AN EXPLORATION OF SERVICE USERS' EXPERIENCES OF A LOW SECURE FORENSIC MENTAL HEALTH SERVICE.

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The candidate confirms that the work submitted is his/her own and that appropriate credit has been given where reference has been made to the work of others

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ABSTRACT

This is an exploratory study of the experiences of service users in forensic mental health settings, including how service users make sense of these experiences and their link to identity. Current research into forensic mental health services is very limited (Coffey, 2006). Research has focussed on describing specific events but has not explored how service users have experienced their environment, relationships, and treatment. The information that has been gathered has focused on medium and high secure settings with very little research having been conducted in low secure setting settings. There was therefore a need for further research to inform clinicians and influence their practice so as to reduce psychological distress and risky behaviour, and to work towards recovery and reintegration into the community.

Semi-structured interviews were conducted with six service users from a low secure forensic mental health service to explore experience. These accounts were analysed using Interpretative Phenomenological Analysis (Smith, 1995) to create themes that reflected experiences, understanding of these experiences and identity. Individual cases and group themes have been presented. Service users described a range of experiences such as feeling vulnerable, experiencing life as having been interrupted and valuing positive experiences with other people. Their understanding of these experiences fell into four categories: biological, psychosocial stress, behavioural and experience as being senseless. Participants used a range of ways from each category to make sense of their experience and these were sometimes contradictory. There was also a theme of participants trying to make sense of other people's thinking. Each participant had a combination of ways of understanding that was individual to them. Participants evaluated their character, ability and affiliation to help define their identity. These evaluations had an interpersonal aspect.

The findings of the study have been discussed in relation to research from settings with different levels of security. They have also been discussed in relation to social psychological frameworks such as Symbolic Interaction (Blummer, 1938, 1969), Social Representation Theory (Moscovici, 1973) and Social Identity Theory (Tajfel and Turner, 1986) to help understand meanings and how identity is shaped by experience.

Clinical implications have been discussed. These include increasing opportunities for meaningful activities and relationships, and working with service users to help them to find ways of coping with their internal experiences, to feel empowered and take an active role in their recovery, and to build positive identities.

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CHAPTER ONE: INTRODUCTION AND LITERATURE REVIEW

This chapter has been divided into three sections. It will begin by describing forensic mental health services in the UK, with a particular emphasis on low secure services, and the need for further research with this population. This followed by a section evaluating current research into forensic mental health settings, and its limitations. The researcher's theoretical stance is outlined, including a description of social psychological theories and their relevance to forensic mental health. The final session will discuss the aims of this study, the rationale behind the method and relevant theoretical methodological considerations.

1.1. Forensic Mental Health Services

Forensic mental health services are provided in secure and community NHS settings. Brunt and Rask (2005) described the roles of a forensic mental health service as being the facilitation of a therapeutic environment, the protection of society and the maintenance of security. Levels of security include community-based services, and low secure, medium secure and high secure services. A service user's level of risk determines which level of security they enter (Kennedy, 2002). The client group currently consists of people who are sectioned under the Mental Health Act (1983), and who have mental illnesses, and who are deemed to be a risk to themselves or others or have offended. McCann (1999) described people in forensic care as being a diverse group with a range of diagnoses, mental health problems and offences.

1.2. Low Secure Forensic Mental Health Services

The Department of Health (2002a) defines a low secure unit as one that delivers:

> *"intensive, comprehensive, multidisciplinary treatment and care by qualified staff for patients who demonstrate disturbed behaviour in the context of a serious mental disorder and who require the provision of security."* (p6)

It describes criteria for admission, including that the service user will have:

> *"behavioural difficulties which seriously compromise their physical or psychological well-being, or that of others and which cannot be safely assessed or treated in an open acute inpatient facility. Patients will only be admitted if they display a significant risk of aggression, absconding with associated serious risk, suicide or vulnerability (e.g. due to sexual disinhibition or overactivity), in the context of a serious mental disorder."* (p7)

In these minimum standards for low secure units outlined by the Department of Health (2002a) treatment is considered to consist of biological, social, environmental, psychological and other interventions. Psychological intervention includes formal

psychotherapy, recreational therapeutic diversion, life-skills training, and boundary setting.

It was estimated that in 2006 there were 1,583 service users being treated within 137 low secure units in Britain (Pereira, Dawson and Sarsam, 2006b). Beer, Turk, McGovern, Gravestock and Brooks (2005) conducted an audit of 139 service users in low secure units, and reported that 35% had spent more than ten years in mental health units, 54% had had past contact with the criminal justice system and 90 of the 139 service users were reported to show moderate to severe violent behaviour. Pereira, Dawson and Sarsam (2006a) investigated 137 low secure units using a survey, and found that most service users were male, single, white, unemployed and had a diagnosis of schizophrenia. Service users commonly had violent and forensic histories and current complex needs. Whilst the majority of service users may fit the profile described by Pereira et al (2006a) there are also other groups. Pereira, Dawson and Sarsam (2006a) noted that there was an overrepresentation of black ethnic patients. Smith, White, and MacCall (2004) stated that people who have been admitted to low secure settings from high secure units can be seen as a distinct subgroup. They found that people from high secure settings were more likely to have schizophrenia, have a more serious index offence, have a longer criminal history and a higher score for risk. Differences have been found between men and women in secure settings. Long, Webster, Waine, Motala and Hollin (2008) gave demographic details of the service users from two low secure units (18 men and six women) who took part in their study on treatment needs. They reported that for men the most common diagnosis was schizophrenia (14 men) and for women it was personality disorder (4 women). The men were likely to be older and to have longer admissions. Ten of the men and two of the women had no convictions. Lart, Payne, Beaumont, MacDonald and Mistry (1999) conducted a literature review of forensic services and found that women are likely to have committed less serious offences than men but are more likely to have had past psychiatric admissions.

Differences between secure settings include the level of the security of the physical environment, and the level of risk presented by service users. Service users in low secure settings present with less serious risk of physical danger and absconding than those who require admission to medium or high security (Department of Health, 2002a). They may have been charged with an offence or show risky behaviours such as challenging behaviour or deliberate self-harm (Department of Health, 2002a). Service users are most often admitted into low secure settings from units with a higher level of security (Smith, White, and MacCall, 2004; Rutherford and Duggan, 2007), although they may also be

admitted from the community or psychiatric units. Low secure services are unlikely to have people who have been transferred directly from prison; around 97% go directly from prison to medium or high secure settings (Rutherford and Duggan, 2007). In addition to differing levels of risk, service user needs also differ across levels of security. Long et al (2008) compared the needs of the service users from two low secure settings to women in a medium secure unit (using the short form of the forensic version of the Camberwell Assessment of Needs) and identified more needs for the service users from the medium secure unit.

Service users are likely to be discharged to supported accommodation or the community, whereas in medium or high secure settings service users are likely to be discharged to a forensic mental health unit with a lower level of security. Low secure units share the aims of treatment, rehabilitation and risk management alongside other forensic mental health settings, but have a greater emphasis on managing the transition into the community. Prins (2005) described low secure services as the final staging post before rehabilitation within the open community.

1.2.1. The importance of exploring experience, understanding of experience, and identity in low secure settings

Research into low secure forensic mental health settings is important as it can guide containment and stabilisation of symptoms and behaviour, but also because it can guide rehabilitation and transition into the community. Research into service user experience, understanding of experience and identity are important areas to consider in facilitating these goals.

Very little is known about how events are experienced in forensic mental health. Studies in other settings suggest that how events are experienced can enhance or negatively affect psychological well-being. Prison studies have shown that exposure to violence can lead to experiencing symptoms of PTSD and the development of coping strategies that may be unhelpful in the long-term, such as cutting off from feelings (Jamieson and Grounds, 2006). Cooke, Baldwin and Howison (1990) state that for some people the experience of imprisonment can lead to anxiety, depression, self injury, withdrawal and mistrust of others around fears of being exploited. Katsakou and Priebe (2007) found that experiencing care could alleviate feelings of fear and uncertainty in their study with involuntary inpatients. Positive experiences in low secure settings can help service users to engage in activities and build skills for the future and are thus important in the recovery process and adjusting to being in the community. Pitt, Kilbride, Nothard,

Welford, and Morrison (2007) noted that active participation in life and meaningful activities form part of recovery. Therefore, experiences in low secure settings can impact on the person during admission and following discharge.

It is important to explore understanding of experience within low secure settings as these understandings shape beliefs about oneself and the world. Understanding of experience has been shown to shape subsequent interaction. Nurse, Woodcock and Ormsby (2003) conducted focus groups with prisoners and found a cycle of negative attitudes in which if officers were perceived to be treating prisoners badly then the prisoners would respond by making life hard for the officer causing them stress, which would then in turn cause additional stress for prisoners. Hawkins, Allen and Jenkins (2005) investigated the experiences of physical interventions for staff and service users with an intellectual disability through the use of semi-structured interviews. They found that the negative emotions generated during the intervention and appraisals of the restraint negatively influenced subsequent interaction for both staff and service users. Staff reported 'walking on eggshells' and still feeling in 'action mode' afterwards. Gudjonssen, Young and Yates (2007) state that it is important to understand perceptions of illness, problems, detention, staff, other service users and the environment when thinking about how to motivate mentally disordered offenders to change. Understanding of events therefore has implications for relationships, treatment, and risk.

Making sense of experience is also important for recovery (Pettie and Triolo, 1999), as this can allow a person to consider how their experiences have arisen, what is needed for change, and to feel hopeful that change is possible. Understanding of experiences can also influence perceptions of self. A person's sense of identity may lead to acceptance of services and their goals or to rejection. In their study with service users with psychosis, Pitt et al (2007) found that the rebuilding of self and empowerment were key themes in recovery. A person's environment can be influential in their reconstruction of identity (Pettie and Triolo, 1999). It can therefore be argued that the development of identity and empowerment during admission can be influential in recovery and readjustment to being in the community, and thus in reducing the risk of relapse or recidivism. The development of a positive identity may be particularly important for people when developing protective factors such as relationships, meaningful activities or a sense of agency when coping with the stress involved in readjustment, increased responsibility for self and stigma from the community. Stigma around mental illness can lead to psychological disturbance such as depression or anxiety (Markowitz, 1998). If the transition is unsuccessful a person may need to be readmitted to hospital and there is

also a considerable risk to self and others. Crawford (2004) states that the risk of suicide is highest immediately following a discharge from inpatient psychiatric care. The risk of violence is also increased following discharge (Steadman, Mulvey, Monahan, Clark Robbins, Appelbaum et al, 1998).

Research into experience, understanding and identity can therefore inform service delivery with the aims of improving quality of life, promoting mental health and reducing risky behaviour and offending. Research therefore has the potential to impact on service users, the people they have personal relationships with, staff members and the wider public through its implications for service delivery. In order to understand lived experience it is important to conduct research in a way that can allow service users to give detailed information about the meaning of experiences for them, rather than solely to describe what experiences they undergo.

1.3. Service User Research: The impact on service users, services, and professionals

There has been legislation passed which obliges the NHS to involve service users in the planning and delivery of organisations (National Health Service Reform and Health Care Professions Act, 2002b). The Health of the Nation' (HMSO, 1991), the Patients' Charter (HMSO, 1991) and the Research Governance Framework for Health and Social Care (Department of Health, 2001) emphasise the importance of service users' views. However, Faulkner and Morris (2003) found that there was little evidence of substantive user involvement in forensic mental health. They concluded that research involving service users was limited in forensic services because of difficulties in accessing service users who would want to be involved and practical problems such as confidentiality and observation levels. They also noted that there was a lack of guidelines on how to conduct collaborative research in these settings. Other perceived barriers included limitations in staff co-operation, and service concerns and restraints on sharing information and its potential effects on security. Since then the National Forensic Mental Health R&D Programme has started to include service user views and various projects are under way (e.g. evaluating and developing forensic mental health services, development of satisfaction questionnaires). However, these projects do not currently include research in low secure settings.

Research involving service users views can show a different perspective to that of staff, and can raise awareness of service issues through their direct experience of services. Their understanding of experiences may differ from the goals of the service e.g. Caplan (1993) reported that staff see interventions such as medication and seclusion as part of

therapeutic care whilst service users may see these as punishment or forced contamination. Service user involvement in the research process ensures that research is meaningful and relevant to service user needs, and can lead to improvements in quality of life and satisfaction with services (Sullivan, 2003).

The effects of involving service users in research and in mental health services have not been fully evaluated yet (Simpson and House, 2002, Minogue, Boness, Brown and Girdlestone, 2005). However, studies appear to show that they can impact on service users involved in the study. Minogue et al (2005) conducted a review of South West Yorkshire NHS Trust and found that the benefits for consumers involved in consultation/collaboration with services were primarily personal, including gaining knowledge and experience, improved sense of well-being, self-esteem and confidence. The benefits for the Trust were in having a service user perspective and focus. Staff and clients found it hard to quantify the effect of their participation in the research on the service but were able to note service changes, such as changes in the information given to service users, and content and wording of leaflets. They also had a strong sense of having put something back into the service. Other studies have found that service users who take part in research derive personal benefits. Simpson and House (2002) conducted a systematic review and found that when service users were involved as employees, trainers or researchers in mental health services they had greater satisfaction with personal circumstances and less time in hospital. This may be because they started to view themselves as part of the system rather than passive receivers of it. Having a socially valued role may have increased their self-esteem, increased their feelings of control over their situation and alleviated feelings of hopelessness. Mowbray, Moxley, Thrasher, Bybee, Harris et al (1996) report that service users may feel more empowered by taking part in research or may gain in self-esteem and confidence.

Studies have found that service user views can also impact on services and professionals. Sitzia, Cotterell, and Richardson (2006) investigated service users' views of their involvement with cancer services. They found that service users reported that a shift in NHS culture towards meaningful service user involvement was a long-term process, but that many felt that they were impacting on services, citing improvements in information and communication. The study also identified the effect service users had on influencing change in service policy and delivery through meetings with influential people, press campaigns and speaking at committees. Stevenson, Sinfield, Ion, and Merry (2004) conducted a study looking at primary care provision through focus groups. Quality standards were designed from the information from the focus groups and nine

practices agreed to evaluate themselves against these quality standards. Three months later it was found that there had there had been over forty changes in service provision. Service user involvement can impact on services by providing insight into access to services, delivery of treatment and care, patient and carer info and support needs (Stevenson, Sinfield, Ion, and Merry 2004).

Service user views may impact upon professionals' language, professionals' behaviour, models of care, and information and communication delivered to clients. This could lead to more effective and better targeted services (Gott, Stevens, Small, and Ahmedzai, 2000; Crawford, Rutter and Thelwall, 2003). For example, therapists' underestimation of the severity of the problem a service user is experiencing has been linked to poor outcome (Mohr 1995). Therefore, if professionals do not have an understanding of service users' experiences in the setting and how this impacts on mental health and behaviour, it is likely that treatment will be negatively affected. Increasing services' and professionals' understanding of the views of service users and their needs will improve the quality of treatment and reduce length of admission. This will affect quality of life for service users, and has financial implications.

1.4. Literature Review

1.4.1. Introduction

This literature review considers existing research in the forensic mental health field. As research into low secure settings is minimal studies from other levels of security and client groups have been included to show how research in forensic mental health has been conducted previously, and to allow the comparison of findings across levels of security. The research from these other settings has been divided into three sections: service users' experiences, understanding of experience and identity because these are key areas in considering quality of life, recovery and reduction of risk.

1.4.2. Literature Search

Electronic databases were used to conduct the literature search. These were PsycINFO, Embase, and Ovid Medline. Search terms included: 'low secure'; 'secure' combined with 'psychiatric'; 'forensic mental health'; 'service user involvement' combined with 'research' and 'secure' combined with 'services'.

1.5. Research into Low Secure Units

Current research into forensic mental health services is very limited (Coffey, 2006). The information that has been gathered has focused on medium and high secure settings with

very little research having been done in low secure setting settings. This may be because they have been ill defined until recently, and the distinction between them and PICUs was unclear. Pereira, et al (2006b) stated that little is known about the provision of low secure mental health services in Britain. Recent research in low secure units has focused at the level of service description including describing service user characteristics (Pereira, et al, 2006a,) and their needs (Smith, White, MacCall, 2004; Long, et al, 2008) and treatment outcomes (Akande, Beer and Ratnajothy, 2007). No research was found that explored service user views of low secure forensic mental health services.

1.6. Research conducted outside of low secure mental health settings: Service User Experiences

1.6.1. Quantitative

Quantitative studies have used questionnaires, satisfaction surveys and rating scales to investigate aspects of experience. Three studies have been detailed below to give examples as to how experience has been investigated quantitatively.

McKenna, Simpson and Coverdale (2003) measured medium secure forensic service user and psychiatric hospital service user views of coercion on admission. They found that there was a stronger sense of coercion for involuntary patients or for people who were angry at admission. The feeling of coercion increased with the perceived use of threats and force and was inversely correlated with the perception of procedural justice. People who felt happy or relieved at admission reported fewer feelings of coercion and had a strong sense of procedural justice compared to those who were not happy. Service users who had experienced restraint reported higher levels of perceived coercion. This study suggests that there are links between legal status and patient perception of coercion for those admitted to services under the Mental Health Act (1983). However, it has limitations, including their use of a structured survey to measure views which meant that answers around participants' degree of influence, control, choice and freedom were severely restricted. The researchers did not ask for further details of the experiences associated with these areas and how the participant felt about them. Whilst they were able to include large numbers of participants the information they found is limited by their use of structured questioning and the restricted options for responses to the questions.

Carlin, Gudjonssen and Yates (2005) used a structured questionnaire to look at patient satisfaction in medium secure units. High levels of satisfaction were reported for contact with care teams, and low levels of satisfaction were found for food. Only 42% reported

satisfaction with treatment choices having been discussed at admission and only 44% felt involved with initial assessment. This number only rose to 53% for satisfaction with inclusion in subsequent care planning. 31% of service users felt that there were too few ward activities. Younger service users reported greater dissatisfaction. The study looked at information given at admission, awareness of restrictions and rights, assessment and treatment, and satisfaction with the ward environment. However, the questionnaire limited participant answers through the range of topics asked about and the categorical responses (yes, no, unsure) that could be given. Satisfaction surveys are limited in their ability to explore topics in that they can say if someone reports satisfaction but cannot give any context to what this means such as if they are satisfied because it meets their expectations but would actually prefer something else.

Experiences of ward atmosphere have been investigated. A study compared patient and staff perceptions of the atmosphere in a maximum-security forensic psychiatric hospital in southern Sweden using the Ward Atmosphere Scale (Brunt and Rask, 2005). The results showed that service users rated lowest mean scores for Autonomy and Involvement and the highest mean scores for Programme Clarity and Order and Organization. Staff and service user views differed on 8 of 10 scales, with only Personal Problem Orientation and Anger and Aggression being rated similarly. This study involved 35 service users. Whilst this study described aspects of experience it did not explore the meaning of these for service users. The use of a rating scale also presupposed which aspects of ward atmosphere are important.

1.6.2. Qualitative Studies

A user-led project, held within medium secure settings, conducted qualitative individual and group interviews with ten women, and a combination of individual and group interviews and mind-mapping with men (Halsall, 2006). Service users were asked to talk about what was important to them at that time. The women reported feeling guilt at having been violent, and had experiences of loss and separation, ill health, and negative side-effects of medication. They also reported feeling bored, feeling anxious and frustrated about experiences with the Home Office and feeling that disagreements with staff undermined trust. Positive responses were found about high levels of care with staff, feeling respected, feeling safe and enjoying leave. The women had goals of getting out of the unit, having enjoyable lives, being with family and partners, having a job and having somewhere to live. The findings from the men included experiences of feeling bored, stress around other service users (drug use, aggression) and staff (feeling: they were not helped; mistrust; anger; lack of time, and not feeling supported or heard).

Positive experiences included experiences with other service users (comrades) and staff (getting on, and feeling supported). The researchers made their own observations of service users' experiences which included: service users needing help to move forward and to cope, there being a lot of activity even though service users reported boredom, that staff seemed to cope well with tension and aggression, that there was a divide between staff and patients in terms of power and that staff spent time in the office and only left to perform tasks rather than for social interaction. The study was designed to be exploratory but the interview questions shown in the appendix of their report suggest that several closed and leading questions were used. This may have restricted responses and influenced what was discussed.

MacInnes (2005) conducted research using focus groups in a medium secure unit to develop a satisfaction scale. In the focus groups themes were found around staff interaction, rehabilitation, the unit's facilities and regime, communication, finance, safety, and gender issues. Staff interaction was the most frequently cited theme and linked to service users assessing how caring and interested staff were, whether they could be trusted and whether they were helpful. Positive and negative experiences of staff were reported. Perception of interpersonal skills of staff was judged as being more important than clinical skills in developing a trusting and positive relationship. Service users also reported that staffing ratios restricted opportunities for staff and service users to spend time together. A theme around rehabilitation involved service users wanting to have activities throughout the week, which related to helping the service user live independently following discharge. There were a range of views as to what was considered helpful such as discussion groups or skills based activities. Service users also noted a need for discharge to be paced at an individual level and for there to be support in place. Experiences of feeling they had been discharged with little preparation and limited support or resources were discussed and linked to previous relapse. Following relapse they then reported feeling mistrustful around future plans for discharge. Experiences of feeling coerced to attend the ward programme, and negative consequences for rule breaking were reported. Service users spoke about feeling frustrated in ward rounds as decisions were made without them or issues they wanted to talk about were not discussed. Service users were also concerned about what was written about them and whether it was accurate. Experiences of not having been introduced to new staff and messages not being passed on were discussed. Service users stated they felt safe on the unit although there were some threats at times. Female service users reported having found observations intrusive. Whilst themes on experience arose the focus of these interviews was to explore topics participants thought were important for

satisfaction with services, and as such will have restricted what was service users were able to say about experience.

Skelly (1994) conducted semi-structured interviews with 14 service users readmitted to a special hospital from a regional secure unit. Service users reported 'playing the game' by complying in order to be discharged. Skelly noted that service users had not internalised the behaviours they were asked to perform by the service, nor were they able to see a rationale for why they were asked to act in this way. Service users also reported a feeling of threat which Skelly suggested was linked to powerlessness. This study was limited by the lack of reflective thinking about the researcher's influence on the study.

Godin and Davies (2005) conducted research with service users to explore past experiences of medium and high secure forensic mental health services, with the aim of evaluating and developing forensic services. They focussed specifically on negative experiences of services, how services can be improved and how service users can move on following their experiences. Data were collected through focus groups and reflexive writings. Negative experiences were found to include feeling that staff had been dishonest or not open, and mistrusting of them, and that staff lacked compassion or respect. Other negative experiences involved experiencing violence, feeling unable to complain and difficulties in seeking help. Services were also seen as not meeting religious or cultural needs. Service users also reported having felt despairing and trapped with little chance of getting out. Stigma from having been in a secure service was also identified, and service users felt it affected employment opportunities and being able to move on with their lives. The researchers commented on how uninvolved the service users felt in decisions about their treatment. They also commented that service users were suspicious of staff and seemed to try to second-guess their actions. The study is limited in that it only focussed on negative experiences, and one of its research questions was 'why are services fundamentally bad' which led how experience was discussed and what was able to be discussed.

1.6.3. Mixed Methodological Studies

Baker (2003) conducted a mixed-methodological satisfaction study of service user opinions on a low secure psychiatric unit with men who were held on sections of the Mental Health Act (1983). This involved the use of a rating scale about the ward environment and involvement in care, and a semi-structured interview. The quality of food and the range of treatments were rated lowest in the rating scale data. There were

individual low ratings for feeling safe, feeling disrespected, having control over cigarettes and money, opportunities to see the doctor and being able to discuss needs in ward rounds. In the interviews the unit was described positively in terms of staff being kind, helpful and respectful and extent of time spent with them, being able to go on leave, leisure activities and the ward environment. There were negative comments about security restrictions limiting what they could do including forming new relationships and making them dependent on staff members who could not always be available. Service users also reported feeling threatened or being attacked and that there were little negative consequences for people behaving in this way. They reported that they had become accustomed to this after time in services. There were individual variations in how involved participants felt in decisions about their care. Baker concluded that the unit had a treatment function but also provided a home for the participants where they may reside for several years. The findings of this study are worthy of note because they have consulted service user views of their experience. However, this study also has weaknesses, such as not having included quotes from service users to illustrate how themes were derived. The meaning of events for service users was not explored. It is also unclear how the information was analysed and therefore it is hard to know the value of findings.

Farnworth, Nikitin, and Fossey (2004) conducted a study in a medium secure setting in Australia which used diary keeping to monitor use of time. Individual interviews and observer field notes were analysed qualitatively. They found that the majority of service users' time was dominated by sleeping and passive leisure time, and commented this was unlikely to enhance physical mental and social well-being. Participants spent their time in similar ways but reported four themes as to how they experienced their time use: killing time, making the most of the situation, creating challenges for themselves and trying to find meaning within occupation. Within this the dominant theme was of trying to 'kill time' and dissatisfaction with their use of time. Barriers were reported including restrictions on when activities could take place, limited material resources and not being able to find quiet areas to carry out the activity. The study is limited in that it was conducted during a period of transition to a new unit, which was better equipped. It is unknown therefore whether these findings were solely specific to that time and context. The study was conducted in Australia, which makes it hard to assess the applicability of the findings to British services, which operate within a different society, and legal and political system.

To summarise, quantitative methods have provided descriptions of experience. However, they have only investigated specific issues presupposed to be of importance by researchers. Whilst they describe the phenomena they do not explore the meaning of these issues for service users or whether these topics would be deemed to be important by service users themselves. In addition to investigating what experiences service users undergo it is important to also understand what these experiences signify to service users. Qualitative studies and mixed methodological studies have elicited descriptions of a range of events and provided detail as to how they were experienced by service users. However, only a small number of studies have been conducted currently and these have had some methodological limitations.

1.7. Understanding of Experiences

There has been little research into how service users make sense of their experiences in forensic mental health settings. In the study by Halsall (2006), which was discussed in the previous section, some frameworks around understanding admission arose for the male participants from a medium secure unit. These were: admission being for rehabilitation, for punishment or being a positive opportunity for change. Understanding of experience was not a research question so it is possible that these were only applicable to the individuals who reported them or that other frameworks are relevant. Hinsby and Baker (2004) conducted interviews with four service users in a medium secure unit to explore accounts of violent incidents. When the interviews were analysed using grounded theory a theme emerged around care and control in which service users felt they were under surveillance, and viewed restraint and seclusion as punishment. Service users used an illness framework in which they viewed violence as being a result of being ill and out of control.

Research has been carried out with people with psychosis in other settings that may be relevant to low secure forensic services as a large proportion of their client group is made up of people with psychosis (Beer, et al 2005). Molvaer, Hantzi and Papadatos (1992) administered a questionnaire exploring attributions of experience to 50 male and 33 female outpatients with psychosis. They found that participants reported that relationships were the main factors in their understanding of their experiences. Angermeyer and Klusman (1988) conducted a study using a checklist and open-ended questionnaire with adult psychiatric patients as to the nature of their psychosis. The majority of respondents had a framework about the cause of their experiences. Service users with schizophrenia tended to link their experiences with influences from their family environment, whereas service users with affective psychoses attributed their

illness to psychosocial stress or biological factors. Metaphysical, mystical, parapsychological, medical and transpersonal frameworks were reported in the study by Romme and Escher (1993), which examined how people make sense of their psychosis.

