

**When service user and research worlds come together: An investigation
into therapeutic engagement in secure settings**

Kieran Matthijs Lord

**Thesis submitted in partial fulfilment of the requirements of Staffordshire
and Keele Universities for the jointly awarded degree of
Doctorate in Clinical Psychology**

29th June 2014

Table of contents

| | |
|--|------|
| Contents (including figures and tables in italics) | ii |
| List of appendices | vi |
| List of abbreviations | vii |
| Acknowledgements | viii |
| Thesis abstract..... | ix |

Contents

Paper 1: Exploring what is known about therapeutic engagement in inpatient male forensic settings: a review of the literature.

| | |
|--|----|
| Journal submission guidelines – <i>Psychology, Crime and Law</i> | 1 |
| Title..... | 3 |
| Abstract..... | 3 |
| Introduction | 3 |
| Therapeutic engagement in forensic settings | 3 |
| Rationale for literature review | 5 |
| Structure of review | 5 |
| Inclusion and exclusion criteria..... | 6 |
| Search strategy and results | 6 |
| Screening results..... | 6 |
| <i>Figure 1: Literature review screening process flow chart</i> | 7 |
| Critical review..... | 8 |
| <i>Table 1: Qualitative results included in the critical review</i> | 9 |
| <i>Table 2: Quantitative results included in the critical review</i> | 10 |
| <i>Table 3: Interventions described in review results</i> | 12 |
| Category 1: Perspectives of engagement..... | 12 |
| Willmot & McMurrin (2013) | 12 |
| Sainsbury, Krishnan, & Evans (2004) | 14 |
| Mason & Adler (2012) | 15 |
| Schafer & Peternelj-Taylor (2003)..... | 17 |
| Category 2: Measuring treatment readiness, motivation and engagement | 19 |

| | |
|--|----|
| McMurran, Theodosi, & Sellen (2006)..... | 19 |
| Rosen, Hiller, Webster, Staton, & Leukefeld (2004)..... | 20 |
| Day, Howells, Casey, Ward, Chambers, & Birgden (2008)..... | 21 |
| Category 3: Engagers and non-engagers..... | 23 |
| Sheldon, Howells, & Patel (2010)..... | 23 |
| McMurran, Huband & Duggan (2008) | 25 |
| Frost & Connolly (2004) | 26 |
| Summary of review findings..... | 27 |
| Theme 1: Therapist attributes..... | 27 |
| Theme 2: Service user attributes..... | 28 |
| Theme 3: Aims and feedback..... | 28 |
| Theme 4: Environmental factors..... | 28 |
| Review Limitations | 29 |
| Recommendations..... | 29 |
| References..... | 31 |

Paper 2: Therapeutic engagement in medium-secure care: An interpretative phenomenological analysis of service users' experiences.

| | |
|--|----|
| Journal submission guidelines - <i>The Journal of Forensic Psychiatry and Psychology</i> | 37 |
| Title..... | 39 |
| Abstract..... | 39 |
| Introduction | 39 |
| Method..... | 41 |
| Ethical approval..... | 41 |
| Participants..... | 41 |
| Procedure..... | 41 |
| Service user designed interviews | 42 |
| Analysis | 43 |
| Diary | 44 |
| Findings..... | 45 |
| <i>Table 4: Super-ordinate themes and sub-themes</i> | 45 |
| Theme 1: 'Different worlds' | 45 |
| 'Coming from different worlds' | 46 |
| 'Meeting at the same level' | 46 |

| | |
|---|----|
| ‘Abnormal home environment’ | 48 |
| Theme 2: ‘What the individual brings’ | 48 |
| ‘Personal attributes’ | 48 |
| ‘Expectations and evaluations’ | 49 |
| ‘Staff Role’ | 50 |
| Theme 3: ‘What the therapy entails’ | 51 |
| ‘Building a trusting relationship’ | 51 |
| ‘Setting up and doing therapy’ | 52 |
| ‘Outcomes’ | 52 |
| Theme 4: ‘Control’ | 53 |
| ‘Having a choice’ | 53 |
| ‘Responding to punishment and feedback’ | 54 |
| Discussion | 54 |
| Limitations | 57 |
| Clinical implications | 58 |
| Future research | 59 |
| Conclusions | 59 |
| Disclaimer | 59 |
| References | 60 |

Paper 3: Hard to reach worlds: Challenges and rewards of conducting service-user informed research in forensic settings.

| | |
|---|----|
| Title | 64 |
| Abstract | 64 |
| Submission details | 64 |
| Structure of reflective paper | 64 |
| ‘Different worlds’ | 65 |
| <i>Figure 2: Graphical display of the overlapping worlds of the target research</i> | 65 |
| The principal investigator and SU worlds | 65 |
| The ex-forensic service user research world | 66 |
| The NHS ethics world | 67 |
| ‘What the individual brought’ | 68 |
| Service-user’s presentations | 68 |
| Expectations and researcher’s role | 68 |
| ‘What the research entailed’ | 69 |

| | |
|---|-----------|
| Having and not having trust in the research | 69 |
| “Having a laugh” | 70 |
| Doing analysis | 70 |
| ‘Control’..... | 71 |
| Having (or not having) control over the research process | 71 |
| Perceptual Control Theory..... | 72 |
| <i>Figure 3: PCT negative feedback loop of the PI’s TE system</i> | <i>72</i> |
| Feedback..... | 73 |
| Conclusion | 74 |
| References..... | 75 |

List of appendices

| | |
|--|--------|
| A: Review screening process..... | I |
| B: Preliminary review searches..... | III |
| C: Qualitative paper screening tool..... | VII |
| D: Quantitative paper screening tool..... | IX |
| E: Certificate of indemnity..... | XI |
| F: Peer review approval..... | XII |
| G: NHS proportionate review unfavourable opinion..... | XVI |
| H: NHS REC unfavourable opinion..... | XVIII |
| I: NHS REC favourable opinion..... | XXII |
| J: Local trust research and development approval..... | XXVI |
| K: Consent form..... | XXVII |
| L: Participant information sheet..... | XXVIII |
| M: Letter to service user research group..... | XXX |
| N: Staff information sheet..... | XXI |
| O: Service user produced interview guide..... | XXIII |
| P: Examples of line by line coding..... | XXXVII |
| Q: Examples of diagrammatic analysis of cases..... | XXXIX |
| R: Examples of diagrammatic analysis across cases..... | XLI |
| S: Diagram of themes..... | XLII |

List of abbreviations

| | |
|---------------|---|
| ANOVA | Analysis of variance statistical model |
| CASP | Critical appraisal skills programme |
| CBT..... | Cognitive behavioural therapy |
| CONSORT | Consolidated standards of reporting trials group |
| CVTRQ | The corrections Victoria treatment questionnaire |
| GT..... | Grounded theory |
| HM | Her majesty |
| IPA..... | Interpretative phenomenological analysis |
| MDT | Multi-disciplinary team |
| MORM | The multi-factorial offender readiness model |
| NHS | The national health service of the United Kingdom |
| NOMS | The national offender management service |
| PCL-R | The Hare psychopathy checklist - revised |
| PD..... | Personality disorder/personality disordered |
| QUOROM | Quality of reporting of meta-analyses group |
| RCQ..... | The readiness to change questionnaire |
| REC | Research ethics committee |
| SPSI-R..... | The social problem-solving inventory – revised |
| STAI..... | The state trait anxiety inventory |
| STRS | The Serin treatment readiness scale |
| SU..... | Service user |
| SURG | Service user research group |
| SUs..... | Service users |
| TA | Thematic analysis |
| TE | Therapeutic engagement |
| TES..... | The treatment engagement scale |
| TMQ..... | The treatment motivation questionnaire |
| UK..... | United Kingdom |
| URICA..... | The Rhode Island change assessment |
| VTRI..... | The violence treatment readiness interview |
| VTRQ..... | The violence treatment readiness questionnaire |

Acknowledgements

I wish to acknowledge Helena Priest for her personal warmth, encouragement and unrivalled knowledge; and Amanda McGowan for her continued support and guidance.

I also wish to acknowledge the service user research team from Manchester University (Angel Delight, Claire Daniels, David O'Brien, Peer Bhatti, and Natasha Peniston), for their inspiration and integral role in this study. Special thanks to Yvonne Awenat and Dan Pratt for introducing me to the world of service user informed research, and moreover how to use it sensitively and effectively.

I would also like to acknowledge all the other supervisors who have helped me on my journey so far: Kate Ross, Damon Mason, Samantha Templeman, Gail Thomas, Paul Moloney, Cat O'Callaghan, John Sorensen, Nish Patel, and Mats Dernevik. Also to acknowledge all the DClinPsy staff and peers, especially Ken McFadyen for setting up and running the IPA group; and Shivani Chotai and Kaz Sefton-Smith for your generous input.

Most importantly, I wish to acknowledge the service users who allowed me into their worlds, and all those I have worked with and learned from along the way.

Thesis Abstract

This thesis describes the process of exploring the therapeutic engagement (TE) experiences of men detained in forensic environments. Therapeutic non-engagement for this hard to reach group can have devastating consequences for themselves, for staff, and to the public. A review of the literature highlighted how individual environments are likely to create specific factors which staff may consider when attempting to engage with men who are detained. There had however been limited investigations into TE from service users' (SUs) perspectives. To better understand the factors involved in TE for men engaged in medium secure care, an SU informed study was completed to explore the lived experiences of men in a regional UK hospital. Using Interpretative Phenomenological Analysis (IPA), the resultant themes included how SUs experienced occupying *different worlds* to staff, as well as themes relating to *what the individual brings* to therapy, *what the therapy entails*, and having or not having *control*. The researcher used the resultant themes to comment on the processes of conducting the research by considering their navigation between different worlds of SU research and ethics, and how implementing the findings achieved personal goals.

Total word count (excluding references and journal submission guidance): 19,467

Paper 1: Journal Submission Guidelines – Psychology, Crime and Law



Disclaimer

Paper 1 has been written for publication in *Psychology, Crime and Law*. General submission guidelines for the target journal have been followed, however for the purposes of thesis submission Ariel font size 12 and extended left hand margins have been used to adhere to University submission guidelines, and for ease of accessibility.

Additional content included for the purposes of thesis review, including non-standard headings will be removed prior to manuscript submission to the target journal.

Relevant general guidelines

- APA Reference Style.
- Times New Roman font, size 12.
- Please use single quotation marks, except where 'a quotation is "within" a quotation'. Long quotations of 40 words or more should be indented without quotation marks. Always use the minimum number of figures in page numbers, dates etc., e.g. pp. 24-4, 105-6 (but using 112-13 for 'teen numbers) and 1968-9.
- Abstracts of 200 words are required for all manuscripts submitted.
- No suggested word limit.
- Each manuscript should have 5 keywords.
- Section headings should be concise.
- All persons who have a reasonable claim to authorship must be named in the manuscript as co-authors; the corresponding author must be authorized by all co-authors to act as an agent on their behalf in all matters pertaining to publication of the manuscript, and the order of names should be agreed by all authors.
- Biographical notes on contributors are not required for this journal.
- Please supply all details required by any funding and grant-awarding bodies as an acknowledgement in a separate paragraph.

- Authors must also incorporate a Disclosure Statement which will acknowledge any financial interest or benefit they have arising from the direct applications of their research.
- For all manuscripts non-discriminatory language is mandatory. Sexist or racist terms must not be used.
- Authors must adhere to SI units. Units are not italicised.
- When using a word which is or is asserted to be a proprietary term or trade mark, authors must use the symbol ® or TM.

Paper 1: Exploring what is known about therapeutic engagement in inpatient male forensic settings: A review of the literature

Abstract

Substantial costs are involved in the treatment of men in prisons, secure hospitals and other forensic inpatient settings for mental health difficulties associated with offending. Engaging in psychosocial therapies is known to be an integral factor for reducing future offending and relapse. However, therapeutic non-engagement can lead to continuing mental health needs and offending, with additional personal and financial costs to service users (SUs), staff and society. The aim of this paper was to explore what is known about therapeutic engagement (TE) within inpatient forensic settings so therapeutic staff can better understand how to optimise engagement. At the time of review, only ten papers met the inclusion criteria, highlighting the emerging nature of research in this area. The five qualitative and five quantitative papers investigated a range of processes associated with TE in forensic settings. Four over-arching themes were identified across the papers which provided insight into how TE is understood. These were *therapists' attributes* including trust, *service users' attributes* such as motivation, a requirement to have shared *aims* and for receiving constructive *feedback*, and *environmental factors* such as having no choice. Limitations of the review are offered, with recommendations for further research into TE in a range of settings from SUs' perspectives.

Key words: Therapeutic engagement, qualitative research, quantitative research, forensic mental health, literature review.

Word count: 8,528.

Introduction

Therapeutic engagement in forensic settings

There are currently around six thousand SUs detained in secure UK forensic hospitals (Centre for Mental Health, 2013). The average cost per year (2008/9) per SU to the public is estimated to be between £152,000 to £273,000 (Centre for Mental Health, 2011). That equates to approximately 1% of the total annual NHS budget. Also, with an average cost per prisoner per annum of around

£35,000 (Ministry of Justice, 2013), approximately 70% of the current 85,000 UK prison population are estimated to have two or more mental health disorders (Mental Health Foundation, 2007). Men make up approximately 80% of the population in secure mental health services, and 95% of the population of prisons.

Mental health SUs detained in forensic settings such as secure hospitals and prisons are usually required to engage in therapies aimed at reducing mental distress and/or for preventing further offending (Rethink, 2011). Poor TE can lead to adverse clinical outcomes, and can negatively affect cost effectiveness of services and staff morale (O'Brien, Fahmy, & Singh, 2009). Many forensic mental health patients who are unable to engage in effective therapies become *revolving door* patients or permanently detained; more than a third of patients who are released from secure forensic care are readmitted, and up to half are reconvicted (McMurrin, 2002). This inability to lead fulfilling lives has a personal and financial cost to the individual and their families, to the victims of their crimes, and to society (Webb, Yágüez, & Langdon, 2007).

Research conducted in forensic services is sparse compared to other mental health settings (Coffey, 2006), however a small number of studies have investigated engagement from the professional's perspective. Some have focussed on SU *motivation*, and propose ideas and models such as the Good Lives Model to encourage greater engagement in therapies (Gudjonsson, Young, & Yates, 2007; Hodge & Renwick, 2002; McMurrin & Ward, 2004). Others have developed tools to measure the phenomenon of engagement from a service perspective (Drieschner & Boomsa, 2008). SU *motivation* for treatment is however just one contributing factor of *engagement* (McMurrin, Theodosi, & Sellen, 2006). Despite this, available research evidence suggests *motivation* has been explored relatively more extensively in forensic settings than the broader concept of *engagement* itself.

Studies related to both *motivation* and *engagement* have often focussed on general treatment (for example psychiatric, psychological, occupational, social, and vocational), rather than focussing on the idiosyncrasies of interpersonal therapies. It is known from a recent systematic review of TE measures that few are generalisable across settings or treatments, highlighting how different environments carry their own unique factors in determining effective engagement in therapies (Tetley, Jinks, Huband, & Howells, 2011).

Rationale for literature review

Little is known about the salient factors that contribute to successful TE in forensic settings; however, the consequences of treatment non-completion including increased reoffending are well documented (McMurrin, 2002). Unique to forensic settings, staff who provide therapeutic interventions are often also involved in the management of their ongoing incarceration. For example, they participate in the multi-disciplinary processes regarding home office conditions, sanctions, and discharge/release. Furthermore, therapies are usually mandatory and conducted in single-sex captive environments.

Without understanding what unique factors contribute to the process of TE in forensic settings, it is unclear how staff should plan and conduct therapeutic work in a way that optimises engagement, given the tension between their roles. This review aims to establish what is known about TE in secure settings. By understanding what factors contribute to or hinder engagement and how it can be accurately measured or promoted, professionals might be better situated to sensitively deliver therapies that are more likely to provide successful outcomes. To meet this aim, the review question was: *what is known about therapeutic engagement in secure settings for men?*

Structure of review

The traditional review was conducted in a systematic, explicit and reproducible manner (Booth, Papaioannou, & Sutton, 2012; Jesson, Matheson, & Lacey, 2011). The meta-search engine EBSCOhost was used to obtain results based on the review aims, from the databases: PsychINFO, Academic Search Complete, and CINAHL Plus with Full Text. No additional results were obtained by searching alternative databases (for example MEDLINE). Search results were then subjected to a screening process to determine eligibility with respect to inclusion/exclusion criteria, and then eligible results were critically reviewed using a standardised process.

Each paper is individually reported within three overarching research topic categories, with methodological critique imbedded in their descriptions. Following a summary of findings comprising four themes which emerged across the three paper topic categories, considerations for future research are suggested.

Inclusion and exclusion criteria

Inclusion criteria: Relating to secure settings; relating to individual/group therapy or therapeutic programmes; and subject of (or substantial contribution of) paper is regarding the nature, exploration, or definition of TE, and/or in how it is measured, or improved.

