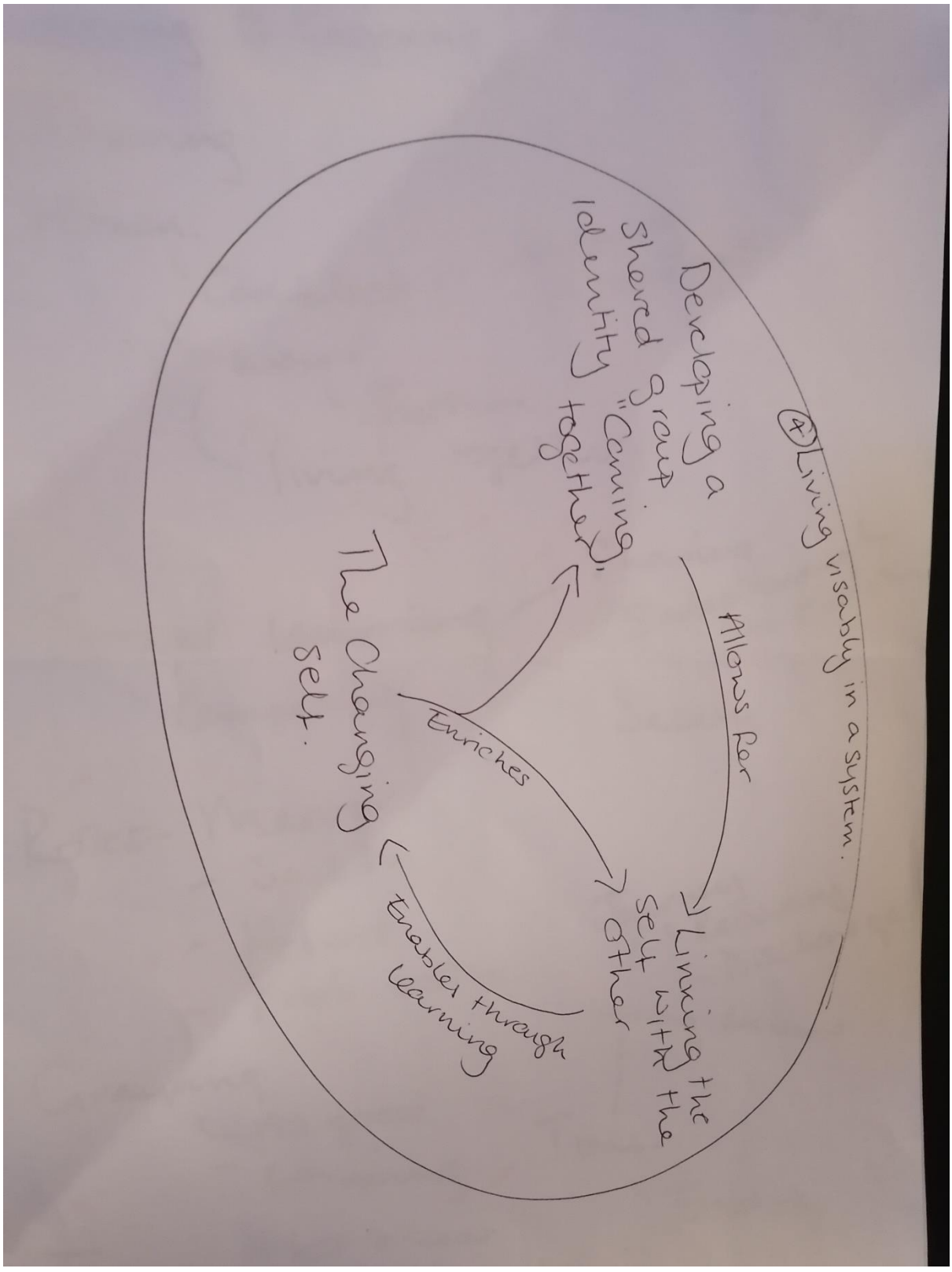
Appendix K. Examples of workings -theoretical sorting, clustering, diagramming