Phillips, Cooke, Cooke and Peters (2006) used a rating scale with 17 people diagnosed with schizophrenia to explore perceptions of the causes of their problems. They found that participants reported different explanations and on average had five explanations of their problems. The highest levels of endorsement were for their problems being caused by psychotic phenomena, nerves, a brain problem, life events, practical problems and childhood experience. Relationship problems and biological explanations such as hormonal or genetic factors were reported but these received lower endorsements. It is unclear whether the participants were currently in contact with psychiatric services and if so at what level. This makes it difficult to compare the findings with a forensic population.

These studies show that people with psychosis in other settings use a range of frameworks for understanding experience and that these can be identified through research. However, it is unknown currently if these findings can be related to service users with psychosis in forensic mental health units or the general population of forensic mental health units.

1.8. Identity

There has been limited research on the beliefs of forensic mental health service users about themselves or how their experiences in secure settings have impacted upon them. It is important to explore this area as the way people categorise themselves can influence who they identify with and how they act. It can also affect their mental health positively (e.g. increased self-esteem allowing negative thinking to be challenged) or negatively (e.g. feelings of depression).

Research from other mental health settings may be relevant to forensic mental health. A study on discourses was conducted with mental health service users in Ireland (Speed, 2006) using discourse analysis within a case study approach. Discourses of being 'patients', 'consumers' and 'survivors' were found. These discourses are interesting as they linked to how the person perceived their levels of agency and responsibility for their recovery. Perception of role is an important area to investigate in forensic mental health as how service users view themselves will affect their thoughts and actions, and thus participation in interventions. Katsakou and Priebe (2007) reviewed five qualitative studies of service users' experiences of involuntary hospitalisation. They concluded that

having a devalued identity can evoke feelings of hopelessness, frustration, low self esteem, which can lead to service users feeling dehumanised and feeling uncertain about themselves and their value. Goffman (1961) claimed that institutions assault a person's sense of self through the loss of self-determination, power, freedom of action and control over the environment. These losses can lead to psychological disturbances and distress (Cooke, Baldwin and Howison, 1990). For example, loss of control can lead to anger, frustration, bewilderment, agitation, hopelessness or depression (Cooke, Baldwin and Howison, 1990). These losses can also lead to apathy, loss of individuality, submissiveness and a lack of interest in the future (Barton, 1966). Westen (1985) states that institutions can affect identity as they wield total control, and provide the only source of meaning and security in a world that seems threatening.

Studies with prisoners have investigated identity. These may be relevant to forensic mental health settings, as part of their client group is comprised of people who have committed offences whilst mentally ill. Sykes (1958) suggested that imprisonment could threaten sense of worth and self-concept through the loss of relationships, rejection by the community, lack of meaningful activity and the loss of autonomy. Jewkes (2006) states that the interruption of an expected life course through imprisonment can negatively affect identity through the failure to experience certain aspects of life such as marriage, children or employment.

Gender difference has been explored in offenders' negotiation of identity (Geiger and Fischer, 2005). Semi-structured interviews were used with 16 offenders. Participants used neutralisation (by excusing or justifying actions) to try to maintain a favourable identity. When considering the past, men and women both acknowledged their actions as wrong but abdicated responsibility through the use of excuses. Alternatively, they used norms to justify themselves and resist stigma in order to maintain a positive identity, which allowed them to accept responsibility whilst denying injury or harm. Males were adept at using this strategy for all negative roles, whereas females were unable to justify the label of incompetent mother and this resulted in apathy and lack of confidence in self.

Presser (2004) investigated how offending links to identity, by conducting qualitative interviews with 27 men who had either confessed to or had been charged with committing violent offences. 14 of these were incarcerated at the time of interview. A theme was found in which participants described a heroic struggle against internal and external difficulties. Participants viewed themselves as either having returned to being morally good as they were before the offence and their actions being unlike them, or as

having always been 'good' by minimising or excusing the offence. All participants excluded viewing themselves as 'violent offenders'.

Studies on violent behaviour have shown that people can people can also take on roles of perpetrator, victim or perpetrator-victim. Sandvide, Fahlgren, Norberg and Saveman (2006) conducted narrative analysis on an interview with a caregiver to explore institutional abuse in services for the elderly. The caregiver described herself as a perpetrator but then moved to taking a victim position. She also moved from describing herself as a perpetrator to that of a guardian. It was suggested that she exonerated herself from blame by presenting herself as being a victim exposed to force. Palmer and Farmer (2002) describe how offenders in prison can be both victims of aggression and perpetrators, and suggest that offenders can move from initial victimisation to becoming perpetrators of aggression to seek a place within the social hierarchy. It has been suggested that perpetrator-victims can be aggressive in an attempt to avoid the stigma associated with the victim role (Palmer and Thakordas, 2005). Palmer and Begum (2006) conducted structured questionnaires with imprisoned young offenders to explore moral reasoning, pro-victim attitudes, and interpersonal aggression. They found that 43% of their participants could be classified as perpetrator-victims, 37% were classified as perpetrators, 7% as victims, and 13% as not involved. They also found that distortions were used and suggested this was to exonerate self from responsibility and negative consequences.

Haney, Banks and Zimbardo (1973) investigated how roles are internalised in their experiment with 24 students who were separated into being prison guards and prisoners in an artificial prison setting. They found that people took on their roles and that this led to around half of the 'prisoners' showing signs of severe emotional disturbance. Prisoners initially rebelled but then became passive, and dependent. It was suggested that the loss of personal identity and the experience of arbitrary control led to the prisoners allowing others to exercise power over them. Haney et al (1973) explained these findings in terms of role compliance. This has since been challenged by Reicher and Haslam (2006) who suggested that self-conceptual uncertainty led to the forming of group identity and conformity to norms. This research suggests that the experience of imprisonment affected identity negatively through a loss of personal identifiability and uniqueness and a loss of a sense of personal value.

These findings on identity from mental health populations and prisons suggest that contact with services can impact on identity but it is unknown how they would apply to a forensic mental health population whose service users have mental illnesses and

negative behaviour. Colombo (1997) suggested that this client group has been given a double deviant identity by society and this may impact on their identity differently to people who have either a mental illness or offending behaviour.

1.9. Limitations of Current Research in Forensic Mental Health

The above studies are useful in helping us to gain some idea of service users' experiences in forensic mental health settings. However, both quantitative and qualitative studies have focussed on describing specific aspects of experience rather than looking at the meaning they hold for the person and their identity. Only a few aspects of experience have been investigated. For example, little is known about positive experiences. There has not been research about perceptions of the purpose of forensic mental health services either with professionals or service users. Some of the areas that have been investigated have not been researched in depth or have been researched in a way that has led to their quality being criticised. Stallard (1996) suggests fixed choice questionnaires are limited to factors that service providers feel to be important, and may not be relevant to the experiences of service users.

Coffey (2006) conducted a literature review of papers looking at the views of service users in forensic mental health. Papers were selected through an electronic literature search using the terms ''forensic'' and ''mentally disordered''. He reported that the volume and breadth of studies are limited and that there are flaws in the conduct, application and reporting of research. He states that available findings can be seen as unreliable due to methodological flaws, and that we know little of people's experience in forensic mental health services. Whilst the paper by Coffey may not have found all relevant studies it shows that there is considerable need for further research of forensic mental health service users' views.

Many studies are conducted outside of Britain and therefore the results are not necessarily applicable to the British mental health system as service users are subject to different cultures, and differently structured mental health services (Pereira, Sarsam, Bhui and Paton, 2005; Salize and Dressing, 2007). Within Britain, few studies have been conducted in forensic mental health secure settings, and those that have been conducted tend to be in medium or high secure settings rather than low secure services. It is currently unknown how the findings from research in other levels of security can be applied to people in low secure services. Differing levels of risk may affect the experiences people are involved in and witness, and how safe they feel. For example, it is possible that as higher levels of security have more restrictions on freedom and fewer

opportunities for control over the environment that this leads to increased feelings of powerlessness, feeling coerced and feelings of low-self-efficacy. Therefore, research is needed in low secure settings to see if these services can be compared to other levels of security.

1.10 Relevant Psychological Theory

Social psychological theories are highly relevant to understanding forensic mental health settings as they help to explain how people develop meanings and identity, and the influence of the social context of the setting upon these. They can therefore help to understand factors such as engagement in interventions and change in behaviour. Social psychological theories have been widely researched and have been used to consider relevant topics for forensic mental health such as representations of mental illness (Foster, 2001; Dixit, 2005), violence (Turner, 2007) and aggression (Hogg and Vaughan, 2008). For example social identity theory suggests that people try to preserve positive identities and that the undermining of these can lead to conflict (Turner, 2007). Towl and Crighton (1996) suggest that areas of social psychology, such as group processes, are particularly relevant to understanding offending and delinquent behaviour. Social psychological theories have also been used in qualitative research to explore experience in health and mental health (Muhlbauer, 2002; Muhlbauer 2008), sense-making (Meiers and Tomlinson 2003) and identity (Gracey, Palmer, Rous, Psaila, Shaw, et al, 2008). Muhlbauer (2008) used symbolic interaction to help understand the findings of 35 semi-structured interviews of caregiver perceptions around severe mental illness. However, these theories have not been used within research in forensic mental health. The research findings of this study will consider the applicability of social psychological theories in forensic mental health care and thereby extend or comment on theory.

1.10.1. Symbolic Interaction

Symbolic Interaction (Blummer, 1938, 1969) suggests that people act towards an object or situation depending on the meaning it has for them, that this meaning arises from social interaction, and that these meanings are modified through an interpretative process used when encountering objects or situations. This is relevant to the forensic mental health population as it suggests that people's thoughts and behaviour are linked to past experience but can be modified through social interaction and through the individual's ongoing interpretation. This implies that if a clinician can work with a service user to identify these meanings they can also be modified through testing out different ways of acting, or through the therapeutic relationship with the clinician.

1.10.2. Social Representation Theory

Social Representation Theory (Moscovici, 1973) looks at how social and culturally shared knowledge influences individual perception, experience and action. It suggests that social representations are a system of values and practices that have the functions of allowing people to orient themselves in their material and social worlds and master them, and to enable communication to take place by providing a group with a code for social exchange and a code for naming and classifying their world and their individual and group history. Social representations can help make sense of experiences and relationships and thus influence how an event is experienced. They can also impact on identity in that they shape how others react to us and how we view ourselves (Howarth, Foster and Dorrer, 2004).

This is important in this setting as it allows us to further consider how meaning arises through social interaction. It suggests that the ways in which service users view forensic mental health settings, and their experiences within them, depend on preconceived ideas about the setting and also on the people within the setting (both service users and staff). It recognises that people's beliefs are not static but can be modified through the setting a person is in and the people that they interact within this setting.

1.10.3. Social Identity Theory

Social Identity Theory (Tajfel and Turner, 1986) is relevant to this study, as it provides a framework for considering when and why individuals identify themselves as being part of a group and act as part of the group. One of the premises of social identity theory is that people place themselves into categories which allow them to identify with groups that can increase their self-esteem. It also states that we compare ourselves to other groups with a favourable bias to our own group. This suggests that service users need to identify themselves with the values of the service for their behaviour and cognitions to change, or positive behaviours and cognitions to be maintained. Therefore, service user involvement is vital in research as involvement in shaping services can help increase identification with the service and thus engagement with its values.

1.11. Rationale for Research

1.11.1. Aims

The following aims were developed so as to be able to add to the existing evidence base and to provide information for services:

- Exploration of the experience of service users in low secure forensic mental health settings.
- Exploration of how service users make sense of their experiences.
- Exploration as to how these experiences link to service users' sense of identity.
- Identification of potential clinical implications from the study's findings.

This study goes beyond service evaluation in its emphasis on: understanding the psychological impact of experience on sense-making and self (rather than on service satisfaction); developing the knowledge base for a population across settings; and evaluating the application of social psychological theory for this population.

1.11.2. How will this study help to overcome the limitations identified in current research?

This study cannot overcome all of the limitations listed earlier. However, it can contribute to overcoming several of the limitations. It is a UK based study, and focuses on low secure services, which have been under-researched. It can contribute to knowledge by challenging assumptions, and by adding depth to a currently limited field of research. It can be considered as partnership research (a level of participatory research) as it will be carried out with service users rather than on them (Boxall, 2006). It also has implications for practice. Newman, Thompson and Roberts (2006) state that three issues should be considered when applying research findings to clinical practice. The first of these issues is whether the findings will deepen or broaden professional understanding of the social world of practice by exploring and interpreting the views of the people within it? Secondly will the study increase insight into how other people view this world and thirdly will this study increase insight into the different meanings and values that may be attached to the social world of practice? Although this study is only able to interpret the views of service users, rather than staff or families, this research is clinically relevant because it will deepen professional knowledge, help service users to be aware of others' experiences and commonalities, and will help to increase insight into meanings attached to experiences.

1.11.3. Qualitative Research

Qualitative methods can provide effective ways of answering the research questions of exploring service users' experiences and understanding of their experiences in forensic mental health services, and can help to address the limitations in current research which have been outlined previously in this chapter. It was therefore decided to use a qualitative methodology in this study as this allowed the collection of people's accounts

of experience, and an understanding of the different meanings attached to these (Green and Britten, 1998).

Other benefits of using a qualitative design were that rich detailed information could be collected, in which it was possible to examine both similarity and diversity. Qualitative methods can provide more open, reflective and informative responses than quantitative methods (Edwards and Staniszewska, 2000). Whilst quantitative methods allow great numbers of people to be interviewed they presuppose what people might say and how they might respond preventing people from expressing themselves in their own terms. This prevents exploration of the range of experiences people undergo. It also limits the depth in which participants can answer. In addition, whilst quantitative designs can tell us that something is happening they cannot tell us what it means to a person for this to happen or their perception of why it is happening.

1.11.4. Rationale for Data Collection Method

A number of approaches were considered. These included: focus groups; diary keeping, ethnographic approaches and semi-structured interviews. It would have been possible to use focus groups but they may not have allowed enough focus on individual experience. Service users may also have felt unable to talk freely in front of other service users. Focus groups also limit opportunities to give narrative accounts. Flowers, Duncan and Frankis (2000) reported finding differences in data from interviews and focus groups, with interview data being more detailed. Diaries were excluded because they require a standard level of literacy to provide detailed information. Service users may have felt uncomfortable about this method due to their level of literacy, or may have seen it as homework and not engaged. Ethnographic studies would have been constrained by their capacity to only observe limited time periods and do not explore how service users make sense of their experiences. Also, the act of observation may have influenced people's behaviour in a setting where there are restrictions on movement and activities. Semi-structured interviews were therefore chosen as their open-ended qualitative approach allows the building of rapport, with detailed exploration of experiences and the introduction of topics by the participant (Smith, 1995). Semi-structured interviews are collaborative, and emphasise participants as primary experts (Alexander and Clare, 2004). Semi-structured interviews also allow the exploration of identity, which was an aim of the study. Identities have been conceptualised as being embedded in stories about the self (McAdams 1999; O'Connor 2000). When people tell stories about themselves and their experiences it is possible to develop themes about identity through descriptions of how they see themselves within the world.

1.11.5. Rationale for Multiple Interviews

Multiple interviews can focus on issues in greater detail than is possible in one interview. Time restraints mean that some important issues may be only touched upon in a single interview. Going back to the participant helps prevent misinterpretations, or the neglect of important issues. It is also allows refinement of the interview itself by seeing which questions get relevant and detailed information, and rephrasing of questions that are vague or which do not elicit detailed answers (Macran, Stiles and Smith, 1999). Additionally, participants may find it easier to explore their experiences after having met the interviewer more than once, enabling subsequent interviews to provide rich detail rather than simply repeating what has been said in the first interview: Clarke (2003) reports that multiple interviews enhance rapport and ease participants' sense of discomfort. Multiple interviews have been used in other qualitative studies (Harrison and Stuifbergen, 2005; Macran, Stiles and Smith, 1999). They have been used to gain information about people's experiences over time (Becker, 2003) or to gain in-depth information about a particular experience (Clarke, 2003).

1.11.6. Methods of Analysis

A range of potential methods was considered including: thematic analysis, grounded theory, discourse analysis and interpretative phenomenological analysis (IPA). It was decided that IPA would be the most effective method to explore the research aims. Braun and Clarke (2006) state that thematic analysis is limited in its' power to interpret. If thematic analysis had been used for this study it would have been possible to meet the goal of describing experience but not to meet the other goals of understanding experience and exploring identity and experience. Warwick, Joseph, Cordle, and Ashworth (2004) analysed their data with both thematic analysis and IPA, and found IPA to be more informative in terms of clinical implications as it found three more major themes than those found by thematic analysis. Grounded theory builds categories of meaning from data. It can be used to uncover social processes and map categories of experience for individuals. Whilst it would be able to categorise individual experience it would not be able to consider the lived experience of this as effectively as IPA could. Discourse Analysis (Potter and Wetherall, 1987) focuses on how people negotiate their meanings though conversation. However, it does not address issues around sense of self and therefore could not meet the goal of exploring identity and experience.

1.11.7. Interpretative Phenomenological Analysis

The data was analysed using Interpretative Phenomenological Analysis (Smith 1995; Smith, Jarman, and Osbourn, 1999). This form of analysis has been described as being effective in conjunction with semi-structured interviews (Smith and Osborn, 2003). IPA has also been used with multiple interviews (Macran, Stiles and Smith, 1999). IPA aims to understand lived experience, how participants make sense of their experiences, and the meanings they attribute to these experiences, and is thus an effective strategy for meeting the research aims. IPA has been described as being particularly useful for topics relating to identity, the self and sense making (Smith and Osborn, 2007)

IPA takes a middle ground in the positivist/relativist debate. It assumes that people's language has significance for them, and that there is a relationship between what is said and the beliefs and psychological constructs held by a person. It draws on phenomenology in its interest in personal perceptions of an event or object rather than in producing an objective statement of the event or object. IPA takes a position of 'hermeneutics with empathy' (Smith, 1995). It therefore focuses on what a phenomenon is like for a person through the telling of their story, rather than questioning what lies underneath their words such as why they are telling the story in this way. IPA also draws upon symbolic interactionism in its belief that meanings are influenced by the social context. It recognises that an individual's perceptions are influenced by expectations and belief, and that context needs to be recognised as important.

IPA aims to understand experience through looking at respondents' accounts of the processes they have undergone: people are not passive perceivers of an objective reality but make sense of their world by formulating their own biographical story into a form that can be understood by them. It is based on a double hermeneutic in that participants interpret their experiences and these reflections are then interpreted by the researcher during the analysis stage. IPA states that some level of interpretation of participants' communication and their physical and mental state is needed as participants do not always wish to, or feel able to, self-disclose about topics that may be painful or have negative consequences for them and it is not possible to gain full access to someone's experience (Smith and Osborn 2003). It is therefore important to consider what the researcher is bringing to the interpretation of data in terms of their beliefs and perceptions, and the researcher's views add to the quality of the analysis (if appropriately reflected upon) rather than detracting from it. Smith (2004) states that the quality of the final analysis is determined by the personal reflective work completed at each stage of the research. IPA has been described as being idiographic, inductive and

interrogative (Smith, 2004). It is idiographic in that it examines each case in detail, focussing on both convergence and divergence, before it analyses cases together and groups themes. It is inductive as its techniques allow unforeseen themes to arise during analysis rather than testing something already known and described in the existing literature. IPA is interrogative as its findings can be discussed within theoretical frameworks. Although IPA differs in some of its epistemological assumptions, it shares concepts with other psychological theory which allows questioning as to how its findings relate to existing theory.

Smith and Osborn (2003) state that in IPA research there does not need to be an attempt to explore a pre-determined hypothesis. However, this does not preclude the use of IPA within theoretical frameworks, and studies have been carried out in this way. Green, Payne and Barnitt (2004) used IPA and alongside a self-regulation model (Leventhal, Nerenz, and Steele, 1984). Swift, Ashcroft, Tadd, Campbell, and Dieppe (2002) constructed their interview and IPA analysis in relation to Aristotle's theory of virtue and vice. Brocki and Wearden (2006) argue that it is unlikely that a project could be embarked upon without the researchers having some knowledge of the current literature. IPA is appropriate for social psychology theories, mentioned previously as being important to the research question, as it considers meanings revealed through language and recognises that cognitions are influenced by expectations and beliefs. IPA has been used extensively within health psychology research (Brocki and Wearden, 2006). Topics have been studied such as the experience of brain injury (Howes, Benton and Edwards, 2005) and masculine identity and health related behaviour (de Visser and Smith, 2006). However, studies have now used IPA to conduct research with mental health populations (Knight, Wykes, and Hayward, 2003; Offord, Turner and Cooper, 2006) and it is therefore a suitable method for analysis in this project. Pitt, et al (2007) used IPA to analyse semi-structured interviews examining psychosis and recovery.

IPA was also chosen as it can show patterns across case studies, whilst still recognising the aspects of individuals' lives from which these patterns emerge (Smith, 1999). This is vital as the study aims to look at how people make sense of their experiences across a range of views. Larkin, Watts and Clifton (2006) state that IPA has a commitment to understand and 'give voice' to concerns of participants and to make sense of these concerns from a psychological perspective.

1.11.8. Rationale for Number of Participants

Qualitative studies vary in the number of participants involved, as emphasis is placed on the quality of the information collected rather than having a set number of participants. The aim is to collect a range of views and sufficient material to allow detailed analysis without creating excessive amounts of information, which might lead to superficial analysis (Malterud, 2001). Brocki and Wearden (2006) conducted a literature review of papers using IPA in health psychology. They found a range of one to thirty people participating in the fifty-two studies they reviewed. They noted that small sample sizes are the norm in IPA to reduce the risk of losing detail. Smith, Jarman and Osborn (1999) suggest that IPA works well with up to ten participants, and Smith and Osborn (2003) have suggested that novice researchers or students aim for sample sizes of five to six. In recent years there has been a trend towards smaller numbers of participants such as in the IPA study by Smith and Osborn (2007) on back pain which used semi-structured interviews with six participants.

1.11.9. Quality Standards

In qualitative research there are standards that can be met to ensure good quality research. Elliott, Fischer and Rennie, (1999) outline seven standards which this study aimed to meet: owning one's perspective; situating the sample; grounding in examples; providing credibility checks; coherence accomplishing general versus specific research tasks and resonating with readers. The research was designed in relation to these standards to fit with good practice and to increase the trustworthiness of the data.

1.12. Summary of Chapter

This chapter has established that research into low secure forensic mental health services is minimal, and that there is a need to conduct further research in order to inform treatment during admission and the transition into the community. It has highlighted the need to consider service users' experiences, understanding of experiences and identity because of their implications for treatment and recovery, and has shown that these areas can be studied. A qualitative methodology was considered to be the most effective way to collect information to understand these areas. The following chapter details how the data collection and analysis were conducted.

CHAPTER TWO: METHODOLOGY

In this chapter the research design will be discussed. An exploratory design was used in which participants were asked to take part in a semi-structured interview, focusing on the experience of being in a low secure unit. This chapter outlines ethical considerations, the recruitment of participants, the interview process, and the data analysis.

2.1. Ethical Considerations

2.1.1. Ethical Approval

This study was given ethical clearance by Leeds (East) Research Ethics Committee. It was also given clearance by West Yorkshire Mental Health R&D Consortium. Please see Appendix D for details of this.

2.1.2. Confidentiality and Data Protection

It was agreed with participants that the information from their interviews would not be shared with the unit in a way that would be identifiable, unless there were issues of risk to themselves or others, or the security of the unit. Participants were asked to give consent for anonymised extracts to be included when the study was written up.

Interviews were digitally recorded. The recorder and transcripts were kept in a locked cabinet to which only the researcher had access. No identifiable information was kept on personal computers.

2.1.3. Establishing Consent

Table 1: Questions asked to establish capacity to consent, and consent.

Questions
"Can you tell me about what we talked about last time we met –when we talked about the project."
"What helped you to decide to come to the interview"
"Have you any questions about the project/about what we're going to do today"
"I'll be recording our conversation today……are you still happy to take part"

At the beginning and end of interviews it was established whether the participant had given informed consent and whether they had the capacity to do so. This was established by following the guidelines set out by the Mental Capacity Act (2005) around checking

whether information can be understood and retained, and the decision making process can be communicated. Table 1 details the questions that were asked to establish consent. All participants were asked to complete a consent form for the study (see Appendix B).

An information sheet was designed, to help allow service users to make an informed choice about participation (see Appendix A). The researcher and service user read through the information sheet together, the reasons for the project were explained, and there was discussion as to what would be required of the service user if they chose to participate. It was made clear that service users did not have to take part. It was also explained that the project was not commissioned by the service and that participation or non-participation would not affect treatment. Once a service user had stated they wanted to take part they were given at least 24 hours until the interview was held so as to give them time to change their minds.

2.1.4. Payment

At the end of interviewing participants received a gift of £10 for taking part. This was aimed at thanking participants and recognising the value of their data and their time. The participants were not informed about this until interviewing had finished. Gifts were not given out until all the participants had completed at least one interview. However, part of the reasoning for paying participants was that it was common practice to do so within the service, and the sum paid was based on the level of payment for research already in place in the service. Therefore, although service users were not informed about the gift, they may have had expectations that they would receive money for taking part. It seems unlikely that this was the case for all of the participants as three people expressed surprise at receiving the gift and one of them initially returned it saying that they had not taken part in order to be paid.

2.2. Recruitment and Selection of Participants

2.2.1. Setting

Service users from a low secure forensic mental health service in Yorkshire were asked to participate in interviews. This is a tier 4 service, in which the client group typically has a serious mental illness and is considered to be a risk to themselves or others and cannot be managed in mainstream mental health services, or who have committed an offence that is not considered to require a higher level of security. This service has assessment and treatment units and a treatment and recovery unit for adults detained under a section of the Mental Health Act (1983). The assessment unit is aimed at men

who are typically in the more acute stages of mental illness, and is targeted at periods of admission of six months on average. The treatment and recovery unit is aimed at rehabilitation and increased leave into the community for male service users who are typically at a more stable stage of mental illness. The average length of stay is 18 months. There is also a women's unit aimed at both assessment and treatment. This setting was selected because its service users could give information about their experiences in a low secure unit.

Interviews were held in a private room in the low secure service. This allowed confidentiality, and minimised disruptions.

2.2.2. Inclusion and Exclusion Criteria

Service users who had a diagnosis of a mental illness and who required the provision of security were included in the study.

Service users were excluded if they did not speak English fluently. This is because the research method required a reasonable level of English to allow the participant to discuss their experiences in detail. The use of interpreters would have restricted the information the interview could elicit.

In order to be able to draw conclusions from differences in participants it is important for the sample to be as homogenous as possible. People with a learning disability diagnosis were therefore excluded as they were considered to form a separate population to other service users in forensic mental health services in terms of their experiences and the service provision they would have received. For example, they would have received different interventions during admission such as those aimed at addressing specific learning needs. Including people with learning difficulties would have made it difficult to compare individual accounts as any differences that arose could be linked to the experience of having a learning disability rather than that of being in a forensic mental health services.