Exclusion criteria: Treatment programmes using medical or physical means, or drugs/medication.

Relating to intellectual disability services.

Search strategy and results

Entering the search terms “(engag* AND therap* OR “therapeutic relationships”) AND (forensic OR prison* OR jail OR inmate* OR secure) AND (men or male [ALL TEXT])”, into EBSCOHost provided 219 peer-reviewed search results, following removal of duplicates. 121 results were provided by the PsychINFO database, 95 from Academic Search Complete, and 55 from CINAHL Plus with Full Text. Using the same terms (on the same day, 5th December 2013) using the Web of Knowledge database provided no additional results. A three stage screening process was then used to determine eligibility (Figure 1), filtering initially by title (A), followed by abstract (B), then whole research paper (C). Preliminary searches conducted between October and December 2013 are detailed in Appendix A.

Screening results

After the screening process, 10 were selected for critical review. Following the initial search, the EBSCOhost software updated the researcher with newly added results from the databases for the specified search terms, on a weekly basis. Each new result was subjected to the same screening process as shown in appendix A. 15 further results were found, none of which were selected for critical review, because they did not meet eligibility criteria for inclusion.

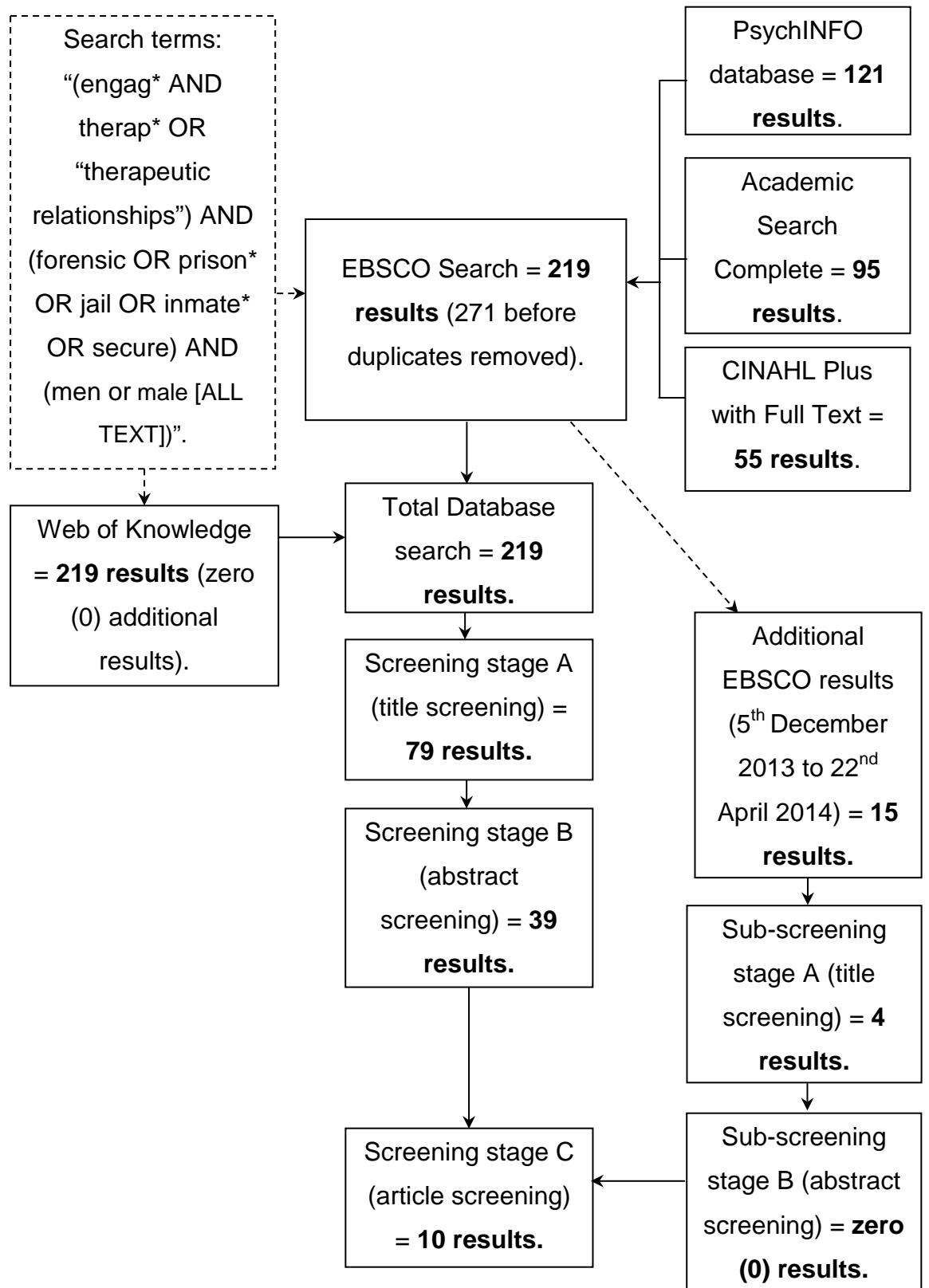


Figure 1. Literature review screening process flow chart

Critical review

The critical review process involved reviewing each eligible result using two sets of twelve standardised questions. One set was created to review qualitative research (appendix C) and was based on guidelines by Elliot, Fischer and Rennie (1999), and the Critical Appraisal Skills Programme checklist for qualitative research (CASP, 2014). The other set used to review quantitative research (appendix D) was based on the CASP for randomised control trials, the CASP for cohort studies, the Quality of Reporting of Meta-analyses group statement (QUOROM; Moher *et al.*, 1999), and the Consolidated Standards of Reporting Trials group statement (CONSORT; Shultz, Altman, & Moher, 2010). These guidelines were used to ensure a consistent methodological critique, which enabled the identification of, and subsequent reporting of the salient factors in respect of the review aims.

Of the remaining ten results, half used qualitative methodologies (Table 1), and half used quantitative methods (Table 2). A range of psychological interventions and treatment programmes were investigated (Table 3). The ten papers orientated to one of three general categories of TE investigations:

- 1: Perspectives of engagement Page 12
- 2: Measuring treatment readiness, motivation and engagement Page 19
- 3: Engagers and non-engagers Page 23

For clarity, direct quotes from papers are presented using ‘single quotation marks’, verbatim extracts by participants reported in papers are presented italicised using “*double quotation marks*”.

Table 1
Qualitative results included in the critical review.

| Authors, publication year and country | Participants | Setting | Purpose/aims | Methodology | Findings |
|--|---------------------|--|---|---|--|
| Willmot & McMurran (2013), UK | 12 males. | High secure personality disorder service. | To explore patients' views on therapeutic change. | Semi-structured interviews, thematic analysis. | In relation to engagement: themes related to listening, being reliable, helping with problem solving, self-disclosure and demonstrating trust. |
| Mason & Adler (2012), UK | 11 males. | High secure hospital. | To explore patients' views on factors that influence engagement in therapeutic group-work. | Semi-structured interviews, IPA. | Themes of culture of the environment, concepts of choice, relationships, trust, motivation, group-work content and expected outcomes. |
| Sainsbury, Krishnan, & Evans (2004), UK | 6 males. | High secure hospital. | Exploring what factors in a forensic setting affect patients' motivations to engage. | Semi-structured interviews, grounded theory. | Themes of support, treatment, culture, safety, external belief, belonging, internal motivation, and therapeutic relationship. |
| Schafer & Peternelj-Taylor (2003), Canada | 12 males. | Inpatient treatment program for violent offenders. | Exploration of perspectives of forensic patients enrolled in treatment programme for violent offenders. | Semi-structured interviews, naturalistic enquiry. | Numerous themes including adjusting to relationships with staff, evaluating expectations and experiences, motivation and coercion, time, power, gender, being or not being there, no voice or being heard, feeling objectified, receiving feedback and defining roles. |
| Frost & Connolly (2004), New Zealand | 16 males. | Medium secure prison. | Exploring TE experiences of men who have sexual abused against children. | Semi-structured interviews, grounded theory. | A six-stage 'Out-of-Group Engagement Model', showing pathways towards and away from TE: Recall, issue identification, rumination, consultation, and reflection. |

Table 2
Quantitative results included in the critical review.

| Authors, publication year and country | Participants | Setting | Purpose/aims | Methodology/ Measures used | Findings/Results |
|---|---------------------|-----------------------------|--|--|--|
| McMurrin, Theodosi, & Sellen (2006), UK | 35 males. | Prison. | To examine URICA (change assessment) & TMQ (motivation questionnaire) in assessing offender's motivation to change. | A range of questionnaires. Wilcoxon signed-ranks tests for pre and post treatment comparison. | Both URICA and TMQ were found to be of limited value in measuring motivation to change. However, the 'confidence in treatment' scale of the TMQ correlated positively with the URICA's 'committed action' scale, and with staff ratings of engagement. |
| Rosen, Hiller, Webster, Staton, & Leukefeld (2004), USA | 220 males. | Prison. | To explore the association between internal treatment motivation and TE for offenders enrolled in corrections-based substance use treatment program. | A range of standardised assessments administered by structure interview. | Higher levels of internal motivation for treatment were related to greater TE. |
| Day, Howells, Casey, Ward, Chambers, & Birgden (2008), Australia | 96 males. | Prison (92), community (4). | To validate a brief self-report measure designed to assess treatment readiness in offenders who have been referred to violent offender treatment programs. | Measures included: Violence Treatment Readiness Questionnaire (VTRQ), Readiness to Change Questionnaire (RCQ), and Serin Treatment Readiness Scale (STRS). | Scores on VTRQ significantly correlated with treatment engagement. VTRQ scores more strongly associated with TE than STRS and RCQ (used to assess treatment readiness). |

| | | | | | |
|--|-----------|--------------------------------------|--|---|--|
| Sheldon, Howells, & Patel (2010), UK | 76 males. | High secure hospital. | To analyse reasons for failure to complete therapeutic programmes. | Retrospective analysis of service evaluation monitoring data using the Multi-Factorial Offender Readiness Model (MORM). | The most common intrapersonal factors for non-completion were: affective arousal (embarrassment and fear of group working); volition (incongruent goals with therapy); and cognitive readiness (negative beliefs about self-efficacy, the therapist or therapy). |
| McMurrin, Huband, & Duggan (2008), UK | 60 males. | Personality disorder treatment unit. | To compare the characteristics of completers and non-completers (due to non-engagement, or expulsion due to rule breaking) of a personality disorder treatment programme | Social Problem-Solving Inventory and State-Trait Anxiety Inventory. | Completers were more rational and less impulsive in their approach to problem solving than non-completers. |

Table 3
Interventions described in review results.

| Authors and publication year | Therapy/Programme |
|---|---|
| Willmot & McMurrin (2013) | 'Dialectical Behavioural' and 'Schema Focussed' therapies. |
| Mason & Adler (2012) | 'Group therapies'. |
| Sainsbury, Krishnan, & Evans (2004) | Multiple therapy programme (not specified). |
| Schafer & Peternelj-Taylor (2003) | Violent offender treatment programme. |
| Frost & Connolly (2004) | Sexual offending treatment programme. |
| McMurrin, Theodosi, & Sellen (2006) | 'Enhanced Thinking Skills', and 'Controlling Anger and Learning to Manage It' programmes. |
| Rosen, Hiller, Webster, Staton, & Leukefeld (2004) | Substance use therapeutic programme. |
| Day, Howells, Casey, Ward, Chambers, & Birgden (2008) | Psychologist led programmes to 'promote understanding of violent offending, identify and challenge cognitive distortions, understand consequences, and relapse planning'. |
| Sheldon, Howells, & Patel (2010) | Psychological therapies: 'Orientation', 'Men's Talking', 'Stop and Think!', Cognitive Analytical Therapy, DBT, 'Substance Misuse Programme', 'Violence reduction' and the 'Sex Offender Programme'. |
| McMurrin, Huband, & Duggan (2008) | Multicomponent treatment, including social problem solving therapy 'Stop and Think!' |

Category 1: Perspectives of engagement

Four papers provided qualitative findings that related to SUs' and professionals' perspectives of engagement.

Willmot and McMurrin (2013) explored the views of twelve patients at a high secure personality disorder (PD) service on how treatment for PD works by interviewing them to obtain subjective experiences 'not readily accessible using quantitative methods'. Thematic analysis (TA) resulted in 39 themes related to 'aspects of change' and 29 themes related to 'change processes'. These themes were conceptualised as belonging to the three subordinate themes of: 'self', 'other people', and the 'future'. The changes described by participants related to core beliefs, increasing awareness and improving skills.

The twelve participants were selected on the basis that they 'had made [therapeutic] progress', which was justified on the basis that the study focussed on change. Those who were not included were clearly identified. It was observed that the sample may not be representative, because participants were relatively old for the service (mean 44.1 years), and had spent relatively longer times in the service and in custody.

However, other measures were taken to reduce potential bias. These included the research team not being involved in the care of the participants. Also, considering the potential for unreliable self-reports with participants having diagnoses of narcissistic PD, a psychometric measure (PCL-R; Hare, 1991) was used to confirm that only one participant met criteria for this diagnosis, with none scoring highly on the 'conning and manipulative' or 'pathological lying' items.

The resultant themes relevant to the understanding of engagement included a preference for having goals, which when achieved gave confidence to engage further. When considering the attributes of staff, other patients and family, factors such as 'giving accurate feedback on [their] behaviour', 'demonstrating trust in them', 'showing care', and having a 'non-judgemental attitude' were all linked to positive therapeutic change processes.

Change was also witnessed when therapists and others 'listened to them', 'were reliable', helped 'with problem solving', and 'self-disclosed'. Another theme highlighted a differentiation between the commitment and persistence of therapeutic treatment by staff in secure hospitals and those in prisons. For example one extract highlighted "*...people say prisons do treatment – they don't, that's just merely window dressing, whereas here it is all about treatment and getting better*", another highlighted how he felt more inclined to work with a therapist who persevered despite being told not to engage.

The descriptions of obtaining ethical approval, preparing and conducting data collection (semi-structured interviews, using questions based on identified key areas of change), completing analysis (TA, using triangulated techniques), and achieving saturation, were all described in rigorous and replicable fashion following established guidelines (Braun & Clark, 2006; Elliot, Fischer & Rennie, 1999). Although the presentation of data was understandable (a diagram may have aided clarity), and the well-considered participant extracts resonated strongly with the reader, there were no identified considerations of potentially

contradictory data. The limitations of generalisability were clearly stated, furthermore a coherent argument in the context of existing literature for the potential relevance of the themes to inform treatment of personality disorder was provided. Examining the effects of the 'wider social [and interpersonal] environment' of therapy processes in was also suggested for further study.

Also investigating the aspects of a high secure hospital's environment that influence patient motivation for treatment engagement, Sainsbury, Krishnan and Evans (2004) interviewed six men undergoing therapeutic work for PDs (therapies not detailed). The paper showed that whilst previous research had focussed on individual factors, it had not been conducted into ascertaining relevant aspects of the environment. Therefore, using grounded theory (GT) was highly appropriate.

Themes of culture of the environment, concepts of choice, relationships, trust, motivation, group-work content and expected outcomes were reported, and later discussed in relation to Maslow's hierarchy, and key aspects of PD service focus group research (Haigh, 2003; Maslow & Friager, 1987). However, no introduction or framework to the themes (described as 'initial categories') was presented, and it was unclear from the insufficient extract presentations if all participant voices had been presented. Increased extracts would have assisted the reader to further appreciate the meaning and validity of the themes; as some appeared incomplete and difficult to follow.

However, some themes resonated in the context of TE, most notably those involving belief, safety, and support relating to the therapist's approach; which led to greater motivations to engage. Safety was coded in two ways, 'practical', pertaining to measures of physical safety from attack or accusation; and 'psychological', related to confidence in staff to contain the participants in the therapeutic relationship, and to believe they were safe. Related to this, staffs' belief ('confidence and faith') in the men's ability to engage, as well as the provision of reassurance and reinforcement of desired behaviours, were considered important. Consistent with the previous study (Willmot & McMurrin, 2013), trust in the therapeutic relationship had an impact on participants' TE, highlighted by extracts which showed how the unexpected loss of a trusted or respected therapeutic relationship negatively affected continued motivation and engagement.

The data collection and analysis, using researchers who were known to, but not involved in the treatment of participants, was assiduously described to ensure accurate replicability. Validity and reliability were achieved by using independent analysis of the codings by a psychologist and a psychiatrist, and by using feedback from two participants. The article clearly described the ethical procedures, and purposely left the semi-structured interview questions 'open' to accommodate potential researcher bias. To obtain a wide range of 'truths' the recruitment was also purposive (Smith, 1996). Selection was appropriately made according to level of engagement in treatment, motivation, time in service, high/low security, age and sentencing/sectioning type.

Although the clinical implications should be viewed with some caution due to the absence of clarity of the reported themes, the study does give credence to the suggestion that the client group have potential to be involved in the evaluation of the services in which they reside. The low number of participants was accepted as a limitation of the study, albeit with respect to 'generalisability', a concept not usually associated with qualitative research of this nature.