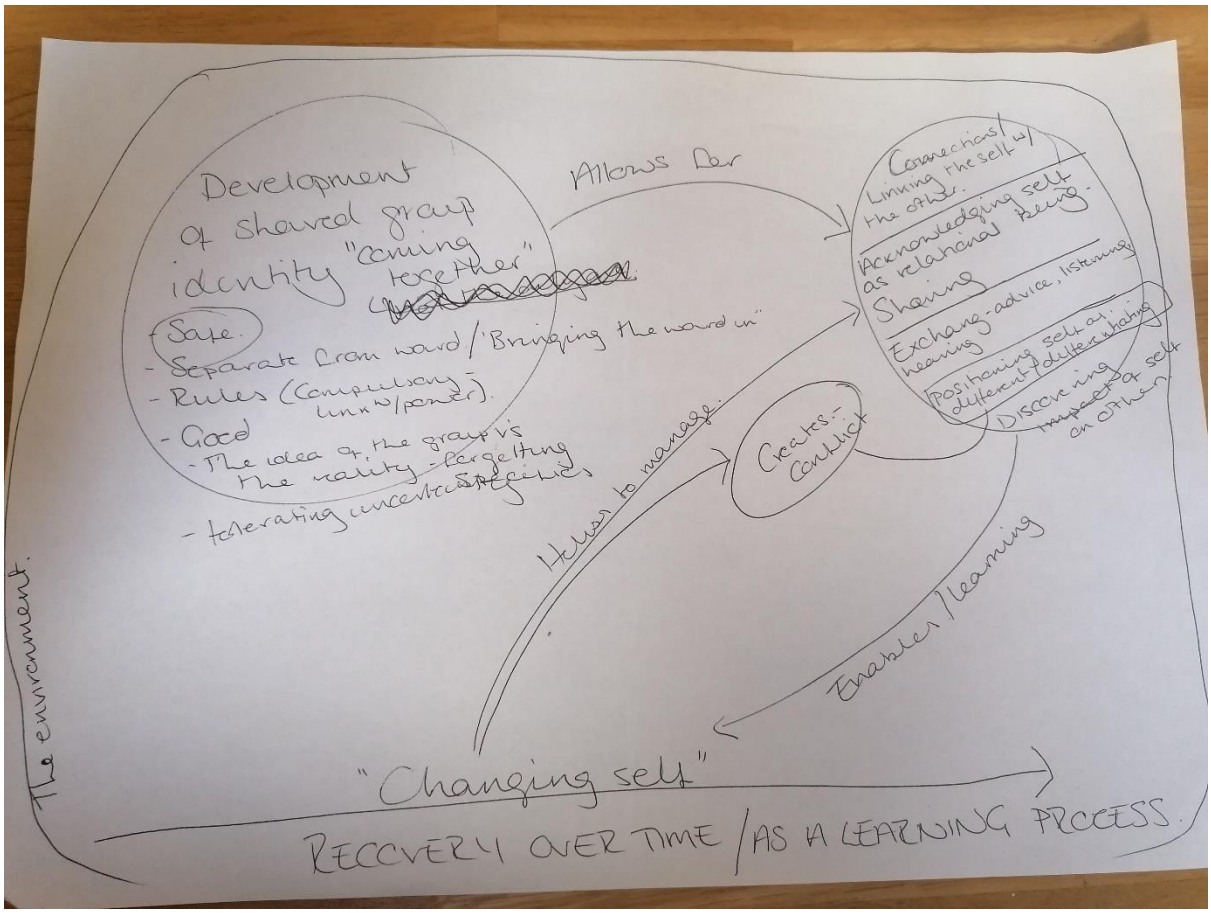


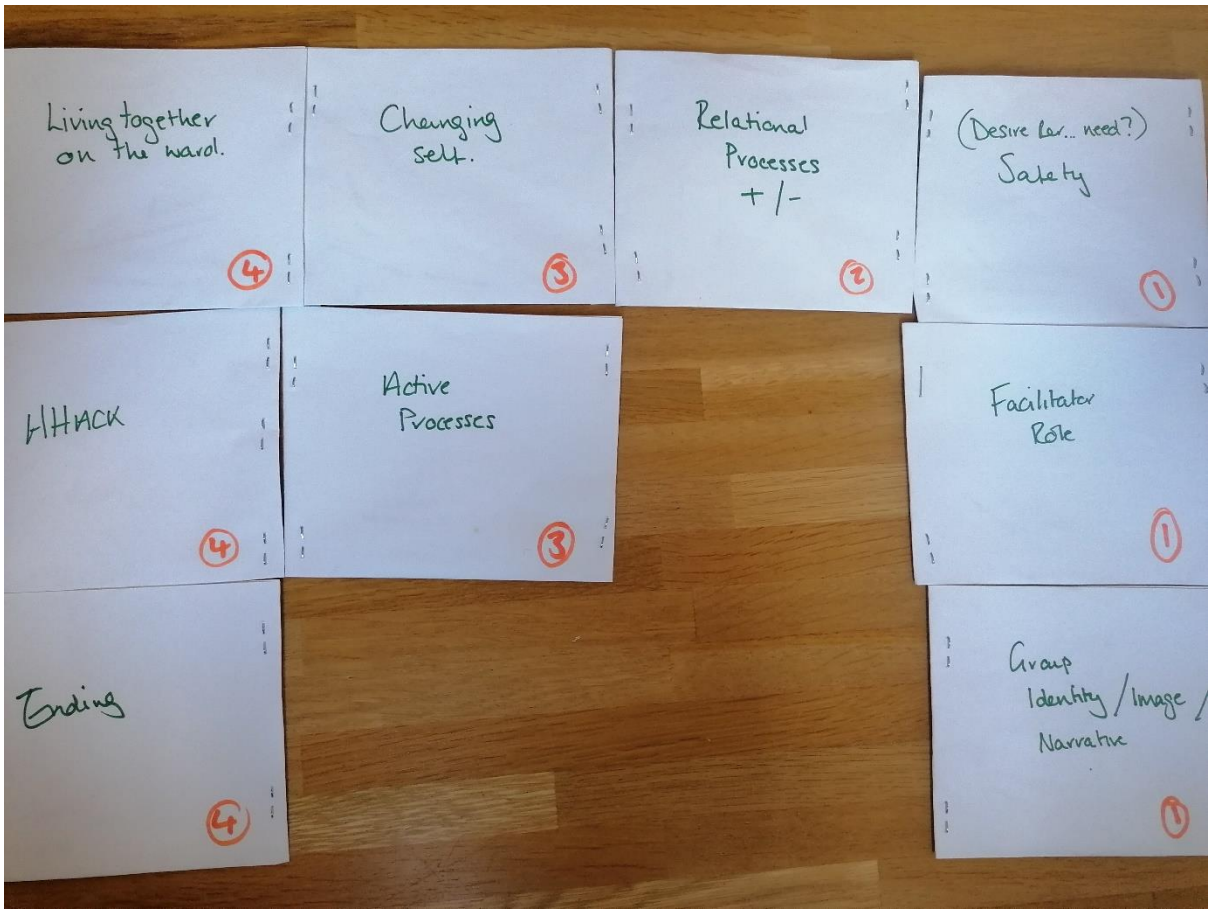

Clustering (SU-01)
Deciding to stop self-harming (84)
Changing thought about suicide (78)
Discovering impact of suicide on others (79)
Learning how others cope (10)
Alleviating distress through relationships (33)
Being supported by group (27)
Discovering impact of self on others (13)
Recieving helpful responses (83)
Repairing (26) relationships
Recieving support & understanding (92)
Feeling sad & isolated (72)
Getting things off your chest (6) - 01-SU
Considering others behaviour (34)
Having individual problems (48)
Recieving negative feedback (53)
Being the focus (56)
Not knowing how to respond (54)


Clustering (SU-01)
Feeling unsupported by facilitators (65)
Wanting facilitators to prevent violence/ unkindness (64)
Being the target of anger (22)
Aggression removed from group (24)
Expressing anger physically (19)
Being Impacted by ward environment (3)
Experiencing risk of physical assault (18)
Defining group as place for analysis of ward issues (2)
Living in unsettled environment (5)
Being confronted by group (28)
Dealing with unpredictability (9)


Giving & Recieving — Exchange.
Sharing
Attack.
Conflict — learning to navigate.
ward
System
living together
Social learning — Sharing
Safe enough to share
Competing
Safety
Roles - Mentor
- Safety
- Advice
- Prob solve
Journey
Recovery.
Discharge
Moving forward
Grouping
As good
- forming
Time.
Ending
Stress - A lot to hear
Asking for a lot.