Capacity to consent to research was assessed by the interviewer prior to interviews. If the participant was unable to understand and retain information about the study, could not use that information to make a decision about participating, or could not communicate that decision, they were considered to not have capacity to consent to the study and were excluded from the study. If someone was deemed to have lost capacity during the duration of the study they were excluded.

No service users who were under 1:1 observations at the time of the interviews were included in the study due to reasons of risk and confidentiality (if observation levels required a staff member to be with the participant continually).

2.2.3. Recruitment of Sample

All service users who met the selection criteria were offered the chance to take part in the project: around 30 people. It was decided to recruit 5-10 participants for this project. In IPA the ideal is to have a homogenous sample (Smith, 1995) to allow the comparison of participant accounts. This study did not employ purposive sampling to recruit a homogenous sample because of expected recruitment difficulties. Instead participants were selected on the basis of order of volunteering, and recruitment was discontinued when sufficient data had been collected.

It had been planned to approach service users through service user development meetings but this was discounted due to low attendance of these meetings. A staged recruitment process was instead used, in which the treatment and recovery unit and the women's service were targeted initially and then the assessment and treatment unit. The option to become involved was offered to the treatment and recovery unit initially because these service users had experience of both the assessment and the treatment units. However, both units were approached so that a range of information could be collected and also meant that the information was not wholly affected by any unusual circumstances such as a unit being unsettled at the time of interview.

Information sheets about the project were left on the unit to allow service users to read through the information over time and to enable informed consent to be given (these are described in the ethical consideration section). Other studies have found difficulties in recruiting forensic mental health users solely through advertisement and have had to actively seek out participants (Godin and Davies, 2005) so the researcher also approached service users in person in the unit's communal areas. This allowed them the chance to ask questions about the project and also helped to alleviate any reluctance they may have had about engaging in a project run by someone they had not met.

2.2.4. Participants

All of the service users had access to the information sheets and the researcher directly approached twenty people. Thirteen of these refused to take part. The majority of these said that being interviewed sounded like too much effort. Six participants were interviewed in this project. A seventh person participated but asked to discontinue the

interview after a few minutes as he said he found it too painful to talk about his experiences. His data was not included in the study. Information about the participants can be found in Table 2. Details of ages and the sections of the Mental Health Act (1983) the person was held under have not been provided to aid anonymity.

Table 2: Participant Information

Participant	No. of Interviews	Ward	Gender	Age	Diagnosis
A	2	Treatment and Recovery	Male	30s	Psychosis
B	1	Women's Service	Female	30s	Personality Disorder
C	2	Women's Service	Female	40s	Psychosis
D	2	Assessment and Treatment	Male	20s	Psychosis
E	2	Treatment and Recovery	Male	40s	Psychosis
F	2	Treatment and Recovery	Male	20s	Psychosis

2.3. Procedure

2.3.1. Developing the Interview

The initial interview was exploratory in nature in that it asked participants to describe their experiences and was based around an interview guide which included a list of issues to be explored and suggested probes to follow up key topics (see Appendix C).

The questions and probes were based on guidance from Smith (1995). It was decided to start the interview with "tell me about being here" as it was hoped that this would be a neutral opening that would not be distressing, and which could answer the research question around experience. The general nature of the question allowed participants to bring in their interests and concerns. The order of the other interview questions and prompts were then guided by the participant's responses to enable the interview to flow smoothly. Questions were designed to be open and neutral rather than leading or value-laden. They were also designed to be simple, and non-technical in language.

The interview guide was practised through role-play with a clinician who was experienced in qualitative research, and working with service users in mental health settings. This allowed discussion as to whether the information collected could answer the research questions and could allow participants to bring in topics that were important

to them. When the interview guide was refined following this it was then practised through role-play on two occasions with peers who had experience of being with people in forensic mental health settings. This allowed feedback on how service users might experience the interview and further consideration as to whether the questions could allow information to be collected that could meet the project's aims. These role-plays suggested that the guide helped to pace the interview and allowed the interviewing to be systematic and comprehensive (Lofland and Lofland, 1995). It facilitated the participant to tell their story in their own words, as questions were open-ended, and non-directive. It also allowed the researcher to become familiar with the interview questions and prompts allowing the interviews to not be disjointed or too rigid.

2.3.2. Conducting the Interview

All interviews were conducted by myself, and were digitally recorded and transcribed, except for one follow-up interview in which the participant asked for the interview not to be recorded. In this interview notes were taken by myself and checked through by the participant afterwards. Whilst the data in this interview may not be wholly verbatim the participant affirmed that the notes represented what he had said during the interview. Several of the interviews were transcribed by myself. The other interviews were written up by a professional transcriber who agreed to maintain confidentiality. Participants were aware that data from their interviews might be seen by a transcriber as this was stated in the information sheet and was discussed prior to interviewing.

The interviews varied on length depending on how long the participant felt able to manage but did not last more than one hour. On average they lasted around 35 minutes. Intervention by myself was aimed at encouraging the participant to keep talking, to give more detail or to stay on task. It was also aimed at clarifying what had been said, and to check my understanding of what had been said.

Whether a follow up interview was held or not was based upon the participant's willingness or capacity to participate, and the researcher's view as to whether more information was required based upon the analysis of the first interview. Five of the six participants were followed up. One participant was not interviewed again because her observation levels changed during the project due to self-harming behaviour and confidentiality could not be ensured. The questions in the follow up interview were based on the topics raised in the initial interview and were intended to clarify or explore further the information from the initial interview. They were open ended to allow new

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information to enter the interview also. Interviews were held in sequence so that the set was finished before the next participant was met with.

At the end of both the initial and the follow-up interviews participants were asked whether they felt uncomfortable about any aspects of the interview and wanted them to be removed. None of the participants requested that information be excluded. Time was also spent discussing how the participant felt about the interview and whether they needed support following it. Participants were offered the option of accessing support either from the nursing team or the psychology team. None of the participants used this option.

The researcher took anonymised process notes immediately after each interview. This included observations and thoughts about the interviewer's interaction in the interview and that of the participant. Comments made outside of the recorded interview were also noted. Participants were aware of this prior to interviewing. A reflective diary was kept alongside these notes, by the researcher to consider how their knowledge and beliefs may have affected interviews and analysis. These measures help to increase the credibility of the study. Observations about the interviewing and data analysis have been included in the results and discussion sections to allow readers to consider the impact of the researcher on the study.

2.3.3. Transcription Conventions

All quotes by participants have been presented in italics. Each quote is followed by brackets showing who said it, in which interview and on which page it was said.
In the quotations the following symbols have been used:

X represents a person's name that has been deleted for confidentiality

Y represents a place's name that has been deleted for confidentiality

..... represents text that has been deleted to make the extract clearer for the reader. For example 'yeah', and 'um' have been deleted in places to aid understanding of the statement, without impeding what was said.

( ) represents text which has been included to aid the reader's understanding.

2.3.4. Data Analysis

Prior to analysis I had attended an IPA conference held in Brighton, 2007. This included presentations about IPA and workshops were run which allow practice at analysing data. I had also attended a Qualitative Research Group, which involved analysing other people's anonymised data for peer review. Transcripts and tapes of the interviews were

reviewed several times by myself. Notes were made next to statements that linked to participants' experiences and of any topics or patterns that appeared repeatedly during the interviews. These notes included summaries of what has been said, associations or preliminary interpretations. Significant or interesting passages representing relevant or repeated ideas were grouped to form themes. These themes were compared against the transcript to check that it compared with what the participant said. Themes were examined for links between them to produce super-ordinate themes. This procedure was carried out for each interview, and themes from a participant's first and second interviews were then combined to produce overall themes. When themes had been produced for each individual set of data patterns were then established across cases to form a master set of themes for the group.

2.3.5. Example of Analysis

Examples of analysis for Danny's interviews have been included to help explain the process. The first stages of analysis involved becoming familiar with the data and making preliminary observations. Table 3 shows extracts from Danny's second interview. Comments have been made in the right column indicating initial thoughts about the data, and also which research aim was considered to be most relevant to the data.

Table 3: Worked example- Initial thoughts on an extract.

	Extracts	Initial thoughts re data
D	I used to find it dead closed in, but now I'm more used to it. More used to the people. There's some odd stupid people here.	Overwhelming, no space? Becoming accustomed (experience) Others are odd/stupid –he sees himself as different (identity)
I	What's odd or stupid about them	
D	They start fights, not everyone but one or two people, just a few people, one in particular. I can't give you names. Don't want anyone to get into trouble.	-Odd/stupid=fighting -Sharing information can get people into trouble (sense-making)
I	What's that like when they start fights	
D	They're ill, not well. It winds me up. I don't do anything in response. I know I shouldn't but if someone winds me up I feel like I could punch them but then I'd be as bad as them. I'm not like that. I don't like violence. I can see that if I did it staff would be thinking that it was my fault for getting wound up, letting him wind me up. And I'd get in trouble.	Aggressive because of illness (sense) -Feelings wound up (experience) -Being different to them, not as bad as them (identity) -Punished/consequences if act like them –staff observing how he acts, feeling has to act differently (sense)

Following this initial stage of noting ideas I then grouped my summaries and preliminary interpretations from each interview to form themes. The themes from both interviews were then considered together, and were separated into 'experience', 'understanding experience' and 'identity' so as to be able to answer the research aims of investigating these areas. The themes for each category were clustered again to produce master themes, and were then further clustered to form superordinate themes. For Danny superordinate themes for experience included: being frightened of own feelings; being frightened of others; feeling connected to some people on the unit; being powerless; and feeling uncertain about where he belongs. Table 4 shows the themes that made up the superordinate theme of being powerless that arose from Danny's data.

Table 4: Table showing the themes that emerged for 'being powerless'.

Master themes	Themes
Feeling his progression through stages is decided by others	Finding himself on different units Feeling he is undergoing tests Feeling helpless re moving Experiencing others decisions as being made arbitrarily Being frustrated about restrictions imposed on him
Feeling he has no choice but to accept the process	Feeling he needs to be compliant or he'll be punished Having adjusted Feeling unable to complain

Further examples of data analysis can be seen in Appendix F. The transcript of an interview with Joan shows preliminary associations, initial themes and the development of these themes.

2.4. Credibility Check

Themes for individuals were checked for agreement through peer auditing. Two peers who were familiar with IPA independently gave feedback about the individual data and coding. An anonymised transcript was given to a peer who noted ideas about the interview and coded it and this was compared to a set of codes I had produced, so as to check that important themes were not being overlooked. Overall they were very similar. However, the peer noted a theme of the participant portraying self as an 'expert patient' that I had not picked up on. I re-read the interview with this in mind and decided to include this as a theme for this individual. Extracts from another interview were coded by myself and checked by a peer to see if others could easily understand the

interpretations. The peer agreed with the coding but suggested adding an additional role for the participant as being a family member. This was something I had noted for other participants but not for this person. I felt this was a useful observation and included this. The group themes were considered during supervision. Advice was given around themes I had coded as feeling frightened by internal distress and feeling vulnerable and frightened in relation to others. It was suggested that these themes could be further grouped into the superordinate theme of 'feeling vulnerable'.

2.5. Summary of Chapter

A semi-structured interview was developed which used open questions to allow participants to bring in their own stories and speak about issues they considered to be important. Six participants took part in the project and five of these had follow-up interviews. The eleven interviews were analysed using IPA, and themes were developed around experience, understanding of experience and identity. These were subject to quality checks. The results are presented in detail in the following chapter.

CHAPTER THREE: RESULTS

This chapter begins with a description of each participant and their interviews to allow the reader to have an overview of the individual and their experiences. Following these portraits there is a description of themes derived across the interviews. These are structured around the research aims of experience, understanding of experience and identity. Themes are grounded in examples of interview data to include participants' voices, to explain how themes have been derived from the data and to allow the reader to draw their own conclusions about the data.

3.1. Reflective Paragraph

This section has been included to help describe my values and assumptions so that the influences of these upon the conducting of the interviews and analysis can be considered.

I became interested in doing research into forensic mental health services during my work in secure settings prior to clinical training. My impression was that the research that had been undertaken was based on service needs and risk management and gave little insight into service users as people. This impression was reinforced when I did a forensic mental health placement during training. Whilst I was aware of the need to manage risk, I also felt saddened at how little opportunity service users had to voice their opinions in a meaningful way. I thought that it was important to be aware of service users' experiences to gain a deeper understanding of how to work with them. I was drawn to qualitative research because it provided an opportunity to do research in a way that included the perspective of the people being studied rather than quantifying the events they experience. Whilst my previous experience motivated me to do this research I am also aware that it has led me to form assumptions about this population and forensic mental health services such as my view that there are tensions between risk management and positive risk taking in services. My expectations of the interviews were that service users would be very curious as to what I was doing on the unit but that they would also be wary as to why I wanted to know this information and that this would affect recruitment. I thought that some people would volunteer to take part in order to 'check out' the project. I thought others might take part because they were bored or because they had a particular event in mind that they wanted to talk about such as a recent event on the ward.

Additionally, I was motivated to undertake research in forensic mental health following my own experiences of talking to people about working in these settings and realising

the level of stigma that service users faced. Some people I spoke to held extremely strong views on whether service users should receive any treatment at all. This shocked me and made me wonder about how service users felt about themselves if they received these kinds of responses, and how they felt about other service users. When I first told my parents about my job offer in a secure setting they said they were worried for my safety and asked why I did not want to work with children as I had been doing. I found this surprising in some ways as my work with children had involved some situations in which I had felt very unsafe, and this made me think about how some client groups are perceived as being more socially desirable than others. These experiences undoubtedly influenced my expectations as to which themes would be found.

3.2. Demographics

Six participants were recruited and five of these were interviewed twice. Participants were aged between twenty and forty-six. Five of the participants had diagnoses of psychosis and one participant had a diagnosis of personality disorder. Participants' names have been changed in order to maintain their anonymity. Individual descriptions are provided in the following section.

3.3. Pen Portraits

3.3.1. Imran

Imran had been in prison on two occasions. He would not give details of his offences. He was transferred from prison to a medium secure service due to experiences of psychosis. Imran had spent around five years in prison and the medium secure setting, and a further two years in this service. He was on the assessment and treatment unit and the treatment and recovery unit. He was discharged to a community hostel shortly after the interviews took place. Before going to prison Imran lived with his mother. He has brothers and sisters who are married and have children, live near his mother and who visit the family home several times a week. He said that he '*does not have a father.*' Imran has lived in different cities in England and has worked in restaurants. One of the staff members recommended that I ask Imran to take part. He agreed immediately to take part but said he was busy and could not take part for a week. He cancelled the first interview because of leave but was keen to re-arrange. Imran said he had volunteered because he liked spending time with people and that he was a '*chatterbox*'.

In the first interview Imran spoke more about his friends, family and life outside of the unit. In the second interview he described negative experiences in this service such as feeling frightened of another service user. Imran described feeling very relieved to arrive

at the service because it was less '*strict*' and '*very different*' to the units he had been on previously. He found it hard to explain why it was different and focused on the range of different activities he was able to do at this service. He stated that his transfers to lower levels of security showed him that he was moving towards recovery. He saw his experiences of psychosis as being negative, and part of an illness that he wanted to recover from through taking medication. He felt that because he was ill and in secure settings he had missed out on things that were important to him such as being with his friends and family or getting married. He described needing other people to help him and to protect him as he feels unable to do this himself.

Interviewer's Experience: As he was my first participant I was relieved that he had agreed to take part. I was a little anxious whether the schedule and myself were 'good enough' to get 'useful' data. This affected the flow of the interviews and the depth to which topics were discussed. I felt Imran volunteered because he liked to spend time with people he perceived as 'professionals' and that he felt 'special' through being asked to take part. He used the phrases '*to tell the truth*' and '*being honest*' throughout both interviews. It seemed important to him to be believed. He described himself as chatty and talkative but in the first interview he seemed reserved and did not give much detail. I found myself trying to draw him out. I wondered if he was worried how the information would be used. In the second interview he was more relaxed and initiated topics.

3.3.2. Chris

Chris is in his twenties. He was transferred to this service from prison. He declined to talk about his offence and instead spoke about being ill. He has been in this service for around four years, and has been on both the assessment and treatment unit and the treatment and recovery unit. He has friends and family near the unit and sees them when he is on leave, but said they do not visit him. He has a chronic physical illness and this meant that he had frequent admissions to hospital.

I approached Chris when he was sat on his own. He said he had volunteered because he attended service user meetings and thought it was important to '*tell people what it's like here*'. He also said he wanted to be '*helpful*'. In the interviews Chris spoke about missing his family and friends. There was a sense of him feeling he belongs with his family and that his 'real' relationships are off the unit. He spoke about getting along with others but said he spent his time mostly on his own. He was very focused on what he had to do in order to leave the unit, to be discharged from his section and to be in the community. He saw himself as being in transition between this unit and a local hostel.

He said his doctor had decided he was moving and that he was now waiting for a date. He described himself as having been mentally ill and in the process of recovering. He associated '*not being ill'* as the main way of ensuring discharge. He also seemed to believe that he needed to pass other people's tests to be discharged, as he spoke about feeling that staff '*get at him'* to do activities and that he has to please others. He spoke about himself in terms of whether he was ill and what he does as a patient, and how this related to being *normal*. This included some of his valued aspects of self, such as going to college and being a service user representative.

Interviewer's experience: I was surprised by how anxious Chris seemed in the first interview. I found myself not following up on some questions because he seemed so anxious. When open questions were asked Chris checked out what I meant by the question. I felt that Chris wanted to be helpful and sometimes was trying to give the answer he thought I wanted. I also felt he was worried he would be judged if he did not give the right answer. I felt that this limited his responses. I found myself asking closed questions to check what Chris had meant when he was being vague, to try to encourage him to talk and because the corridor outside the room was very noisy. This also affected the depth of answers given, as did our level of rapport. I felt unsure as to whether a follow-up interview would be useful and was relieved when he seemed more relaxed and gave slightly longer answers in the second interview. I felt that there was more rapport between us in the second interview and that it was less awkward for both of us.

3.3.3. Martin

Martin is in his forties. He was living in a hostel near to his family prior to coming into this service. He was admitted to a psychiatric ward in the service after taking an overdose, and was transferred to the low secure service due to fire-setting.

Martin wanted to start interviews immediately. He seemed disappointed when it was explained that the interview could not be held that day and tried to tell me information about himself anyway. In the first interview Martin seemed focused on how he could be safe from aggression or exploitation from other people. He also spoke about lending service users money to be *kind and generous.* This seemed to be linked to getting people to like him so that he would not be attacked. He said it annoyed him that staff told him not to lend money as he then had to refuse service users and he felt he was not able to be helpful. Martin spoke about doing activities and helping others and feeling needed by doing this. Martin had a Mental Health Review Tribunal between the two interviews and was told he was not going to be discharged as he had hoped he would be. In the second interview he spoke less about lending money and spoke more about his view of his

symptoms. He said he was admitted because he was '*ill*' and this had affected his behaviour. However, he felt it was unfair that he was here and minimised the risk involved in his actions. He also spoke about being ill in response to stress from outside the unit, and said that there was no point being on the unit as he was not going to be ill there. He told me that being on the unit was like a break from life, and that it was '*like a resting place*'.

Interviewer's experience: Martin had capacity to consent and take part, but I was initially worried that he would not be able to concentrate, and that this would mean that no useful data could be collected. However, I relaxed once I realised that his changing between topics was linked to him being agitated about an experience which he wanted to talk about but was unsure whether to or not. He was upset that he was '*in trouble*' and had been '*told off*' by staff for lending money to another service user: I found that he was fixed on this topic. In the second interview I felt happier that we were discussing a wider range of topics as I felt I had more understanding of what life was like for him generally.

3.3.4. Sharon

Sharon is in her thirties. She was taken into care as a child and stated she has spent her life in places like this. She has only recently become in contact with her family again. She has been to psychiatric units, prison, and high and medium secure units. She stated that it was around 15 years ago that she moved from high secure to medium secure. From the medium secure unit she came to this service. She had been on this unit for around five months when she was interviewed.

Sharon approached me to say she wanted to take part in the project after she had read an information sheet I had given to someone else. She spoke about the importance of service users *'having a voice'* and people being informed about their views. In the interview Sharon seemed to have thought about some of the questions beforehand. Some of the answers she gave seemed as if they had been planned and I was unsure if they were statements she had said before in previous meetings or if she had prepared what she wanted to say in order to be able to tell her story. She gave a detailed overview of the service and how it generally is on the unit for service users, but gave very little detail about her individual experience. Sharon spoke about her experiences in terms of her being ill, and that this affected how she appraised others' intentions and her behaviour. She told me that when she is ill she worries people will harm her and there were themes about being unsure whether she could trust others. She spoke about other people as frightening because of the power they have over her life including where she lives. She

described times she had moved units and having been distressed by this. She also talked about being worried about the future and living on her own. She seemed to feel at home in psychiatric units and was anxious about the prospect of being in the community. She spoke about worrying that she would not cope on her own and that she would be rejected because of having been a patient. She seemed to be relieved that her section meant that she could not be easily discharged. She spoke about the staff members having suggested discharge to her recently and her feeling *scared about the unknown*. A week after the interview she self-harmed and was put on 1:1 observation levels. Plans for discharge were postponed. Sharon appeared to want care and friendship from staff, but also felt that they were not always available for her and worried that if she spoke about her problems this would be used against her. She attributed behaviour such as self-harm to others not being there to support her when she felt distressed. She described herself as being someone who works and being a service user representative and gave examples in which she could affect change.

Interviewer's experience: In the interview she seemed confident and 'in control'. I felt anxious at times in response to this and I wondered if she was controlling parts of the interview in order to block in-depth exploration. I also felt she was keen to present herself as an expert and I found this intimidating. I felt silly when I asked for more detail about her statements and although I tried to explore further I was aware of impulses not to do so. I was very ambivalent as to whether a second interview would be useful but decided to ask her anyway as other participants had given more detail when followed-up. However, a second interview did not take place because she had self-harmed and her observation levels changed. My interpretation of the self-harming behaviour was that it linked to her anxiety about discharge plans and not wanting to leave.

3.3.5. Joan

Joan is in her forties. She moved houses when she was a child on a few occasions and lived abroad, returning to Britain alone as a teenager. She said had little money at this time and was very relieved when she got a job. She described being on the dole and hating this. She has no qualifications. Her mother has since returned to Britain and they are in contact. Her brother and sister have remained abroad. Before she came into this service she had been living on her own in a flat. She had been in this service for three years when she was interviewed. She said she has been to around five secure settings in the past (with differing levels of security).

She was on her own when I approached her. When I asked her if I could talk to her about the project she said she would like this as she was '*bored sat on her own.*' Joan said that the service was *'OK'*, and that it was '*better*' than some places she had been because there was less '*fighting*' and '*C&R*' here. She stated that she is not ill and that her experiences of distressing smells and hearing voices are real but that other people do not believe this. In both her interviews there were themes of feeling that admission was unfair and because of this not knowing what to do to be discharged. She described different strategies she had tried but feeling that nothing had worked. There was a sense that she felt that she had '*done nothing wrong*' so she did not have to change but instead could only '*wait*' until others decided to discharge her. She described feeling judged by others and persecuted. She attributed this to her being white and Asian doctors being prejudiced against her for this, to the restrictions she faces as an '*ex-con'* and her appearance which she said led other people to think that she was a lesbian or frightening. There was also a sense of her feeling that being admitted meant that she was not independent or in control and that this worried her because she viewed others as judgemental, persecutory or unreliable. She also saw herself as needing to be physically strong to be able to stand up for herself and to work to provide for herself. She gave examples of times she had been aggressive to get her needs met or to teach others a lesson.

Interviewer's experience: Joan used the phrase '*do you know what I mean*' throughout both interviews. She seemed to be checking my understanding of what she was saying and also my response to it by saying things like '*but that's normal isn't it'*. She also checked how the information would be used and when this was explained she seemed to feel reassured and talked in more depth. She said things like '*I know it's on tape but I don't care*'. At the end of the interviews she described having enjoyed having the chance to talk about herself and have someone be interested in her. She said she felt *'lighter'*. I felt pleased that she was chatty. However, I also found myself moving away from potentially distressing topics when she made comments, such as calling me *sweet,* which left me feeling uncomfortable and distracted.

3.3.6. Danny

Danny is in his twenties, and has diagnoses of psychosis and ADHD. He came to this unit from a medium secure setting, and before that he had been in a psychiatric unit. Although his behaviour has been aggressive he has not been charged with an offence. He and his family are from the local area, and he is in contact with them. When I spent time on the unit Danny seemed very interested in who I was and why I was there. He asked several questions and also chatted about himself. He first said he did not want to take

part in the project, but approached me on another occasion and asked if he could take part. He said the reason he had changed his mind was because he had '*nothing to do*' that day. He agreed to take part in the second interview only if it was *'off the record'* and not digitally recorded. Danny spoke about feeling unsafe around other people both on the unit and off the unit and feeling grateful to staff for managing violent situations. He also talked about being wound up by other people and not being able to respond as he normally would (by punching them). He said that there were other ways to wind people up instead. He spoke about having to accept some of other people's decisions and behaviour but also talked about times when he had '*done something about it*' such as when he had complained about a staff member's behaviour. Danny said he was here as a consequence of his '*behaviour*' and said '*I can't complain because it's my fault I'm here*'. He spoke about being '*processed and pushed into a social world*' indicating that he is here to be changed and for his behaviour to become more socially acceptable. He spoke about moving through units with the end goal of being discharged from his section.

Interviewer's experience: In the interviews Danny changed from topic to topic and these did not always seem related. I felt confused in the first interview and unsure as to whether the data collected would be meaningful and found myself wanting to interrupt him. I thought the changing of topics was partly representative of his ADHD but was also a way of avoiding uncomfortable topics such as his relationships with his family. I also thought he was worried how the information would be used. For example, he asked *'so what happens to this, me being recorded'*. I thought he believed I was part of the service and that this affected what he said in both interviews. After the first interview he asked me if it would be me who did his ADHD assessment. The second interview was not recorded and I thought that he had requested this because he did not believe that information would not be shared with the service. He seemed to be less guarded and calmer in the second interview and I felt more able to see how the interview went without wanting to take control of it. He asked personal questions such as where I lived, and I felt slightly uncomfortable that I was asking him personal questions but would not respond to his. However, I was also very aware that he knew he should not ask these questions. He said '*you're not allowed are you, to tell me stuff about you*'. I thought that this allowed him to have control, but was also a way of testing me to see whether I could be trusted to hold boundaries and not to share information.

3.4 Group Analysis

The group analysis has been divided into three sections: experience, understanding of experience and identity in order to help answer the research aims.

3.5 Experiences in a Low Secure Forensic Mental Health Service

Table 5 describes the group themes and their associated sub themes. These are detailed below with extracts.