Using Interpretative Phenomenological Analysis (IPA; Smith, 1996), Mason and Adler (2012) also explicated the views of men in a high secure hospital, however specifically about their experiences of engagement in therapeutic group-work. The relevance of investigating TE and compliance due to the specific environmental influences and relationships between security and therapy found in secure settings was plainly outlined.

Although the aims of the qualitative study were established in the introduction, the group of eleven men are later discussed in separate 'rehabilitation' and 'acute' phases of care, questioning the homogeneity of sample participants, as required for IPA studies (Smith, 1996). In contrast to the previously reviewed studies where those with PD were purposively sampled, participants with a PD diagnosis were excluded on the presumption that they might provide unreliable data.

The findings were illustrated by a summary diagram which assisted the reader to navigate the interconnected descriptions of the themes, which were coherent and integrated. Participants' experiences were brought to life from the extracts provided, and the six 'key themes associated with engagement' were appropriate and relevant: 'motivation', 'content of group-work', 'choice',

'expected outcomes', external 'locus of control', and 'relationships'. The stories were made more credible by the inclusion of some contradictory extracts. For example one theme, 'locus of control', included extracts from those who witnessed the importance of autonomy in their decision making. Despite a majority reporting a sense of learned helplessness, and lack of 'choice' due to the secure environment, some participants expressed that being informed of the nature of the proposed work assisted their engagement and choice making.

Trust was a considerable factor in the 'content of group work' and 'relationships' themes, whereby uncertainty over disclosures in group settings (feeling 'awkward and unsafe'), led a majority of participants to state a preference for individual interventions to consider criminogenic issues. Others communicated how unfavourably pitching the complexity and duration of groups was likely to affect their engagement. The participants placed an elevated importance on group outcomes, which were conceptualised as being required for discharge, and for increasing their learning about and awareness of mental illness.

In common with Willmot and McMurran (2013), the influence of external motivation in the forms of interest/concern, support, recognition, feedback, and rewards were found to be pertinent factors in influencing motivation to engage. Most participants concurred that staff having an honest, caring and helpful attitude, sense of humour, and respect, were aspects of therapeutic rapport that would develop trust and engagement. One extract demonstrated how a therapist's background (qualifications and experience) was an influential factor in their likeliness to engage. The protracted discussion of results in the context of existing research and theory concluded with a summary of two overarching themes of influence, the nature of the secure environment, and the concept of choice. Participants' engagement in therapies in such settings was therefore concluded to be highly influenced by how the balance of security and therapy was achieved. A pragmatic table of implications for practice was delivered, in line with these findings.

Whilst 'service user led initiatives' were used to develop the design, it was not clear what direct involvement SUs had. Additionally, despite the researchers claim that personal and professional experiences were considered, no specific theoretical orientations or epistemological positions were stated; they do however specify how the Health Belief Model (Strecher &

Rosenstock, 1997) was used to shape interview questions. The individually conducted, non-triangulated analyses, conducted as part fulfilment of an educational qualification; and the required involvement of participants' responsible clinicians due to ethical approval conditions, were sensibly propounded as further limitations. Although the study focussed on therapeutic group work experiences, the composition of these groups is not expanded upon.

Limited sample interview questions and data collection methodology were provided; thereupon it was difficult to ascertain if sufficient interpretation had been used in the analysis, or to be confident of successfully reproducing the research. Furthermore, two of the three indicative questions provided sought to gain 'current' and 'future' *views* contrary to lived experiences. A sizable ratio of extracts also selected opinions and beliefs, rather than reflections on experiences; as might be expected from an IPA study.

Although the aim of Schafer and Peternelj-Taylor's research (2003) was to explore patients' perspectives of boundaries in therapeutic relationships, the findings constituted a broader reflection of engagement in therapy. Using a naturalistic enquiry methodology by interviewing 12 males enrolled in a treatment for violent offending on three occasions, five themes were presented.

Significant to TE, one sub-theme that shone was the adjustment to new relationships, wherein participants reflected on their suspicion and difficulty dealing with staff having a friendly nature, in comparison to being treated like "*a convict*". In common with previous review articles, factors involving the requirement of trust in the therapist, and the contradictions of choice were also recorded. When choice was offered or suggested to participants, this developed a sense of self-efficacy, and a move from feeling 'coerced' to 'motivated'.

Perhaps surprisingly absent in other review papers, one sub theme was the power inequality between therapists and participants. Due to primary therapists having "*all the power*", and holding "*the key to everything that's going to happen*", participants reported not wanting to get on the "*bad side*" of them. As therapists generally compile reports during and following treatment in forensic settings, the importance of their conclusions was paramount for engaging SUs. This confirmed a unique engagement consideration for participants in this setting, whereby some considered the terms of their

therapeutic relationship more important for future plans of release, rather than for promoting any personal therapeutic interests. Evaluation of the therapist as a guide (their 'ability to help', 'integrity', and 'genuineness'), was also reported. Reports from other participants, as well as monitoring for consistency between verbal and non-verbal communication, were examples of other actions taken by participants to evaluate therapists.

Also integral to TE were therapists "*being there*", and participants "*being heard*". In opposition "*not being there*" or being seen as a "*nobody*", was judged as "*frustrating*" and showed a lack of interest from the therapist, which affected the development of "*therapeutic*" relationships. Being treated as if they "*had an interest*" in their own treatment process by observing that therapists incorporated their views into reports was viewed positively by participants. Being treated "*like a person*" resonated from the extracts provided. For example, providing generic feedback was a cause for concern, whilst therapists who provided specific feedback 'enhanced the therapeutic relationship', and were "*open*", "*honest*", and "*direct*".

Participants experienced their primary therapists as also having alternative roles, including as enforcers of rules, and within social relationships. The sensitive balance of these roles employed by staff, between and during therapy sessions, was likely to hinder or promote engagement. The participants reported a differentiation between those who are "*intellectual*" and "*remain in their heads*", those "*who care*" and were "*in their hearts*", and those who were "*in their wallets*". Staff who were "*in their heads*" 'did everything by the book', did not consider participants' priorities, and were perceived as being unable to connect with participants. Staff "*in their wallets*" appeared uninterested in the participants' treatment and although they were "*likely to give a good report*", their commitment to helping was doubted. Staff who were "*in their hearts*" were concerned with "*feelings*", "*support*" and "*comfort*". For this valued group self-disclosure was particularly appreciated by participants. Some participants however preferred to keep all interactions with therapeutic staff treatment orientated. "*Keep[ing] a professional barrier very firmly in place*" provided a safe environment for engaging in therapy.

The method was lucidly described by following guidelines (Lincoln & Guba, 1985), whereby the developing construction of understanding of therapeutic relationships and boundary maintenance was conducted in conjunction with

the participants over time. The analysis methodology was explicitly stated, incorporating data analysis software, and by using triangulated hypothesis testing. Furthermore the influential role of the researcher on the construction of participants' experience was openly evaluated and reported. Due to the large number and conceded complexity and interconnectivity of the reported sub-themes, the paper may have benefitted from a diagram to aid with navigation, and extended data extracts to validate theme origins.

Although only vaguely reported, the clinical implication that nursing staff should examine the impact of the variable nature of their professional role (other than as primary therapist), stemmed directly and appropriately from the data.

Category 2: Measuring treatment readiness, motivation and engagement

Three papers investigated measurement of TE across a range of forensic settings, using specifically generated and adopted tools.

To examine the utility of the Rhode Island Change Assessment (URICA) and the Treatment Motivation Questionnaire (TMQ) in assessing offenders' motivation to change, 35 male prisoners completed the assessments before and after treatment (McMurrin, Theodosi, & Sellen, 2006). A previous study investigating the URICA with offender populations found limited concordance with the efficacies found in clinical populations, whilst the TMQ (developed for those with alcohol problems), had not been previously used with offenders.

The URICA (32 item, five point scale measure) and TMQ (26 item, seven point scale) effectively have three and four sub-scales respectively, all relating to aspects of pre-therapeutic motivations. Using a criterion measure of staff-reported treatment engagement (0-100% in three areas: motivation for therapy, concentration and contribution, and compliance with the demands of the programme), sub-sections of each measure were correlated with effective engagement in psychological therapies.

The results showed that only the TMQ's 'Confidence in Treatment' sub-scale showed evidence of motivation to change. This sub-scale correlated positively with the URICA's 'Committed Action' sub-scale ($r_s = 0.47, p < 0.01$), the only other sub-scale to have a significant positive change following

treatment, and the only sub-scale to significantly and positively correlate with TE.

The description of method, including the assessment measures used, the participants, and the procedure (including the appropriate use of Wilcoxon signed-ranks tests), enabled accurate replication. The variables were well defined and presented in a summary table. Potential bias was mitigated by comparing the three researcher staff ratings of engagement which showed a highly significant inter-rater reliability ($r_s = 0.70 - 0.76, p < 0.001$). This resulted in an overall mean rating score being used as the criterion measure.

The results however had limited application due to the poor ability of the measures to assess engagement (and motivation to change). Indeed the authors stated that they should be 'taken only as indicative' due to the low number of participants and reliance on staff reports. Some valid considerations for future research however were proposed. Because non-completion of therapy had been found to potentially 'have a damaging effect' (Hollin *et al.*, 2004), it was suggested that the process of actually engaging in and completing therapy may also be important to consider when measuring TE (as well as motivation). Further recommendations were to use staff *and* SU rating measures, and to focus on the therapeutic alliance.

Studies into the efficacy of community-based substance use therapies have illustrated how important 'motivation for treatment' is for SUs to become therapeutically engaged. Rosen, Hiller, Webster, Staton and Leukefeld (2004) argued that there had not been a similar focus in prison settings, and therefore examined the association between treatment motivation and TE for 220 incarcerated offenders in a treatment programme. In line with community-based research (Broome, Knight, Knight, Hiller, & Simpson, 1997), higher levels of 'problem recognition' and 'desire to help' were predicted to be associated with greater 'commitment to treatment', and higher confidence in treatment (used as indicators of TE), using self-report measures.

The results were reported using figures and tables to demonstrate the main findings. These included how having higher levels of (internal) motivation were associated with higher TE, even after controlling for confounding factors ($r_s = 0.20, p < 0.001$). Higher levels of 'desire for help' were associated with greater treatment engagement ($r_s = 0.37, p < 0.01$; $r_s = 0.42, p < 0.01$); however this was moderated by 'problem recognition' ($b = -0.147, p = 0.05$). It

was concluded that offenders with a greater awareness of the negative effects of their problems (indicated by higher problem recognition) were more likely to be engaged than others. The reportedly 'surprising' result that 'desire to help' was not related to 'commitment to treatment' was not omitted from the discussion despite it being counter to predictions and other aspects of the Texas Christian University (TCU) Treatment Motivation Model (Simpson & Joe, 1993), on which the paper is theoretically based. 'Problem recognition' and 'desire to help' are the first two of three stages of the TCU that substance users purportedly progress through. The final stage is 'treatment readiness', which is described as the stage at which individuals are 'committed to making changes' and 'confident that treatment can help'.

The study was conducted as part of a larger study (1,102 participants), where only data collected from those included in a substance abuse treatment programme across four US prisons was included (220 males). The express therapeutic content of the treatment programmes was not described; however the data collection procedures (structured interview incorporating a number of assessment measures) were described meticulously and bivariate correlation analyses of the clearly defined variables were appropriate.

The results were discussed in relation to the prediction and existing literature, which concluded that 'assessment of motivation needs to be an integral part of substance' treatment in forensic settings. Also efficacy of treatment is likely to vary depending on individuals' motivation for treatment. It was further recommended that 'motivation for treatment' should be aided by empirically validated pre-therapy motivational interventions, such as motivational interviewing (Miller & Rollnick, 1991) and other cognitive and behavioural techniques (Czuchry & Dansereau, 2000; Sia, Dansereau & Czuchry, 2000). It is suggested that using these methods would build knowledge of consequences, and aid in increasing individuals' understanding of their problems, moving them into the 'contemplation stage of change'.

Whilst Schafer and Peternej-Taylor (2003) explored the factors for those enrolled in a violent offender treatment programme, Day *et al.*, (2008) sought to validate a self-report measure to assess treatment readiness for such therapies. Unlike the former, this paper described the psychologist-led programmes, which involved promoting understanding of violent offending, identifying and challenging cognitive distortions, understanding consequences,

and relapse planning. The primary measure investigated was the Violence Treatment Readiness Questionnaire (VTRQ; Day *et al.*, 2008), a 20 item self-report questionnaire (included in the study appendix), adapted from the Corrections Victoria Treatment Questionnaire (CVTRQ).

The CVTRQ had been found to correlate positively with TE in cognitive skills programmes, it was found to have adequate discriminant and convergent validity, and was found to be easily administered by staff with no specific qualifications (Casey, Day, Howells, & Ward, 2007). The four components of the assessment were 'attitudes and motivations', 'emotional reactions', 'offending beliefs', and 'efficacy' in line with the Multifactor Offender Readiness Model (MORM), a framework for understanding readiness and engagement in offenders (Ward, Day, Howells, & Birgden, 2004).

The study had three aims. Firstly, to establish if a face-to-face interview (the Violence Treatment Readiness Interview [VTRI], also based on the MORM) predicted treatment engagement better than the self-report measure. Secondly, to determine if readiness for treatment changed during the course of the therapy. If so, it was argued that the VTRQ may be used as a measure for improving readiness for programme participation (as suggested by Rosen *et al.*, 2004). Finally by measuring TE and participant satisfaction, it was hoped to examine the extent to which the measure predicted engagement and treatment performance.

The 17-item Treatment Engagement Scale (TES) was created by using a factor analysis of three existing measures. The TES contained three subsections: perceptions of the treatment process; confidence in the treatment; and therapeutic alliance. A range of further assessments were administered including for self-deception, self-efficacy in tasks, treatment readiness (using the Serin Treatment Readiness Scale [STRS]; Serin, 1998), and stages of change (using a moderated version of the Readiness to Change Questionnaire, initially developed for alcohol use; RCQ; Rollnick, Heather, Gold, & Hall, 1992).

Multiple bivariate correlations confirmed the VTRQ's construct validity, and the significant positive relationship with the TES supported its predictive validity ($r = 0.46$, $p < 0.001$). Scores on the TES also increased between the mid-programme and end programme, although it is unclear why only the mid-programme data was used for analysis. Neither the RCQ ($r = 0.19$, $p > 0.05$)

nor STRS RCQ ($r = 0.24, p > 0.05$) significantly correlated to the TES, highlighting their inability to measure treatment engagement in this setting. Scores from the VTRQ ($r = 0.49, p < 0.01$) were more highly correlated with treatment engagement than the semi structured interview scores (VTRI; $r = 0.04, p > 0.05$), which was considered in the context of offenders being potentially more likely to respond in a socially desirable way when face to face, undermining the validity of the scores.

Of the 96 convicted male offenders, 92 completed the questionnaires. Mid- and post-test measures were unfortunately collected only from 53 participants due to drop out, declined consent, and due to facilitators failing to administer measures to their groups. The comprehensively described scoring and analysis was conducted blind, with five participants' data removed due to unsuitable scores on the self-deception assessment. Internal consistency reliabilities and descriptive statistics were provided for all assessment measures, which showed acceptable internal validity for the VTRQ at pre and post-test; however, the average deception score in the sample was higher than predicted for a prison population.

Although the sample size was admittedly low for a scale validation, and relied on a self-report instead of behavioural measures, the easily replicable study does highlight the potential use in the VTRQ for determining eligibility, and likely TE in similar settings. It is also suggested that the measure may be of use to inform the designs of treatment readiness/motivation interventions.

Category 3: Engagers and non-engagers

Three papers focussed on understanding reasons for treatment engagement and drop out.

Similarly to the development of the VTRQ, Sheldon, Howells and Patel (2010) used the MORM to create guidelines to assess TE in a secure environment. However, instead of a focus on treatment readiness, they sought to investigate the levels and reasons of completion and non-completion of therapeutic programmes for residents of a personality disorder unit. Due to uncertainty over the capacity to engage SUs with a PD who are deemed to pose a high risk to others, service evaluation data was examined using MORM guidelines to classify reasons for non-completion.

The clear display of information regarding treatment starters and completers of the extensive therapeutic programmes, allowed ready orientation to the service and study design. The categories of readiness variables identified in the MORM were manualised, and then applied to clinical transcripts taken from electronic notes relating to reasons for failing to attend any particular treatment programme session. The variables/categories in the MORM manual included: internal readiness; affective, volitional, behavioural and identity factors; and external readiness factors (circumstances, location, opportunity, resources and support).

The computerised entry records relating to non-completion or engagement were searched using terms commonly used in readiness and engagement literature including 'non-completion', 'withdrawn' and 'exclusion'. Any non-completion event was subjected to a dichotomous scoring system, whereby the MORM categories were scored as either definitely/possibly present, or absent. A blind pilot of 20% of computer extracts showed inter-rater agreement of 93%, and also highlighted additional reasons for non-completion/engagement not found in the MORM. These four reasons were subsequently added to the manual: being excluded from therapy because of an external decision to transfer to another forensic setting; refusal to attend due to negative evaluations of group members; and medico-legal reasons.