④ Living visably in a system.
Developing a shared group identity "Coming together"
Allows for
Linking the self with the other
Enriches
The changing self.
Enables through learning


Development of shared group identity "coming together"
Safe
- Separate from ward / 'Bringing the ward in'
- Rules (Compulsory - link w/ power)
- Good
- The idea of the group vs the reality - forgetting
- tolerating uncertainty
Allows for
Connections / Liming the self + / the other.
Acknowledging self as relational being.
Sharing
Exchange - advice, listening, hearing
Positioning self as different / alike
Discovering impact of self on others
Creates - Conflict
Have to manage.
Enables / learning
"Changing self"
RECOVERY OVER TIME / AS A LEARNING PROCESS.
The environment.



Appendix L. Examples of memo-writing

"Getting things off your chest – People talk about getting things off their chests, a kind of dumping of their thoughts into the group but don't seem to be holding on to or giving much importance to what comes next. I'm wondering if they care what comes next? Or is there something about saying things out loud which is enough for some people. Is there something about the types of things which could come after getting things off your chest which group members don't really want to hear?"

"Coming from different angles – There's something here about the different motivations for attendance. People are recognising this difference and are accepting it in that they aren't expressing strong dislike of motivations which are different from their own, but are they able to acknowledge their own motivations? What if those motivations aren't completely "good" – some have been open in saying they attend because they're bored, other people have assigned these less favourable reasons to other people."

"Living together – There's something about living in a visible way which invites and allows feedback from others on your behaviour e.g. self-harm, aggression. P1 spoke to me about her changing opinion of self-harm as a result of the group. It was about having impacted other people, but also being seen. She hadn't lived in an environment before whereby her self harming had an effect on other people. There's something upsetting about this, and whilst it was upsetting for her to be in an environment where she was visible, perhaps there's something in that which means she's cared about?"

"Bringing things – Wondering if there's something about people bringing things to the group – there is often language around bringing things, like baggage, something you carry?"

"Disconnect – There's something here about how the facilitators are noticing a disconnect or lack of genuine relationship and the group members are talking about having friends outside of the group. They aren't necessarily building relationships within the group? Perhaps they don't need personal connections for the group, maybe relationships get in the way? Group attendance is for individuals, just with witnesses?"

"Rehearsal – Learning how to interact in a different way linked with the sense of disconnect or at least not close relationships could create an environment of rehearsal. As though the group provides a safe space within which you can try out a different way of interacting, see what happens and perhaps that's why its not seen as a negative thing that close friends are seen as outside of the group (if at all)."

Appendix M. Inter-rater reliability check

Focussed Code:	
Initial Codes	**Narrative Extracts**
	"I would quite often hurt myself and then when I went to the group and they were saying how stressful it was and going on and it just made you sit back and thought of others"
	"I think… it's like I said, you should think of others before you act and relationships grow stronger then because you have better consideration for each other"
	"it changes because you've gotta realise how it effects everyone else on the ward"

Focussed Code:	
Initial Codes	**Narrative Extracts**
	"I dunno just listen to our complaints and how we're feeling and that"
	"… being able to unload your stresses. Um… having someone to talk to, that's a big issue there because you're left for so long without anybody to talk to"
	"having a group and having someone to talk to you were able to get rid of some of the stress"
	"… just being able to vent really"

Focussed Code:	
Initial Codes	**Narrative Extracts**

	"and some people just enjoy going there and just having a chat with the door shut like"
	"I dunno I think some people might go because it looks good"
	"sometimes it seems that people have got a bit of an agenda"
	"yes wanting to talk about dynamics and things like that but also, um, in that slightly fixed way of um, this is something I need to do because, we do this and its part of getting discharged"

Focussed Code:	
Initial Codes	**Narrative Extracts**
	"it's the pain of thinking to a certain extent"
	"You know that fear of, I can only do it this much, and then I need a couple of weeks and I might come back a bit later on."
	"I think they have a sense that if they do too much of that or they look too kind of… that someone might forget that their distress is still there, and I guess in their minds the idea might be that that might mean that then staff, don't, err, forget."