Table 5: Group Themes for Experience

Theme	Subtheme	Theme	Subtheme
Feeling vulnerable	• Finding internal experiences frightening • Finding other people provocative • Experiencing others as aggressive and scary • Mistrusting others • Feeling helpless and needing others to protect them • Trying to find ways to manage distress • Feeling ambivalent about being with others	*Feeling powerless*	• Feeling passively moved within a system by others • Being frustrated about being prevented from doing things • Feeling compelled to comply with others decisions • Constantly feeling assessed
		Finding it meaningless here	• Feeling bored and trying to pass the time • Meaningful things happen off the unit • Trying to increase time off the unit
Experiencing life as having been interrupted	• Being separate to life outside/the community • Missing out on family, friends and activities • Hoping to return to their lives	*Valuing positive experiences with other people*	• Feeling cared for • Being protected • Being helped • Having someone to talk to • Experiencing companionship

3.6. Feeling vulnerable

This section refers to participants feeling vulnerable in relation to their feelings and to others. It includes a feeling of ambivalence raised by feeling vulnerable and wary of others but also having positive experiences with people.

3.6.1. Finding internal experiences frightening

Imran, Sharon, Martin and Chris spoke about feeling frightened or upset by what they were experiencing such as hearing voices or feeling paranoid. They spoke about this leaving them feeling out of control.

It's all to do with the illness making you hear voices, and you're ill so it's your brain's not functioning right (Martin, 2, p6)

3.6.2. Finding other people provocative

Joan, Danny, Sharon and Martin spoke about other people provoking them and being responsible for them feeling *upset* or *wound up*. They explained their negative behaviour as being responses to other's actions. Danny and Sharon said this made them feel out of control.

3.6.3. Experiencing others as aggressive and scary

Four participants mentioned having witnessed or experienced other service users' having been verbally or physically aggression whilst they were on the assessment unit or in the women's service. Two participants mentioned experiences of verbal aggression on the treatment and recovery unit. Participants spoke about feeling stressed, and being frightened of being hurt by others' aggression.

In the past this guy –he's not here now-he went for me, and the staff broke it up so…and they sorted it out so we shook hands and that was the end of it. That's one thing I didn't like since I came here……he hit me you see and he apologised. That was a difficult time. After we shook hands, well before then I was really scared. I was worried he might attack me again. (Imran, 2, p4)

Patients can get you stressed and run down. (Martin, 1, p1). *They take the piss out of me. The patients. They say nasty cruel things* (Martin, 2, p1)

Joan and Martin spoke about feeling that staff members were aggressive during control and restraint (C&R).

And then she pressed her alarm button so some of them came over, dragged me, come down to seclusion……Not very nice. Being held in restraint (Joan, 2, p14)

It's like they're trying to hurt you (Martin, 2, p5)

Imran, Danny, and Martin described other people's behaviour as being unpredictable. They spoke about other people's behaviour as being *for no reason* or because people were mentally ill and *not in control*.

I've seen a couple of fights here. I don't like seeing violence..... Somebody wanted a can of pop or something and battered a member of staff. (Danny, 1, p4)

They're all not very well the residents. There's a few altercations (Imran, 2. p7)

Martin and Imran also stated that they had felt at risk from people who did not like them.

3.6.4. Feeling helpless and needing others to protect them

Imran, Martin and Danny stated they felt unable to do anything to stop other people's aggression and that they needed staff to help them. Martin and Imran reported times when staff had helped them.

He was a big lad, he was really big and I couldn't do anything about it. I told the staff though cos they can. (Imran, 2, p3)

3.6.5. Mistrusting others

Mistrusting others involved worrying about other people's intentions and being afraid that they would be exploited or harmed, or finding others to be unreliable resulting in disappointment or feeling betrayed. Four people said they were mistrustful of people's intentions.

There's always a catch to something (Martin, 1, p1)

They pretend to be nice to you but then they try and stab you in the back (Joan, 2, p4)

Martin spoke about other service users having taken advantage of him by borrowing money and not repaying him. Danny spoke about other people saying *you've got to meet your own needs.* Four participants mentioned being worried that sharing information would have negative consequences for them either in terms of restrictions being placed on them or being viewed negatively by staff.

It's a bit hard because they're quite keen to take your access and leaves off you so it you're not feeling well all your leaves get stopped. It makes me worse. Madder and sometimes you just can't tell the staff how you're really feeling. (Sharon, 1, p6)

(Dr X) *he used to think you were being at him if you told him straight how you really felt he'd put you down as prejudiced and all sorts* (Joan, 1, p2)

Two people stated that their concern about negative consequences of sharing information had affected what they told staff.

Tell lies and you can get away with it, it's the best way to be truthful, to give a lot of bullshit and they think that's real, she's ok. (Joan, 1, p2)

Sharon and Martin also voiced concern around information being shared with other clients either by themselves or by staff. Sharon spoke about confidentiality having been broken by staff and service users finding out information about her and other people. Martin spoke about not being able to trust service users and feeling betrayed by them as *they go tell on you to staff. The patients.* (Martin, 1, p10)

3.6.6. Trying to find ways to manage distress

Five of the participants described trying to find ways of coping with their feelings and spoke about trying to distract from their feelings through strategies including keeping busy or avoiding people.

You can see the pool table there. If you're really not feeling well you can take your mind off things. (Imran, 1, p2)

But once you get into the situation you find, you find things to combat the loneliness. (Danny, 1, p3)

Sharon and Danny described feeling they needed help to manage their feelings.

3.6.7. Feeling ambivalent about being with others

A theme was found for five participants of feeling frightened or mistrustful about being with other people but also wanting to elicit help from them or companionship. This theme was labelled 'feeling ambivalent towards others'. Sharon spoke about enjoying and wanting more social time with staff but also feeling worried about spending time with staff and how they would use information about her. Chris spoke about feeling nervous around staff and service users and choosing to spend time on his own, but also needing and experiencing other's help and having friendships with service users. Martin, Sharon, and Chris spoke about how staff members were not always available to do things with them, and them often being in the office. They all said they did not want to spend time with staff, but this left them feeling disappointed and annoyed as they needed staff to help them with things in order to move towards discharge. Chris said he avoided approaching staff because they were always busy.

3.7. Feeling powerless

This theme referred to participants feeling that the unit was part of a wider system that they were being moved through by other people. This linked to their experiences of having been in other units previously. Participants appeared to feel that they had little control over what happened to them.

3.7.1. Feeling passively moved within a system by others

All of the participants spoke about their admission as being part of an overall system that they had to progress through in order to return to the community. As well as moving through levels of security and treatment in different units the four male participants also described progression through the different wards here. All the participants thought the next step for them would be to go to a community based hostel.

> *I'm going here first right then I'm getting discharged to Y.* (Danny, 1, p1)

> *When I leave here they won't want me to go straight to a flat they want me to go to a hostel.* (Chris, 2, p8)

There was a theme for all participants of being passive as they moved forwards or backwards within this system based on clinicians' decisions, and that things were done to them rather than with them. All of the participants spoke about others people making decisions for them. Four of the participants felt they had little influence in the decision making process.

> *Like you have to come and wait then to see what they've got decided and they all make their minds up and then they come and tell you afterwards, so you go back in the room and they tell you.* (Chris, 2, p13)

> *(re tribunals) They're too intimidating. Someone who's sat there who decides what you do for the rest of your life. They decide what happens for the rest of your life..... Cos they decide and they're frightening.* (Sharon 1, p14)

Joan, Imran and Sharon spoke about trying to not get their hopes up because they had little control over whether something would happen or not.

> *I try not to think of what places will be like, just get thrown in and get it over and done with and take it from there.* (Sharon, 1, p8)

3.7.2. Being frustrated about being prevented from doing things

Four people spoke about being frustrated about experiencing restrictions or at having to wait indefinitely and being helpless to speed things up.

> *One time when I applied for leave from the home office and that took half a year for just answering back.* (Chris, 2, p11)

> *You get stressed. You're not allowed to do things.* (Martin, 1, p1)

3.7.3. Feeling compelled to comply with others decisions

All of the participants spoke about feeling that they had to comply with clinicians' decisions because they were worried that if they did not it would affect their treatment negatively, and their length of admission.

I can complain but I just want to get discharged from this place. (Danny, 1, p1)

No. I didn't agree with it but I didn't have much choice. (Joan, 1, p1)

Joan spoke about having to take medication even though it had negative side effects for her such as her *passing out* and feeling like *death warmed up.*

They increased it. They increased it. Not so happy but the stuff I'm on is better than what I was on before. They decide. I don't think I need any medication at all. (Joan, 1, p3)

Danny and Chris spoke about having become accustomed to the unit, and having learned to accept it over time.

(When I first came here) overwhelmed..... I used to find it dead closed in, but now I'm more used to it. (Danny, 2, p 1)

3.7.4. Constantly feeling assessed

Chris, Martin and Danny described being asked lots of questions and feeling that staff members were assessing their mental state, and their behaviour constantly.

(re the Dr) *how I am, how I'm doing, and am I doing alright, am I getting on with the patients, how are you getting on with staff, how are your home leaves going. He asks me all that stuff.* (Martin, 2, p8)

3.8 Experiencing life as having been interrupted

This section refers to participants feeling that they are separate to the community and also feeling that their lives have been placed on hold by being on the unit.

3.8.1. Being separate to life outside

All of the participants spoke about being separate to '*the real world.*' Examples were given of differences between the service and '*the real world*'.

(Re separate male and female units) *I think it's unrealistic, because there's not just women in the real world. How are people going to cope from leaving a women's environment to go and live in the real world. It's not going to work. It's unrealistic.* (Sharon, 1, p10)

Instead of giving people drugs they should be made to work for their food. If you want to eat you've got to work for it because that's the way it is in the real world. (Joan, 1, p14)

Four participants described their life as having been interrupted or put on hold, and wanting to return to these lives. Imran spoke about having to learn to fit in again because he had been away from his life for so long.

I want to go back to my normal self, reality. I want to go back to what I call myself, back to my home. (Martin, 1, p3)

I think everyone gets upset sometimes because they just want to get out and carry on with their life and stuff. (Chris, 2, p9)

It's been a long time since I went out in the community, so I'll have to get used to it when I go out. (Imran, 2, p3)

However, Sharon spoke about always having been in units and this being her life. She described feeling scared about leaving what she saw as her home, to have to learn to try and fit in the community and risk being rejected. Danny reflected that he wanted to join the *social world* and that he had not been part of this previously.

3.8.2 Missing out on family, friends and activities

Five of the participants described feeling they were missing out on parts of their lives such as events and relationships by being on the unit and not in the community.

You get to do more things outside. (Martin, 1, p2)

(re friends) *been a few years. Big things had happened.* (Imran, 1, p10)

I miss my nephews and nieces, yeah I do. (Imran, 1, p6)

There was a sense of life beginning on discharge and having to wait until discharge for the things that were important to them. Imran spoke about not being able to get married whilst he remains on a section, as he is unable to go abroad for the ceremony (Imran, 1, p11). Chris said in the future he might '*go out for a date*' (Chris, 1, p3).

3.8.3. Hoping to return to their lives

All of the participants spoke about returning to their lives after leaving here except Sharon. Joan and Chris spoke about returning to being the same as before. For Danny, Martin and Imran it seemed as if they felt they would return to their lives but that these would be improved either because they had additional skills or because they would be more accepted.

3.9. Finding it meaningless here

In this section participants spoke about feeling that the things that mattered to them happened off the unit. They reported doing similar things on the unit and off the unit,

which suggested that meaning did not come solely from their activities but also came from factors such as interaction with people they valued.

3.9.1. Feeling bored and trying to pass the time

Four participants described feeling bored on the unit and doing activities to try to fill the time. Sharon stated that the activities on the unit were *babyish*.

> *It's a hospital, all you do is eat, sleep, drink and washing, there's no activity. You get bored.* (Martin, 1, p2)

> *Well it can be very frustrating, there's nothing much to do.* (Joan, 1, p1)

3.9.2. Meaningful things happen off the unit

There was a theme for all the participants of meaningful things happening off the unit, and feeling happy or excited about going on leave outside the unit. This excitement seemed as if it was linked to being with friends or family rather than the type of activity. When participants spoke about being on leave they spoke about the activities they did with others, or being with other people.

> *I go out on leave a few times a week to my gran's or my mum's. I've other leave. Sometimes I go to see my mates.* (Chris, 1, p1)

> *I play PlayStation and games with my nephews and nieces. Then I chat to my mum, find out what they've been up to and that.* (Imran, 1, p6)

Joan and Martin spoke about not being able to do the things that make them feel worthwhile on the unit. For Joan this was not being able to have a job or do physical exercise and therefore not feeling independent or strong. For Martin it was not being able to do things for other people to make him feel wanted or valued.

3.9.3. Trying to increase time off the unit

Three of the participants spoke about trying to increase their time off the unit, and five of the participants spoke about being eager to be discharged. Joan and Imran stated that the happiest they had felt on the unit was on hearing they may be discharged.

> *Well I think I'm getting there. I don't think I'll be here much longer. That's what a nurse said after the ward round. 'you're on the way out', I thought 'wahey'* (cheered). (Joan, 2, p1)

> *Well the happiest time I had was when I went to my tribunal and they discharged me.* (Imran, 2, p1)

3.10. Valuing positive experiences with other people

All of the participants reported having had positive experiences with staff or other service users on the unit, and that these were important to them. These experiences identified themes of companionship, having someone to talk to, feeling protected, being helped, and feeling cared for. Imran attributed the positive changes that he saw in himself as being related to the support he had received from staff, and said that he had always felt he could go to them.

> *The staff they're always there for you if you have any problems, you can really talk to them, anything at all they're always there for you.* (Imran, 1, p1)

Danny and Sharon spoke about companionship having helped them to adjust to being on the unit and feel less lonely. Sharon said *I got to know personalities, got to know them, so I didn't feel so much alone.* (Sharon, 1, p9)

3.11 Individual Themes re Experience

In addition to group themes, themes were identified that were specific to individuals. Imran and Martin both spoke about a theme of moving towards recovery which included sub themes of: experiencing positive changes in oneself including feeling better; building skills; seeking and accepting help; feeling more in control of oneself and wanting change to happen; and taking some responsibility for change.

> *I was really, really poorly, I was very poorly. But nowadays I'm better and it's alright.* (Imran, 1, p12)

> *It's alright if you know how to deal with it and know how to calm down. Trying to acknowledge it and learn to manage it so it doesn't flare up. Those kind of things.* (Martin, 2, p6)

However, Joan spoke about feeling weakened, deskilled and less independent after being in hospital. She said: *You get addicted to being waited on hand and foot and you're not working up a good appetite.* (Joan, 1, p14). Joan also talked about feeling put down by staff, not being listened to and feeling disbelieved. She said: *The power goes to their heads and they talk down to you as if you're a bloody idiot* (Joan, 1, p6).

Chris described experiences related to his chronic physical illness including having to be admitted to hospital and missing out on things because of this.

3.12 Understanding of Experiences

Table 6: Table showing 'who said what' about understanding experience

Theme	Subtheme	Theme	Subtheme
Biological	• Attributing experience to illness • Admission for Recovery	*There's no reason*	• It's senseless being here • What I'm experiencing is real
Behavioural	• Punishment • Containment • Rehabilitation/ developing independence skills	*Evaluation of others sense-making*	• What I'm experiencing is real • Trying to be seen as they think other people want them to be • Having to pass tests
Interpersonal Stress	• Asylum • Respite • Admission is persecution • Skills keep me safe		

Table 6 shows the range of themes that arose for participants' understanding of their experiences. Four superordinate themes were identified to explain reason for admission and purpose for being here. A superordinate theme was also found around trying to make sense of other people's reasoning. Participants all used an illness framework to think about their experiences. Alongside the illness framework participants used a range of other, and sometimes contradictory, frameworks. For example, Joan spoke about it being senseless that she was here whilst also using explanations around illness, persecution and needing to follow rules. Each individual had their own pattern of themes (these are shown in Table 7).

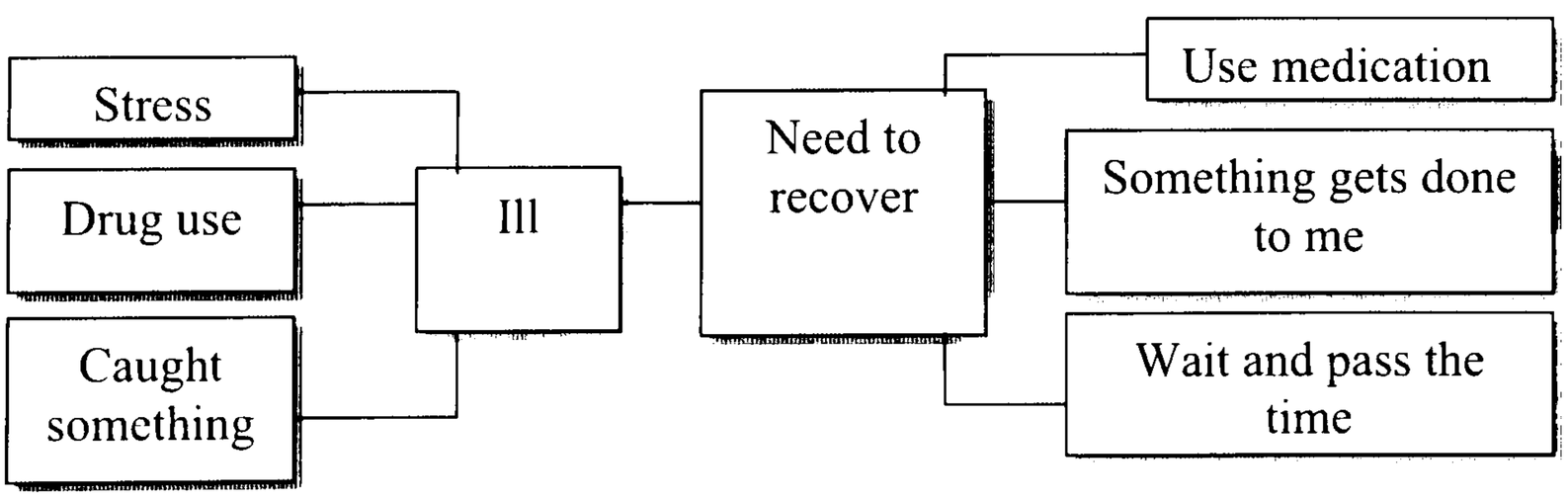
Table 7: Table showing individual patterns of themes

Subtheme	Imran	Sharon	Joan	Danny	Martin	Chris
Attributing experience to illness	*	*	*	*	*	*
Admission for Recovery	*			*		*
Asylum				*	*	
Respite					*	*
Admission is persecution			*			
Skills keep me safe	*				*	
Punishment			*	*	*	*
Containment		*		*		
Rehabilitation/developing independence skills	*			*	*	
It's senseless being here			*		*	
What I'm experiencing is real	*	*	*			
What I'm experiencing is real	*	*	*	*	*	*
Trying to be seen as they think other people want them to be			*	*	*	*
Having to pass tests			*	*	*	*

3.13 Using a Biological Framework

This framework was developed from themes around symptoms being caused by illness, or a physical response to stress or drug misuse. Participants used one or more of these explanations. Figure 1 shows the relationship participants described between their symptoms and biological factors and their beliefs as to what they needed to do for recovery.

Figure 1: Diagram showing understanding of symptoms as being an illness



3.13.1. Attributing Experience to Illness

The most commonly used framework for understanding experience was that of illness. All of the participants spoke about being ill, and identified this as a reason for their admission.

I think at first I was bit unwell when I came. Well with my mental health that's all. (Chris, 2, p2)

I am ill and I'm not 100%. (Imran 1, p5)

Within this, however, there were individual differences in the experiences participants described as illness. Imran spoke about thinking that people were able to read his thoughts. Chris and Martin described illness as not being able to do anything and them sleeping all of the time. Martin also spoke about hearing voices, as did Joan. Sharon said she was ill when she thought people were talking about her and wanted to harm her. Danny did not describe what illness meant for him.

Once or twice a week I don't feel well I keep thinking people are in my thoughts. (Imran, 1, p6)

When I was poorly I was probably having quite a lot of sleep or I'd sit in the chairs in the hallway. (Chris, 2, p3)

Participants also had different beliefs about why they were ill. Two participants spoke about drugs use as being a cause of their unusual experiences. Imran linked his illness to illegal drug use, whereas Joan said she was unwell because of the effects of coming off her prescribed medication.

Well I might have been mentally ill because I'd decided I wasn't going to take this injection up my arse anymore. So I was coming off that, coming off drugs can be harder than before you had them, it can make you worse. (Joan, 1, p13)

Other participants spoke about illness as being something they had caught or something that had been caused by stress. Two participants attributed it to both.

I had problems. I had to deal with stuff. I was unwell. (Chris, 2, p3)

Paranoid schizophrenic, an illness where it sticks in the brain,..... it's something you catch, could happen to anyone. (Martin, 2, p5)

Chris and Martin said that it was because of illness they could not do things rather than lack of ability. Attributing experience to illness therefore had a protective function, as well as being explanatory, in that it suggested that the experiences could be temporary and were not inherently part of the person.

3.13.2. Using a recovery framework

All of the participants spoke about believing they would be well in the future. They all said they were hopeful and believed change was possible. Three people linked admission

as being a medium for recovery. The other three people did not give an explanation. The three participants spoke about being given treatment such as medication to recover.

> *The doctor said that I suffer from paranoid schizophrenia and he said to go on medication, and then I got to overnight stays with my mum.* (Imran, 1, p13)

There also seemed to be a feeling that something was done to them whilst they were in hospital that made them better.

> *I feel more relaxed, more happy and talkative, you know. It's just part of being here. I don't know what does it. Just being here.* (Imran, 1, p4)

Danny also spoke about waiting for the illness to go suggesting a belief about being here to recuperate. In addition to passively receiving treatment, Imran and Martin both spoke about learning to become more in control of their feelings about their experiences. Imran also spoke about changing his behaviour. Recovery for them therefore involved some element of personal responsibility.

> *I don't want to do drugs and that. I'll stay away from people that take the drugs and that. I haven't touched drugs for about five years now.* (Imran, 1, p9)

The three participants all felt that being well meant the absence of symptoms but they also believed it would have different outcomes for each of them. For Danny it meant he would enter society and be accepted. Martin spoke about returning to a time before he was ill when life was good and having skills. Imran felt that recovery involved a return to his life but it improved because he would have things he wanted.

> *So hopefully I'm going to get over my illness and as I say one day get out and get a job.* (Imran, 2, p2)

3.14. Using an interpersonal framework

This framework centred around the belief that others are harmful. Themes included: the unit being a sanctuary for asylum from others' aggression (Martin, Danny); the unit being for respite from the stress of other people (Martin and Chris) and feeling admission was due to persecution (Joan). In this framework threat was seen to be located outside of themselves, and for Martin, Danny and Chris it was also located outside of the unit. This contradicts the theme for experience around feeling vulnerable on the unit. It may be that they feel vulnerable both on and off the unit, but that on the unit there are people they believe will protect them. Therefore the threat would not decrease but the potential for harmful consequences would be reduced on the unit.

For Martin and Danny the unit represented a place where they would be protected. Danny spoke about the service as keeping him safe from threats from people outside.

They have doors and security checks and stuff like that. Safe. No-one can get in. (Danny. 2, p6)

Martin and Chris both spoke about having felt stressed before being admitted. Martin said he had felt lonely and stressed about being devalued before coming here. In this framework admission was a break from stress before returning home when they were rested. Activities were considered to be for pleasure or reducing stress.

It's like a holiday, it's like a camp, like a resting place. (Martin, 1, p3)

In contrast Joan used a framework around being persecuted by people within the unit. She felt admission was due to racial persecution from Asian doctors because she was white. She spoke about not knowing what she had to whilst she was here and this led her to use a range of different strategies to try to ensure discharge. It was very important for her to try to be independent and strong because others were persecutory or unreliable.

(Dr X) dead set against me from the start because I'm white you know. It's always been brown doctors who put me in these sort of places. White doctors they haven't only brown doctors. (Joan, 2, p3)

Let's get her, you know what I mean .....they've got a chip on their shoulder. It's not our fault. We weren't even thought of when those things were going on. (Joan, 2, p3)

3.15 Using a Behavioural Framework

This section was developed from themes around admission being to punish, contain or change negative behaviour.

Three of the participants described their negative or aggressive behaviour as being a result of illness. Four participants felt that other people provoked their behaviour and that it was justified. Harmful behaviour was therefore seen as linking to the biological and interpersonal frameworks and participants felt they were not responsible for it.

Joan, Danny and Martin held a belief that there are rules in life to follow for the world to function and be safe, and that breaking these rules leads to negative consequences such as being punished or their behaviour needing to change either through containment or rehabilitation. This belief therefore contradicts with the belief that they were not responsible for their behaviour due to illness or provocation. They seemed to manage this conflict by minimising the extent to which they had 'broken the rules' or by

justifying it. They also seemed to move between feeling their actions were wrong and feeling that it was unfair that they were being punished.

3.15 .1. Attributing experience to being punished

Four people used a framework around being punished. Danny and Martin felt they had broken rules through their behaviour.

> *It's my fault for getting put in here. My behaviour and the consequences of my behaviour has pushed me into this place.* (Danny, 1, p1)

You just want to be in the community not stuck here, tied in the doghouse. (Martin, 1, p1)

Joan said she should not be here because she had not broken the rules but that she was still being punished.

> *They only take you if you've done something wrong. And I hadn't done anything wrong.....I just felt they were wrong. Instead I ended up here.* (Joan, 2, p8)

Chris reflected that he must be here to be punished because the unit seemed the same as prison to him and he had been there because he had committed an offence. He spoke about being here to wait until he was discharged, which suggested he felt as if he was serving time.

> *(in prison) it's just like in here, activity skills.* (Chris, 2, p3)

The four participants all spoke about having to comply on the unit because they worried they would not be discharged or that there would be negative consequences.

> *Then you get in trouble. You get told off by staff.* (Martin, 1, p10)

Martin and Joan spoke about believing observation, control and restraint and seclusion could be used punitively.

> *I've been to real rough places, you know, I mean cruel places where they really give you some stick with drugs and with physical abuse.* (Joan, 2, p12)

In addition, Martin spoke about needing to comply because people who behaved badly were sent away from the unit and would thus be vulnerable and without support.

3.15 .2. Using a containment framework

Danny and Sharon spoke about a framework based on their behaviour needing containing. They felt they were unable to manage their feelings and behaviour without help from others and indicated that they were here for to be contained, and that they were not responsible for doing this. There was a sense of them being protected from

their own risk, and that the threat of violent behaviour was from within them. Sharon spoke about self-harming when staff had been unavailable.

I needed to speak to someone and staff were too busy because they were on obs. And then I just self-harmed. (Sharon, 1, p 4)

They both mentioned experiences of staff having been helpful in containing their behaviour when they were feeling stressed and either wanted to self-harm or be aggressive to others.

I'm given support. I mean like if I'm off it there's one girl (staff) who she doesn't ask me questions. She just takes me into a room and blasts music. (Sharon, 1, p5)

Danny also spoke about staff members helping him feel more in control by making sense of things for him.

3.15 .3. Rehabilitation

Danny spoke about being here to be *processed* or *rehabilitated* in order for his behaviour to change and for him to return to the *social world*. He said he was unsure how this change would happen but felt that something would be done to him by staff.

It's a matter of me misbehaving and getting processed and pushed forward. (Danny, 1, p1)

Martin and Imran also used a rehabilitation framework but had different understandings of this. They believed part of the reason they were here was to build skills in order to promote independence. For Martin this was so he would have skills that would be of value to others and would therefore not be rejected or attacked. For Imran building skills was a way of ensuring he would be independent and not return to secure services.