The results were concisely reported, showing an overall non-completion rate of 17.6% (31 non-completers in a five year period), and a table summarised the categories that each of the 136 attrition events was allocated to (some events were allocated to multiple categories). The most common external factors were multidisciplinary team (MDT) exclusion (due to poor behaviour or attendance, or breaking rules, 22%) and transfer from the unit (17%). Exclusion from a programme was also conceptualised as a patient choice factor if the SUs had behaved in a way known to lead to exclusion. The most common intrapersonal factors were: affective arousal (for example shame or embarrassment); volitional (having other goals); and cognitive readiness (appraisals and beliefs about the therapy or therapeutic staff).

There were a number of reported limitations to the study, including the limitation of the MORM to identify all variables associated with non-completion, using the potentially subjective nature of staff notes, and not investigating the degree of non-completion (for example at what stage). The low number of

extracts and reliance on staff reports (not considering non-completers' views) were however not reported. As reported, treatment non-completion is only one form of non-engagement ('the most extreme'), as it is possible that SUs physically attended all sessions but engaged psychologically at a minimal level. This led to the sensible recommendation that a 'wider range of methodologies' and 'differentiated and more subtle' measures are required to investigate engagement and non-completion.

McMurrin, Huband and Duggan (2008) compared three groups of PD treatment programme starters. They explored the characteristics of those who completed programmes, those who were expelled for rule breaking, and those who were removed because they were not engaged. All 60 participants were residents at a PD treatment unit where they received multi-component psychological therapies. A majority of study data including age, IQ and psychopathy scores, was obtained from routine admission data, and although no ethical approval was reported, a further two measures to test hypotheses were administered. These measures were the Social Problem-Solving Inventory – revised (SPSI-R; D'Zurilla, Nezu, & Maydeu-Olivares, 2002), a 52 item self-report questionnaire to examine problem orientations (negative and positive), and problem solving styles (rational, impulsive/careless, and avoidant); and the State-Trait Anxiety Inventory (STAI; Spielberger, 1999), a 40 item self-report measure of 'state' and 'trait' anxiety.

Contrary to predictions, an impulsive/careless style of problem solving was not found to be predictive of the excluded group, and the avoidant style was not found to be predictive of the non-engaged group. Since the two non-completer groups were not-significantly different, they were combined to form one sample ('non-completers'). A further comparison then resulted in a significantly higher score for completers on rational problem solving, and a significantly lower score on impulsivity/careless style. A summary of all test statistics was clearly provided in a series of tables, which also showed how a prediction of high anxiety associated with treatment non-completion was not found in either group. The participants showed no significant differences across groups for mean age or IQ. However, Tukey's honest significant difference tests of the one-way ANOVA data showed that the psychopathy scores (PCL-R; Hare, 1991) for the expelled group were significantly higher than for the completers group and non-engagers.

Whilst the results may not offer clinical implications, in part due to the low sample size (although the sample size allowed sufficient power for the two group comparison), and also due to the insignificant three group results, it is commendable that the results have been disseminated considering the potential for publication bias. The reasons for predicting that anxiety and problem thinking styles would affect engaging in treatment were grounded in theory and prior empirical studies (Ladouceur, Blais, Freeston & Dugas, 1998), and although these predictions did not actualise, the study furthers our understanding of the highly individual nature, and complexity of engagement in forensic settings.

A six-stage 'Out-of-Group Engagement Model' was produced by interviewing 16 males enrolled in a prison sexual offender treatment programme (Frost & Connolly, 2004). The focus on between-session factors had been clearly identified as a necessary area for exploration with regard to TE. GT was an appropriate methodology considering the scarcity of research into the phenomenon, and the researchers utilised a gradual and generative methodology as the study progressed to obtain the data.

The six themes were reported as stages. They were clear, understandable, and notably supported by extensive extracts, including those that exhibited unsuccessful engagement experiences. It is unclear how using a bottom-up approach to analysis resulted in such defined and sequential themes, but the summary diagram aided the connection between data and the model. The model suggested that potential for engagement was improved if participants completed the following five in-between session stages: successful recall of material, salient issues identified, ruminates on identified issues, consults, and reflects. There is a potential for disengagement should participants be unsuccessful at each consecutive step.

All the participants were described as recalling material from the session; however, two of the men 'disengaged' at the following stage, where a majority of participants articulated issues that the therapy had brought to their attention, for example their behaviours or victims. Twelve men engaged in the following stage of 'rumination', where they allocated cognitive resources to, and underwent an emotional response to their identified issues ('pondering, puzzling or agonizing about them'). One extract highlighted how a participant cried after ruminating about the effects of their offence. Depending on

individual participants' comfort with the feelings and topics ruminated upon, it was found to both divert from and maintain engagement.

For the ten men that undertook the next stage, consultation, this involved exploring their experiences with others in the prison unit. The process for those who consulted was multi-faceted, involving trust, safety, and reciprocity; for those who chose not to consult, it was reported that the process of engagement ended at this stage. Five of the ten men underwent a 'reflective' process, which was a process of 'consideration' of the issues in the context of the feedback provided, for example by applying content from the therapy to enable a different perspective on themselves. The final stage, 're-evaluation and reengagement', was a theoretical stage inferred from the statements, as the subsequent treatment session was not included in the study. Despite this, it was predicted that those who had reached the former stage were likely to possess the motivation to proceed.

It was conceded that a lack of independent reliability checking was a limitation to the findings; however the independent study stages were well described to aid with replication. It was suggested that the 'tentative' findings may not be applicable outside the specific prison environment sampled. However this paradoxically questions the purpose of creating a model, and for suggesting the general importance of out of group experiences on TE.

Summary of review findings

Despite the alternative approaches to investigating *TE* in secure settings, as evidenced by the three categories of research papers reviewed, a number of common factors were observed. To identify over-arching themes across papers, all reported sub-themes and factors were first listed, then re-conceptualised using a numeration technique to produce four themes with broad potential clinical implications.

Theme 1: Therapist attributes.

Having *trust* in a caring, supportive, interested, open, respecting, honest, genuine therapist who self-discloses was almost universally reported as being an indicator of likely enhanced TE. Having a therapist without a sense of humour, who does things by the book, is unable to balance their alternative

roles, and sees the SUs as “*nobodies*” were purported predictors of reduced likeness of TE.

Theme 2: Service user attributes.

Intrapersonal factors related to the SU were less frequently reported as important by SUs themselves, but were the main focus for staff and researchers in a majority of papers. The model of engagement between sessions for example (Frost & Connolly, 2004), encompassed factors solely relating to the individual SU: generally cognitive and change processes. Perhaps unsurprisingly, having higher levels of motivation and a desire for help, and having more rational rather than impulsive problem solving styles were found to predict treatment engagement.

Theme 3: Aims and feedback

There was an overlap across studies in the reported importance in ensuring the proposed (often required) therapy aims met with the personal goals of the participants. Without contracting and clearly establishing the purpose and path of proposed therapies, confidence and engagement in treatment was likely to be reduced. Participants differentiated between receiving generic or *specific feedback*, with the latter creating increased motivation for engagement, and the former leading to negative evaluations of the therapist's motivations or skills.

Theme 4: Environmental factors.

Factors related to the environment were multi-dimensional and service specific, but one major concurrence was the concept of *choice*. Across papers, participants often reported that they had no choice to engage in treatments, whereby for some simply being given a choice could move them from feeling coerced to motivated.

Being in a secure setting did not predict feelings of security for participants, who also consistently reported a need for physical and psychological safety to effectively engage in therapies. Participants also consistently reported themes related to embarrassment and fear related to concerns of disclosure in group therapies. Whilst the assessment measures in some papers were not found to accurately measure the phenomenon of *engagement* or *motivation for treatment*, the process of investigating their

efficacy also highlighted the unique nature of each forensic environment, and of each SU.

Review Limitations

With noted exceptions, the therapeutic interventions taking place in the institutions studied were not described in sufficient detail to understand how the makeup of the interventions themselves (for example using cognitive, behavioural, psychodynamic, or reflective methods) affected engagement.

Papers related to offenders with an intellectual disability were excluded from the review. Whilst the percentage of prisoners and SUs with an intellectual disability in secure hospitals is not known, it has been estimated that between 20% and 50% have a specific learning disability, 7% have an IQ of less than 70, and 25% have an IQ score of less than 80 (Disability Rights Commission, 2005; Hayes, Shackell, Mottram, & Lancaster, 2007). Also, although 30% of the reviewed studies related to PD, it is estimated that at least 50% of the offender population has a PD (Ministry of Justice, 2011). Therefore it is accepted that there may be an under-representation of factors associated with such conditions in the review.

Recommendations

The review highlights an emerging body of knowledge about the factors that contribute to *TE* for men in forensic settings. Useful themes relating to *TE* have been found within a range of SU perspective studies, albeit resulting from specific explorations into change, group-work, motivation and treatment perspectives. Furthermore, a number of studies have investigated ways to empirically measure treatment engagement, and the reasons for non-completion, which has advanced our understanding of its context specific and sensitive nature. This review therefore highlights that there have been limited investigations directly into *TE* in secure care and this represents a significant gap in the literature. It is recommended that further research be conducted to directly explore the process of *TE* from the SU's perspective, in a range of forensic settings. In addition, in line with multiple paper recommendations, the development of sensitive measures, based on staff *and* SU recommended indicators is required to more accurately measure *TE* in these settings.

In line with the recommendation for implementing pre-intervention motivation plans (present in a number of review papers), a further clinical recommendation is that therapists might benefit from considering the themes participants identified as likely to aid with this, which included being offered genuine choices, and focussing on developing trust in emerging therapeutic relationships.

Paper 1 References

- Booth, A., Papaioannou, D., & Sutton, A. (2012). *Systematic approaches to a successful literature review*. London, UK: Sage.
- Braun, V., & Clark, V. (2006). Using thematic analysis in psychology, *Qualitative Research in Psychology*, 3 (2), 77-101.
- Broome, K. M., Knight, D. K., Knight, K., Hiller, M. L., & Simpson, D. D. (1997). Peer, family, and motivational influences on drug treatment process and recidivism for probationers, *Journal of Clinical Psychology*, 53 (4), 387-397.
- Casey, S., Day, A., Howells, K., & Ward, T. (2007). Assessing suitability for offender rehabilitation: Development and validation of the Treatment Readiness Questionnaire, *Criminal Justice and Behavior*, 34, 1427-1440.
- Centre for Mental Health (2011). *Pathways to unlocking secure mental health care*. London, UK: Centre for Mental Health.
- Centre for Mental Health (2013). *Guidance for commissioners of mental health services*. Retrieved from <http://www.jcpmh.info/wp-content/uploads/jcpmh-forensic-guide.pdf>
- Coffey, M. (2006). Researching service user views in forensic mental health: A literature review, *The Journal of Forensic Psychiatry and Psychology*, 17 (1), 73-107.
- Critical Appraisal Skills Programme (2014). *CASP Checklists*. Retrieved November 4, 2013, from <http://www.casp-uk.net/#!/casp-tools-checklists/c18f8>
- Czuchry, M., & Dansereau, D. F. (2000). Drug abuse treatment in criminal justice settings: Enhancing community engagement and helpfulness, *American Journal of Drug and Alcohol Abuse*, 26, 537-52.

- Day, A., Howells, K., Casey, S., Ward, T., Chambers, J. C., & Birgden, A. (2008). Assessing treatment readiness in violent offenders, *Journal of Interpersonal Violence*, 24 (4), 618-35. DOI: 10.1177/0886260508317200
- Disability Rights Commission (2005, June). *Disability Rights Commission Disability Briefing*. Retrieved from <http://disability-studies.leeds.ac.uk/files/library/DRC-Disability-Briefing-June-2005-final.pdf>
- Drieschner, K. H., & Boomsma, A. (2008). The treatment engagement rating scale (TER) for forensic outpatient treatment: Description, psychometric properties, and norms, *Psychology, Crime and Law*, 14 (4), 299–315.
- D’Zurilla, T. J., Nezu, A. M., & Maydeu-Olivares, A. (2002). *Social problem solving inventory – revised (SPSI-R): Technical manual*. North Tonawanda, NY: Multi-Health Systems.
- Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields, *British Journal of Clinical Psychology*, 38, 215–229.
- Frost, A. & Connolly, M. (2004). Reflexivity, reflection, and the change process in offender work, *Sexual Abuse: A Journal of Research and Treatment*, 16 (4), 365-380. DOI: <http://dx.doi.org/10.1023/B:SEBU.0000043329.65730.ff>
- Gudjonsson, G. H., Young, S., & Yates, M. (2007). Motivating mentally disordered offenders to change: Instruments for measuring patients’ perception and motivation, *The Journal of Forensic Psychiatry and Psychology*, 18 (1), 74–89.
- Haigh, R. (2003). A very sticky label: Gathering service users’ opinions of the DoH Personality Disorder Strategy. Paper presented at British and Irish Group for the Study of Personality Disorders Annual Conference, Dublin, Ireland.
- Hare, R. D. (1991). *The Hare psychopathy checklist – revised*. North Tonawanda, NY: Multi-Health Systems.

- Hayes, S., Shackell, P., Mottram, P., & Lancaster, R. (2007). The prevalence of intellectual disability in a major UK prison, *British Journal of Learning Disabilities*, 35 (3), 162–167. DOI: 10.1111/j.1468-3156.2007.00461.x
- Hodge, J. E., & Renwick, S. J. (2002). Motivating mentally disordered offenders. In M. McMurrin (Ed.), *Motivating offenders to change: A guide to enhancing engagement in therapy* (pp. 221-234). West Sussex, UK: John Wiley.
- Hollin C., R., Palmer, E. J., McGuire, J., Hounsome, J., Hatcher, R., Bilby, C., & Clark, C. (2004). *Pathfinder programmes in the probation service: A retrospective analysis*. Home Office Online Reports, No. 66/04. London, UK: Home Office.
- Jesson, J. K., Matheson, L., & Lacey, F. M. (2011). *Doing your literature review: Traditional and systematic techniques*. Los Angeles, CA: Sage.
- Ladouceur, R., Blais, F., Freeston, M. H., & Dugas, M. J. (1998). Problem solving and problem orientation in generalized anxiety disorder, *Journal of Anxiety Disorders*, 12, 139–152.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.
- Mason, K., & Adler, J. R. (2012). Group-work therapeutic engagement in a high secure hospital: Male service user perspectives, *The British Journal of Forensic Practice*, 14 (2), 92–103. DOI: 10.1108/14636641211223657
- McMurrin, M. (Ed.). (2002). *Motivating offenders to change: A guide to enhancing engagement in therapy*. West Sussex, UK: John Wiley & Sons.
- McMurrin, M., Huband, N., Duggan, C. (2008). A comparison of treatment completers and noncompleters of an in-patient treatment programme for male personality-disordered offenders, *Psychology and Psychotherapy*, 81, 193–198. DOI: 10.1348/147608308X288762

- McMurrnan, M., Theodosi, E., & Sellen, J. (2006). Measuring engagement in therapy and motivation to change in adult prisoners: A brief report, *Criminal Behaviour & Mental Health*, 16 (2), 124-129.
- McMurrnan, M., & Ward, T. (2004). Motivating offenders to change in therapy: An organizing framework, *Legal and Criminological Psychology*, 9, 295-311.
- Maslow, A. H., & Frager, R. (Eds.). (1987). *Motivation and personality*. New York, NY: Longman.
- Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*. New York, NY: Guilford Press.
- Ministry of Justice (2011). *Working with personality disordered offenders: A practitioners' guide*. London, UK: HMSO.
- Ministry of Justice (2013). *Costs per place and costs per prisoner: National offender management service annual report and accounts 2012-13 management information addendum*. London, UK: HMSO.
- Mitchell, J., & Latchford, G. (2012). Prisoner perspectives on mental health problems and help-seeking, *The Journal of Forensic Psychiatry and Psychology*, 21 (5), 773–788.
- Moher, D., Cook, D.J., Eastwood, S., Olkin, I., Rennie, D., & Stroup, D.F. (1999). Improving the quality of reports of meta-analyses of randomised controlled trials: the QUOROM statement, *The Lancet*, 354, 1896–1900.
- O'Brien, A., Fahmy, R., & Singh, S. P. (2009). Disengagement from mental health services: A literature review, *Social Psychiatry and Psychiatric Epidemiology*, 44 (7), 558-68.
- Rethink (2011). *Forensic mental health services*. London, UK: Rethink Mental Illness.