Focussed Code:	
Initial Code	**Narrative Extracts**
	"a lot of the time the patients were like, at your throat"
	"Certainly when there's lots of staff and lots of patients outside and shouting and laughing or whatever"
	"Really moody, and they'd snap at you and it's like oh my god"

For Matching Up	
Initial codes	**Focussed codes**
Considering others (1-14)	Struggling with progression
The pain of thinking (69-7)	Coming from different angles
Changing behaviour as it affects others (1-78)	Getting things off your chest
Attending with an agenda (71-6)	Discovering impact of self on others

Chatting in safety (21-5)	Feeling attacked
Feeling attacked (82-1)	
Unloading stress (77-8)	
Fearing engagement (70-7)	
Having someone to talk to (82-8) Getting rid of stress (83-8)	
Being intruded upon (8-7)	
Sharing complaints and feelings (3-8)	
Attending to facilitate discharge (140-7)	
Venting (35-5)	
Suspecting superficial engagement in others (20-5)	
Fearing staff will forget distress (77-7)	
Thinking of others before acting (1-34)	
Being snapped at (27-4)	

Appendix N. Reflexive journal extracts

"What comes next usually when I get something off my chest? A conversation about it, a dissecting of the relevant issues, advice, a related story that the other person sees as relevant to what I've just said? Do I want to hear that? I think I do yes, but not always, there is sometimes a 'confessional' aspect to what I'm doing? It depends for me on who I'm talking to, in terms of whether I respect their input, but it's also about my mood. Could this be true for group members? Is there something that they don't really want to hear in response, they don't want advice really, perhaps they aren't ready for it, don't value it, don't value it from other group members? Need to check this out, aware that my own reasoning may cloud if I don't check explicitly."

"I don't feel completely comfortable on the ward, definitely don't feel in direct danger, but not completely safe. When I look at residents of the ward, they often physically portray relaxation. They're often in their pyjamas, walking slowly, laughing in meetings, joking around with each other. In interviews they express some fear, not naming it as such, but they name the safety of the group in comparison to the ward. I wonder what image I project on the ward when I feel unsafe. I don't think I look in the least bit frightened. I've been given feedback from most supervisors about how I manage risk and complexity calmly, but I tend

not to feel calm in the moment. Is there something I'm doing, and seeing in the residents of the ward? Do we all feel unsafe, threatened, but portray an image that communicates otherwise? What's this about? Hiding vulnerability perhaps?"

"I asked a question about this idea from a memo about rehearsal, whether group members could use the group as a place to practice different kinds of social interaction outside of their norms. I asked it of a facilitator and it felt as though there was some resistance. I'm trying to pick apart what parts of the interaction were coming from me, which were representative of the group process and which were coming from the respondent. I need to acknowledge my role in raising this code for further exploration, it felt important enough for me to chase, but I've checked back and it absolutely came from the data and therefore from accounts of the groups experience, but it was me that saw it to be important. I think perhaps the respondent felt slightly resistant to framing the group as a place for rehearsal, perhaps because there's something inauthentic about rehearsal. I need to continue with this thread in my next interview as more data is necessary to clear it up. In fact I think I need to make sure one of my next interviews is with a service user, perhaps the investment in the group felt by facilitators is going to make it difficult at times for them to reflect on possible group processes which do not represent fully what they have held in their minds about the group until now."

Appendix O. Journal of Forensic Psychiatry and Psychology - Notes for contributors. Retrieved from: https://www.tandfonline.com/action/authorSubmission?show=instructions&journalCode=rjfp20

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- Should contain an unstructured abstract of 200 words.
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- Please include a word count.

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Updated 4-03-2020

Appendix P. Example of transcribed and coded interview (P1-SU)

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Appendix Q. End of study feedback to HRA/REC

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