My hopes, get out in the community and stay out, don't have a relapse and come back. (Imran, 2, p2)

(Re being here) *Good place for me, cos this is rehabilitation it is, it's a rehab ward. It's to help me get into the environment. To begin to do things again. It's like living skills.* (Martin, 1, p8)

However, for Martin and Danny there was also ambivalence about the need to change as they also felt that their behaviour was in response to illness or other people's behaviour.

3.16. There is no reason to be here

This had two strands: being here is senseless and my feelings are real, not part of an illness. Joan and Martin spoke about not being able to make sense of being here. For

Joan this was because she felt she had done nothing wrong and therefore had not need to change and because she believed her experiences were real.

I wanted to be out to be honest. I was so pissed off it was unbelievable. There's no reason for me to be here. (Joan, 2, p6)

Dr X thought it was all in my head, I know it wasn't in my head at all. It really happened. (Joan, 1, p12)

Martin felt that he did not need to be here because his illness was caused by stress from being in the community and that he had become well once this had been removed. He also minimised the impact of his actions.

I should be out. I'm not going to be poorly here. I'm not like it no more here. (Martin, 2, p2)

He said that the people who had caused him stress would feel bad that they had driven him to an overdose and would stop being cruel to him.

Imran, Sharon and Joan spoke about feeling what was happening to them was real.

Because I think it's true when I think these beliefs in my head. (Imran, 2, p4)

3.17. Evaluation of other people's beliefs

3.17.1. Trying to make sense of others decision making

The above frameworks all describe how the participants have made sense of their experiences. However, there was also a theme for all participants of trying to make sense of other people's decisions and frameworks and what they wanted from the participants. All of the participants spoke about the doctor as being the person who held power over them and that other professionals gave the doctor information, although three participants also referred to the Home Office.

Well it's not up to a nurse is it. It's up to a doctor, what he feels. The nurses well they tell the doctor how well I'm doing, if I'm doing well, and that gets him in the frame of mind maybe you know, out of here soon. (Joan, 2, p2)

It seemed as if it was the doctor's decisions they tried most to make sense of although there was a sense of participants trying to second-guess what all clinicians wanted.

3.17.2. Trying to be seen as they think other people want them to be

There was a belief that they needed to be seen as being well or to be behaving by the doctor in order to be discharged. Chris and Joan spoke about having to please professionals.

It's up to them whether you stay here or not. (Joan, 1, p1)

Because I can't please her, no matter what I do, there's nowt good that I do...not even when I have tried hard as well, tried hard. (Chris, 2 p11)

Themes around complying or doing what they were told were found for four participants in order to get positive evaluations. Participants spoke about telling people what they want to hear, lying or omitting information so that they would not be judged badly.

They've got a lot of power these doctors. They do have a lot of power. If you get on the wrong side of them you might as well just forget it. (Joan, 2, p2)

In his second interview Danny initially asked me to exclude information because he thought staff would disagree with his view and that he would be judged as being irresponsible. Joan spoke about trying different strategies to try to please others.

Well I don't know how to go about it (leaving) because I...I sort of try to be nice and oh sometimes it works and sometimes it doesn't. (Joan, 1, p6)

I've been honest and it hasn't got me anywhere, so what, what can I do. (Joan, 1, p2)

3.17.3. Having to pass tests

Four participants spoke about believing leave and activities are tests that they need to pass to progress through the system and move towards discharge.

*I think one of the doctors had been on about can I just go to college. If you got college and everything's fine with staff and then on my own so I can have more leave and stuff, and they trust me more when I'm going out to college. (*Chris, 2, p6)

But you get some leave and that to go out. And you come off obs and you're seen as more well so you might get more leave or come here. (Chris, 2, p5)

There was a sense of it being important to be seen to be different but that they did not necessarily believe they needed to change or that they would continue with these activities after discharge. Four participants linked the type of unit they were on to signifying how well they were and how close to discharge they were. They also spoke about the type of activity they were doing signifying progress.

And they were saying I'm a lot better so they're going to send me to a low secure and here I am. (Imran, 1, p13)

I think I got a lot better so I was sent to ward Z (Chris, 2, p2). I think when you're on this ward it's more for when you're going out...ready for when you go somewhere else. (Chris, 2, p4)

3.18. Using own and others experience to inform frameworks

This section refers to how all the themes seemed to develop from observations made by participants on their own past and current experience, and on other people's experience. Joan and Imran spoke about comparing past experience of services to this unit.

I've been places like this before. I knew before I came in what's what. (Joan, 2, p12)

you can go out (here) whenever you want, in prison you can't you have to stay in your cell 22 hours a day, just two hours association. (Imran, 1, p12)

Sharon gave an example of using her observation of another service user's leave having been restricted to inform her view that she should be careful what she tells staff.

One girl went on leave.....the following day she told them she'd had a shandy so they took her leaves off her and she still hasn't got it back and that was five weeks ago. (Sharon, 1, p6)

Beliefs about whether people are harmful or helpful also shaped understanding of experience. These beliefs were not static.

It all depends how I'm feeling. It seems really, I know it's not, but at the time it seems really people are talking about me and laughing at me behind my back, spying on me, it all depends how I'm feeling. (Sharon, 1, p5)

If I'm upset I won't talk to anyone. Because I get. I start getting the feeling they're out to get me. (Sharon, 1, p1)

3.19. Identity

Table 8: Group Themes for Identity

Theme	Subtheme	Theme	Subtheme
Character	• Morality • Attractiveness	*Affiliation*	• Similarity • Normality • Role • Belonging
Ability	• Skills • Ability to defend self		

Table 8 shows the three group themes that emerged for identity. These themes were derived from the stories people told about themselves but also from their stories about

other people. For example, when Imran spoke about having *nice, caring* friends this was interpreted as a description of others but also as indicating who he sees himself as being like. These three group themes can be seen to fall into one overarching category which has been titled seeking acceptance and safety. Participants seemed to evaluate their sense of self in polarised terms e.g. clever or good, similar or different (see table 9). All of the themes were described in this split way, except for wellness which was described as having three positions (ill, recovering, well). At times participants described their identity as featuring opposing positions e.g. I am both good and bad. However, the unwanted aspect was then rejected as not being part of them. For example, the illness aspect was acknowledged but not seen as a permanent feature of themselves.

Table 9: Table showing identity positions

Subtheme	Associated Positions
Morality	Good/bad
	Innocence: Responsible /not responsible
Attractiveness	Likeable/unlikeable
Skills	Clever/stupid
	Skilled/helpless
Ability to defend self	Weak/strong
	Able to protect self/defenceless
	Powerful/powerless
Similarity	Similar/different
	Superior/inferior
	Equal/unequal
Normality	Normal/abnormal
Role	Valued/devalued role
Belonging	Belonging/rejected

3.23. Seeking Acceptance and Safety

Participants appeared to define their identity based on their character, their level of ability and their affiliation. Their sense of their own identity appeared to come from their assessment of their relationships with other people. Underlying these themes were aims of being someone who is both accepted and safe. This can explain the emphasis on other people's judgements (that is reported in the following sections) as these aims could not be met without other people valuing their identity. It also appeared that in addition to being accepted, it was important for participants to belong with people they valued as this gave them value also. Participants spoke about having aspects of themselves that they both valued and devalued. Aspects they devalued were those devalued by other people (staff and community). They acknowledged the presence of these aspects but justified them or rejected them so that they were viewed positively by themselves and

others. Their original sense of self therefore appeared to remain intact during admission, or was improved upon e.g. through building skills, but did not incorporate devalued aspects as permanent features of self.

3.20. Character

Character comprised of themes around morality and likeability. Participants described their character as being shown by their behaviour and how they related to others, rather than referring to qualities within themselves. Participants also spoke about how others related to them. They therefore used their relationships with others to help guide their evaluations of identity.

3.20.1. Morality

Five participants spoke about 'moral' aspects of themselves. Morality, or whether they were 'good' or 'bad' people, seemed to be based on the virtue and innocence of their behaviour. Sharon and Martin seemed to consider themselves as morally good because of how they related to others. Sharon described herself as being *honest.* She and Martin also spoke about being the kind of people who help others. Martin referred to himself as *kind and generous.* Imran and Martin described aspects of themselves as bad. Imran worried he was *bad* because of the thoughts he has. He also made reference to the *serious* nature of his section and what it said about him and what he had done. Martin referred to his impulses and behaviour as having been 'bad' because of other people's responses such his family being upset or him being judged as needing to be in hospital. This therefore suggests that their view of their morality incorporates other people's perceptions of the virtue and innocence of their actions, as well as their own perceptions. They also seemed to make judgements about their behaviour based on its consequences. Whilst Martin and Imran referred to aspects of themselves as being bad, they also found ways to reject these aspects. For example, Imran related his thoughts to him being unwell rather than being typical of him. Martin minimised the impact of his behaviour. He referred to *trashing* his room as not having been *bad* because his father had not reacted strongly to it.

> *He weren't fussed anyway so it doesn't matter.* (Martin, 1, p6)

This rejection of negative behaviour was similar for all of the participants. The participants were reluctant to give details of their risky behaviour or offences. Three of the participants said they were not in control or responsible for their behaviour because of their illness. Four participants described their behaviour as a response to other's provocation or victimisation.

They provoke you. They start drawling on and you just want to get up and punch them. (Joan, 1, p16)

People do things and it winds you up. (Martin, 1, p1)

They spoke about their actions being justifiable because they were responses to people doing 'bad' things to them. Joan spoke about hitting another service user to stop her taking Joan's possessions.

I gave her a belt for it anyway, she hasn't done it again. Just a backhander across her face I gave her... I've belted her a few times as well but I won't do it again, she's changed. (Joan, 1, p8)

In the quote below Sharon referred to staff training she is involved in which staff role-play being service users. In this she minimises aggressive behaviour and refers to it as being provoked by others.

(They role-play and see) *how would they feel if their access was taken off them because they shouted at someone, something simple like that, because they're under strain.* (Sharon, 1, p11)

Therefore all of the participants described their negative behaviour in terms of them being innocent because they were either not responsible for their actions or that their actions were necessary. They therefore identified themselves as either 'innocent but unwell' or 'innocent and attacked' or both. This can be understood as seeing themselves as intrinsically good people whose negative behaviour was not typical of them or was just. It also shows moral relativism in that their actions were seen as moral or immoral depending on the context.

3.20. 2. Attractiveness

This referred to whether participants perceived themselves as being likeable or not. Four participants referred to likeable aspects of themselves. Imran and Martin described themselves as *nice*. Joan referred positively to her *sense of humour*.

Only Martin spoke about not having liked himself at times. He spoke about feeling like this because he was not able to do things and was lonely.

I were run down and tired and fed up with myself. (Martin, 1, p5)

All of the participants spoke about other people's views of them. Danny, Imran and Chris spoke about other people liking them because they were friendly, supportive or did

similar activities. Imran spoke about service users who liked him and said he spent time with them:

Just talking and being friendly with them, just laughing and joking, talk, listen to what they have to say if they've got any problems you know. (Imran, 2, p7)

They therefore identified themselves as being people who others found to be attractive and who they would want spend time with. It seemed important for them to be people who could get on with other people and be liked. This may have been due to factors such as a need for company, value derived from others seeing them positively or because they would be safer if they had friends. Joan spoke about being in a restricted environment and not wanting arguments.

Most of my time is spent with service users, because you're living together you've got to get on. (Joan, 1, p7)

Joan, Imran and Martin referred to being disliked by others, and feeling that this put them at risk.

I think they think I'm a little scary, they don't like me. They don't like the way she speaks. Let's get her……It's true. It can do a lot of harm. (Joan, 2, p3)

Participants therefore considered their identity in relation to how likeable they were. This seemed to link to feeling that if they were likeable they would be accepted and also that they would be less at risk.

3.21. Ability

All of the participants spoke about aspects of their ability. Aspects included: physical ability; cognitive ability; practical skills; ability to defend oneself and independence. Their assessment of their ability appeared to be focused around how vulnerable they were to other people.

3.21. 1. Skills

All of the participants spoke about not being able to accomplish tasks or having limited skills. Joan spoke about not being able to do activities she had once enjoyed. She attributed this to medication and spoke about a time when she had stopped taking medication and people had commented favourably on her having improved. Chris and Martin spoke about illness affecting their ability to do tasks and activities, and that they were more able to do these as their illness improved.

I hadn't been so good, been weak, not so clever……I can do things now. (Martin, 1, p4)

Sharon and Danny spoke about not being in control of themselves. All of the participants spoke about needing help from others, indicating they saw themselves as helpless at times but also as being people who could be helped. Martin said: *I can't do much… I need help.* (Martin, 1, p2)

Five participants described aspects of themselves showing them as able and independent, or moving towards this. There was a sense that they felt that they could protect themselves by being of value to others and by not having to rely on others. Sharon said she was able to *fend for herself.* Imran and Martin spoke about developing skills. Imran spoke about developing skills so he did not have to return to secure units. Being someone whom had practical ability therefore meant he would not be somewhere he saw as unsafe and he would not be helpless. Martin spoke about not being clever and indicated that this made him vulnerable to others' aggression and exploitation.

*They pick on me, yeah. Would do anyway cos I'm slow***.** (Martin, 2, p4)

He had developed a positive identity around doing things for others so that he would be wanted or needed, allowing him to be safe.

When I visit home, all I do is build sheds, DIY, playing, help to make drinks……All I've wanted that they need me, do things to the house, do things. (Martin, 2, p3)

Therefore participants reported having strengths and weaknesses, and their evaluation of their ability helped to shape their identity. Weaknesses that were reported were aspects that could change. For example, they could become more skilled with others' help or as their illness passed. Ability determined how vulnerable they saw themselves as being and their value to others.

3.21. 2. Ability to defend self

Five of the participants spoke about their ability to defend themselves from other people's provocation or aggression. Imran and Martin spoke about being people who others were aggressive towards, and them being unable to defend themselves. Martin also described himself as someone who is exploited by others.

Don't like being used for things… a lot of them get cigarettes off me. (Martin 1, p10)

When discussing their experiences all of the participants spoke about feeling that they were passive as things were done to them and being powerless to change this.

However, Joan, Danny and Sharon spoke about being able to defend themselves.

Danny talked about not being able to be physically aggressive on the unit, but having found other ways to retaliate to other people provoking him such as him winding people up.

There's other ways to wind people up without punching them. (Danny, 2, p2)

This suggested that he felt that others would not then provoke him because this would be unpleasant for them or because they would be punished for responding aggressively. He therefore saw himself as being able to defend himself. Joan described herself as being a strong person who could protect herself. She identified with Xena the Warrior Princess. Joan described a situation where she had intimidated a policeman.

He was next to this car and he had this grin on his face and I just looked at him and the grin dropped……good. (Joan, 2, p4)

However she also felt that medication had weakened her and made her vulnerable. She spoke about medication affecting her memory, her ability to think clearly, and her ability to do things. She also spoke about becoming physically weakened on the unit due to a lack of exercise and work.

I find my brain's dead. Brain dead. (Joan, 2, p11)

Therefore participants described conflicting aspects of identity such as being vulnerable and helpless but also being able to be independent and protect themselves. Their ability seemed to determine whether they incorporated being 'helpless' and a 'victim' or being 'capable' and a 'defender' into their identity. Power was also linked to this.

3.22. Affiliation

All of the participants used comparisons between themselves and others to determine who they were like, their value to others, and where they belonged.

Normality

Joan, Imran, Martin and Chris defined themselves in terms of whether they were 'normal'. Chris, Imran and Martin felt that their illness had affected them but that this was temporary and that they were quintessentially well people who would return to their normal lives.

I was very poorly. But nowadays I'm better…I'm going to get over my illness and get out, get a job again you know. (Imran, 2, p2)

They spoke about doing *normal* activities, having a *normal life* outside of the unit and having the same hopes as other people.

Married, kids, job... That's what I'd like, yeah. (Imran, 1, p11)

I was just like doing the normal things you would do. Just the things I like to do watch TV and stuff. (Chris, 2, p1)

Joan also defined herself in terms of normality but for her it was about not having felt normal for some time due to her admission.

*I can't remember what it's like to be normal. (*Joan, 1, p4)

3.22. 1. Similarity

Participants described themselves in relation to whether they were similar or dissimilar to other people. All of the participants spoke about liking people who were similar to them. Danny, Chris, Imran and Martin described themselves as being similar to their family and friends.

We're similar to tell you the truth. I like to have good fun when I get out; go for a drink, nightclub, and they like that as well. They like to go out, they're active. (Imran, 1, p9)

Joan spoke about liking staff members who had a good sense of humour. This was a characteristic she had identified in herself. Sharon spoke about being similar to some 'patients' and being friends with them because they liked similar things.

Well they're on the same wavelength. I get on with everyone, but I get on with a few better than others..... Same interests. (Sharon, 1, p3)

All of the other participants rejected the idea of being like other service users. They described other service users as being ill, out of control and aggressive.

There's some odd stupid people here. (Danny, 2, p2)

They act about stupid, wild. They're just wasting their lives in here doing fuck all, being just a patient, just causing trouble and kicking off, they kick off. (Martin, 2, p5)

I don't say horrible things to anybody but some patients do, you know what I mean. (Joan, 1, p5)

Four participants spoke about having friends on the unit but these relationships were with people they considered to be like them (and therefore not like other service users) or people they spent time with until they could return to their 'real' friends.

Yeah, some people I prefer to others as well, yeah. Nice people, I don't think there's much wrong with them to tell the truth. (Imran, 1, p2)

Joan, Danny and Martin referred to themselves as being superior to other service users.

I know I shouldn't but if someone winds me up I feel like I could punch them but then I'd be as bad as them. I'm not like that. (Danny, 2. p2)

They wouldn't be in my house all them lot. They make a mess and...unhygienic. They're not clean enough and that. (Martin, 1, p3)

All of the participants made a distinction between themselves and staff members in terms of role. Four participants also noted a difference in territory and commented on staff being in the office rather than on the ward with patients. They did not speak about how they saw their value in relation to staff.

Participants used comparisons with others to determine their own value. They identified with people they saw as being similar to themselves. These tended to be people they valued and they rejected the idea of being similar to people who they viewed negatively. Relationships were not built solely on the basis of others accepting them as they also included an assessment of own and others' value.

3.22. 2. Role

All of the participants defined themselves and others through roles. They mostly referred to staff members' professions when describing them.

All my doctors, my social workers, my main nurse is there sometimes, some of my main nurses are there, and some students and nursing staff. (Chris, 1, p4)

They all spoke about having a devalued role as a patient.

People here are patients. The problem is if they call you patient they start treating you like spanners. (Danny, 1, p5)

All of the participants said they were *patients*, but for five people this role was seen as a temporary one that had been allocated to them by other people. This may link to their beliefs about their symptoms as an illness they have caught and will recover from, and therefore seeing illness as not being part of who they are.

This Indian doctor decided that I was mentally ill. (Joan, 1, p11)

The doctor said that I suffer from paranoid schizophrenia. (Imran, 1, p13)

Only Sharon identified with being a patient, and she had built a positive identity around this. Whilst she described herself as having an illness her focus was on the value that the patient role allowed her to have such as deriving power and self-esteem from her role as a service user representative and being someone who helps others.

We all have a meeting once a fortnight and then it's all brought back to me and then I take it to these forums. (Sharon, 1, p12)

Well I'm a service user rep, go to all the meetings and that all over the place, with X fighting for patients rights. (Sharon, 1, p11)

Four participants perceived their main role as being a family member. This was a valued role that they had built into their identity. Danny and Martin spoke about being a son. Chris described himself as a grandson. Imran spoke about being a son, a sibling and an uncle. Joan valued her role as someone who worked, although this was on hold. Imran also described himself as someone who had worked and would work again. Sharon, Chris, Danny and Imran also described having a role of being a friend, and therefore identified themselves as being valued. Participants therefore saw themselves having a range of roles. However, they only incorporated some of these roles into their identity.

3.22. 3. Belonging

All of the participants except Sharon spoke about belonging outside of hospital. Chris, Imran and Martin described themselves belonging in the community. Sharon indicated that she felt she belonged in hospital, and spoke about having been in inpatient units since she was young. She described feeling distressed when she had to move units as she regarded them as her home. She talked about arguing against her section being lifted because she wanted to stay on the unit and being worried about being rejected by people in the community.

I was worried if, if they didn't like me, if they didn't want to know me because of my illness. (Sharon, 1, p13)

Joan and Danny spoke about not knowing where they belong, because they are being different to other people. Danny spoke about wanting to enter the community and having been sent away because of his behaviour. He therefore identified with the negative appraisal from others and felt he had to change or hide parts of himself to be acceptable. Joan alternated between feeling rejected because she was different and superior or because she was inferior.

She spoke about herself as being someone who had been in prison and who was rejected for this.

Can't even go to New Zealand cos they don't take ex-cons. I can go on a holiday but I couldn't stay there..... they won't let me go live there. (Joan, 2, p11)

However, she also rejected the idea of her being inferior and other people's negative judgments of her.

Well I know I'm perfect No I know I'm better than what they think I am. As long as you know it you don't have to prove it. (Joan, 1, p15)

Participants considered their identity in terms of whether they belonged and if do who with. The places and people participants described themselves as belonging with were those they valued and that gave them value, and which accepted them.

3.24. Summary of Results

3.24. 1. Experience

- Group and individual themes were identified.
- Participants were able to describe both positive and negative experiences.
- Positive experiences included themes around companionship, belonging, being helped and feeling protected.
- Negative experiences included themes around feeling vulnerable, feeling helpless or powerless and not belonging where they are.
- The majority of the themes for experience were related to interaction with others.
- Participants were on different wards and at different stages but identified similar themes.

3.24. 2. Understanding experience

- Illness and punishment were the most commonly mentioned ways of understanding experience.
- All participants used a range of frameworks (between 5 and 8 frameworks were identified).
- No-one had the same pattern of frameworks.
- Some frameworks had different meanings for people.
- The frameworks individuals described were contradictory at times e.g. 'I'm ill' and 'what I'm feeling is real'.
- The majority of frameworks involved passivity rather than taking an active role.
- All of the frameworks located difficulties outside of the person except illness and containment, which were both seen as atypical of the person and temporary.
- The frameworks could be used to suggest that the difficulties they were experiencing were temporary or were not their responsibility, and how the framework was understood has impact on how participants perceive their role and that of others.

- All of the participants were trying to make sense of clinicians' understandings, and there was a theme of needing to be seen positively by others and pass tests to be discharged.

3.24. 3. Identity

- Participants reported having opposing features of identity such as being both helpless and skilled.
- They saw themselves as victims or defenders rather than as perpetrators. They accepted a patient role but saw this as temporary.
- Participants defended themselves from incorporating unwanted features into their identity by minimising them, rejecting them or viewing them as temporary. They also justified their acts so that they were no longer seen as negative. This meant that their original identity remained intact or was only added to positively.
- The view of unwanted aspects as being temporary may also show hope for recovery and the belief that they can change.
- Aspects of identity were seen as dynamic and interconnected.
- Identity was shaped by comparisons to other people, and their past and future selves.
- They used their own view of themselves and others to define their identity but also used other people's views of them.
- Positive identity appeared to come from the approval of powerful or valued others, and their ability to protect themselves.
- The aspects of self that they spoke about only show value in relation to others rather, than being valuable on their own.
- Being valuable to others was seen as important for acceptance and safety.
- They saw themselves as having a variety of roles but only some of these were integrated into their identity.
- All of the participants had used an illness framework to understand their experiences. However, only Chris incorporated illness into his identity as a permanent feature. The other participants considered illness in terms of how it affected their responsibility for their behaviour or how vulnerable it made them to others.

CHAPTER FOUR: DISCUSSION

In this chapter the main findings and implications of the research are discussed in relation to the current evidence base, and in relation to the three previously outlined psychological theories: social identity theory; social representation theory; and symbolic interaction. Consideration has been given to the strengths and limitations of the study, and the significance of the study's findings to the research aims has been reviewed. Recommendations for further research have been made.

4.1. Main Findings and Implications

4.2. Experiences

This study found group themes of: feeling vulnerable, feeling powerless, experiencing life as having been interrupted, experiencing life on the unit as being meaningless, and valuing positive experiences with staff and some other service users.

4.2.1. Feeling vulnerable

Participants spoke about feeling frightened of their internal experiences, which they labelled as illness and being something that they wanted expunged. In addition to causing distress these frightening internal experiences can lead to feelings of hopelessness or to the development of negative beliefs about self-efficacy (Mancini, 2007). In this study distress from internal experience led to participants feeling vulnerable in relation to threat from within the person and to threats from other people.

Other research has also reported that service users can feel unsafe in secure units (Halsall, 2006, Godin and Davies, 2005), and there is a risk of witnessing violence or being assaulted in mental health settings: a recent review of mental health trusts in England reported that 45% of nurses and 15% of patients had been assaulted in the last year (Health Care Commission, 2008). Being exposed to violence can undermine the therapeutic environment and can lead to post-traumatic stress reactions (Benson, Secker, and Balfe, 2003), social withdrawal and interpersonal distrust (Haney, 2001). Attention needs to be paid to finding ways to help service users feel safer (from others and from themselves through the building of coping strategies) to enhance quality of life and psychological well-being, but also to allow development. The hierarchy of need model (Maslow, 1987) suggests that for self-actualisation to take place other needs must be first satisfied including safety. In this study service users appeared to be striving for

safety and belonging, which would then make it difficult for them to focus on development and change.

Mistrust of others has also been reported elsewhere in forensic mental health settings (MacInnes, 2005; Halsall, 2006). Feeling unsafe, ineffective communication and lack of trust have been described as barriers to recovery (Gilbert, Rose and Slade, 2008). Mistrust can affect willingness to engage in treatment, disclosure of difficulties and help-seeking (Gudjonssen, Young and Yates, 2007). This has implications for risk management and recovery. Mistrust was linked by participants in this study to being ill and to past experiences with others. It is therefore important to spend time with service users to build relationships, and to promote the belief that people can help with their problems by being reliable and available.

Within this study there was a theme of ambivalence, in that service users needed others or wanted to spend time with them but were also worried about trusting them. Other studies have reported positive and negative experiences of staff (MacInnes, 2005; Katsakou and Priebe, 2007) but have not noted themes around ambivalence. This ambivalence may make the person unsure whether to engage with treatment or trust them. However, it also shows an interest in being with others and having positive relationships, and therefore has implications for engagement with professionals and services.

4.2.2. Feeling powerless

Themes were reported around being passive, feeling frustrated by restrictions, and feeling constantly assessed. Participants reported compliance with intervention in order to be discharged, rather than being coerced. This compliance has implications for future behaviour as the need for change may not have been internalised and may only persist whilst behaviour is under surveillance. These themes have been found in other forensic settings. For example, studies in medium secure units have reported feelings of powerlessness (MacInnes, 2005; Godin and Davies, 2005). MacInnes (2005) found that service users spoke about decisions being made without them. Service users have reported feeling assessed and under pressure to perform well to enable discharge (Godin and Davies, 2005).