- Rollnick, S., Heather, N., Gold, R., & Hall, W. (1992). Development of a short "readiness to change" questionnaire for use in brief opportunistic interventions among excessive drinkers, *British Journal of Addiction*, *87*, 743-754.
- Rosen, P. J., Hiller, M. L., Webster, J. M., Staton, M., & Leukefeld, C. (2004). Treatment motivation and therapeutic engagement in prison-based substance use treatment, *Journal of Psychoactive Drugs*, *36* (3), 387-96.
- Sainsbury, L., Krishnan, G., & Evans, C. (2004). Motivating factors for male forensic patients with personality disorder, *Criminal Behaviour and Mental Health*, *14* (1), 29-38.
- Schafer, P., & Peternelj-Taylor, C. (2003). Therapeutic relationships and boundary maintenance: The perspective of patients enrolled in a treatment program for violent offenders, *Issues in Mental Health Nursing*, *24*, 605-625.
- Serin, R. (1998). Treatment responsivity, intervention, and reintegration: A conceptual model, *Forum on Corrections Research*, *10*, 29-32.
- Sheldon, K., Howells, K., & Patel, G. (2010). An empirical evaluation of reason for non-completion of treatment in a dangerous and severe personality disorder unit, *Criminal Behaviour and Mental Health*, *20* (2), 129-14.
- Shultz, K. F., Altman, D. G., & Moher, D. (2010). CONSORT 2010 statement: Updated guidelines for reporting parallel group randomised trials, *British Medical Journal*, *340*, 698-702.
- Sia, T. L., Dansereau, D. F., & Czuchry, M. L. (2000). Treatment readiness training and probationers' evaluation of substance abuse treatment in a criminal justice setting, *Journal of Substance Abuse Treatment*, *19* (4), 459-67.
- Simpson, D. D., & Joe, G. W. (1993). Motivation as a predictor of early dropout from drug abuse treatment, *Psychotherapy*, *30*, 357-368.

Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology, *Psychology & Health, 11*, 261-71.

Spielberger, C. D. (1999). *The state-trait anxiety inventory*. Odessa, FL: Psychological Assessment Resources.

Strecher, J., & Rosenstock, I. M. (1997). The health belief model. In A. Baum (Ed.), *Cambridge handbook of psychology, health and medicine* (pp. 113–117). Cambridge, UK: Cambridge University Press.

Tetley, A., Jinks, M., Huband, N., & Howells, K. (2011). A systematic review of measures of therapeutic engagement in psychosocial and psychological treatment, *Journal of Clinical Psychology, 67* (9), 927-41.

The Mental Health Foundation (2007). *The fundamental facts: The latest facts and figures on mental health*. London, UK: The Mental Health Foundation.

Ward, T., Day, A., Howells, K., & Birgden, A. (2004). The multifactor offender readiness model, *Aggression and Violent Behavior, 9*, 645-673.

Webb, S., Yágüez, L., & Langdon, P. E. (2007). Factors associated with multiple re-admission to a psychiatric hospital, *Journal of Mental Health, 16* (5), 647–661.

Willmot, P., & McMurrin, M. (2013). The views of male forensic inpatients on how treatment for personality disorder works, *The Journal of Forensic Psychiatry & Psychology, 24* (5), 594-609. DOI: 10.1080/14789949.2013.823219

Paper 2: Journal Submission Guidelines - The Journal of Forensic Psychiatry and Psychology



Disclaimer

Paper 2 has been written for publication in *The Journal of Forensic Psychiatry and Psychology*. General submission guidelines for the target journal have been followed; however for the purposes of thesis submission Ariel font size 12 and extended left-hand margins have been used to adhere to University submission guidelines, and for ease of accessibility.

Additional content included for the purposes of thesis review, including non-standard headings will be removed prior to manuscript submission to the target journal.

Relevant general guidelines

- APA Reference Style.
- Times New Roman font, size 12.
- Please use single quotation marks, except where 'a quotation is "within" a quotation'. Long quotations of 40 words or more should be indented without quotation marks. Always use the minimum number of figures in page numbers, dates etc., e.g. pp. 24-4, 105-6 (but using 112-13 for 'teen numbers) and 1968-9.
- A typical manuscript will not exceed 5,000 words not including references. Manuscripts that greatly exceed this will be critically reviewed with respect to length. Authors should include a word count with their manuscript.
- Review papers (e.g. systematic reviews, meta-analyses, law reviews) and some empirical studies may require greater length and the Editors are happy to receive longer papers. We encourage brevity in reporting research.
- Manuscripts should be compiled in the following order: title page; abstract; keywords; main text; acknowledgements; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figure caption(s) (as a list). All tables and figures should be cited in the text.
- Abstracts of 150 words are required for all manuscripts submitted.

- Each manuscript should have 3 to 6 keywords.
- Section headings should be concise.
- All persons who have a reasonable claim to authorship must be named in the manuscript as co-authors; the corresponding author must be authorized by all co-authors to act as an agent on their behalf in all matters pertaining to publication of the manuscript, and the order of names should be agreed by all authors.
- Biographical notes on contributors are not required for this journal.
- Please supply all details required by any funding and grant-awarding bodies as an Acknowledgement in a separate paragraph.
- Authors must also incorporate a Disclosure Statement which will acknowledge any financial interest or benefit they have arising from the direct applications of their research.
- For all manuscripts non-discriminatory language is mandatory. Sexist or racist terms must not be used.
- Authors must adhere to SI units. Units are not italicised.
- When using a word which is or is asserted to be a proprietary term or trade mark, authors must use the symbol ® or TM.

Paper 2: Therapeutic Engagement in Medium-Secure Care: An Interpretative Phenomenological Analysis of Service Users' Experiences

Abstract

Service users (SUs) detained in forensic hospitals are usually required to engage in psychological therapies aimed at reducing mental distress and/or for preventing further offending. Poor therapeutic engagement (TE) can lead to adverse clinical outcomes and reoffending, at a cost to the individual, staff, the service provider and the public. To understand what factors influence TE from a SUs' perspective, the experiences of ten male residents of a medium-secure hospital were explored. Using a service-user informed design, interpretative phenomenological analysis (IPA) of interview data was completed. Four super-ordinate themes emerged: *different worlds; what the individual brings; what the therapy entails; and control*. Consideration of how these factors may be of use to professionals working in secure care settings is discussed in relation to existing theory and research.

Key words: Therapeutic engagement, interpretative phenomenological analysis, service-user design, forensic mental health, treatment engagement, offence recidivism.

Word Count: 7,210.

Introduction

There are estimated to be around six thousand SUs detained in forensic services at any one time in the UK (May 2013; Centre for Mental Health). SUs in secure hospitals are usually engaged in treatments which target mental distress and offence recidivism (Rethink, 2011); however they generally engage less well than those in the community (McMurrin, 2002). A meta-analysis of sixteen studies into treatment non-completion has shown that re-offending and other damaging effects are higher for those that do not complete treatment than for those who were not offered treatment at all (McMurrin & Theodosi, 2007). This indicates that treatment non-completion itself may in fact cause increased risks to the individual and society.

A recommended focus for research and practice in offender treatment engagement is for theoretically based, empirically evidenced models of engagement to be produced (McMurrin & Ward, 2010). This is in addition to the

creation of psychometrically robust assessments and the integration of strategies to improve engagement in treatments (McMurran & Ward, 2010). There have however been limited investigations into therapeutic non-engagement in forensic inpatient settings, which have often focussed on understanding internal SU factors for engagement from a professional's perspective. Some have found associations between engagement and SUs' motivation and readiness for treatment (Day *et al.*, 2008; Rosen, Hiller, Webster, Staton, & Leukefeld, 2004). Others have investigated the personal characteristics that lead to treatment drop-out, such as being less rational and more impulsive (McMurran, Huband, & Duggan, 2008); or being embarrassed/scared, having incongruent goals, or having negative understandings of self or therapist efficacy (Sheldon, Howells, & Patel, 2010).

Studies that have investigated TE from the SU's perspective have consistently highlighted the importance of external factors on SUs' ability to be engaged, and likeliness to remain engaged. An exploration of SUs' experiences of therapeutic change found an association between therapists' attributes and engagement (Willmot & McMurran, 2013). Others identified how interpersonal factors such as trust, relationships and support, and environmental factors such as having a choice, ward culture, and feeling safe, affected engagement (Frost & Connolly, 2004; Mason & Adler, 2012; Sainsbury, Krishnan, & Evans, 2004; Schafer & Peternej-Taylor, 2003). A comprehensive review and synthesis of the literature on TE in forensic settings is available elsewhere (see paper 1).

There is little evidence to suggest that SUs were involved in the design of existing studies into TE, or in the delivery and design of forensic services in general (Faulkner & Morris, 2003; National Survivor User Network, 2011; Sainsbury Centre for Mental Health, 2008). However it is obligatory in the United Kingdom for NHS and independent providers to involve SUs in the planning and delivery of services, according to associated guidance (Health and Social Care Act 2008; Health and Social Care Act, 2001; NHS Reform and Health Care Professions Act, 2002). Involving those with direct experience of mental health difficulties, due to their unrivalled expertise and knowledge in a specific field, can be invaluable in sensitively understanding how to investigate phenomena of interest to clinicians (Mental Health Research Network, 2013).

The research question that this study aimed to investigate was:

What were SUs' experiences of TE with clinical psychologists and other therapeutic staff in secure care?

It was hoped this could lead to further understanding of the factors clinicians might consider when planning and delivering treatments, and to optimise the likelihood of successful TE.

Method

Ethical approval

Peer review and sponsor indemnity were provided by the sponsor institution (appendix E and F). Due to the participants being detained for treatment within an NHS hospital, whilst potentially having contact with the criminal justice system, approval from North Wales NHS research ethics committee required specific guidance from a National Offender Management Service panel representative (appendix G, H, and I). Subsequently, the host NHS trust provided research and development approval (appendix J). Introducing the topic of TE had the potential for vulnerable men to be made more aware of difficulties in their environment and interpersonal relationships. However, due to their incarceration it was considered unlikely they would have the opportunities to remove identified concerns. Part of the agreed proposal therefore was for participants to name a chosen staff member/family member prior to involvement in the research for the principal investigator (PI) to contact should their involvement cause any distress.

Participants

Participants were ten male SUs detained in a medium-secure NHS facility in the West Midlands, UK. The participants were aged between 21 and 48 (mean age 27.5 years), and were all subject to hospital orders for detention and treatment relating to index offences which included sexual/violent offending and arson. All participants had active diagnoses of major mental disorder, including schizophrenia; none had a diagnosis of personality disorder (ICD-10, 2010). Due to the sensitive nature of the secure hospital environment, individual demographic details are not provided, as this was considered highly likely to breach anonymity for some participants.

Procedure

Responsible clinicians provided written consent to approach eligible participants. All participants who were able to understand the purpose and nature of the study,

and who could to provide informed consent were included. Those who were considered by their responsible clinician to be acutely unwell and those whose participation may cause an increased risk to themselves or others were not approached. In total, 20 of the service's 45 residents were approached and provided with study information (appendix K). Written consent was provided by all participants following a period of at least one day from the study information sheet being issued and verbally presented (appendix L).

Of those excluded from the study, seven of the 20 residents consented to be interviewed but declined to be audio recorded; two did not consent and did not offer reasons for not providing consent (nor were obligated to do so); and one resident did not adequately understand the study information. Participants had a right to withdraw their participation until synthesis of data occurred during analysis. No participants requested to withdraw their consent or data. Consent forms and other documentation with identifiable information were kept securely according to National Institute for Health Research Good Practice Guidelines (NIHR, 2011). Staff were informed of the purpose of the study by presentations at multidisciplinary team meetings, and by making the study information available by Email and on noticeboards (appendix M).

Service-user designed interviews

Although it is recommended good practice to involve SUs in the design and delivery of research in all health settings, it is rare in forensic services. To ensure ecological validity in the current study however, the PI consulted with an ex-service user research group (SURG) to ensure the type of questions and language used were sensitive for the population and research aims (appendix N). The group of five, with personal experience of forensic environments, met to establish the questions that they considered were pertinent to TE based on their own experiences. With guidance from a clinical psychologist and the PI, the group developed a list of potential questions to investigate the phenomena (appendix O). For the purposes of the interviews, this topic guide was used flexibly in accordance with recommendations to use questions that seek to explore the lived experiences of participants (for example closed questions were rephrased in practice in an open manner; Smith, Flowers & Larkin, 2009). The overarching topics were: relationships with psychologists and other therapeutic staff; the process of being involved in therapeutic work; and the nature of

therapeutic activities in forensic settings. Example questions included: *Can you tell me about your experience of working with a clinical psychologist? What was your experience of engagement? Can you tell me about someone you have worked with that has made a difference? In what way do you like to do therapy?* Although questions were not uniformly phrased or ordered, the overarching topics were covered within and across all interviews.

All audio-recorded interviews were conducted by the PI in private rooms situated on the wards of the participants, at agreed times. The PI was experienced in conducting research interviews in forensic settings, held a postgraduate research qualification, and had undertaken additional postgraduate and professional training courses/workshops in conducting interviews for the qualitative method employed. The mean interview duration was 37 minutes with a range from 17 to 48 minutes (excluding introduction and termination dialogues). The participant who completed the interview in 17 minutes did not use English as a first language, resulting in comprehension difficulties (as described later). Interviews were subsequently transcribed verbatim on site by the PI, with each participant's name substituted with a pseudonym, and other verbalised names individually coded (for example *Staff Number 1*). To preserve anonymity, specific content or nuances of speech that could potentially identify participants were also re-worded.

Analysis

Due to the exploratory nature of engagement experiences of SUs in forensic care, data was investigated using Interpretative Phenomenological Analysis (IPA; Smith, 1996). IPA is an idiographic approach to understanding how groups of individuals make sense of a particular phenomenon. IPA also incorporates a hermeneutic understanding of conducting research, congruent with the PI's social-constructivist epistemological position, whereby meanings are socially constructed, and interpretation of others' experience is not possible without influence of the researcher. Following guidelines for completing IPA (Smith *et al.*, 2009), individual transcripts were read whilst listening to the audio files to gain a greater understanding of each participant, and then read again recording initial thoughts about the data (in a reflective diary; described later).

Following this, line by line initial coding was completed by using an in-text tricolour recording methodology: Descriptive and linguistic codes were

commented on separately between data lines, with related conceptual codes recorded on the right-hand margin. Following the initial coding, emergent themes were developed and reported in the left-hand margin (examples of these processes are shown in appendix P). The emergent themes were entered into a computer database noting the location of contributory extracts. Connections across emergent themes were then established by considering their abstraction, polarisation, contextualisation, function and frequency (Smith *et al.*, 2009). The resultant case themes were conceptualised graphically to aid with understanding their interconnectivity (appendix Q), and recorded on a computer database. An iterative process then followed for the remaining cases, before patterns across cases were established leading to synthesis and reorganisation into superordinate themes (appendix R).

Adhering to good practice recommendations (Smith *et al.*, 2009; Yin, 1989), transcript inclusion, initial coding, emergent theme production, and super-ordinate theme emergence were regularly checked and independently audited by the research team, and within a host institution IPA research group; further guidance was sought from members of a national IPA group. Participants were not asked to contribute to theme validation due to the potential for confidentiality breaches within an environment where information security is paramount; however the findings were discussed with all interested participants individually.

Diary

Initial thoughts resulting from reading and listening to transcripts were recorded in a reflective diary. The reflections related to general topics that resonated with the PI as being important to the participants. No attempts were made to interpret these reflections; however they were revisited following the super-ordinate theme production to check that the topics which initially appeared important to the participants were covered within the reported themes. It is acknowledged that the process of recording these topics may have influenced future interpretations, despite attempts to separate them from the analysis process.

The diary also recorded reflections on non-verbal observances during interviews, and the processes of using service-user consultation, obtaining ethical approval, and recruitment. These entries included reflective commentaries associated with the PI and SUs' involvement in the study design, method, and analysis, and are described further in paper 3.

Findings

In total 496 themes were identified across participants. By reconfiguring the resultant 65 case themes, four super-ordinate themes and eleven sub-themes were identified (Table 1 and appendix S; all themes were present in at least half of the cases).

Table 4: Super-ordinate themes and sub-themes.

| Super-ordinate theme | Sub-theme | Theme present in cases |
|----------------------------|--|--|
| Different worlds | 1) Coming from different worlds | Ant, Bob, Den, Hal, Ken, Obe, Rod. |
| | 2) Meeting at the same level | Ant, Den, Hal, Rod, Jim. |
| | 3) Abnormal home environment | Ant, Bob, Den, Fin, Hal, Jim, Ken, Obe, Ted. |
| What the individual brings | 1) Personal attributes | All cases. |
| | 2) Expectations and evaluations | Ant, Den, Fin, Jim, Rod, Obe, Ted. |
| | 3) Staff Role | All cases. |
| What the therapy entails | 1) Building a trusting relationship | Bob, Den, Fin, Hal, Jim, Ken, Obe, Rod, Ted. |
| | 2) Setting up and doing therapy | Ant, Den, Jim, Ken, Obe, Rod, Ted. |
| | 3) Outcomes | Bob, Den, Hal, Ken, Obe, Ted. |
| Control | 1) Having a choice | Ant, Bob, Den, Fin, Jim, Ken, Obe, Rod, Ted. |
| | 2) Responding to punishment and feedback | Ant, Bob, Jim, Obe, Rod, Ted. |

Different worlds

All participants described how being in *different worlds* affected how they engaged in therapeutic work. Participant's reported their own and therapists' movements between different spatial and environmental positions, which were dependent upon where they and therapists were from, where they were currently located, and where they were going to.