Powerlessness has been linked to mental health problems such as self-injury, and depression (Proctor, 2002) and can affect hope (Geiger and Fischer, 2005). Gudjonssen, Young and Yates (2007) stated that feeling discouraged or unfairly treated can lead to

resentment and a lack of co-operation, and can hinder treatment motivation and therapeutic engagement. There is a need to promote empowerment including acquiring a sense of perceived agency, control and self esteem (Linhorst, 2006) for the future as in the community service users will need to be autonomous and to have the confidence to be able to make decisions whilst taking responsibility for them and having the competence to carry them out. Participants in this study described themselves as needing help from others. If they do not feel empowered or develop resources this may lead to negative therapeutic reactions in which people appear to be recovering but then deteriorate because improvement can lead to support being withdrawn (Bateman and Holmes, 2005). This appears to have happened for Sharon who self-harmed following discharge planning. She spoke about feeling supported on the unit but not being confident she could cope on her own.

This sense of empowerment needs to be in relation to self as well as others. Participants in this study felt out of control and unable to achieve tasks due to illness, and this has been found elsewhere. Connor and Wilson (2006) reported that mental health service users from other settings often felt they had lost control of their life due to their mental illness. A forensic service can aid service users move towards empowerment through offering collaborative interventions that allow a person to be informed about treatment, to have involvement in decisions or an understanding of why they have been made, support in learning how to recognise symptoms and the development of coping strategies (Mancini, 2007). Service users should also be encouraged to take personal responsibility to manage their internal experiences and their recovery (Ridgway, 2001). In this study only two participants reported having any responsibility for their recovery, and these participants reported that being able to use strategies to manage their internal experiences meant they felt less frightened of them and more able to embrace new challenges because they were no longer feeling overwhelmed by their distress. Psychosocial interventions can be used to help service users to feel more in control of the internal experiences. Mueser, Corrigan, Hilton, Tanzman, Schaub, et al (2002) found that a structured psycho-education programme was able to help service users manage their own conditions and resulted in better symptom management and lower rates of relapse. Coping strategy enhancement within a CBT approach has been shown to be helpful in reducing anxiety and delusions for service users with psychosis (Tarrier, Harwood, Yusopoff, Beckett, Baker, et al 1993). Self-help is also important in recovery; in Cohen's study (2005) on recovery 94% of the participants said they had used self-help strategies.

4.2.3. Experiencing life on the unit as being meaningless

Experiences of boredom have been reported in several studies in forensic mental health settings (Morrison, Burnard and Philips, 1996; Halsall, 2006). Farnworth, Nikitin, and Fossey (2004) commented on service users' time being spent sleeping or in passive leisure. Their participants reported trying to pass time and dissatisfaction with how time was spent. This was also reported by service users in this study. This study also reported finding activities meaningless as well as boring. This may impede recovery as meaningful occupation is a key aspect in recovery (Ridgway, 2001; Mancini, 2007). It also has implications for risk as purpose in life, and reasons for living can mediate the relationship between stressful life events and suicidal behaviours (Wang, Lightsey, Pietruszka, Uruk and Wells, 2007). There is therefore a need for services to try to introduce meaningful activities and these could help service users to learn new skills leading to increased confidence in themselves and enhancing their self concept and belief in self-efficacy. The development of positive self-efficacy beliefs can positively influence future motivation, persistence and competence (Mancini, 2007). Strong (1998) conducted a study with twelve people with mental illness to explore recovery, and concluded that meaningful work linked to getting on with life, finding a place in the world and becoming a capable person. In this study there were overall themes for identity of wanting to feeling accepted and feeling safe by people who were valued by the participants. This suggests meaning may be associated with activities that help service users to feel valued or have a sense of belonging, such as jobs or opportunities to build skills which will be of worth when they are in the community. Joan and Imran reported that paid jobs were important to them, whereas Martin focused on having valuable practical skills. Chris spoke about doing an art course at college but wanting to be able to learn to drive or take an information technology course. Having positive relationships was also meaningful for them, and this is described in more detail in the following section.

4.2.4. Valuing positive experiences with other people

Valuing contact with staff members has been reported in medium secure units (Carlin, Gudjonssson, and Yates, 2005; Halsall, 2006). Baker (2003) found that service users reported positive experiences with staff in a low secure psychiatric setting. Positive relationships can provide security, understanding, and confirmation, allowing service users support to develop (Horberg, Brunt and Axelsson, 2004). In intervention, the therapeutic alliance is considered to be the central process factor in psychotherapy (Gaston 1990) and can affect outcome. Hellerstein, Rosenthal, Pinsker, Samstag, Muran,

et al (2001) found stable and high levels of alliance in good outcome cases and more variability in poor-outcome cases. In this study participants reported experiences of feeling cared for and being supported by staff, and experiencing companionship with staff members and service users. Positive experiences fell into two categories: interactions that meant they were not left vulnerable or in need (such as protection or help) and interactions which affirmed a positive identity (such as friendship) and were enjoyable. These service users therefore placed value on both relationships with staff and practical support from them. Service users in other studies have stated that relationships are more important than specific interventions (Macinnes, 2005; Mancini, 2007). These findings suggest the need for staff to spend social time with service users, in addition to meeting for care-planning and interventions. However, the opportunities for staff to be able to do this may be restricted by other demands on them. In this study service users reported having positive experiences but also that nurses spent a lot of time in the office and that they had to seek them out, or that they were on observations and were not always accessible.

4.2.5. Additional themes derived from this study

The above sections described the themes from this study that have been found in common with other forensic mental health settings. However, additional themes arose which have been not been reported in either medium or high secure units, such as the themes of being passively moved though a system, and viewing the service as only being one part of a wider system. Other studies have reported positive and negative interactions but have not discussed ambivalence about interaction. The theme of life having been interrupted has not been reported elsewhere in forensic mental health research. Participants in this study reported a view of returning to a life that was the same as before or that was similar with some improvements in their ability to be independent. This raises questions as to whether service users associate their previous lifestyle with their mental illness and whether they see a need to change this so as to avoid future difficulties. They may be approaching discharge naively, in that they may be assuming that everything will be as it was, or that there will be no problems for them. Participants reported being separate to the community and missing out on important life events. This may be detrimental to service users' relationships and may impact on their progress, as social support is linked to recovery (Cohen, 2005). Jewkes (2006) reported that prisoners report life course interruption, and that the failure to experience certain life events such as marriage can negatively affect identity as can loss of employment. She also found that prisoners reported feeling they existed in the wrong time following lengthy imprisonments and felt they belonged to a younger generation than people their

same age. Admission to forensic mental health units is aimed at managing risk, stabilising mental illness and moving towards recovery. However the length of time service users spend in units may be destabilising because of the impact on support systems, sense of belonging and identity.

4.2.6. Which themes were not reported in this study?

Some themes did not emerge that might have been predicted based on the findings of studies previously conducted in forensic mental health settings and with people with severe and enduring mental illnesses. Loss has been reported as a major theme following hospitalisation (Katsakou and Priebe, 2007) but this was not reported in this study, possibly because of the view that life was on hold but would be returned to. Studies have also explored coercion (McKenna, Simpson and Coverdale, 2003) in forensic units but this was not a theme that emerged in this research. Other studies have noted negative experiences around C&R and seclusion (Sequeira and Halstead, 2002). This was mentioned by two participants but was not a group theme. Instead, a group theme emerged of feeling safer because staff used C&R and other strategies to manage frightening situations. This difference may be due to service users in this study viewing restraint as being for people who were aggressive and therefore something they saw as not applying to themselves. Another aspect reported in the literature is that of bullying (Ireland, 2004). Participants in this study did not report being bullied by others although this may have been incorporated within the theme around fear and mistrust of others for them. However, it may be that they did not experience aggression as bullying, or did not wish to be seen as people who are bullied. Participants linked aggression to a person's illness. One can speculate that if aggression was experienced as bullying, this understanding may change to seeing the person's behaviour as being deliberately targeted at some undesirable aspect of self, and thus would be very threatening to identity. This study did not find experiences of guilt or shame as found in the study by Halsall (2006). Stigma was also not reported as a group theme. Feeling stigmatised has been widely reported across mental health populations (Godin and Davies, 2005; Rice, 2006). Frustration was reported in this study but anger and hostility were not. This is surprising as two participants reported feeling that admission was unfair. It is possible that they were concerned about the effects of disclosing anger.

Being institutionalised was not a theme. This might have been expected due to the length of time participants had spent in mental health services, and their reports of feeling powerless. Barton (1966) described signs of institutionalisation including apathy, loss of interest especially in things that are not present, lack of interest in the future, loss of

individuality and resigned acceptance. Participants in this study did not show any of these signs. All but one of the participants were keen to leave the setting, and they were all very focused on the future. It may be that service users are hopeful that being in a low secure unit suggests that they are near to leaving the forensic system, and that the emphasis on the transition into the community counteracts institutionalisation.

It could be surmised that the level of leave available in a low secure unit could allow access to drugs and alcohol, but surprisingly only two participants mentioned misuse of substances and neither reported this in relation to their current situation. Substance misuse has been reported in the forensic mental health literature as being common (Isherwood and Brooke, 2001; Scott, Whyte, Burnett, Hawley and Maden, 2004), and service users in the study by Halsall (2006) stated that substance misuse by other service users was a major reason why they felt unsafe. It is possible that service users were reluctant to discuss attitudes towards drugs and alcohol in case these were shared with the service. Joan mentioned the possibility of her using marijuana in the future and immediately made reference to the interview being recorded; she then changed the subject.

4.2.7. Summary

The findings from this study have both similarities to and differences from findings in earlier studies. Different levels of security may mean that people undergo different experiences in forensic mental health services, or that experiences are given different meanings and importance across settings. The differences may also be due to variation in how the data was collected. The aim of this study was to explore the experiences the participants spoke about as being important. Other studies have preselected specific areas of experience to investigate. However, this study suggests that it is possible that some comparisons may be made between studies undertaken in different levels of security. New themes have also emerged to those found in earlier studies of medium and high secure forensic mental health services such as viewing life as being interrupted. Further research needs to be conducted before it can be clarified whether these themes are specific to these participants or whether they are relevant to service users in other secure settings. It has previously been suggested that service users may have low expectations of services or may feel anxious about criticising services (Baker, 2003). This study shows that service users are able to report critical opinions about services and distressing experiences.

4.3. Understanding of Experiences

Four frameworks for making sense of experience were identified: biological, behavioural, interpersonal and there being no reason for admission. These frameworks each contained an understanding of why their experiences had arisen, the purpose of admission and what was needed from the service user. Illness and punishment were the most commonly mentioned themes. An additional theme was found of trying to make sense of others' thinking.

4.3.1. How do these findings relate to previous research?

Some frameworks have emerged during semi-structured interviews in forensic mental health research but these have not been the main focus of the research and it is unknown if other frameworks were also used. These frameworks are similar to some of the themes found in this study. Service users have reported using frameworks of illness, and of punishment for rule breaking in studies conducted in other levels of security (Hinsby and Baker, 2004; MacInnes, 2005; Halsall, 2006). In Hinsby and Baker's study punishment was linked to restraint and seclusion. Two service users spoke about this, but it was not a group theme. Instead, in this study punishment was linked to life being interrupted and being away from their 'normal' lives. It could be speculated that being away from the people and activities that they viewed as being meaningful was experienced as punishing. The studies in forensic mental health settings did not report the themes of asylum, and independence and skills building that were reported in this study. Studies examining forensic staff members' perceptions have reported therapy and security frameworks and their concerns that these can be conflicting (McFadyen, 1999; Mason, 2002).

Themes from this study have been reported in other settings. Biological and interpersonal stress frameworks have been reported in studies with people with psychosis (Angermeyer and Klusman, 1988). Koivisto, Janhoven, and Vaisenen (2004) found that service users with psychosis in a psychiatric unit concluded that care should protect them and empower them. Goodwin, Holmes, Newnes and Waltho (1999) conducted semi-structured interviews with adult inpatients and found that service users compared hospital to prison. Haglund and Von Essen (2005) conducted 20 semistructured interviews with voluntary patients who reported that locked doors on psychiatric wards made the ward seem like a prison and a sanctuary. Five of the six participants had diagnoses of psychosis so it is not surprising that there are similarities between this study's findings and studies conducted with people in other settings who have psychosis. Additionally, the similarities may also be linked to the framework

reported in this study of punishment as being about separation from meaningful things. rather than where they have been placed.

It was surprising that some themes did not emerge. Research with people with psychosis has found other ways of making sense to those found in this study, such as mystical or spiritual frameworks (Romme and Escher, 1993) life events, practical problems and traumatic childhood experience (Phillips, Cooke, Cooke and Peters, 2006). Ramon, Castillo, and Morant (2001) used questionnaires and interviews to explore meaning of diagnosis with 50 adults with personality disorder, and found that participants linked their diagnosis and their history of abuse. In this study abuse was not mentioned. This was surprising as studies with forensic service users have found high levels of past abuse and PTSD (Adshead, 1994; Spitzer, Chevalier, Gillner, Freyberger and Barnow, 2006) and thus it might be assumed that some of the service users in this study would have had experiences of abuse and would incorporate these into their ways of understanding experience. However, it is possible that this is a framework that is used to understand experience but that it was too distressing for service users to discuss this. Spirituality may not have been reported because it was not meaningful for these participants. Alternatively, service users may have felt reluctant to discuss their spirituality in case it was dismissed or seen negatively. Godin and Davies (2005) reported that service users felt that their beliefs around religion were sometimes perceived as symptoms of mental illness. Koslandert and Arvidsson (2007) explored spirituality through interviews with twelve mental health service users. They found that service users felt that nurses avoided discussing spirituality and also lacked knowledge of it. It is possible that spirituality was not mentioned in this study because this might have contradicted with their frameworks around their experiences being caused by an illness that could happen to anyone rather than having a connection to them as people. It might also contradict their hopes that what they were experiencing was temporary, and that all that was required of them was to comply with medication, and lead to feelings of despair and hopelessness that they will ever be able to control what is happening for them.

4.3.2. Implications

All of the participants reported using an illness framework. They described having hope for the future and beliefs that recovery is possible. These have been described as being vital parts of the recovery process (Wilken, 2007) and it is important for services to support these.

Participants reported using several of the different frameworks to understand their experiences. Other research has also reported this (Angermeyer and Klusman, 1988; Holzinger, Kilian, Lindenbach, Petscheleit, and Angermeyer, 2003). Forensic services have been described as having goals of therapy, security and protecting society (Brunt and Rask, 2005). Participants reported frameworks around medical intervention and recovery, and containment but did not report protecting society as a theme. They also reported other themes to those of services, such as punishment. This suggests that staff and service users perceive services differently. There were also variations between service users who reported individual patterns of ways of making sense, and that different meanings were ascribed within frameworks such as rehabilitation being to build skills or to change behaviour. Angermeyer and Klusman (1988) noted that the types of frameworks used were linked to diagnosis. They found that service users with schizophrenia tended to link their experiences with influences from their family environment, whereas service users with affective psychoses attributed their illness to psychosocial stress or biological factors. This is in contrast with this study, which found that each individual had their own pattern of ways of making sense of their experiences even though five of them had the same diagnosis. For example, Danny felt he had been sent away from the community because of his illness and his risky behaviour, whereas Joan reported contradictory beliefs that she was being persecuted for being different, that her experiences were real but also that she was ill. No other studies reported that people have patterns of sense-making that are specific to them as individuals.

Some of the frameworks reported by participants were contradictory, such as experience being seen as senseless and then being reported as illness. Contradictions in ways of understanding experience have been found in other studies. Messari and Hallam (2003) reported that 3 of their 5 participants alternated, within a short period of time, between describing their experiences of psychosis as being real and as being part of an illness. Sheffield, Barlow, Lambert, Hoyal, Thompson et al (1999) noted contradictions between the reports of events described as both interpersonal conflicts and self-destructiveness in their study of 10 service users narratives of borderline personality disorder.

It is important to work with service users to identify and explore their frameworks as these have implications for engagement with services and behaviour. In this study, understanding of symptoms, and purpose of admission both contributed to participants' understanding of what was required of them. For example, within the frameworks around illness and punishment (which were most commonly mentioned) participants saw themselves as passively receiving treatment or punishment rather than being

actively engaged in treatment. A punishment framework may also elicit strong negative emotions such as resentment which can hinder therapeutic success and can also lead to aggressive behaviour (Gudjonssen, Young and Yates; 2007).

If service users understand their role as being passive then they might not actively seek to take part in their recovery and may only engage in the interventions that fit with their understanding of what is needed. For example, if the person believes they are admitted for respite they will not understand the need to do more than have a break from their stressful situation. Additionally, if people do not understand, or place importance on, an intervention they are unlikely to continue with it once it is no longer being reinforced by others. They may also not see a need to continue with interventions in the long-term and this may have negative consequences. For example, if illness is seen as being temporary there is a risk of non-compliance with medication, and this has been cited as a major cause of re-admission to hospital (Kent and Yellowlees, 1994). This suggests a need for service users to incorporate active ongoing participation into their understanding of intervention and their roles, and for services to work with them to encourage this.

When participants described their experiences they made very little reference to treatment. One participant mentioned having psychology sessions, and two participants mentioned medication. This initially seemed surprising but it may be linked to their understanding of their experiences as illness and therefore something to be treated medically. This may also explain why in this study only Joan reported concerns about medication, in contrast to some other studies which have reported that service users often have a negative view of medication (Goodwin et al, 1999). Research with other populations has suggested that some service users may understand treatment as solely involving medication. Kiliana, Lindenbach, Lobig, Uhle, Petscheleit and Angermeyer (2003) conducted semi-structured interviews to investigate empowerment and disempowerment in 100 outpatients with schizophrenia. They found that 51% of the participants saw treatment as only involving medication. These participants were more likely to report feeling helpless or indifferent rather than actively involved in their care.

If medication is seen as the sole form of treatment other interventions may be perceived solely as forms of assessment or something they are forced to do that has no meaning, and this may explain the theme that arose of needing to pass tests. In this study activities were seen as forms of assessment or ways of passing the time by all of the participants. Only two participants mentioned them as being related to recovery. Having to comply and pass tests has been reported elsewhere. Messari and Hallam (2003) found a discourse of service users regarding CBT for psychosis as them engaging with a

powerful medical system in order to hasten discharge. Skelly (1994) reported that service users in a high secure setting saw themselves as 'playing the game'. Prison studies have found themes of prisoners complying in order to make daily life easier, and to increase their chances of leave and discharge (Crewe, 2006). If service users are only engaging to please others or to enable discharge this means that positive behaviour may not be maintained following discharge.

In this study there was also a theme of trying to make sense of others' thinking. This may be linked to trying to gauge what is needed to pass tests or hasten discharge. However, this may also be because participants do not fully understand the purpose of interventions. Koivisto, Janhoven, and Vaisenen (2004) reported that service users felt care had not been defined by staff and that they made their own conclusions about care. Godin and Davies (2005) reported that service users felt that professionals rarely shared their thinking and that this left them trying to make sense of their intentions, and worrying that professionals had a hidden agenda. If service users are not involved in decisions about their care or receive limited explanations for decisions this is likely to increase their feelings of mistrust and may lead to them jumping to negative conclusions, which will influence their perception of treatment and their interactions.

4.3.3. Summary

This research has suggested that whilst there are commonalities in understanding experience, service users have patterns of frameworks that are specific to them. This has not been reported elsewhere in forensic research. This study also found that participants used frameworks around containment, persecution, recovery, and respite to make sense of their experiences, admission, and what was required from them, in addition to the themes of illness and punishment that have been previously reported by other studies. It has therefore extended understanding of frameworks used in forensic settings beyond that of the therapy-security distinction.

4.4. Identity

In this study participants reported themes of defining identity through assessment of their character, their ability and their affiliation in polarised terms. This is similar to the findings of de Bonis, de Boeck, Lida-Pulik and Feline (1995) who reported that people with schizophrenia and people with borderline personality disorder were more likely to describe themselves in polarised terms rather than through salient attributes. Participants in this study also used their relations with others to help define these aspects of self rather than inner qualities. For example, their character appeared to be defined by the

morality of their behaviour and how others responded to them and their actions. They did not follow a strict moral code for behaviour but instead defined it by its consequences. There was an absence of reports of positive aspects of self that did not relate to other people. Participants placed value on themselves in relation to their value to others and this was seen as important for acceptance and safety. However, this may mean that they are reliant on others to feel self-worth. Admission may affect identity by separating service users from the people they rely on to provide this self-worth. However, this may show another contradiction as it may be that these relationships have led to feelings of low self-worth. It is therefore important to consider how service users can build a positive identity based on their attributes being of value to themselves for their self-esteem and to protect against further distress, and to provide them with a self they can respect. Harrop and Trower (2003) suggest that psychosis results from a failure to construct a self, and that a form of self-construction failure arises from only receiving affirmations from others for fitting in with their conditions.

Violence is a major reason for admission (MacInnes, 2000) to forensic mental health services. However, participants spoke little about offences or aggressive behaviour. Any behaviour that could be judged negatively was minimised or justified and thus avoided taking negative aspects into their identity. This is similar to the findings of Geiger and Fischer (2005) in which offenders neutralised their actions to maintain a favourable identity. Participants in this study spoke about struggling with internal or external difficulties and their behaviour being in response to this. These themes are similar to those found in the study by Presser (2004) of men who committed violent offences, who described their moral self as good and the offences being atypical of them or excusable. In this study, as in Presser's study, participants did not identify with being violent, or an offender. Studies of violence have found that roles of perpetrator or victim may be identified (Sandvide et al, 2006, Palmer and Begum). Riessman (2002) suggests that a victim identity may be preferable to that of perpetrator. In this study participants appeared to identify with being a victim or a defender, rather than a perpetrator. In either the victim or defender roles their behaviour is considered to be a necessary response to threat from others rather than aggressive. These positions therefore can be seen as being aimed at protecting the person from blame and possible consequences such as punishment or rejection. They also explain why neither guilt nor shame were found as themes. The defender role may also boost self-esteem by presenting oneself as strong or powerful. It also allows service users to manage any contradictions in self such as being good and bad, by reframing this as 'I do bad things but for a good reason and thus am still good'.

Participants took on a role of being a patient and spoke about not having been responsible for their actions due to illness. It therefore seemed preferable for them to identify with being ill and vulnerable (if they could not be seen as a defender) than to be seen as bad. However, Andersson (2008) states that the victim position is devalued as it is viewed as weak, passive and suffering. Mental illness also carries stigma (Godin and Davies, 2005; Rice, 2006). It therefore seems as if the participants have taken on these roles but only temporarily as they are devalued. Chris was the only person who spoke about illness as a permanent feature of his personality and this may be due to acceptance of his chronic physical illness rather than mental illness. This can explain why illness experiences and an illness framework were reported but service users did not report illness as a stable feature of their identity. Charmaz (1991) stated that service users often move from accepting an illness identity to rejecting it because it threatens self-esteem. Participants spoke about their vulnerability as something that was temporary and which could change through recovery or the development of skills in order to preserve their self-esteem and maintain hope. It allowed them also to keep their original identity intact by viewing negative aspects as only being part of a temporary role for which they are not responsible and from which they will recover. It is possible that interventions examining these negative aspects may be perceived as threatening to the service user's identity and couldlead to disengagement or hostility (Pettie and Triolo, 1999).

Guntrip (1968) has suggested that it is more threatening to be seen as weak and vulnerable than to be seen as bad. These participants appear to have found a way to reject considering themselves as either in the long-term, but were more willing to be seen as weak in the shorter-term. Being a victim also allows them to be seen as special in that others' provocation or persecution shows they deserve special attention even if it is negative or unfair. Guntrip (1968) suggested that people would rather be viewed as being 'special' rather than negligible. This attempt at portraying oneself as important or special may help to explain the shifts between definitions of self found within this study.

In addition to linking to self-esteem, appearing vulnerable may link to survival. Participants spoke about being helpless and needing help from others. Being seen as vulnerable may elicit helpful behaviour from others and belonging, whereas being seen as bad may lead to rejection or threat. Djiker and Koomen (2007) suggest that 'selfish' behaviour such as hurting others may be punished whilst those who cannot cooperate due to illness receive care and treatment. They also mention that some people may be treated with fear, and thus being bad may also lead to further threat or punishment. Studies have found that people who are considered as being deviant rated highly on

social undesirability and low on pity (Towler and Scheider, 2005). However, it has also been found that presenting as ill can change other people's perceptions of oneself. Corrigan, Demming-Lurie, Goldman, Slopen, Medasani et al (2005) found that mental illness was seen with more fear and less pity than leukaemia. However, if it was presented as a medical condition, similar levels of fear and pity were recorded to leukaemia.

Whilst it may be protective in some ways, this rejection of unwanted aspects may also be damaging in terms of trying to move towards recovery and the reduction of risk as there is no perceived need for self-development or change. Jacobson (2001) found that recovery was associated with recognising the problem, and transforming oneself to fit with their new circumstances, using mental health services to aid this transformation and reaching out to others for support. People who deny or seal over their experience of mental illness have a poorer outcome than those who integrate their experience (McGlashan, 1987).

Participants also measured their identity through the activities they undertook. This was similar to the findings of 165 interviews with people with chronic illnesses conducted by Charmaz (2006) to investigate how pursuits link to self-concept. She stated that participants measured pursuits to evaluate their health and their self-concept. These included work pursuits and avocational activities. This link between identity and activity further supports the need for meaningful worthwhile activity mentioned in the discussion of experiences earlier. One of the most important factors in recovery is the development of an empowered identity of agency and competence (Pettie and Triolo, 1999; Ridgway, 2001). This could help service users feel less vulnerable and more skilled, and allow them to consider activities in relation to self-development and satisfaction, rather than just in terms of protecting oneself by being of value to others or by achieving discharge to be away from threat as reported here. Belief in one's own self-efficacy can also help perseverance in the face of obstacles and resilience following setbacks (Bandura, 2001). Ventura, Nuechterlein, Subotnik, Green and Gitlin (2004) reported that a sense of self-efficacy was linked to better psychosocial coping in relation to negative life events for people with psychosis.

This study also shows that participants used concepts of normality to define their identity. Other studies have also reported that aspects of identity can be evaluated with reference to beliefs about normality (Halsall, 2006; Aujoulat, Luminet and Deccache (2007). Being seen as normal by self and others may be important for this client group as a strategy to try to minimise threat and to increase the likelihood of belonging with

people who are able to protect or help them and who can provide them with self-worth through acceptance.

It might have been expected that the length of time service users spend in services might lead them to regard them as their home or where they belong. Baker (2007) suggested that the unit she investigated had provided a home for the participants. This is in contrast to the findings from this study, in which only one participant identified the service as providing her with a home. Other participants identified belonging elsewhere and the service being a temporary residence. This may be due to their negative appraisal of other service users and their feelings of threat from others and may explain why institutionalisation was not found as a group theme. Viewing oneself as different to other service users can protect self-esteem but may also restrict an opportunity for developing positive self-efficacy. Mancini (2007) reported that being with people who had had similar experiences and had achieved recovery had provided his participants with positive role models and helped them to feel hopeful and motivated.

4.4.1. Summary re identity

This study has therefore been able to consider identity in people in forensic mental health services and how this links to research in other settings. Prior research around stigma suggested that service users may have viewed themselves negatively. However, this was not found in this study. Instead service users rejected negative aspects of themselves by minimising or justifying their actions or portraying themselves as not being responsible for their actions. This lack of identification with a criminal or deviant identity can be seen as a positive in that it protects self-esteem, but also because service users instead see themselves as belonging in the community and therefore have some willingness to engage in behaviour that promotes this belonging. However, a person's minimisation of actions or denial of responsibility can hinder their moving away from risky behaviour and offending. Positive attributes of self were not reported (except in relation to others) and service users will need support to help develop these for their self esteem and to help protect them if facing negative life events.

4.5. Passivity and denial

The findings of this study suggest that service users have experiences of being passive, and that they can see their role in treatment as being passive. Passivity seemed to link to experiences of being powerless, but also seemed to arise because service users do not always see themselves as being responsible for their change and can deny the extent of their behaviour. For example, they spoke about negative aspects of themselves as being

temporary, and minimised, excused or justified their actions (this is discussed further in the following section on identity). Pollock, Stowell-Smith and Gopfert (2006) have discussed how prison can lead to people moving from roles such as 'protector' to 'crushed' or 'worthless'. These positions can be painful and therefore denial of guilt or shame may take place. However, denial and passivity can hinder recovery which requires factors such as recognition of the problem, and the transforming of oneself to fit with new circumstances (Jacobson, 2001). Denial and passivity can therefore hinder recovery and quality of life for the service user, but can also hinder the reduction of risk as a person may continue to be dangerous due to not having gained adaptive skills to manage a situation without aggression or due to denial of how their actions have contributed to the situation.

One way to intervene with denial or passivity may be to through the therapeutic community approach. Therapeutic communities aim to encourage personal responsibility and empowerment rather than dependence on professionals (Campling, 2001) and thus behaviour change. Concerns about change being impossible may be alleviated through interactions with group members who have achieved change and who can offer advice and support. The culture of open communication allows the service user the opportunity to think and talk about their feelings, and for their behaviour and ways of relating to be commented on within a supportive environment as they are happening. Service users are encouraged to offer and receive feedback from others and this can challenge denial and passivity. Being welcomed into a group may also have particular importance for this client group as one of the key themes from this study was a need for acceptance and safety. Therapeutic communities may also be helpful in addressing psychopathic and sociopathic features[1] such as lack of remorse or guilt, or lack of empathy through the consideration of the impact of negative behaviour on others, having to adhere to the community's standards and the challenging of rationalisation or blaming of others. Therapeutic communities have been developed to work effectively with people with severe psychological disturbances in prisons and forensic mental health settings (Kerr and Gopfert, 2006). Lees, Manning and Rawlings (1999) reviewed international literature review on the effectiveness of therapeutic communities, including services in secure services, and found that therapeutic communities can have a positive effect on mental health and functioning. Dolan, Warren, Menzies and Norton (1996) examined service usage by people with personality disorders before and after treatment, and found that therapeutic communities were cost-effective.

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[1] These psychopathic features can be predictive of violence (Pollock, Stowell-Smith and Gopfert, 2006)

4.6. How do the findings relate to psychological theory

This next section discusses the findings of the study in relation to social psychological theories, in order to consider whether the findings fit with these theories and whether these theories can add to understanding of the data.

4.6.1. Symbolic Interaction

Symbolic interaction (Blummer, 1938, 1969) suggests that people derive meanings from social interaction and the sharing of interpretations of symbols. These meanings are modified through an interpretative process involving an internal creation of meaning, which is then checked externally and with other people. People then act towards situations and other people based on these meanings, which in turn leads to further modification of the meanings. Additionally understanding of self is developed through this interpretative process. Symbolic interaction is therefore relevant to this study as it gives a framework that can help to explain how meanings arise, and how identity is formed, and how these factors influence experience and are influenced by experience. Experience, understanding of experience and identity were found to interlink in this study. For example, experiences of being unsafe linked to frameworks around others being persecutory and identities around being a victim or a defender. Symbolic interaction can allow us to understand the relationship between experience, meaning and identity.

This interpretative process based on past and current interaction can help to explain why each individual had their own specific pattern of frameworks even though similar events were experienced, and also why shared interpretations were found. It can also explain the theme that arose around ambivalence to others and the use of contradictory explanations. Participants reported experiences of being helped and feeling threatened and therefore it can be speculated that they are trying to make sense of this by using frameworks developed from past experience until a framework can be modified that can incorporate the contradictory experiences, although it is also possible that different frameworks were used because participants tried to second-guess what the answer was that the interviewer wanted, or gave the most socially appropriate answer.

Symbolic interaction can explain some of the data reported around changed expectancies of others, changed identity and behaviour. Imran had experiences of being attacked by service users and therefore spoke about interpreting others comments as threatening. However, he reported that over time he was able to consider whether the comments were

threatening or if they formed banter between friends. This suggests that his interpretation was modified as social interaction over time showed that he was unlikely to be attacked. These experiences and interpretation also appear to have shaped his identity as he described a changed view of himself as helpless and a victim when he was first admitted to being likeable and not vulnerable at the time when he was interviewed.

This theory can also explain participants' explanations that they were defending themselves from attack. In an interaction sequence loop a person's perception of someone influences how they act towards them. This in turn influences how the other person responds to them, in conjunction with their own interpretations of the situation. Therefore if one person sees another as being frightening they may interpret any behaviour by this person as aggressive and respond accordingly. The other person may then interpret the other person's behaviour as being aggressive towards them. This may then escalate unless one of the people acts in a way that breaks the cycle. Additionally, a person may incorporate the other person's perception into their identity. Joan's story about being restrained illustrates this. She spoke about a staff member doing something that she did not like and interpreted this, based on her expectancies of Asian people, as the woman behaving unfairly towards her. In turn the woman perceived Joan as being aggressive and responded to her by telling her to stop acting in this way or that there would be negative consequences. This further strengthened Joan's view that she was being unfairly persecuted and under attack. The situation escalated until Joan became aggressive, which she explained as self-defence. The nurse felt threatened and initiated control and restraint procedures to protect herself and to manage the situation. In this situation both people felt attacked by the other and responded to this perception. Joan had experienced other situations where people had responded to her as if she was aggressive, and to her actual aggression, and she spoke herself as someone who other people saw as being scary. She then made her own interpretations as to why this was.

The Suspended Identity Model (Schmid and Jones, 1991) is based on symbolic interaction principles and has been used to suggest that prisoners can suspend their identity whilst in institutions. They describe how preconceived meanings of prison can lead to an expectation that prison is a violent place that a person needs to survive. Schmid and Jones (1991) argue that a pre-prison identity may be suspended if it leaves the person vulnerable, and a temporary identity may be developed to allow interaction with other inmates. This temporary identity is developed through social interaction and interpretation. The original identity can then be returned to at a later date depending on the level of integration into prison life that has taken place. This may also apply to

forensic mental health settings. Four of the participants spoke about their lives having been interrupted and their understanding that they would recover and return to their lives. It is therefore possible that their original identity was also placed on hold and that temporary aspects of identity were developed. This would also explain how participants felt able to form relationships with other service users but were also able to consider themselves as being different to them. It may also explain how unwanted aspects of identity such as being a patient are taken on but then seen as being temporary. It may also explain why no experiences of stigma or shame were reported as these would only be directed at the temporary self. This has implications for recovery if service users appear to have integrated their experiences into their identity and ways of understanding the world but that this is only temporary.

4.6.2. Social Representation Theory

This theory can help us to further consider meaning making and experience.
Social Representation Theory (Moscovici, 1973) looks at how social and culturally shared knowledge influences individual perception, experience and action. It suggests that members of a community develop a system of values and ideas to allow codes for social exchange. These codes or representations are used to help understand the world and to master it. This can therefore, further explain why there were shared explanations for experience in this study such as illness frameworks.

Social representations of mental illness have been explored. Morant (1995) conducted semi-structured interviews with sixty mental health workers in Britain and France to explore definitions of mental illness. Two social representations were found including a medical social representation based on the assumptions of psychiatry and a functional social representation based on assumptions of mental illness as an inability to cope and function. These representations were also found in the study by Foster (2001), which analysed newspaper articles and focus groups with students to explore representations of mental illness. Both studies also noted that people with mental illnesses were seen as being separate to people in the community because of their different and inexplicable experiences, but also as similar as there was a view of a continuum existing between normality and mental illness experiences. The studies also noted a unified social representation of mental illness as being unpredictable, permanent, violent and separate. Foster (2001) also found a theme around mental illness being positively associated with creativity.

In this study, participants used both the medical and functional social representations to explain what they were experiencing. Additional social representations were used around the purpose of secure units being for containment, and treatment. These can be considered as professional social representations of mental health services. The range of explanations used by participants may be due to the fact that there are several models of mental illness within mental health services. In addition to using 'expert' representations participants also used 'lay' social representations such as forensic mental health units being for punishment, and individual interpretations. Only one participant spoke about their experience as being part of a continuum and normal. This may be because psychosis is more associated with otherness than diagnoses such as depression and participants may share this representation. In this study the participants shared representations about people with mental illnesses being separate and threatening. However, they did not seem to apply this to themselves, only to other service users. This may be explained through Social Identity Theory (see below).

Social representation theory may be able to explain the range of explanations given by participants as they may reflect the range of different representations that society and mental health services hold about mental illness and treatment. Their contradictory nature may be because they are trying to make sense of something that is explained in several different ways but for which there is no one definite answer.

The use of particular social representations may have benefits for service users in terms of protecting self-esteem. Foster (2001) found representations which linked mental illness with violence or criminal behaviour but which held that people with mental illnesses were also absolved from responsibility. Participants shared this representation around responsibility, and this may help to explain why participants described themselves as ill as their risky behaviour then became justifiable. Djiker and Koomen (2007) suggest that the more responsibility someone feels the more negative reactions they feel they deserve for undesirable behaviour. Frameworks around illness being linked to social pressure may also be more protective than biological or genetic frameworks as they suggest that the illness is not inherent within the person. Social representations of illness as deriving from social pressure was seen less negatively than biological frameworks, as they were seen as evoking sympathy rather than fear, and something that can be rectified rather than the biological which was seen as something that could only be controlled rather than cured (Foster, 2005). Participants in this study used an illness representation that suggested mental illness was similar to disease or infection in that it was temporary and not their fault for having 'caught it'.

4.6.3. Social Identity Theory

This theory suggests that we place ourselves and others into categories that say something about the person. Comparisons are made between the group the person belongs to and other groups, with a favourable bias towards the group the person identifies with. Identifying oneself with a particular group can increase self-esteem.

It was mentioned previously that participants saw other service users negatively. This has been found elsewhere. Harris, Waschull and Walters (1990) suggest that people may be negative or ambivalent to people in similar groups. Their study of obese people in the community found that they were aware of representations and to some extent shared them. Molinari and Riva (1995) found that obese women in their study gave negative ratings to obese people but described themselves positively as modest, kind, warm and large. However, these participants may all have been placed as belonging to a group that they do not themselves identify with. In this study participants generally rejected seeing themselves as being similar to other service users. This therefore suggests that participants do not see themselves as forming a group, or categorise themselves based on diagnosis or by being a service user. Participants in this study did define identity through location but only when it showed them moving towards discharge and was therefore positive. They accepted the label of patient as they described themselves as ill but did not necessarily incorporate this into their identity as being a permanent role. Identity was also shaped by comparisons to other people. They did not see themselves as being similar to other service users in terms of behaviour. Instead they placed themselves primarily in a category of people who belong in the community with their families. This allowed them to compare themselves favourably to other service users and see other service users as part of an out-group. Participants recognised themselves as being different to staff members in terms of role, power and location (they saw staff as being based in the office and not the ward). However, they did not talk about what these differences meant, possibly because they may be damaging to self-esteem.

In this study participants placed themselves and others into categories based on roles and behaviour. Participants reported a range of roles including patient, friend, and family member. This is consistent with social identity theory, which suggests that individuals have a range of personal and social identities which each inform the person of who they are (Tajfel and Turner, 1986).

Social identity arises from the individual's self-concept formed through perceived membership of social groups (Hogg & Vaughan, 2002). As participants reported feeling

vulnerable and helpless it may be that social identity was most salient in order to gain or maintain membership within a powerful or valued group allowing a positive self-concept. This may explain why their identity was described in relation to others rather than on their own character traits. Crocker and Wolfe (2001) suggest that people who may be stigmatised can avoid low self-esteem by basing their esteem on other's approval. However it is also possible that describing self in relation to others is the result of having experienced an identity crisis (Erikson, 1968) in which their continuity of life (either through symptoms or admission) has been disrupted and there has been a loss of personal sameness. Pettie and Triolo (1999) suggest that this can lead to comparison becoming central in order to relocate and reorient oneself, and that everything therefore becomes a point of reference to establish who one is and who they belong with. Striving for group membership and belonging may also explain why participants did not incorporate unwanted aspects into their identity as being perceived as deviant may lead to rejection.

Social identity theory can help to explain contradictions found in the different aspects of identity presented by service users. An individual can belong to a range of different groups, and their self-concept is therefore made up of multiple social identities and these may be contradictory (Tajfel & Turner, 1979, 1986). Arniot, de la Sablonniere, Terry and Smith (2007) present a model which describes how multiple social identities can be held by a person. They suggest that a self-anchoring process occurs in which own characteristics are projected onto a group. This can lead to highly differentiated isolated social identities with little overlap between new and old identities. Compartmentalisation takes place to prevent conflict between the identities, and to allow multiple identification and an increased overlap between identities. This is followed by integration in which conflict between identities is recognised and resolved in successful development through the creation of higher order categorisations that recognise similarities between identities

4.6.4. Summary of links with social psychological theories

These theories have helped increase understanding of how experience, understanding of experience and identity interact. They have also enhanced the understanding of these findings including the contradictions reported for understanding experience and identity. They also help to explain the underlying need for presenting oneself favourably in that this increases the possibility of belonging and thus self-esteem, help and protection. They also reinforce the need to pay attention to the therapeutic relationship. Other studies have shown that service users state that the quality of therapeutic relationships is very important and dissatisfaction with the service often relates to problems in these

relationships (Byrt and Reece, 1999; Ford, Sweeney and Farrington, 1999; Ryan, Moore. Taylor, Wilkinson, Lingiah, et al., 2002). The findings of this study also stress the importance of clarity of information given by professional including the need for explanations for decision making to be shared. When situations are ambiguous or unclear service users try to make sense of these based on past interaction and the conclusions they reach such as being punished or others being untrustworthy may hinder engagement. It is also important for professionals to reflect upon their own attitudes and behaviour. Symbolic interaction suggests that how people behave towards us shapes how we interpret what is happening, our responses to them and how we view ourselves. If service users are viewed as aggressive or out of control they may be interacted with based on these attitudes. Being viewed as threatening may lead the service user to identify with this, or respond as if there is a threat to them. This may lead to the service user responding aggressively and escalate situations. This study also has social implications in that stigma and social representations of mental illness as being frightening may lead to service users being treated negatively. This may provoke feelings of being at risk and in need of defending themselves, and feelings of low self-efficacy and self-esteem.

4.6.5. Psychoanalytic Theory

The above social psychological theories are able to help us understand the data and emphasise the role of presenting favourably to others and oneself. However, psychoanalytic theory can also add to this understanding as the concepts of anxiety and defences can help to explain the underlying mechanisms that allow contradictions to be tolerated and a favourable identity to be maintained. Turner (2007) proposes that psychoanalytic and social psychological theories can be used together to complement understanding.

Distress arises when certain beliefs and emotions are triggered. If these thoughts and emotions such as anxiety, envy, or anger are considered to be inappropriate or unacceptable by the society the person is part of, the experience of them will be painful or uncomfortable. People may unconsciously defend against these emotions or the thoughts that lead to them, rather than experience the distress. Ambresin, de Roten, Drapeau and Despland (2007) describe defence mechanisms as unconscious mechanisms aimed at dealing with painful emotions, thoughts or situations, which arise from internal or external stressors. Defences prevent the experience of pain but are also driven by fear of punishment for unacceptable or forbidden feelings or impulses (Lemma, 2006). Defences therefore can be seen as attempts to manage intrapsychic and interpersonal

conflict, and the process of distorting or excluding information or emotion can lead to the development and maintenance of contradictory models of relational experience (Lemma, 2006); the concept of defence mechanisms can help to explain the contradictions found in this study such as descriptions of self as likeable and being disliked.

The minimisation of negative aspects in this study may have been defences of rationalisation (turning something unacceptable into something acceptable), as may the process of experiences such as threat from within not being incorporated into identity but instead being regarded as an external illness. Splitting allows two opposing thoughts to be kept apart, and this can mechanism can explain participants' description of selves in polarised terms. Projection occurs when a person attributes unwanted or unacceptable thoughts and feelings to someone else. This might therefore further explain the themes in this study of others being attacking or out of control, and the need to defend oneself. Emotions about one's personal self or social identity may be repressed or denied, leading to intensification and transmutation of shame and other negative emotions into anger which may then be directed at the person who was perceived to be the cause of it. This may explain some aggressive behaviour. The use of defences against pain can explain why there were no themes of shame, guilt, grief, loss or experiences of stigma. If service users did not defend against these they may experience an overwhelming sense of distress in relation to their view of self and others view of them. Smith and Osborn (2007) state that people who are shamed feel inferior, powerless, vulnerable to punishment and unattractive.

4.7. Findings in Relation to the Study's Aims

This study aimed to investigate experience, understanding of experience and identity within a low secure unit and it was able to uncover individual and group themes for these areas. It has been shown that both social psychological theory and psychoanalytic theory have relevance for understanding these findings and forensic mental health. This study has therefore been able to add to the evidence base for low secure forensic mental health. For the quality of the findings to be evaluated fully the way in which the research was conducted must also be considered. Therefore, reflections on the study and its strengths and limitations will be discussed in the following section.

4.8. Evaluating the Research Process

4.8.1. Reflections on the Sample

This sample was comprised of people from the same service and five of the participants had the same diagnosis. Several service users declined to take part and it may be that the participants who did volunteer were not wholly representative of this service or other services. Pereira et al (2006a) suggest that most service users in low secure settings are male, single, white, unemployed and had a diagnosis of schizophrenia. Only two participants from this study meet this description. However, many of the views reported by participants were similar to each other, and to the views expressed by service users in other levels of security, which suggests that they were not atypical of a forensic population.

4.8.2. Evaluating the interview method

The qualitative methodology allowed participants to talk about their experiences in detail and to spontaneously bring in topics that they felt to be important. This allowed them to tell their story using their own words and to give weight to areas they felt were significant. This meant rather than simply describing aspects of the service, such as the physical environment or ward rounds, themes emerged around what experiences meant for the person including interpersonal and intrapersonal aspects. However, the findings of this study rely upon the assumption that verbal responses can represent experience and beliefs, and that the story is given in good faith as a representation of their experience.

In this study a theme was found of trying to make sense of others. It is possible that participants will say what they think the researcher wants to hear and their comments therefore need exploration. For example, all of the participants said that this unit was *ok* or *alright*. However, when this was explored further participants said that the unit was good in comparison to other places but that they also had experiences that had been distressing. This suggests that the use of a qualitative method for this study was more helpful in exploring the meaning of experience than quantitative methods. For example, if participants had been asked to give categorised answers the deeper meaning of the comments would have been lost.

It is also possible that what was discussed was shaped by their expectations of me as a psychologist. Meddings and Perkins (1999) found that service users had different expectations of interactions with professionals. Nurses were seen as people who offered practical help, care and social chat, psychiatrists were seen to be interested in symptoms

and medication and psychologists were seen to talk about deeper personal issues. Participants may therefore have made assumptions about what to discuss based on past experiences with psychology professionals. This may help to explain why there was so little discussion around the content of their 'illnesses' even though all of the participants used this framework, as well as issues around trust. It is also possible that the emphasis on relationships in the data was influenced by participants' expectations of my interests.

It is possible that the information that was collected was restricted by participants' concerns about how the data may be used. All of the participants in this study checked several times how the information would be used, and made references to the digital recorder during the interview. However, participants spoke about their experiences in more detail once they had reassured themselves that information would not be shared with the service. On a few occasions the participant was present when I informed staff that the interview had ended. This seemed to help increase confidence that information from the interview was not being shared as they were aware of what I had said about them. With other participants I clarified at the end what I would say to staff members.

Participants may have presented themselves favourably to defend against painful thoughts and feelings, or to minimise negative consequences if information was shared. This may have restricted what was talked about and is thus a limitation. However, absences of information are also useful for research and can be interpreted e.g. in this study service users declined to talk about risky behaviour but spoke about illness suggesting that there is a greater stigma for them around aggression or offending.

The second interviews allowed the researcher to check their understanding of information, increasing engagement, and generating more information allowing new themes to be brought in after participants had had time to reflect on the first interview. Participants spoke for longer without prompting and in greater detail in the follow-up interviews. This may have been because rapport and trust had been developed. They also brought in topics that they had avoided talking about in the first interview. For example, Joan initially said that she had not had any negative experiences during her admission but was later able to talk about a time when she had been placed in seclusion.

Whilst multiple interviews enabled information to be collected in more depth, they restricted the number of potential participants as considerable amounts of information were collected in each interview. However, six participants is a suitable number for qualitative research and IPA (Smith and Osborn, 2003), and this sample size allowed detailed information to be collected and analysed, and themes to be generated for

individuals and across cases. A greater number of participants would have made it difficult for the interpreter to hold narratives in mind and analyse beyond a superficial level. The sample size means that caution should be applied when thinking about how the findings from this study might fit with other samples. It is also possible that if more participants were interviewed then more themes may have arisen.

4.8.3. Evaluating the analysis

Using IPA for analysis in this study had both strengths and limitations. A strength of IPA is that it allows the generation of both similarities and differences between participants, and therefore individual stories are not lost in the analysis. This study has used pen portraits to allow the individual to be seen, in addition to the discussion of group themes. Another benefit is that IPA relies on the researcher making sense of the participant's experience and their own experience of the interview including their observations such as non-verbal information and their feelings, and is therefore not solely reliant on what is said. However, this may also be a limitation due to the subjective nature of interpretation. IPA tries to acknowledge this by emphasising the need for the researcher to reflect upon how their own ideas may have influenced the data, but the extent of reflexivity is dependent upon the researcher's ability and willingness to reflect on them self. This study has included reflective paragraphs to allow the reader to gain some insight into how the study may have been influenced. It is possible that important themes may have been dismissed during analysis. However, peer auditing of analysis was used in this study and this reduced the risk of information being ignored or distorted.

4.8.4. Reflections on the researcher's role

4.8.4.1. Interviewing

Overall I felt that the interviewing process allowed participants to bring in their own information and guide what was discussed. The majority of statements that I made were to clarify information or to prompt for more detail, rather than introducing topics for discussion.

I feel I followed the interview guide questions, although I was flexible in the ordering. At times I was aware that when I used prompts I asked closed questions and had to use another prompt following this. One interview felt more like a structured interview because the participant gave short answers or said 'I don't know' leaving me to ask several questions. In the second interview this was different and the participant gave more detail about his experiences spontaneously. I was anxious about my interview

skills and the quality of the data. I found that this anxiety decreased as I conducted more interviews and was more able to feel confident in the interview process. My anxiety may have meant that initial interviews were not as in-depth as they could have been, but the follow-up interviews offered opportunities for more depth.

I was also aware that my knowledge of secure units meant that I had made some assumptions during the interviews as to what was meant and had not explored these further. For example, a participant used the phrase taken down in reference to C&R. I assumed this meant restraint as I have heard service users use this phrase but also realised it could have meant they were taken to another room. Lykkeslet and Gjendal (2007) discuss the pros and cons of 'practice close research' in which a study is carried out in an area a person is familiar with. They suggest that a person's preconceptions can risk additional or contrary information being obscured. They suggest that a way to manage this is to make one's preconceptions explicit early in the research process. I attempted to do this through the use of diary keeping about my thoughts on entering the study and during it, and to use this record to consider my impact on the interviewing and analysis.

I did not feel scared during any of the interviews. However, I was aware of not probing certain topics in-depth. This was partly because they were distressing to the participant or because I felt the information would be more suitable for a therapeutic interview. I also wondered afterwards if I had been concerned about provoking participants not because of risk to myself but because of concern they would drop out of the research. An example of this occurred in Martin's interview when he spoke about fire-setting and I asked him to tell me about what had happened. He became evasive, and then asked me how much longer the interview would last. I did not press him to talk about the topic and the interview continued. I also felt intimidated by one person's confidence during the interviewing and was aware that this meant that I accepted what was said rather than exploring further. For example, a statement was made saying that all of the service users felt the unit was boring and I accepted this rather than exploring whether this was her personal view or based on information received by her in her role as a service user representative.

4.8.4.2. Analysis

I decided to look at the data and to order it into initial themes as suggested by Smith. After I had done this I decided to place the themes into experience, understanding of experience and identity. This was done because the themes appeared to be clustering

together in this way. However, the decision to do this was also influenced by my wishing to specifically investigate these areas. I was helped to make this decision by my awareness that IPA does not follow a rigid structure. Smith (2004) suggests that the use of IPA cannot be prescriptive, and that the guidelines he has given are suggestions which can be adapted and developed by researchers. I examined published IPA studies and noted that other studies have taken this approach of using categories. For example, Green, Payne and Barnitt (2004) used IPA to look at the illness representations of people with non-epileptic seizures. As part of this they coded the data to fit with the elements of the self-regulation model including those of identity and cause. Brocki and Wearden (2006) state that the use of IPA with a predetermined framework is not prohibited.

It can be argued that there should not be a distinction between experience and understanding of experience as IPA looks at lived experience. I felt that the category of experience reflected how the setting was experienced for the participants and its meaning for them. However, I also wanted to answer research questions around which explanatory frameworks were used and identity. I thought that as I had drawn out initial themes solely around experience that by adding these two categories I would be adding to the depth of the analysis rather than constricting it. However, I think it likely that these would have emerged as themes anyway (as they seemed to be doing so after the initial themes emerged and because they seemed very important to the participants). This is also supported by the several published studies that have used IPA and found themes around explanations and identity. For example, studies using IPA have found themes on seeking explanations for people with psychosis (Gupta, Johnson and Gleeson, 2007). Clare (2002) reported finding themes around reactions, explanations, and emotional responses to Alzheimer's disease. It is possible that using these three categories restricted the analysis and that without them different themes may have emerged. However, the initial themes seemed to fit easily into the three categories with no themes being excluded. Quality checks were undertaken and the themes that arose were deemed to be appropriate interpretations. However, as there is so little research into low secure settings it is hard to say whether important themes were missed. Confirmation of the trustworthiness of the analysis may occur when further research is conducted and the findings are compared to those of this study. A further measure of the trustworthiness of the analysis is whether the themes resonate with people's experience of these settings. Extracts of interviews, my reflections and examples of how themes were developed have been included to allow the trustworthiness of the analysis to be considered as Smith (2004) stated that the quality of IPA can be determined through the level of personal analytic work done at each stage. He suggested that there are at least three levels of

interpretation: including social comparison, metaphorical, and temporal. He stated that for a novice researcher interpretation at the level of social comparison is 'good enough'. In this study very little metaphorical language was used so the data was primarily interpreted at the social comparison and the temporal levels.