Coming from different worlds

Participants often described experiences of how staff coming from different backgrounds and having different realities affected how they wished to be engaged:

'...[staff] are not in my world, I am in my world...you've got your little world now that you're in, whereas my world is the real world, what I have been in all my life' (HAL).

Coming from the same background was reported to be a more pertinent factor for how likely the therapist was to understand the participant's world than their professional training. Backgrounds were described by participants in terms of "culture" which included the influences of religion, class/social standing, ethnicity, fashion, and social interests/activities:

'If someone was from my culture, then I'd find it easier to engage with them because they are quite likely to understand the lives and the situations that you have in my culture every day, so it's not about what job it is or anything like that, it's more about the individual and the culture...I can't really put my finger on it, but it's just a wavelength, like a way of thinking, and a way of traditions' (BOB).

For some, regardless of backgrounds, by purposely sharing part of their own world, therapists were able to enter the world of the participants.

'It's just the way they approach you. I suppose they come over when you are talking. Just really friendly and you know they'll tell you stuff about their own lives' (KEN).

By putting the participants at ease, participants were able to feel in the same world as the therapist.

'I did feel very comfortable. She made me feel very comfortable...just by listening' (ANT).

Meeting at the same level

The different worlds that people occupied were often described in terms of hierarchical levels that could or could not be scaled, generally determined by social background, occupation, and educational attainment.

'There's different levels to different people. Like [Clinical Psychologist] can sit there and use a wide range of vocabulary with me, and I would be ok, but some people can't really understand what she's on about' (ANT).

'They are more educated than me, they're up the ladder compared to my level of life I think, I just categorise them as up there, and me down there you know. I could never say that I am on a par with a psychologist... water finds its own level don't it?' (HAL).

When staff revealed similar backgrounds, SUs were more likely to consider them to be on the same level.

'They would be in my shoes, they'd know how it is...they'd have the same perspective of it than me, but a better one because they'd obviously got through it' (DEN).

For some, meeting at the same level was a challenge due to having a different sex. Ted highlighted how engaging with women was on a different level.

'If it was a man I would do [a preferred social greeting], but if it was a woman, just shake her hand like'.

Hal highlighted how for some, it was more difficult to engage on a personal level with women in the social world of the ward.

'You've got female staff coming in and you think "woah, I don't want to talk about that because this might offend her, and that might offend her"...because if there's women about, it aint the same thing is it?'

However when engaging in therapeutic work, Hal would find it more appropriate to speak about personal issues with women due to their maternal connotations, than with men *because they are not on the same level.*

'I found talking to her pretty easy...and I laid everything on the table...I felt comfortable telling her everything, but with men...I don't want to talk about things that happened in my childhood, you know like abuse and any of those things, and I wouldn't go into detail with a man so much I just felt open like she's my mother sort of thing'.

Some participants experienced staff engaging at their level by actively moving into their world, by using professional skills including listening, by being empathic and showing that they are genuinely interested. Ant described how his psychologist could:

'... talk to people on their level...she really does listen, and she does take note of everything I say...she knows her stuff and knows how to...connect with people'.

Others however experienced staff being static and not willing to move towards the participants' worlds.

'The doctors sit there, they're timid...I don't know what it is with the doctors, some doctors speak and the rest of them, you look around the room and they daren't even look at you...as if they can't be arsed (DEN).'

Abnormal home environment

The secure ward itself was considered to be one of the worlds in which the participants resided, both literally (*'I've got to live in this environment'* (HAL)), and in comparison to the normal/outside/real world. Despite being their *home*, usually associated with a place of comfort and safety, the environment was considered unstimulating, hostile, and scary to the participants, who felt they were under continual surveillance. For some however, this had now become their reality.

'I have been here a while now, so it's, this is normality I suppose' (KEN).

As well as being under surveillance themselves, the participants were also engaged in observing others, and regulating perceived threats within their home environment. For example, some participants explained how despite the hospital being their home, they lived with a fear of others who lived there, and used strategies such as creating alternative identities to manage their concerns.

'With everyone, you know, you have to be careful in this place with who you try to speak [to]. You know, so if somebody new [comes in], [at] first [you] watch him, you know, and if he is not friendly, [you] just don't speak with him' (FIN).

'I say I've done a different thing...I've got to, they'll lynch me' (TED).

What the individual brings

There were a number of themes which highlighted how participants had personally experienced the *individuals* they had worked with, how this was influenced by the *role* they held, and with the inter-personal *expectations* and *evaluations* between SU and therapist.

Personal Attributes

Participants offered almost universal agreement on the traits they had observed in staff which encouraged their ongoing engagement. Therapists who were affable, personal, approachable, open, honest, used humour, listened, used eye contact, showed they cared, and showed a genuine interest were associated with positive

engagement. Some participants were particularly affected by not being met with a direct approach from staff.

'I'd rather be told straight, and given a straight answer than not...sometimes...they won't tell you what's going on, and you have to wait, and wait, and wait, and then it's just losing your mind, it's just like that' (DEN).

'They are sort of sitting there going like this and it's patronising, and you are like, come on, just tell me what you think, what you really want me to do and what you want, explain what you want out of me...let's get down to the nitty-gritty and stop pulling punches on each other, that's my perception of it anyway' (HAL).

For some of the participants, engagement was enhanced when therapists related from their own experiences, or the experiences of other SUs.

'They might have said "well this happened a couple of years ago, you are not the only person we done this with, and they got through that sticky patch"' (JIM).

'And it's like "we all know what it's like to feel like that and for the feeling before we self-harmed". So that's good in a sense, because you have got people around you that have been in the same situation' (OBE).

Participants favoured staff who gave the impression that they were doing the work specifically for their purpose.

'Making me feel like they are there for me, so that [makes] me feel better' (FIN).

Expectations and evaluations

Staffs' perceived positive evaluation of SUs was a motivating factor for a number of participants.

'If there's someone that's doubting me or who I am or what I actually say then I will take it on board to...improve myself, it's very important to me that people...perceive me as a good lad' (ANT).

Many participants experienced anxiety as a result of feeling judged due to their offending, despite their expectations of professional practice.

'I have been a bit, not paranoid, but a bit aware that what they think of me. I get that a lot with some of the staff on the ward, like around my index offence. And it is embarrassing...I expect them not to judge me, as a professional. But then again, I sometimes get the feeling thinking "now what do they think of me?"' (OBE).

Staff who did not outwardly judge participants were positively evaluated.

'Just good people...just the way they ask me questions and like don't take anything, even if it's offensive they don't take it as a bad thing' (BOB).

Participants were able to identify the motivations of therapeutic staff by consciously and subconsciously *reading* them. Some observed how staff would enter the participants' worlds to carry out work *on* them, rather than connecting *with* them.

'I feel like they are not there to help me, they're just coming in and doing the work and then they're not bothered about you...you can tell by the body language, facial expressions...it felt bad you know' (JIM).

Staff Role

Participants had differential engagement experiences with staff across defined professional roles. There was a consistently reported hierarchy of power headed by psychiatry.

'Whatever the doctor says goes, the doctor doesn't have to listen to anybody' (ANT).

Although participants experienced individual differences within roles, they separated out the '*professionals*' (psychologists and psychiatrists), from other ward staff, and the SU.

'There is a them, them and an us' (HAL).

'You got the doctors as in psychiatrist doctors, you got the doctors as in psychology, and you got the staff on the wards' (ANT).

'I mean there's like that professional boundary as well I suppose...it's a little bit different from the [ward] staff...I wouldn't fist pump my doctor' (OBE).

Therapeutic staff included psychologists and nurses; however there was a distinction in how their roles affected participants' understanding of how the individual would engage.

'[Psychologists] get to the core of things, the [nursing] staff don't want to do that. You can speak to them, but it's not as deep as when you do psychology' (BOB).

'The psychologist gives you tools to help...[ward] staff manage you, where psychologist give you like relaxation or write it down and stuff like that, staff will just talk to you' (JIM).

Participants also spoke about psychologists having dual roles. As well as a formulatory and therapeutic role, psychologists also held a position of substantial power, particularly evidenced when producing reports, which affected participants' progression through forensic care.

'[Staff number 13] is my psychology worker, I got my CPA [Care Programme Approach meeting] next month, and she says how well I am doing' (TED).

'I know that a lot of things get wrote down and I know that it is mainly their job to do that...and sometimes you have to sort of hold back in conversation because you don't want to say nothing that is going to get you, "oh why did you say this thing on this day"' (ANT).

What the therapy entails

How therapies had been established and conducted in the past were likely to affect participants' future TE.

Building a trusting relationship

Building a trusting relationship was an integral theme for effective TE. Speaking to participants '*with respect and dignity, as a person, not as a mental health patient* (JIM)', was considered an important first step for therapists. Participants did not trust in therapeutic staff by default.

'So it's gotta be the right person you know. You might get a psychologist who you can't talk to' (JIM).

They required time to prove their trustworthiness, then they were able to disclose and speak about their '*deep stuff*' (ANT).

'Unless I've got to know him over a period of time, I wouldn't sort of open up to him much' (HAL).

'I can trust them, I can speak with them, I don't need to be caring if they know' (FIN).

'It's like a trust thing, I know he's not going to say something that is going to make me upset' (OBE).

An important prerequisite of trust was staff maintaining confidentiality. A break in confidentiality led to a break in trust and engagement.

'If I told them something in confidence they wouldn't go telling everyone' (OBE).

'If they did I'd feel let down by them, the trust would go, unless I gave my permission to do, obviously I'd feel a bit let down by them' (DEN).

Setting up and doing therapy

TE was enhanced by staff being clear about the purpose and set up of therapy from the outset and then conducting it in a simple way without excessive burdens.

'Come and see me, explain about the course, explain if I have to do it or not, how long the course is going to be...shake my hand, introduce yourself, say where you are from...say look we're going to be doing work with ya, it's private and confidential...' (JIM).

Many of the participants experienced burden as a result of doing work that was too complex, too long or involved home-work. There was a preference for doing things in simple, clear, repetitive ways, and within short regular sessions.

'It wasn't head-burning, it wasn't too overpowering, it wasn't too much, it wasn't easy, but it wasn't too much' (OBE).

'She explained everything in layman's terms, like broke it all down and made it easier for me to understand what she was trying to do... a simple thing that she gave me was a set of traffic lights, and she was on about, "where am I in the traffic lights"...it was useful and I sort of dwelled on that, you know it was easy, easy to work out' (HAL).

'I can take two or three things out of a group that I can do and that's all good' (ANT).

Outcomes

Desired outcomes to therapeutic work for participants were experienced in with the personal gain of new skills, and losses of burdens.

'I felt like a big load of weight had just been lifted from my shoulders' (DEN).

'It sort of straightened my brain out if you like... it gave me some positive things and she was giving me positive things' (HAL).

'I feel it in myself...less voices, less feeling bad' (FIN).

Staff were however experienced as being more interested in practical outcomes.

'That's what they want anyway, for me to attend more' (KEN).

Control

Participants reported a range of experiences that related to having or not having *control*. These included how having a *choice* about participation in therapy and staffs' use of *punishment and feedback* regulated their TE.

Having a choice

Participants reported mandatory participation in therapies:

'It's not a choice; I have to do it if I want to help (FIN).'

'There are some things like my anger management, that's compulsory, like even if I don't want to, I've got to do it (DEN).'

Having a choice about participation in therapeutic work was universally experienced as a motivating factor. Interestingly, Jim related his experience of being involved in the research interview itself:

'You've come up to me, you've asked me if I want to do this, and you've asked me nicely, and you told me "you don't have to do it".'

For some, despite preferring to be involved in decisions about participation, there was a resignation about the clinical team having control over their treatment.

'I can take it either way, I can be fully involved and lead it, or I can just do what the team ask me, and there's nothing more really you can do' (ANT).

Having involvement in decisions relating to therapeutic care was considered a prerequisite for effective therapy. If participants were not involved in decisions, they might attend but were unlikely to be meaningfully engaged:

'It's paramount isn't it, you have got to be involved in your own care, because they can't decide something without you, you know what I mean?...they can lead you to water but if you don't want to drink it you don't want to drink it....because if you are forced to do it, you are not going to put the effort into it' (JIM).

'Sometimes you haven't got a choice who you gotta do it with, I'm not as open as I am with others, so I kind of hide myself away from them. Whereas if I was with somebody else then I'd be more open' (DEN).

A majority of participants positively reported being given opportunities to take at least some responsibility for their treatment planning.

'There are times for me when I can make a decision on a proposal or what to do, and how to move forward, and what I want, and what the doctors want, so we do jointly make decisions and stuff like that' (ROD).

Responding to punishment and feedback

Many participants spoke about their experiences of receiving feedback in the form of actual and perceived punishments which led to disengagement, and compared this with experiences of receiving tailored, personal constructive feedback which encouraged greater engagement.

'If [the therapist] told someone about their progress or something like that then, you know then that's good but if they come along with negatives it'll kind of like bog you down and stuff like that, so no it's not a good idea to put someone down, because you know, you want positive things' (ROD).

Discussion

The aim of this study was to explore the TE experiences of SUs detained in secure care, to illuminate factors that might be considered when planning for, assessing, and being engaged in therapeutic work. The findings show a number of themes which were relevant to, and furthermore actively involved staff who are engaged in clinical work and research in forensic settings. Interpretation of the experiences described by participants produced themes which demonstrated how TE was influenced by the *different worlds* in which SUs and staffs occupy; *what the individual brings* to therapy; *what the therapy entails*; and SUs' perceived *control* over their therapeutic care. Whilst the research was designed to concentrate on participants' experiences of working with clinical psychologists, SUs' responses included TE experiences with therapists from a range of professions.

One unique finding suggests that SUs' engagement was affected by an understanding of their positions in relation to therapeutic staff. For example, participants experienced coming from, and occupying different worlds and levels to therapists. Without conscious effort from the staff to scale different positions, the SUs were less inclined to engage. A movement towards observing the world from the position of the SU fits with the humanistic therapeutic principle of *'empathy'* (Rogers, 1961). This principle maintains that without viewing the world from the SUs' point of view, therapists are only able to understand SUs from external frames of reference; and are therefore crucially unable to understand actions and behaviours as if they *were* the SU (Rogers, 1961). The findings of the current study suggested that as well as entering and observing the world from an

SU position, the men also benefitted from the therapist making such movements known.

A further foundation of the humanistic approach is the proposal that therapists should provide unconditional positive regard (UPR) to SUs regardless of what they have done or where they have come from (Rogers, 1961; Standal, 1954). Therapists' traits found to be predictors of effective TE in the current study including *showing that they cared*, and demonstrating a *genuine interest*, are commensurate with this notion of UPR. However, the study's findings also showed that for some SUs, the differences in the worlds they occupied due to gender or culture were always likely to affect any meaningful engagement in interpersonal work, regardless of the UPR or other actions demonstrated by therapists.

Such preferences are not unique to the current study's findings. For example, ethnicity was one of a number of factors which comprised the *culture* 'world' described by some participants. A meta-analysis of ethnic therapy matching found moderately strong effect sizes for SU preference for (and positive perceptions of) therapists of their own ethnicity; however almost no therapeutic benefit effect according to shared ethnicity was found (Cabral & Smith, 2011). Whilst pairing SUs with therapists of the same background may be neither ethical nor possible in practice, awareness of such potential barriers or opportunities might be important factors to consider as part of establishing suggested pre-treatment preparation procedures (McMurrin & Ward, 2010).

Staff who were static, and did not make the necessary movement towards the level of the SU, were perceived as uncertain and untrustworthy. Trust was similarly reduced for any staff that were perceived to have breached confidentiality without just cause; or for those who were not direct and open about their motivations (for example discussing the men's care as a team behind closed doors without the SUs' involvement). In common with other recent SU perspective studies, being part of a trusting relationship was found to be required for ongoing TE (Mason & Adler, 2012; Willmot & McMurrin, 2013). Promisingly, the current study's findings suggested that staff were able to build the SUs' trust by listening, and by giving the impression that they genuinely care about the individual they are working *with*.

Regardless of staffs' movements and efforts, it was apparent that SUs did not perceive that they had a choice to participate in many therapeutic activities; they

had to do them. Due to the nature of the environment, whereby staff held hierarchical levels of power, the men were more likely to be involved in therapies without being meaningfully engaged, than risk any punishment or disruption to their path out of forensic care by not attending. Mason and Adler (2012) suggested that a sample of forensic SUs engaged in group work had a developed a sense of 'learned helplessness' (Seligman, 1975). Learned helplessness may be explained in the context of the current study. For example, the participants reported being forced to attend (potentially non-effective or counterproductive) therapies; however due to not having control over their involvement, they continued to attend even if they were not meaningfully engaged. Similarly, Mason and Adler (2012) also highlighted that being clear about proposed work from the outset was likely to aid in the choice making process and therefore TE.

Schafer and Peternej-Taylor (2003) found that SUs enrolled in a treatment programme for violent offending evaluated therapists' genuineness and identified inconsistencies between therapists' verbal and non-verbal presentations. Additionally, the current study found that SUs reported being skilled in consciously and intuitively '*reading*' the motivations of staff. This skill was in part developed due to a unique necessity to be on guard to survive in forensic settings. The men accepted that staff had their '*own lives*' when away from the wards, but also had an expectation that whilst at work their focus should be on helping SUs to get better. The SUs were confident that they could accurately predict how motivated staff were to meet this brief based on their observations, interactions and subconscious understandings ('*you just know*'). Participants were also aware of the power that staff held over them, and how the therapists' role affected how and to what degree they were likely to be engaged in therapeutic work. SUs were understandably motivated to ensure they received favourable feedback to aid with progression and eventual discharge.

Finally, despite the reality for SUs that they were engaged in therapies in their own (scary, abnormal) home, experiences suggested that therapists did not regularly offer the choices or everyday comforts that participants expected, such as negotiating a time and duration of session. Although not recorded, another example was from Hal who explained that he had been in a weekly meeting for a number of years with his care team, and was never offered a drink despite there being a coffee jug in the room for staff to share each week; this added to a sense of '*us and them*'. Other normalising behaviours such as using humour as part of

an overall affable personal presentation were also recognised as contributing to SUs' positive evaluation of staff attributes. Humour as a fundamental aspect of treatment has shown promising effects within forensic settings (Minden, 2002); however considering the nature of some therapeutic work in a forensic ward it is understandable that this may not always be applicable to therapeutic sessions.

Limitations

There are a number of limitations to the existing study. Firstly, it may be predicted that there could be a positive bias on how participants reported experiencing engagement due to being purposely selected by their responsible clinicians for inclusion. Also, although the study sought to investigate the lived experiences of SUs in TE, it was not possible (nor ethical) to restrict participants from speaking about other forms of engagement, for example social engagement within a ward setting. This was however considered during analysis and selection of extracts to highlight themes.

One participant did not use English as a first language; however he was able to understand the consent process. In common with other participants whereby difficulties with comprehension were observed, the participants' responses must be considered in the context of the findings. These included a preference for presenting things in a simple way, and having to take time to build trust in staff before disclosing '*deep stuff*'. Despite three participants stating during the interviews that they trusted the interviewer, it is unlikely that sufficient interactions had occurred prior to interviews for all to trust the PI.

Conducting interviews in rooms where the participants usually participated in therapies may also have been experienced in a way that was analogous to doing therapies themselves. Furthermore, a number of participants explicitly referenced feeling tired and/or being affected by psychotropic medication at the time of the interviews. Whilst every effort was taken to present the questions in a way that would be inclusive of a range of comprehension levels and presentations in a non-judgemental and confidential manner, it cannot be assumed that given these considerations, all participants gave a full reflection of their experiences.

In line with NHS recommendations, SU consultancy was used to aid with the design of the interview schedule. The benefits and challenges of this process are discussed elsewhere (see paper 3, page 66).

Clinical Implications

The findings of this study are reflective of experiences in one NHS medium-secure forensic service; however it is expected that due to similarities in the environment and nature of treatments that the observed themes may be transferable to other forensic settings where men are detained and receive therapies aimed at offence recidivism and/or mental health improvement.

It is suggested that staff working therapeutically with men in forensic settings may be advantaged by considering how to use the themes reported in the current study. The findings suggest that meeting men '*on their level*' by using preferred social greetings, by using humour, and being clear from the outset about the purpose of engagement, is likely to enhance TE. Also, whilst men are often detained against their personal wishes in secure hospitals, there is a potential for clinicians to offer choices to SUs regarding the set up and delivery of therapies; including a consideration of the SU's preference to keep work simple. Furthermore, the findings suggest that being direct and open can prevent SUs from feeling excluded and more likely to enter into the trusting relationships required for effective TE. Staff may also benefit from remembering that their place of work is the SUs' home. SUs are likely to already feel punished for being in secure care, therefore offering specific feedback is suggested to be a more advantageous strategy than punishment for SU errors.

Conclusions

A number of themes were found by conducting an interpretative phenomenological analysis of TE experiences reported by a sample of participants detained in a medium secure hospital. Unique findings included the conceptualisation of the different worlds occupied by staff and therapists, and the learned ability of SUs to evaluate the attributes and motivations of the staff they are working with. Other themes were congruent with existing qualitative research exploring engagement in forensic settings, including the importance of building a trusting relationship, and offering SUs a choice in their care. The findings may be of utility to other clinicians and researchers seeking to understand how to improve TE in secure care.

Future research

The current study sought to investigate the lived experiences of a homogenous group of men in a medium secure setting. It is suggested that in line with the recommendations for engagement models to be produced (McMurrin & Ward, 2010), that the experiences of a range of men and women in other forensic locations be investigated. By compiling the findings, it is expected this will contribute to the development of psychologically-robust quantitative measures to further investigate how variable approaches from staff affect TE in secure settings. This research also highlights the considerations and limitations for the active involvement of SUs in research design in secure settings. It is hoped that the observed potential for SU informed research will be realised in future studies.

Disclaimer

This study was sponsored by Keele University, and conducted within an NHS hospital; the findings and discussions are those of the author, and may not reflect the views of either institution.

Paper 2 References

- Cabral, R. R., & Smith, T. B. (2011). Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions and outcomes, *Journal of Counselling Psychology*, 58 (4), 537-554.
- Centre for Mental Health (2013). *Guidance for commissioners of mental health services*. Retrieved from <http://www.jcpmh.info/wp-content/uploads/jcpmh-forensic-guide.pdf>
- Day, A., Howells, K., Casey, S., Ward, T., Chambers, J. C., & Birgden, A. (2008). Assessing treatment readiness in violent offenders, *Journal of Interpersonal Violence*, 24 (4), 618-35. DOI: 10.1177/0886260508317200
- Faulkner, A., & Morris, B. (2003). *NHS National programme on forensic mental health research and development: User involvement in forensic mental health research and development*. Liverpool, UK: NHS.
- Frost, A. & Connolly, M. (2004). Reflexivity, reflection, and the change process in offender work, *Sexual Abuse: A Journal of Research and Treatment*, 16 (4), 365-380. DOI: <http://dx.doi.org/10.1023/B:SEBU.0000043329.65730.ff>
- Health and Social Care Act (2001). London, UK: HMSO.
- Health and Social Care Act (2008). London: UK: HMSO.
- International Classification of Disorders [ICD-10] (2010). *International statistical classification of diseases and related health problems, 10th Revision*. Malta: World Health Organization.
- Mason, K., & Adler, J. R. (2012). Group-work therapeutic engagement in a high secure hospital: male service user perspectives, *The British Journal of Forensic Practice*, 14 (2), 92–103. DOI: 10.1108/14636641211223657

- McMurrin, M. (2002). *Motivating offenders to change: A guide to enhancing engagement in therapy*. West Sussex, UK: John Wiley & Sons.
- McMurrin, M., Hubbard, N., & Duggan, C. (2008). A comparison of treatment completers and noncompleters of an in-patient treatment programme for male personality-disordered offenders, *Psychology and Psychotherapy*, 81, 193–198. DOI: 10.1348/147608308X288762
- McMurrin, M., & Theodosi, E. (2007). Is treatment non-completion associated with increased risk of reconviction over no treatment? *Psychology, Crime, and Law*, 13 (4), 333-343.
- McMurrin, M., & Ward, T. (2004). Motivating offenders to change in therapy: An organizing framework, *Legal and Criminological Psychology*, 9, 295-311.
- Mental Health Research Network. (2013). *Involving service users and carers*. Retrieved July 26, 2013, from <http://www.mhrn.info/pages/involving-service-users-and-carers.html>
- Minden, P. (2002). Humor as the focal point of treatment for forensic psychiatric patients, *Holistic Nursing Practice*, 16 (4), 75-86.
- National Institute for Health Research (2011). *A pocket guide to good clinical practice, including the declaration of Helsinki*. Geneva, Switzerland: ICH Secretariat.
- National Survivor User Network (2011). *Unlocking service user involvement practice in forensic settings*. London, UK: National Service User Network.
- NHS Reform and Health Care Professions Act (2002). London, UK: Department of Health.
- Rethink (2011). *Forensic mental health services*. London, UK: Rethink Mental Illness.

- Rogers, C. R. (1961). *On becoming a person: A therapist's view of psychotherapy*. Boston, MA: Houghton Mifflin.
- Rosen, P. J., Hiller, M. L., Webster, J. M., Staton, M., & Leukefeld, C. (2004). Treatment motivation and therapeutic engagement in prison-based substance use treatment, *Journal of Psychoactive Drugs*, 36 (3), 387-96.
- Sainsbury Centre for Mental Health (2008). *A review of service user involvement in prison mental health research*. London, UK: Sainsbury Centre for Mental Health.
- Sainsbury, L., Krishnan, G., & Evans, C. (2004). Motivating factors for male forensic patients with personality disorder, *Criminal Behaviour and Mental Health* 14 (1), 29-38.
- Schafer, P., & Peternelj-Taylor, C. (2003). Therapeutic relationships and boundary maintenance: The perspective of patients enrolled in a treatment program for violent offenders, *Issues in Mental Health Nursing*, 24, 605-625.
- Seligman, M. E. P. (1975). *Helplessness: On depression, development, and death*. San Francisco, CA: W.H. Freeman.
- Sheldon, K., Howells, K., & Patel, G. (2010). An empirical evaluation of reason for non-completion of treatment in a dangerous and severe personality disorder unit, *Criminal Behaviour and Mental Health*, 20 (2), 129-14.
- Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology, *Psychology & Health*, 11, 261-71.
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory method and research*. London, UK: Sage.

- Standal, S. (1954). *The need for positive regard: A contribution to client-centered theory*. Unpublished doctoral dissertation, University of Chicago, IL.
- Willmot, P., & McMurrin, M. (2013). The views of male forensic inpatients on how treatment for personality disorder works, *The Journal of Forensic Psychiatry and Psychology*, 24 (5), 594-609. DOI: 10.1080/14789949.2013.823219
- Yin, R. (1989). *Case study research: Design & methods* (2nd ed.). Beverly Hills, CA: Sage.

Paper 3: Hard to reach worlds: Challenges and rewards of conducting service-user informed research in forensic settings.

Abstract

Using the themes found in paper 2 as headings, the principal investigator (PI) provided a reflective commentary on the process of conducting the research: The 'different worlds' of the researcher, service users (SUs) and SU researchers are described in relation to obtaining ethical approval. 'What the individual brings' highlights how individual SU factors, and the PI's role influenced the study design and outcomes. 'What the research entailed' provided a critique of the consent, selection and analysis phases of the research, whilst reflecting on interpersonal trust and humour between researcher and SUs. Not having 'control' over the research processes led to frustration for the PI; however using the findings in practice is shown by a negative feedback loop to demonstrate how personal goals have been achieved.

Word Count: 3,729.

Submission details

This commentary paper is for the purposes of reflection about the research process from the PI's perspective, and as an adjunct to papers 1 and 2 to aid the reader to understand the PI's personal journey. It is therefore not written with publication in mind.

Structure of reflective paper

This commentary paper uses the themes that emerged from paper 2, to highlight the areas of reflection by the PI throughout the study process, which were recorded in a study diary throughout (see paper 2, page 44). Upon careful consideration of the four super-ordinate themes presented in paper 2 (page 45, appendix S), there was a reciprocal resonance for theme titles for the PI when exploring their own experiences.

The PI required an understanding of the *different worlds* occupied by the study participants, which was made possible by navigating the worlds of NHS ethics and SU consultancy. *What the individual brings* allowed the PI to consider what was going on in the worlds of individual participants, and how the PI's role was likely to have influenced the research process. *What the therapy entails* was

reconceptualised in terms of what the research entailed, including recruitment, consent and building trust. Finally, throughout the research process the PI recorded different experiences of having, or not having *control* over the outcomes and direction on the study.

Different worlds

The aim of the study was to explore SUs' experiences of therapeutic engagement (TE), to better understand how to optimise engagement. The challenge however was to navigate the often remote worlds of the SUs, the PI, and ethical procedures. Figure 2 indicates how the study aims would only be achieved by successfully integrating these worlds.

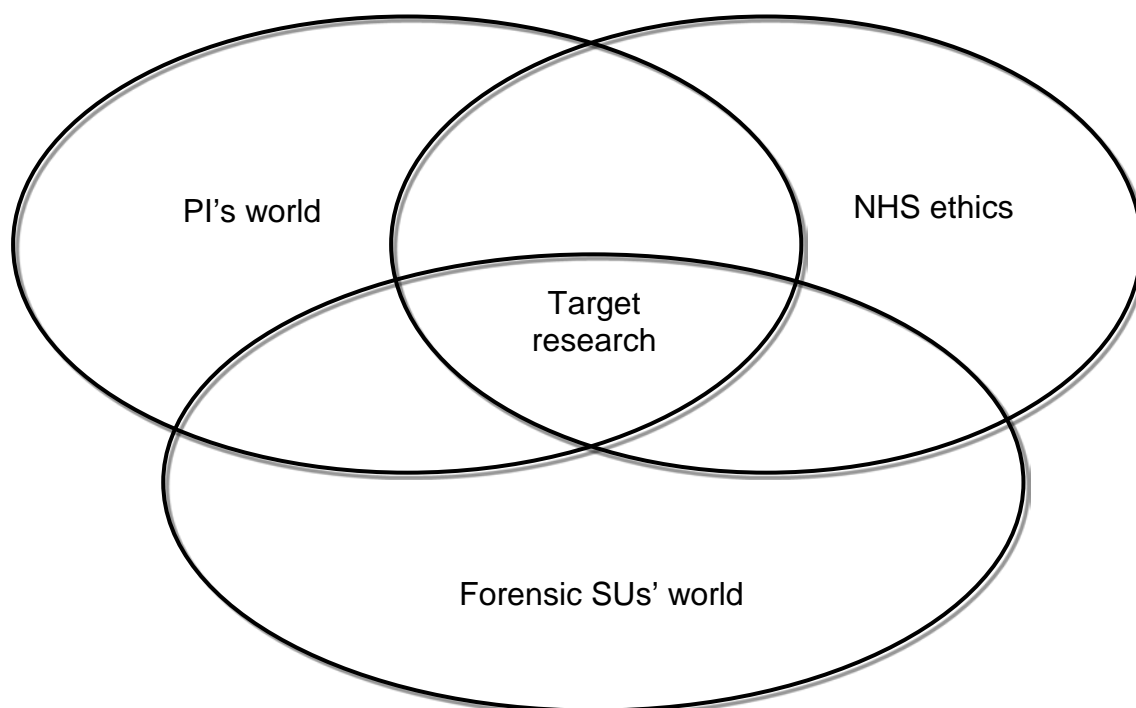


Figure 2. Graphical display of the overlapping worlds of the target research

The principal investigator and SU worlds

The PI's *world* consisted of a motivation to understand the SUs *world* better which was born from their past experiences of working with SUs in forensic environments. It became apparent through experiences working and conducting research in prisons and secure hospitals, that SUs in forensic settings occupy a hard-to-reach world, where they are often excluded and stigmatised. Furthermore, the PI had anecdotal evidence of concerns raised by men in similar settings about

their experiences of engagement. As a man, of similar age to many men in secure care, and having previously experienced his own mental health difficulties, the PI has often empathised with the stories presented to him by those in secure settings. Although committing crimes had never been justified to the PI, the origin of their offending has been understood in the context of psychological formulation. Although the PI has achieved personal reward from working therapeutically with men in forensic settings, he has observed that some others either may not be similarly motivated, or they have not been aware of what factors were important to the men they were engaging with. It was this question that inspired the research.

The ex-forensic service user researcher world

Whilst the PI had experience of working with and researching male SUs in forensic care, it was not assumed that this qualified him to be best placed to design a study to sensitively enter and investigate their world. The PI had recently been involved in establishing a professional service user research group (SURG) as part of a separate larger study into conducting therapy in prisons, whereby the members all had forensic experiences of their own. Their research skills were developed by regular support and training from academic and clinical professionals, including clinical psychologists and nurses.

The PI paid the SURG for their consultancy into the study design which included the development of an interview topic guide, and guidance for how to best engage in the research (paradoxically for a research project that sought to explore SUs views on engagement). This was a challenging process because the PI needed to remain clear about the purpose of the consultancy. Group members were encouraged not to speak about their own TE experiences which may have influenced the PI when developing themes later on. For example, the group was reminded regularly that the purpose was to create questions, rather than answering them, despite the answers likely to be of personal interest to the PI. The additional guidance provided by the group included *“being real”*, which when expanded upon, related to using language that was appropriate for the target participants, not *“speaking like a robot off a script”*, and being clear that the research motivations were for a greater good, rather than for self-interest. The group predicted that employing these strategies would influence the participant’s research engagement, but not the content of their responses.

The NHS ethics world

Ethical review is a necessary and important process which considers the worlds of service users to ensure that they (and those investigating them) are protected whilst being involved in research. To conduct research in NHS settings and with NHS patients, NHS research ethical approval is required by a regional NHS research ethics committee (REC). To conduct research with offenders, National Offender Management Service (NOMS) ethical approval is required; this includes those in contact with prison, probation and police services. For secure hospitals there is an overlap because those detained in forensic care are NHS patients; however they are also likely to be in contact with the criminal justice system. Despite any contact with the criminal justice system, forensic SUs are officially under the care of the NHS, and therefore do not ordinarily need NOMS approval for research.

However, there appeared to be a lack of understanding at the first REC meeting attended by the PI about which jurisdiction medium-secure hospitals came under. Indeed the PI was verbally informed they should seek approval from NOMS *“just to cover all bases”*, which would be *“required”* for the panel to approve the study, despite a member of the NOMS ethical team being present. Frustratingly this suggestion delayed the progression of the study, with additional guidance provided which suggested the SU consultation was required prior to ethical approval. There appeared to be further confusion in the second REC meeting attended by the PI. Whilst approval was offered for the study in part based on the production of NOMS guidance, the committee initially wanted the PI to use the topic guide created by the SURG verbatim. The importance of using a more flexible approach, as required by IPA methodology (Smith, 1996), was difficult for some panel members less versed in qualitative design to justify; however because flexibility had been suggested by the SURG, sufficient credence was achieved.

The PI reflected that such processes, if not sensitively understood by their own members, were likely to discourage researchers from exploring the worlds of some of the hardest to reach members of society, leading to further isolation. The PI felt obligated to forward additional information from NOMS to the regional NHS REC panel members so that they might have a better understanding for future prospective researchers.

What the individual brought

Service Users' presentations

All of the men interviewed were under the influence of prescribed psychotropic medication, with many also prescribed combinations for a range of non-mental health related conditions. Whilst the proposed purpose of such medications is to improve the mental function of SUs, the use of many psychoactive drugs and polypharmacy creates side-effects which are likely to have affected the participants' ability to concentrate and to provide fluent reflections of their experiences. Medication is one factor which was explicitly stated by SUs to have contributed to feeling "tired" at the time of the interviews; others stated that the interview process itself was tiring, even after 15 minutes. Two participants requested and took short breaks, and a number offered briefer answers as the interviews progressed. It was predicted that the interview times were likely to be shorter than for some other participant groups often involved in qualitative research (for example using staff and/or community samples). This was why a sample size of ten was selected consistent with previous research in the same NHS setting (Vass, 2012), and comparable with the qualitative studies critically reviewed in paper one; larger than the sample size of one-to-seven usually suggested for IPA (Smith, 2008).

Although the medium secure hospital provided a service for adults without intellectual disabilities, it is possible that some participants may have experienced undiagnosed difficulties across particular domains of intelligence, including attention and comprehension. Despite ensuring questions were easily understood, the PI observed three participants who had difficulties comprehending at least one question, or words within questions. One participant had consistent difficulties with comprehension, word production and fluency. This observation is considered in the context of prison populations where men are on average found to have lower IQs and educational attainments than the general population (HM Inspectorate of Prisons, 2009).

Expectations and researcher's role

One theme which emerged at the initial coding stage of analysis (not included in the final themes) was an apparent need for some participants to seek reassurance from, or to impress the PI. For the participants, their involvement in the research may have been in part due to a need to show their teams that they

were progressing. The forum that they usually had to evidence their progression was in MDT meetings, which were routinely held in the same room as the interviews were conducted.

Furthermore, the PI introduced himself with words that included “*psychologist*”. Based on the theme which highlighted the importance and definition of professional role by SUs (page 50), this is likely to have affected how they chose to come across in interview. For example, it is possible that in line with their understanding of a psychologist’s role, there was an expectation that their responses would be fed back to their care team, and therefore more favourable and less extreme experiences were presented. For others it was considered likely that having the opportunity to speak to someone whose role is generally defined by confidentiality and/or separation from other professionals, may have encouraged them to speak about experiences they might otherwise not have had the opportunities to do so, due to fears of retribution or punishment.

‘What the research entailed’

Having or not having trust in the research

A sizeable minority of SUs approached to participate in the study offered consent to be interviewed, however not to be audio-recorded. Furthermore the use of an audio-recorder in the forensic hospital led to concerns being raised by one member of staff who was not aware of the study. The SUs who did not consent to being recorded were not asked for their reasons, but it is likely in the context of the study findings that some did not *trust* what the researcher would use the recording for. One SU explained that “*I have got so much to tell you, if you weren’t recording I’d be well up for it*”. One of the sub-themes that emerged from the data for the participants who were recorded was the need to build a trusting relationship, whereby that trust developed over time. It was unlikely that the PI had sufficient opportunity to build trust with all those approached despite using the suggestions provided by the SURG and their own clinical skills. It could be suggested that emergent themes related to trust may have been more numerous had those SUs who declined to be recorded had their experiences included.

Another criticism of the method involved the purposeful selection of potential participants by their responsible clinicians. Whilst this was required by the NHS REC to ensure those at risk were not included, it may have provided a biased

selection by including SUs who were likely to be more favourable about their TE experiences.

“Having a laugh”

During the interviews, a number of participants made jokes and encouraged the researcher to respond with laughter. Analysing the transcripts showed that when humour was introduced and responded to with some participants, this increased the richness of subsequent responses. The PI was mindful of the advice given by the SURG to not come across as a “robot”, so when prompted he used humour appropriately and sparingly to build engagement in the interview process. Interestingly, two of the participants who were involved in relatively more regular humour exchanges also explicitly stated that they trusted the PI, and also provided lengthier responses than most others.

Doing analysis

Following the completion of interviews, the PI transcribed and anonymised the recordings and then used IPA to explore the meanings of the experiences SUs had described. Analysis was an extended process which involved peer and research group quality validation and checking. However, a majority of the analysis was completed at the PI’s home, using a range of methods which evolved with the data. The PI had used IPA before in practice and had attended recent workshops aimed at implementing it into the current research; this experience helped to ensure the analysis processes were transparent and replicable, but moreover that it was conducted in a flexible way depending on the data (Elliot, Fischer, & Rennie, 1999). Following the development of emergent themes the PI discovered that the data was best understood using visual representation. Although not previously considered to be a visual person, the emerging themes including “*different worlds*” and “*different levels*” and the movement between them by participants and therapists was found to be better understood when they were positioned spatially.

This process involved setting up a dedicated room to provide sufficient space to diagrammatically capture the relationships and dimensions of the emergent themes for each individual which helped the PI to understand the interconnectedness of the themes. This was conducted initially within participants (appendix Q), and subsequently across participants (appendix R). However, the

PI had difficulty collapsing emergent themes into sub-ordinate themes using the diagrammatic method. Each emergent theme was literally observed by the PI to have had its place within the context of individual participants' experiences, and he was at first anxious that individual meanings would be lost by the process of super-ordinate theme development. To accommodate these concerns, the PI found that analysis across participants was better conceptualised using listing methods, which were then later re-conceptualised diagrammatically (appendix S).

It was not possible to allow the participants to contribute to theme validation (due to the potential for anonymity and legal issues associated with forensic services), which was a personal frustration to the PI due to the value the PI placed on SU input. However the completed findings had been discussed with all interested participants following analysis. The three participants who subsequently expressed interest in observing the finalised themes offered verbal validation and confirmation that the themes made sense to them individually.

'Control'

Having (or not having) control over the research process

The PI related strongly to the SU theme of *control* which emerged in paper 2 (page 53). At times during the research process, the PI felt powerless, despite having overall responsibility for the study's progression. Not having control on a number of occasions, and for extended periods of time led to frustration, and anxiety. For example, the progression of the study was halted for extended periods by decisions made by REC panels; and furthermore when two of three responsible clinicians at the research site were unavailable to provide consent to approach SUs. The study had restrictions applied as part of the fulfilment of an educational award, therefore the longer the time taken to get the control back, the more pressure there was to progress the research when it was retrieved. However, by initiating the ethical process as soon as possible, and by allowing a six month *buffer* period in the study design, the interviews and analyses were completed ahead of schedule.

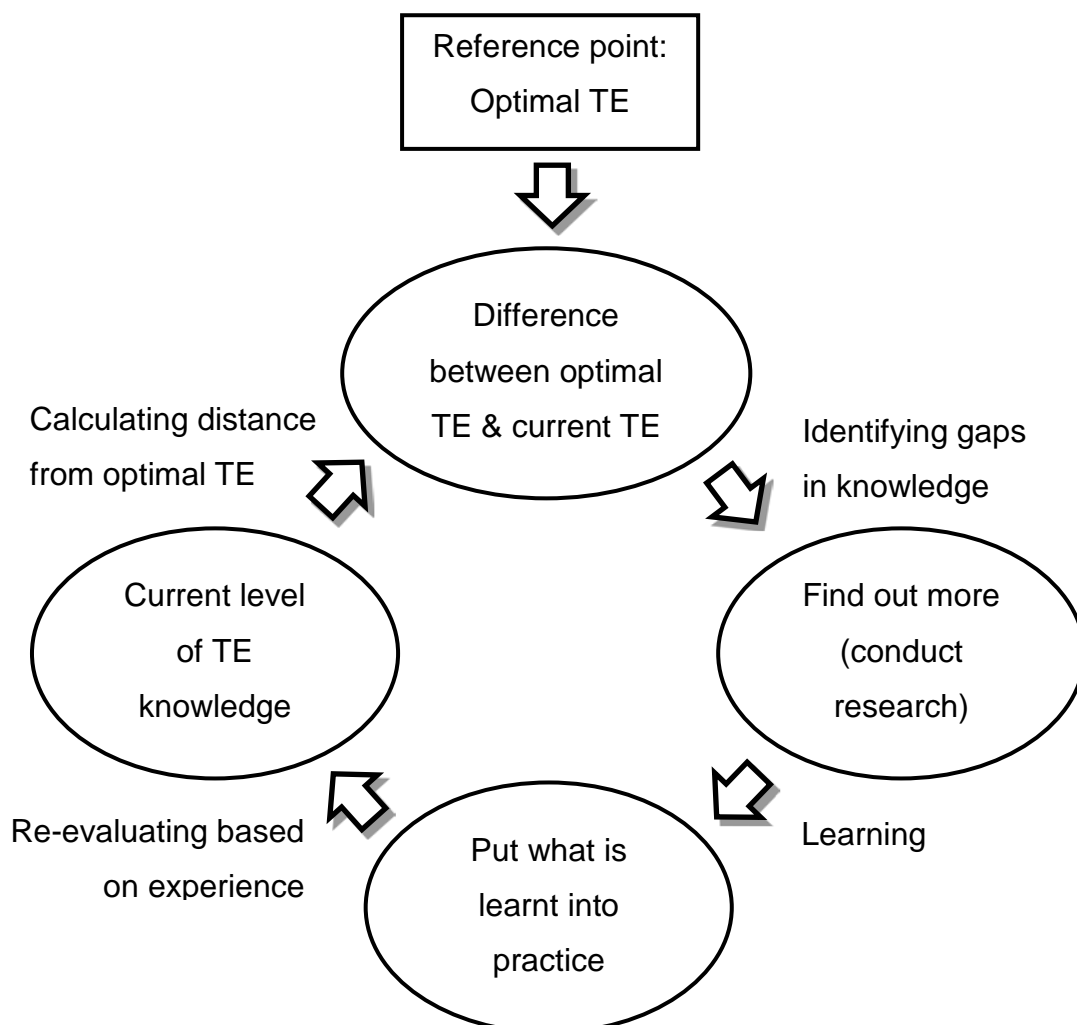
The lack of control over a research study experienced by the PI was frustrating, however it was considered important to apply some perspective by comparing this to the lack of control experienced by the participants. Whilst the PI was able to manage a lack of control by applying strategies to accommodate potential barriers, for the SUs in secure care they had often become resigned to

their lack of control due to their environment, and their perceived lack of power. The PI reflected on how difficult they would find a comparable situation, and furthermore how fundamental engagement with staff might be to allow access to the control and power that might be required, to make progression through secure care.

Perceptual control theory

The PI has a personal interest in understanding behaviour by applying perceptual control theory (PCT); whereby behaviour is defined as the control of perception, by an organism seeking to mediate its relationship to its environment (Powers, 1979). At the time of conducting the research the PI was learning about how to use PCT to understand human behaviour. In PCT terms, the PI's perceived ability of engaging SUs (perception) is controlled by attempting to learn more about what TE means (behaviour), and then reevaluating these abilities against a desired external reference level after putting what has been learnt into practice (figure 3).

Figure 3: PCT negative feedback loop of the PI's TE system.



In summary, the PI sought to achieve optimal engagement by testing out what had been learnt from the research (and practice), and then checking out whether this got him closer to understanding how to optimally engage with SUs. The SUs with whom the PI has been engaged in therapeutic work have since offered feedback to the PI about their engagement experiences, which have generally supported the PI's use of behaviours expected to optimise TE. Using this framework, the research processes undertaken (papers 1 and 2) are just two ongoing examples of behaviours taken by PI towards meeting the goal of achieving optimal TE with SUs. It is accepted that the goal may never be achieved due to the idiosyncratic nature of TE across individuals and environments as highlighted in papers 1 and 2, however for as long as the *optimal engagement* reference point exists, the PI shall endeavour to *control* for this by continually applying what has been learnt in research and practice.

Feedback

Following the completion of interviews the PI assumed a clinical role within the research site. The PI had subsequently been engaged in individual therapeutic and assessment work with some of the participants, and had engaged informally after interviews with all others. Due to the specificity of the findings the PI had applied the knowledge gained from the themes and clinical implications suggested in paper 2, and also the themes provided by each individual participant when conducting therapeutic work. Although the PI considered their approach to be defined already by directness, being affable and other themes from paper 2, these provided reassurance that personal traits were already potentially beneficial to TE.

Such applied responses had included giving greater control to the SUs over the content of therapeutic work and scheduling; and being clear from the outset about the purpose of work, each other's expectations, and desired outcomes. Also, the PI had met 'on a level' by greeting the SUs in a way that they were comfortable with; by engaging in normal homely activities such as making drinks before sessions, and by being open when possible about the world he came from. The PI also paid particular attention to the theme that suggested therapeutic work should be "simple", by planning work according to the comprehension levels at which the participants presented; and also by using introducing multimedia to sessions to clarify more complicated concepts and in line with the participants' personal interests.

By disseminating the findings of paper 2 widely it is hoped that others may benefit from the experiences described by the participants. However, there has already been some benefit from relaying the findings to other team members who work within the secure hospital (and at the host NHS trust's research conference where the findings have been presented). Some staff had described how the findings "ma[d]e sense" but they "hadn't thought of [them] like that" before. Some initially had difficulties understanding how individual themes could be applied to their practice. For example, one senior clinician explained they "wouldn't fist pump [their] client"; however, this resulted in discussions about alternate ways in which they could 'meet at a level' whilst being genuine to themselves and the SU. Additionally, the PI reflected specific themes and known transcript quotations at team and supervisory meetings, which helped teams to think about therapeutic matters from the SUs' perspective; it is hoped that in doing so this may have had some impact towards improving TE for these men.

Conclusion

Exploring the TE experiences of men produced themes which were reciprocally used to summarise the process used to produce the themes by the PI. The experience of researching TE for men in secure care allowed the PI to explore how their own world was influenced by others around them. By understanding how the worlds of SUs and research governance collide, they were able to take greater control of the process and ensure a SU voice was heard. By using flexible and creative methods they were able to better understand how SUs experience the world in which they are forced to reside, and how they might be able to access it. And finally, by incorporating the literature base, and moreover the understandings gained from the themes in paper 2 into practice, the PI had been able to improve their own practice, and influence the practice of others; modelling this process shows that it is an on-going feedback loop which is regulated by on-going learning to meet the PI's personal goal of improving TE.

References

- Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields, *British Journal of Clinical Psychology*, 38, 215–229.
- HM Inspectorate of Prisons (2009). *Disabled prisoners: A short thematic review on the care and support of prisoners with a disability*. London, UK: HM Inspectorate of Prisons.
- Powers, W. T. (1973). *Behavior: The control of perception*. Chicago, IL: Aldine de Gruyter.
- Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology, *Psychology & Health*, 11, 261-71.
- Smith, J. A. (2008). *Qualitative psychology: A practical guide to research methods*. London, UK: Sage.
- Vass, N. E. (2012). *Exploring the experiences of hope in medium secure care: An interpretative phenomenological analysis*. Unpublished doctoral dissertation, Staffordshire and Keele Universities Doctorate in Clinical Psychology, Stoke-On-Trent, UK.