IPA's flexibility is one of its strengths but I found that this lack of guidelines meant it was difficult for me to gauge what was 'enough' in terms of interpretation. Looking back on my decision-making process I feel that my decision to use categories during the analysis was partly motivated by my anxiety around there not being a fixed analytic procedure. Smith (2004) stated that novice researchers can be too tentative, and can be hesitant to continue to analyse the data. His view is that this level of interpretation is 'good enough' rather than forcing the researcher to be insightful.

I had no previous experience of IPA prior to beginning this research project. Whilst I had attended the IPA conference and qualitative research support group workshops I did not feel wholly confident in using IPA. This led me to be very tentative when interpreting the data as I was worried whether I was 'getting it right' or not. I felt worried that I would move too far away from the participants' stories or exclude themes. I looked at descriptions of the analytic method in published IPA studies and spoke to people who were experienced in using IPA. Even so I had several attempts at analysing the data and organising it into themes and discussing it in supervision before I felt confident enough that the themes reflected both the participant's experience and my interpretations of this.

It is possible that the interpretations that I made were too literal and that the data could be further interpreted. This may be shown by the number of themes that I found. For each research category I found between three and five superordinate themes (e.g. identity themes: affiliation, ability, character). This is not an unusual amount for IPA. For example, Larkin and Griffiths (2002) presented six overarching themes in their study of addiction and recovery. However, if the categories are considered together there are thirteen superordinate themes. It is difficult to know if this is an unusually large sum as the constraints of journal articles mean that sometimes not all of the findings are reported. For example, Flowers, Duncan and Knussen (2003) explicitly stated that they found several themes but that only those findings that related to the research question were being reported. It is not possible to have guidelines as to how many themes suggest an interpretation is complete. Instead the aim is to have analysed the data until no new themes have emerged. I think it is possible that had I been more experienced at using IPA I may have been to interpret the themes further but I felt that I had taken the

analysis as far as I could at that time. The final analysis shows themes that are more abstract than the subthemes, showing that interpretation has taken place. However, in future research I would extend the analysis so that it was conducted by more than one researcher or by using more than one analytic method (such as thematic analysis or discourse analysis) as this would reduce the possibility of themes being missed or under-interpreted.

In the tables and discussion of the results I presented master themes to help detail how the superordinate themes had been derived (as part of the quality standards around transparency). From this it can be seen that there are a different number of master themes (and subthemes) that contribute to each superordinate theme. All of the superordinate themes are considered to be equally important even though they are composed by different numbers of subthemes which were also reported by different numbers of participants. Themes are not selected solely because of frequency. Although a theme may only have been reported by a few participants it may be equally as important as though reported by more people as it may clarify other themes or may articulate what another participant has been unable to say as precisely (Brocki and Wearden, 2006). In the text I have spoken about some themes in more detail. This is because I felt the interpretation for these themes required more clarification than for others, or because they had not been reported in as much detail elsewhere in the forensic mental health literature and were thus important to explore further.

It is also possible that my own experience of secure units meant that analysis was influenced by my expectations of what would be found. However, not all the themes that I had expected arose. For example, I had expected to find themes about spiritual or mystical thinking. I also felt surprised by some of the themes that did arise such as all of the service users saying they were ill and describing themselves as patients. I had expected more people to say that they were not ill and should not have been admitted.

4.8.5. Quality Standards

In chapter two the standards set by Elliot et al (1999) were outlined. These standards can help evaluate qualitative research and will now be discussed in terms of this study to allow the reader to assess the quality of the study

Owning one's perspective: throughout the project the researcher's perspective has been described. This included descriptions of: epistemological stance; why this research question was chosen; experience of the interviews and how experiences in forensic mental health settings may have influenced both interviews and interpretations of the

data.

Situating the sample: the sample has been described in detail to allow comparisons to other settings and research. In addition to giving demographic information individual pen portraits have been included. This situating of the sample can allow a reader to make interpretations about the analysis and whether findings can be compared to other research or clinical experience.

Grounding in examples: in the analysis quotations from the interviews have been given to illustrate what was said by the participant and how this was then interpreted. This allows a reader to reflect upon the researcher's interpretation of the data and to consider alternative interpretations.

Providing credibility checks: the analysis of the data has been discussed with supervisors who have experience in conducting qualitative research and of forensic mental health settings. Transcripts and examples of analysis have been discussed with members of a qualitative support research group

Coherence: tables have been provided showing sub-themes to detail how the themes were derived.

Accomplishing general vs. specific research tasks: the findings have been compared to both previous research and psychological theory. Clinical implications have been presented.

Resonating with readers: I have felt engaged with this study and the stories of the participants. I have endeavoured to retell their stories through quotes, themes and discussion in a way that allows the reader to feel empathy and to be able to compare the study with their own experience.

4.8.6. Implications for Future Research

As this study is one of the first of its kind within a low secure setting it would be helpful to discuss the findings of this study with service users in order to explore how they resonated with their own experiences. It would also be interesting to conduct a similar study but to use a different research method such as ethnography to see how the themes might be added to through the observation of relationships and experiences. Participants in this study appeared to have concerns as to whether their interviews would be shared with the service. This may have affected what was discussed and it may therefore be useful to conduct research with people who have been discharged from low secure units. Whilst this would involve retrospective recall and would be shaped by subsequent recall these service users would not have concerns as to whether their length of admission would be lengthened through taking part in interviews. Another approach might be for service users to conduct interviews as participants may feel able to talk more freely with

someone who has undergone similar experiences. In this study the majority of participants had a diagnosis of psychosis. Whilst this is typical of low secure units (Pereira, Dawson and Sarsam, 2006a) it would also be interesting to purposively select a sample with different diagnoses such as personality disorder to see if this affected the findings of the study. A longitudinal study might be conducted to see how understanding of experiences and identity change with length of admission or following discharge. This could further support the use of social psychological theories in considering service user experiences. It would also be of value to study transitions between secure services in order to help understand more about the similarities and differences of experiences in these settings.

Future research is also indicated to measure the impact of the new Mental Health Act (2007) on service users and services following its introduction this year. This is an amended version of the Mental Health Act (1983). Amendments include roles being opened up to include other professional groups such as the move from Responsible Medical Officer to Responsible Clinician. Research could explore whether the frameworks used by service users change following the move from medical officers and ASW's to the inclusion of other professionals within these roles and them being renamed. It could be speculated that illness will continue to be frequently used but that other frameworks may become more prevalent such as rehabilitation skills. Under the amended act it will also be possible for some service users (who are detained under sections 3 or 37) to be treated in their own homes under Community Treatment Orders (CTO). It will be interesting to see how this influences experiences of feeling vulnerable and frightened of others, and whether life is still experienced as being interrupted. It will also be interesting to see what the representations of community treatment orders are, as there have already been negative portrayals of these in the media.

4.9. Conclusion

This qualitative study has endeavoured to explore service users' experiences in low secure forensic mental health services, their understanding of these and the links between experience and identity. Eleven interviews were held and the information from these interviews has been analysed using IPA to provide themes for each of the research aims.

The majority of the themes that emerged were interpersonal in nature. The themes suggested that the service users in this study experienced low secure services both positively and negatively; for example participants reported feeling frightened of other

people but also needing help and wanting relationships. Frameworks for understanding experience included explanations of what they were experiencing and why, and their role within this. Participants most commonly reported using frameworks of illness and punishment to help understand their experience. In the illness framework experience is understood as being caused by an external temporary factor, and that their role is to be in a passive position of being given treatment by others. The punishment framework suggests that experience is understood as being connected to negative behaviour, and that their role is to be passive and comply until they are discharged. In this framework most participants accepted that they had 'broken the rules' but found ways to minimise or justify their behaviour. Other frameworks were also reported and each individual had their own pattern of making sense, which was distinct to them and that this shapes their understanding of the unit and their identity. In this situation participants have retained some original sense of self and have only taken on unwanted aspects of self temporarily (such as the role of patient). This can be seen as aimed at protecting themselves from feeling loss or shame. Participants' sense of self and understanding of experience was shaped by the views of other people and society, in addition to their own interpretations. Experience, understanding and identity are therefore seen as interrelating and can be understood through social psychological theories and psychoanalytic theories. This study has been able to add to the literature base for low secure forensic mental health and has shown there to be both similarities and differences between experiences reported across settings. Clinical implications have been made in view of the study's findings. These include reflections on the importance of therapeutic relationships in engaging service users but also to provide them with positive experiences of others that can help them to trust others, and help them to build a positive sense of self-worth. The importance of empowerment and taking an active role in recovery has been discussed, as has the need to work with service users to identify the frameworks they use to understand experience as these help to shape how they act, their view of themselves and others, and their level of engagement in interventions. The findings of this study have implications for reducing psychological distress and risk, and promoting recovery, and therefore are of value for service users, people who work with them and service provision, but also for the wider community as interventions, which enable the successful reintegration of service users and reduction of risk are of benefit to society.

4.10. Personal reflections

I was saddened to uncover feelings of fear and powerlessness, and these have made me aware of a contradiction between the goals of society of supporting people whilst managing risk, and service users feeling they are being punished and have been taken

away from the things that they value to somewhere they feel unsafe. Prior to this study I had not fully considered how long service users can spend moving through the mental health system and how this may make them more vulnerable in some ways, such as the effects of this on their self-esteem and their relationships. However, I also felt heartened by the theme of service users having experienced positive experiences within the service. I was very struck by how important it was for the participants to have people who responded to them warmly, and with interest, and how they valued this as much if not more than interventions.

One of the things that I hope to take with me from this study is the importance of meaningful activity, and the need to work with service users to help them identify what is meaningful for them and to support them to become involved in this. I am also very aware of a need to encourage service users to become active within their care, and that this may involve working with them to incorporate this into their understanding of experience and their roles.

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APPENDICES

Appendix A: Information Sheet

HEADED NOTE PAPER –LEEDS UNIVERSITY

An exploration of service users' experiences of low secure forensic mental health services. Researcher: Catherine Wilkinson (Psychologist in Clinical Training)

You are being invited to take part in a research study. It is important for you to understand why the research is being done and what it will involve before you decide to take part. Please read the following information carefully, and discuss it with other people if you wish. If you have any questions please contact Catherine Wilkinson. You can ask a member of staff to arrange for Catherine to come and talk to you about the project.

Thank you for taking the time to read this.

1) Why is the study being done?

The project is part of the requirements for the Leeds University Doctorate in Clinical Psychology. It is aimed at looking at service users' experiences of being in a low secure forensic mental health service, how people understand their experiences, and the impact of their experiences on them. There has been little research looking at forensic mental health services from service users' views. More research is needed to inform services and the professionals who work within them. Understanding and listening to service users' views will allow forensic mental health services to consider their current service provision.

2) Do I have to take part?

No. It is completely up to you to decide if you want to take part. Saying no will not affect your treatment or length of admission in any way.

3) What will happen if I agree to take part?

If you agree to take part Catherine will meet with you to discuss the project. You will be asked to take part in an interview to discuss your experiences of being in a low secure unit. These interviews will take place in a private room at the XXXXXX. At the beginning Catherine will check that you understand what you have to do, and that you want to take part. She will ask you to fill in a consent form. At the end of the interview she will check whether you still want to be part of the project and how you fell about the information you have discussed. If you do not feel happy about a topic that you have discussed being included this will be removed (unless it affects your level of risk). You can withdraw from the project at anytime. You do not need to give a reason, and this will not affect your treatment at the XXXXXXX.

If Catherine and you both feel that your experiences have not been discussed fully then you will be asked to take part in another interview. The interviews will last around one hour and will be digitally audio recorded. When the project is finished you will be able to see a summary of the research findings.

4) What are the possible risks or disadvantages of taking part?

It is possible that you might feel upset when talking about your experiences. If this happens you will be offered support by either nursing staff of members of the psychology team at the XXXXXX. You do not have to discuss anything you do not

want. If you feel uncomfortable when discussing something let the interviewer know and it will stop being talked about.

5) What are the possible benefits of taking part?
It is unlikely that you will gain any direct benefits from taking part. However, you might feel that talking about your experiences is helpful.

6) What will happen to the information I discuss in the project?
The information you give in your interview will only be seen by the researcher, transcriber and supervisors. It will not be disclosed to anyone in an identifiable form unless there are serious concerns for your welfare, concerns for other people's safety, or unless you have disclosed something illegal or that might threaten the XXXX security. No report will include any information that might enable another person to easily identify you. Digital recordings and transcripts will be made anonymous and will be kept securely. No information will be kept on home computers. Digital recordings will be destroyed at the end of the study. Anonymised transcripts may be kept for up to 6 years by the Department of Clinical Psychology to allow journal articles to be written up by the researchers. If you are concerned about the use of quotes from your interview(s) in the report you will be able to check this with Catherine Wilkinson.

7) What happens when the project is finished?
When the project is finished everyone who took part and staff will be able to see the summary of the research findings. This will not include any information that could identify you. There will also be a presentation about the findings. The project will be submitted as a report to the University of Leeds Clinical Psychology Doctorate Course. The project will also be written into a journal article. No identifiable information will be used in the report or presentation. Quotes from interviews will be used but they will be made anonymous.

8) Who is organising and funding the project?
The project is part of the qualification for the Doctorate in Clinical Psychology, which is being undertaken by Catherine Wilkinson. Funding for the study comes from the Leeds Teaching Hospitals NHS Trust and Leeds University.

9) Who has reviewed the project?
The project has been reviewed by the Leeds (East) Ethics Committee, the Research and Development department at Leeds Mental Health Trust, and an independent panel of reviewers at the University of Leeds.

10) What if I'm not happy with something about the project?
If you have any concerns or complaints about the project or how you have been treated during the project please contact XXXXXXX in writing at the Programme in Clinical Psychology, Leeds Institute of Health Sciences, Charles Thackrah Building, 101 Clarendon Road, Woodhouse, Leeds, LS2 9LJ. If you need help with writing a letter you can gain support from the staff at the XXXXXXX as they are independent to the project.
If you want to take part please ask a staff member to contact Catherine Wilkinson to arrange for her to visit you to discuss the project or you can contact her on XXXXXXXX

Appendix B: Consent form

HEADED PAPER –LEEDS UNIVERSITY
CONSENT FORM

'An exploration of service users' experiences of a low secure forensic mental health service'

Researcher: Catherine Wilkinson (Psychologist in Clinical Training)

This form is to help check that you understand what the project involves.

	YES	NO
I have read the information sheet (dated August 2007) for this project, and I have had the chance to ask questions about the project.	☐	☐
I understand that I can withdraw at any point, without giving a reason, and that this won't affect my treatment or my status under the Mental Health Act.	☐	☐
I understand that I do not have to talk about anything unless I want to.	☐	☐
I am aware that the information I talk about will be confidential unless it means that I am at risk or someone else is at risk, if I disclose a crime, or it threatens the security of the XXXXXXXX	☐	☐
I consent to interviews being digitally audio recorded	☐	☐
I consent to extracts from my interview (s) being used in a report, in talks and in posters when they have been made anonymous.	☐	☐
I agree to take part in the project	☐	☐

_____	_____	_____
Name	Signature	Date
_____	_____	_____
Researcher	Signature	Date

Appendix C: Topic Guide

Introduction

- Discuss consent
- Discuss how long meet for
- Discuss what interview involves
- Discuss the aim of interview
- Remind participants about confidentiality, and times that it may be broken.
- Remind participant they can stop the interview at any time

"As you know I am interested in finding out about your experiences of being at the X and your view about how they have affected you. Please tell me about……"

1) "Tell me what it is like being here now"

Prompts:

- Tell me what has happened to you now that you are here? How do you feel about this/what thoughts do you have about this?
- Tell me about your hopes from being here.
- Tell me about being on the ward.
- Tell me about the activities that you do. What do you think about these?
- How do you think decisions are made about you being here? How do you feel about this?
- Tell me about any good times you have had here
- Tell me about any negative times you have had here
- Can you give me an example of this…
- Was this a typical experience of being here?
- Can you think about anything that has been helpful whilst you've been here
- Can you think about anything that has been unhelpful whilst you've been here
- Can you tell me about a recent difficulty you have had. Tell me how you coped with this.
- Tell me about what helps you make decisions here/act /what you tell people

2) "Tell me about your relationships"

Prompts:

- Tell me about how you get on with the other service users
- Tell me about your contact with staff members
- Tell me about contact with friends/family whilst you've been here.
- How do you feel about this/what do you think about this?
- Have your relationships changed since you have been here?
- Have you been able to talk to other people about your experiences? How was this?

3) "Tell me about your life before coming here"

Prompts:

- Tell me about your friends/family/activities/housing
- Tell me about any contact you've had with mental health services before coming to the XXXXXXXX.
- Tell me about your views of mental health services/forensic services before coming here?

4) "Tell me about your view of why you came here."

- "Is this the same view as you had before?"
- "Tell me what led to this change?"
- "How much do you feel this is due to……."
- "Are your views different to the staff team's views?" Can you give me an example?

5) "Tell me about your experience of coming here"

Prompts:

- Tell me about what happened when you first came into the unit?
- What did you think was happening at this time?
- What happened first? How were you feeling…..? What did you think about… ? Tell me how you managed with these thoughts and feelings?
- Then what happened to you?
- Did you compare this unit to other units? (If have had prior contact with services).

6) "How has being here changed how you see yourself?"

7) "Tell me about your thoughts about the future"

Prompts:

- How do you feel about the future/what thoughts do you have about the future?
- Tell me about what you see yourself doing after you leave here
- Tell me about who you'd like to spend time with after you leave here
- Would anything be different in the future? Would you be different in future?

Additional questions -age, -diagnosis, how long they've been on the unit

End of interview:

- Review consent again. Ask if there is any information that they are concerned about having given during the interview.
- Check out how the participant is feeling, and whether any additional support is needed
- Discuss whether a further interview is needed. If not, explain how they will be able to access the research findings.

Appendix D: Ethics Approval

Leeds (East) Research Ethics Committee
Room 5.2, Clinical Sciences Building
St James's University Hospital
Beckett Street
Leeds
LS9 7TF

Telephone: 0113 2065652
Facsimile: 0113 2066772

10 October 2007

Miss Catherine Wilkinson
Psychologist in Clinical Training
University Of Leeds
Charles Thackrah Building
101 Clarendon Road
Leeds
LS2 9LJ

Dear Miss Wilkinson

Full title of study: **An exploration of service users' experiences of a low secure forensic mental health service.**

REC reference number: **07/H1306/87**

Thank you for your letter of 1 October 2007, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for other Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

R&D approval

All researchers and research collaborators who will be participating in the research at NHS sites should apply for R&D approval from the relevant care organisation, if they

have not yet done so. R&D approval is required, whether or not the study is exempt from SSA. You should advise researchers and local collaborators accordingly.

Guidance on applying for R&D approval is available from http://www.rdforum.nhs.uk/rdform.htm.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

Feedback on the application process

Now that you have completed the application process you are invited to give your view of the service you received from the National Research Ethics Service. If you wish to make your views known please use the feedback form available on the NRES website at:

https://www.nresform.org.uk/AppForm/Modules/Feedback/EthicalReview.aspx

We value your views and comments and will use them to inform the operational process and further improve our service.

07/H1306/87	**Please quote this number on all correspondence**

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

Yours sincerely

Dr John Holmes
Chair

Email: ann.prothero@leedsth.nhs.uk

Appendix E: R&D Approval

Our Ref: 2007 / 062 / L

West Yorkshire Mental
Health R&D Consortium
Research & Development Department
North Wing, St Mary's House
St Mary's Road
Leeds LS7 3JX

Dear Catherine,

RE: Service users' Experience of Forensic Mental Health Settings

I am pleased to inform you that the above project has been approved by the relevant Consortium panel and we now have all the relevant documentation relating to the above project. As such your project may now begin within the Trust.

This approval is granted subject to the following conditions:

- You must comply with the terms of your ethical approval. Failure to do this will lead to permission to carry out this project being withdrawn. If you make any substantive changes to your protocol you must inform the relevant ethics committee and us immediately.
- You must comply with the Consortium's policy on project monitoring and audit.
- You must comply with the guidelines laid out in the Research Governance Framework for Health and Social Care[2]. Failure to do this could lead to permission to carry out this research being withdrawn.
- You must comply with any other relevant guidelines including the Data Protection Act, The Health and Safety Act and local Trust Policies and Guidelines.
- You must adhere to the Trust's Counter Fraud policies. If you suspect that research misconduct or fraud is taking place you must report this immediately following the instructions provided in the enclosed Counter Fraud leaflet.
- If you encounter any problems during your research you must inform your supervisor and us immediately for advice/assistance.
- Research projects will be added to the National Research Register.

Once you have finished your research you will be required to complete a Project Outcome form. This will be sent to you nearer the end date of your project (Please inform us if the expected end date of your project changes for any reason).

We will require a copy of your final report/peer reviewed papers or any other publications relating to this research. Finally we may also request that you provide us with written information relating to your work for dissemination to a variety of audiences including service users and carers, members of staff and members of the general public. You must provide this information on request

If you have any queries during your research please contact us at any time

Yours sincerely

John Hiley (Research Governance & Programme Manager)

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[2] Details from:
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4108962&chk=Wde1Tv

Appendix F

Table 10: Marked transcript for Joan

Initial observations	**Extracts (R-participant, IV-interviewer)**	Themes
Hoping vs avoiding getting her hopes up because she has to wait for others to decide/agree Having to be told by staff –not able to decide herself, unsure re trust	R well I think I'm getting there. I don't think I'll be here much longer. That's what a nurse said after the ward round, 'you're on the way out', I thought 'wahey' well he might be wrong. He might be totally wrong…….	Feeling uncertain
	IV. How did it feel hearing him say that?	
Surprise –not letting self hope? Something to be given/done to her	R Surprised. IV. Surprised?	
Waiting? Passing time?(it's been a while) I have to please others? I have to comply?	R yeah, well I thought I've been quite a while. And I haven't hit people and I haven't lost my temper. I've just kept calm and cool. Can this pick up my voice? (*ref. To Dictaphone*) IV yeah. We can listen back to it if afterwards or test it if you want…… IV We were talking about how you were feeling	Trying to make sense of how to be discharged
Not asking –because it won't make a difference? Not wanting to be dependent?	R. I was a bit surprised yeah. I didn't ask him for it *(???unclear*) Just hope it's true…..you know	
Doctors have power –need the doctor's approval/goodwill	R well it's not up to a nurse is it. It's up to a doctor, what he feels. The nurses well they tell the doctor how well I'm doing, if I'm doing well, and that gets him in the frame of mind maybe, you know, out of here soon. Right now it's all talk……	Trying to be seen as others want them to be
They've got power –I haven't I have to please others-can't get on their 'wrong	R. they've got a lot of power these doctors. You know what I mean. They do have a lot of power. If you get on the wrong side of them you might as well just forget it. Well, Dr X, I prefer him to the other doctor,	Feeling powerless Trying to make sense

side'	the Indian doctor before him. He was a pain in the arse.	of how to be discharged
	IV in what way? What happened?	
I'm being persecuted for being white by Asian Doctors Experiencing things as being done to her (re put me in) -passive	R. well, dead set against me from the start because I'm white, you know what I mean. It's always been brown doctors who put me in these sort of places. White doctors they haven't. Only brown doctors.	I'm being persecuted for appearing different Feeling powerless
	IV Why do you think there's that difference?	
They're frightened of me because I look scary It's not my fault 'they don't like us' –-I'm not like them	R well……I think they think I'm a little scary, they don't like me. They don't like the way she's speaks. Let's get her, you know what I mean. It's true. It can do a lot of harm. Because they don't like us, a lot of people who come over here, they don't like us at all. Do you know what I mean? You know, they've got a chip on their shoulder. You know, it's not our fault. We weren't even thought of when those things in India were going on. You know.	I'm being persecuted for appearing different
	IV so is it that you think that because of things in the past that some people have a problem with other people and with you.	
-Experiencing others as unreliable, unreasonable or harmful -Do you know what I mean –invitation for me to agree and not explore further?	R yeah. They pretend to be nice to you but then they try and stab you in the back. Do you know what I mean.	Feeling vulnerable
	IV. Can you think of a time when that's happened?	
Moving away from the topic?	R. well coming in here. ……. what else do you want to know.	
	(*unclear –participant coughing*) *discussion re admission.*	
	IV. You were saying you've not had any bad experiences here.	
Seemed hesitant. Changed mind re what saying (and 1st interview)-increased rapport/trust?	R well I have…….	
I've been put –passive- done to me	R well….I've been put in the seclusion room, at the end, for banging the wall, this nurse…I asked if she'd close the door…and she was just	

some of them came over, dragged me –done to me 'them' –I'm/they're different bit of a scrap –minimising it nurse-role not using name	having a cig. I said there's smoke coming into the dining room…can you please close the door love. That's the second time I'd said it and she just left open the door. I pulled it to and then she pulled it and I pulled it. In the end it got into a bit of a scrap. And then she pressed her alarm button so some of them came over, dragged me, come down to seclusion.	
	IV how were you feeling during this	
-They think they're right –but nothing I can do even if they're wrong? Link to other comments re people being risky/untrustworthy -Said pissed off but sounded tired/weary	R ah, pissed off……one thing, a lot of nurses seem to think they're always in the right. Nobody's always in the right. You know what I mean. Sighed	Feeling vulnerable
Prejudice: Ignorant to me 'cos I'm white, her prejudice towards people Link to interview 1-'persecuted' and in this interview	R. well she was being bloody ignorant. Another bloody Indian. She's got straight hair. I wonder if she straightens it. I can't tell. I think it's quite straight. I don't know if she's Indian or Negro	I'm being persecuted for appearing different
	IV you said she was being ignorant to you	
(I was) reasonable Not my fault –others I'm reasonable –not aggressive	R. yeah, well I thought she was. I wanted that door closed and I was waiting for my dinner. I didn't want smoke coming in the dining room. I think it was quite reasonable, don't you……I asked her twice. Then the third time I went to grab the door. She had the door as well……	Being reasonable Being unheard
Punished? 'people' – different to me They have power?	R. yeah. yeah she pushed it (*ref to security alarm*) and people came running and I was taken down. Took me down there –seclusion.	Others in control/have power
Being disbelieved	R not very nice ……being held, restraint, everyone getting the wrong end of the stick. Cos they all believe what the staff say, you know what I mean….	Feeling powerless

……indicates a pause by the participant

Table 11: Examples of how themes were further analysed and grouped after initial themes for Joan: Bold indicates subthemes shown in extracts from table 10.

Theme	Cluster	Sub themes (from throughout interview)
Feeling disempowered and vulnerable (experience)	Feeling powerless	**Experiencing things as being done to her**
		Being disbelieved/unheard
		Avoiding getting her hopes up because she has to wait for others to decide/agree
		Being talked about when she's not there and unable to influence what's decided
	Becoming weakened	Medication affecting memory/thoughts /motivation/
		Feeling unfit
		Becoming dependent on others
	Feeling vulnerable	**Experiencing others as unreliable, unreasonable or harmful**
		Feeling the treatment she receives can be harmful but that she has no choice but to accept it
It's senseless me being here (understanding of experience)	Believing her feelings are normal/real.	Everyone is the same/has these experiences
		Others think I'm ill, I don't
		What I'm experiencing is real
	Believing she shouldn't be here and left trying to make sense of how to be discharged	**All I can do is wait**/resign myself
		I need to lie or omit things: if I tell them different views to theirs I won't get out
		I have to please others
		I don't know what I need to do to pass their tests: