

EXPLORING HOSPITAL POLICY MAKERS' UNDERSTANDINGS OF FORENSIC INPATIENT SEXUALITIES

Jason Poole

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For Paula Reavey, who forever changed the way I understand myself and the world.
Your kindness opened more doors for me than I would have ever thought possible.

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ABSTRACT

Background: UK professionals' understandings of their roles with regards to service users' sexualities is an under-explored area in clinical research and training, particularly within forensic mental health pathways where they may be exclusively conceptualised in terms of their potential negative underpinnings and outcomes. Secure services typically have no policies governing or promoting sexual expression, and tend to prohibit sexual intimacy. However, recent developments in national guidance and findings emerging from UK-based and international research raise questions as to this approach's utility in providing rehabilitative care. To date, no research has investigated forensic hospital policy-makers' sense-making practices around detainees' sexualities.

Aims: This study aims to examine hospital policy-makers' understandings of forensic detainees' sexualities, and how these relate to their experiences of practice and their vision of a policy governing sexual expression in hospital. The research is one part of a broader project that has previously explored detainees' and professionals' understandings of how sexualities operate within forensic institutions, and aims to support the development of policy and training materials.

Methods: The present research draws upon a social constructionist epistemology, using a qualitative, thematic decomposition approach to examine the socially-sedimented discourses at play within the forensic hospital. Ten policy-makers were recruited the largest provider of forensic inpatient services in the UK, and participated in semi-structured interviews.

Findings: Three themes were identified: 1) Risk and Uncertainty, 2) Artificial Realities, 3) Detained Bodies. The implications of each of these are discussed in terms of their sub-themes.

Conclusion: Despite being broadly consistent with policy-makers' understandings of holistic, rehabilitative practice, the prospect of lessening restrictions on detainees' sexual expression presents a number of challenges and concerns. 'Traditional' institutional and populist discourses concerning forensic

professionals' responsibility to prevent harm tended to supersede those supporting positive risk-taking and human rights-based approaches. The propensity for UK tabloid media to depict forensic detainees and professionals in an unfavourable light, and the accompanying potential for increased government scrutiny, was understood as a primary barrier to enacting less restrictive practices. The hospital itself was positioned as vulnerable to the predations of wider society.

1. Introduction

1.1 Overview

This thesis aims to develop an understanding of how members of a UK forensic hospital directorate make sense of detained persons' sexualities and the institution's role in promoting, repressing, or disregarding these through the application of (in)formal ward policies and practices. This chapter draws upon the works of Michel Foucault to situate the forensic hospital in its socio-historical context, proceeding to problematise contemporary forensic inpatient discourses and practices with regards to detainees' sexualities. Present-day forensic practice is explored in relation to international human rights law, with emphasis on detainees' ability to form and maintain intimate relationships and the dilemmas that this presents for hospital staff. The chapter further examines the historical construct of 'sexuality' as an individualised biological and intrapsychic characteristic, presenting an account of sexualities as residing in the networks of relationships between detainees, staff, the hospital, and the outside world. Finally, the key aims, rationale, and research question for the thesis are presented.

1.2.1 Notes on terminology

- The word 'sexuality' is used in this chapter and throughout the thesis as a broad term without a singular definition. It refers to how people might feel as sexual beings, including their relationships with: feeling intimate with themselves and others; feeling and being romantic; feeling sexually attractive; feeling sexually attracted to others; feeling desire; and feeling sexual pleasure (Brown et al., 2014).
- Persons residing in secure wards are primarily referred to in this thesis as 'detainees' rather than 'patients'. This is intended to acknowledge the conflictual subject positioning of those detained as simultaneously requiring 'care' and 'control' by the institution (Holmes, 2002). The term's use is

intended to avoid presenting a sanitised account of forensic inpatients as people who are simply using a service, instead recognising that they are subject to involuntary detention (Jacob & Holmes, 2011).

1.1.2 Identifying relevant literature

Following an initial scoping review of extant research, it was established that literature specifically concerning the sexualities of forensic detainees in the UK is scarce. Moreover, the positioning of forensic practice across both justice and mental health frameworks presented difficulties in terms of evaluating relevance. For instance, the experiences of and accompanying frameworks surrounding sexualities in prisons appears salient to this research at times, and less so at others. In response to these complexities, the literature search initially focused on two themes: the interactions between forensic detention, relationships, and policy, and the interactions between sexuality, psychological wellbeing, and mental health practice. In reviewing the literature concerning these topics, human rights law and its relationship with sexualities and justice/mental health practices consistently emerged, and was incorporated into the review as a third theme.

The approach to the literature review involved conducting a systematic search of electronic databases concerning psychology, sociology, medicine, and other (social-) sciences. These included Science Direct, PsycINFO, PsychARTICLES, PubMed, and SCOPUS. Open source repositories including ResearchGate and Academia.edu were also used. The terms ‘forensic inpatient’, ‘offenders’, ‘sex’, ‘sexuality’, ‘relationships’, ‘policy’, ‘human rights’, and ‘Article 8¹’ were used individually and in combination with one another. Further search terms were added as revealed by the literature, including ‘governmentality’, ‘relational security’, and ‘conjugal visits’. Those full texts that were considered to be of potential relevance to the research, following abstract readings, were obtained and incorporated into the review. Those considered relevant tended to be explicitly concerned with sexual expression within forensic

¹ Article 8 of the European Convention on Human Rights, which protects a person’s right to respect for their private and family life, including the possibility of enjoying (un)married relationships without government interference.

inpatient hospitals, or alternatively focused upon constructs or contexts that were related to this, such as policy's role in the promotion of UK detainees' rights to privacy and family in prisons, or staff members' engagement with patients' sexualities on open wards. Full texts addressing tangentially related issues in separate contexts tended to not be considered salient (e.g. one article examining primary care mental health professionals' engagement with sexualities was not included).

468 articles were initially found. Titles and abstracts were reviewed for relevance to this research and subject-specific limiters were applied. For instance, texts concerning policy and legal frameworks were only deemed relevant if specific to UK-based forensic services. Due to the scarcity of literature addressing sexuality in forensic settings, this was included regardless of date of publication, country of origin, type of methodology, or participant population. Literature explicitly concerned with the prediction and prevention of sexual offences was largely omitted, due to their being concerned with sexual violence rather than sexual expression. The search identified sixteen articles directly related to sexuality in forensic inpatient settings. A full account of the literature search process is included in Appendix A.

1.2 Forensic Inpatient Units

1.2.1 Historical context and discursive tensions

The responsibility of societies to prevent those experiencing psychological distress from causing harm to others can be dated to antiquity, featuring in Plato's laws (translation by Saunders, 1970). In Britain, the societal tendency to detain those demonstrating signs of 'madness' began in earnest in the mid-seventeenth century, in a period known as the 'great confinement'. This practice further developed under political absolutism, with a ruling class that privileged rationalist philosophies emerging from the Enlightenment, including concepts of 'social physics' emphasising institutional balancing and social harmony (Foucault, 1964). Within this context, the value and inherent morality of low-class individuals came to be socially defined by

their ability to engage in state-sanctioned production, and so the 'lunatic poor' became positioned as unwelcome Others, akin to beggars and petty criminals in their 'idleness' (Porter, 1990). The solution to the presence of these unwanted people was to engage in the dual practices of embarkation² and confinement – simply removing Othered bodies from population centres was insufficient, and steps had to be taken to ensure that they could not return (Foucault, 1964). Asylums were thus constructed with physical security as a priority, marked by high walls, isolation and mechanical restraint (Crichton, 2009).

The early 19th century saw the emergence of a more humane, albeit paternalistic, alternative to medical interventions of the time (e.g. blood-letting, purging, and physical restraint). This 'moral treatment' sought to engage detainees in work and religious instruction so they might overcome their idleness, with conformity to polite social behaviour viewed as evidence of treatment success (Tuke, 1813/1964). The mass detention of 'lunatic paupers' became a formalised duty of the state following the passing of the County Asylums Act 1845, which required justices of the peace to establish asylums in their counties. Within these spaces medical intervention and moral treatment became merged. Ensuing attempts to classify and manage the large populations that these shifts created contributed to the development of a new medical discipline, psychiatry, and madness was re-positioned from a moral failing to a medical malady (Foucault, 1964; Pilgrim & Rogers, 1993). By 1930 around 250,000 people were detained in British institutions (Jones, 1993), in which physical restraints had largely been replaced by complex systems of rules and practices that served to maintain a safe environment via the institutionalisation of detainees (Crichton, 1995).

The establishment of state-run asylums coincided with the development of a national prison service, culminating in the Prison Act 1877. Psychiatric expertise was relied upon in justice proceedings throughout the 19th century, and primarily concerned itself with establishing whether an individual could be considered responsible for

² Foucault (1964) describes this as a ritualised practice by which those deemed 'mad' would be physically removed from population centres, originally in 'mad ships' – actual sailing vessels. The tendency for those removed in this way to return to their point of origin resulted in the creation of the 'madhouse' and accompanying technologies of confinement designed to prevent this from occurring.

their own actions, and what risks they might pose to themselves and others (Havard & Watson, 2017). Even prior to the nationalisation of criminal detention, it was understood that people with mental health problems were overrepresented in the prison population (Guy, 1869), a trend that continues into the present (McRae, 2015). The Criminal Lunatics Act 1800 marked the first legal provision for convicted persons believed to have not been in control of their faculties outside of gaoling or release, and gave the state power to detain indefinitely those acquitted of criminal acts due to insanity. Similarly to the 'lunatic poor', these 'criminal lunatics' required their own centres of enclosure in order to maintain the public good (Deleuze, 1995). The first of these spaces, Broadmoor Criminal Lunatic Asylum, opened in 1863.

Contemporary NHS England and Wales forensic inpatient services consist of 7718 male and female beds arranged across 3 high-secure hospitals (including Broadmoor), 57 medium-secure units, and a growing number of low-secure units. Admission to any of these services is predicated upon a history of violence or the belief by healthcare professionals that a person presents a risk to public safety or, in extreme instances, themselves (Davoren et al., 2015). Despite these differing levels of security having existed for some time there is limited clear guidance delineating them, with definitions relying upon clinical judgement. For instance, primary distinctions between a person's detention in a medium-secure rather than a low-secure unit are their being considered a 'serious' rather than a 'significant' risk of harm, and the belief that their escape from hospital must be 'prevented' rather than 'impeded' (NHS England, 2018). These services' policies and practices may become defined by *"a combination of common sense, comparison with elsewhere, official guidelines, and learning from security breaches"* (Crichton, 2009, p. 333).

People may be detained in forensic inpatient services immediately following court proceedings, or may be transferred from prisons or mental health services due to heightened levels of concern regarding their level of risk and mental state (Joint Commissioning Panel for Mental Health, 2013). Though reliance upon experienced clinical judgement can be efficacious in preventing harm in forensic inpatient settings (e.g. Fuller & Cowan, 2008), institutional pressures from any of these trajectories may skew practice towards placing detainees under higher levels of security than are strictly necessary (Pilgrim & Rogers, 1993). This concern was made manifest in the

Mental Health Act 2007, which established a broad definition of ‘mental disorder’ under which a person might be legally detained in preventive custody. Moreover, the Act removed stipulations from the Mental Health Act 1983 under which people could only be detained indefinitely if beneficial treatment could be made available to them. At time of writing, people in the UK may be admitted to forensic services in which no effective treatment is available to them if it is felt to be in the interests of public safety (Glover-Thomas, 2011; McRae, 2015).

The historical underpinnings of forensic inpatient services have situated them in a unique position, bridging both carceral and healthcare systems, and producing discursive tensions as to the function of the sites, the roles of staff, and the anticipated outcomes for detainees (Holmes & Murray, 2011). At its baseline, the forensic hospital meets a societal need, as those detained within may present a real and significant risk of harm to themselves and others. This reality serves to maintain historical discourses concerning madness and criminal behaviour as frenzied states experienced by immoral Others, which are reproduced within contemporary media representations depicted by hyper-moralistic British tabloid news (Cooper & Cross, 2017). The removal of forensic detainees from society, in tandem with the persecutory discourses surrounding them, produces double stigmatisation of detainees as offenders and recipients of mental health treatment. They may consequently become disconnected from the relationships they experienced prior to detention (Marshall & Adams, 2018).

The influence of the institution in people’s lives can become ‘total’ (Goffman, 1961; Holmes & Murray, 2011), particularly for the minority of individuals subject to long-term detention (10-15+ years) (Shah et al., 2011), who may experience significant disconnection from both the outside world and their own pre-admittance identities (Quirk, Lelliot & Searle, 2006). Staff may find themselves simultaneously inhabiting conflicting positions as ‘peace officers’ and ‘agents of care’, while they are themselves subject to surveillance under bodies of psychiatric and psychological knowledge; a micro-physics of power that strategically maintains restrictive practices (Foucault, 1977; Holmes, 2005). These tensions may be conceptualised as producing uncertainties, and accompanying anxieties, for both staff and detainees, necessitating ongoing renegotiations of relational security.

1.2.2 Relational Security

Similarly to Tuke's (1813/1964) 'moral treatment', contemporary forensic inpatient praxis emphasises that ward security cannot be maintained with physical safeguards alone. Rather, the quality of relationships experienced by detainees serves to promote their safety and that of staff. In secure settings, this is conceptualised as 'relational security', which in tandem with physical and procedural securities is understood to prevent the occurrence of unwanted or dangerous behaviours (Faulk & Taylor, 1986; Allen, 2015a). Despite its acknowledged importance, relational security has received less attention in policy, training and research than its physical and procedural counterparts (Aitken & Noble, 2001; Exworthy & Gunn, 2003; Parry-Crooke & Stafford, 2009), and has been consequently referred to as the 'poor relation' by comparison (Tighe & Gudjonsson, 2012). Moreover, the concept is difficult to define, with its constituent constructs (e.g. 'therapeutic relationships' and 'boundaries') themselves resisting coherent delineation (Chester & Morgan, 2012; Chester & Alexander, 2017).

In preeminent guidance (Allen, 2015a), relational security is constructed as concerning detainees' relationships with: their treatment team, with emphasis on clear boundaries and purposeful therapy; other detainees, with emphasis on the mix of detainee demographics and the 'patient dynamic' (or relationships across detainees and the team); the inside world, with emphasis on a detainee's personal world and their relationship with the physical environment of the ward; and the outside world, with emphasis on visitation and the maintenance of pre-existing connections external to life on the ward. However, practice and research tends to focus on the first two of these themes, with models of relational security prioritising team dynamics and detainee-staff relationships almost to the point of excluding detainees' valued connections (e.g. Chester & Morgan, 2012; Kennedy, 2002).

For forensic professionals, detainees' pursuit of intimacy presents a number of concerns, which may act as barriers to both groups' desire to include sexual issues on the treatment agenda. These include: detainees' (fluctuating) capacity to consent to participate in emotional attachments and sexual intercourse; sexual exploitation of those who lack capacity or other vulnerable individuals; accusations of rape or

sexual abuse and the management of these; unsafe sexual practices; (un)wanted pregnancies; experiences of trauma and past histories of abuse; sexually transmitted infections; HIV/AIDS; violence in response to relationships; and transactional sex (Dein, Williams & Dein, 2007; Dein & Williams, 2008; Hunter & Ahmed, 2016; Quinn & Happell, 2016; Series, 2014). One systematic review has identified a high rate of 'risky' sexual interactions between psychiatric patients (Meade & Sikkema, 2005) and there is evidence to suggest that persons who receive diagnoses of chronic and severe mental illness are more likely to contract sexually transmitted infections than non-psychiatric populations (Lagios & Deane, 2007). However, a recent meta-analysis indicates that diagnosis of mental illness is likely to be an unreliable correlate confounded by its strong association with other factors impeding access to safe sexual practices, such as low socioeconomic status and ethnicity (Hughes et al., 2016).

Accounts offered by those detained in secure services describe geographic, financial and institutional barriers to developing and maintaining relationships both within and outside the ward, including admissions far from home and limited access to communications technologies (Brown et al., 2014; Ravenhill et al., 2019). Pursuit of intimacy in these spaces is subject to scrutiny and intervention, with risk-saturated narratives of predation, vulnerability, and liability contributing to a broad tendency for professionals to prohibit intimacy (Bartlett et al., 2010; Brown et al., 2014; Buckley & Robben, 2000; Ravenhill et al., 2019). Impeding relationships in these ways can be understood as a culturally-situated praxis within the UK. Forensic institutions in Germany and the Netherlands, for example, can regard sexual relationships as complementary to treatment, noting that hindering these may result in detainees feeling frustrated, with accompanying elevated levels of risk on the wards (Tiwana, McDonald & Völlm, 2016).

UK forensic inpatient spaces may thus currently engage with relational security in a somewhat dissonant fashion, discarding evidenced strategies of risk reduction (Allen, 2015a) due to anxieties that entertaining them might paradoxically increase the likelihood of untoward incidents (Dein et al., 2016; Ravenhill et al., 2019). The mechanisms by which facilitating detainee relationships can be understood to align with forensic institutions' goal of supporting detainees will be explored in greater

depth later in this chapter. These include: increased perceived positive aspects of the ward stay (Moses, 2010; Gilbert, Rose & Slade, 2008); reduced recidivism and enhanced rehabilitation amongst those charged with offences (Stevens, 2013); reduced likelihood of future diagnosis of mood, anxiety, and substance use disorders (Fals-Stewart, Birchler & O'Farrell, 1999; Newcomb, 1994; Overbeek et al., 2006; Whisman, Uebelacker & Bruce, 2006); and increased willingness to adhere to treatment plans and motivation to leave hospital (Deegan & Drake, 2006; Tiwana, McDonald & Völlm, 2016).

As indicated by these examples, relationships likely hold greater ontological meaning for detainees than the preservation of 'security' alone, and we may instead understand risk reduction as a favourable side-effect of supporting these. Forensic inpatient professionals are not unaware of the salience of sexual expression and intimacy to detainees, and many may themselves experience discomfort when expected to prioritise potential risk over supporting detainees' values (Davis et al., 2018; Ravenhill et al., 2019). However, it must be acknowledged that the detention of people in forensic hospitals arises from significant concerns regarding their ability to function outside of hospital, including pronounced risks of harm to themselves and others. The facilitation of intimacy, within the hospital or in the community, may subject staff to a number of possible contexts in which harm, which they may feel responsible for, might occur. The practice of primarily situating detainees' personal connections within risk-saturated discourses, rather than those concerning wellbeing, may then be understood as protective of staff as they attempt to negotiate the complex dilemmas that detainees' sexual desires present to them (Holmes, 2005; Jacob & Holmes, 2011).

The noted discrepancies between research and practice may find their roots in the framing of relational security when disseminated amongst inpatient staff, which emphasises the value of staff 'knowing their patients' so that they might intervene pre-emptively in a manner that contains security breaches before they occur (Chester & Alexander, 2017; Dale & Storey, 2004). Prevention of, rather than response to, untoward incidents is viewed as the 'gold standard' of risk

management. However, the implication that all such instances can be prevented may foster a 'culture of blame' within services, in which a primary outcome of incident reviews becomes to establish which professionals are individually culpable for not successfully predicting harm (Morgan, 2007). The perception of safeguarding processes as facilitators of professional blame may be understandably discomfiting for staff, and may incentivise them to enact greater levels of restriction than they would otherwise feel are necessary.

Just as reliance upon overt degrees of restriction may conflict with professionals' personal views, these practices also chime poorly with current trends in legislative and policy frameworks promoting the individual rights and responsibilities of psychiatric patients (Care Quality Commission, 2017; Care Quality Commission, 2019). As such, institutional prohibition of intimacy tends to be situated within informal policies and practices rather than official documentation or training that would conflict with national guidance (Ravenhill et al., 2019). An absence of formal policy necessitates the application of 'soft power' in secure services (Crewe, 2011), rather than authoritarian intervention. This manifests as detainees who are made responsible for managing their own risk, made explicit in the notion of the 'supervisable' forensic detainee, whose 'stability' is constructed as their choosing to be predictable and tolerant of control and intrusion by professionals (Blom-Cooper, 1995; Crichton, 2009). Relational security in forensic mental health settings thus relies upon a neoliberal governmentality, or 'neo-paternalism', which emphasises detainees' adherence to an ethics of self-government as the primary indicator of their being deserving of liberty (Brown et al., 2014; Crewe, 2009; Foucault, 1997).

1.2.3 (In)formal policy as governmentality

Foucault's (1991) theory of governmentality presents a helpful means of understanding (in)formal forensic policy, emphasising a complex network of power relations intended to exert social control over governed objects via the application of three forms of power: sovereignty, discipline, and government. This construct attends to more overt expressions of power within sovereignty and discipline,

including technologies of domination, punishment and reward, while also acknowledging the influence of an ethics of self-government (McNay, 1994). In the UK, policy concerned with the management and governance of detained persons has recently shifted towards the neo-paternalistic exertion of soft power, with prison officers' roles becoming more concerned with the promotion of 'positive' behaviours (Crewe, 2009).

Neo-paternalism bears linkages with the psychiatric construct of relational security, emphasising the importance of staff-detainee relationships to ensure that detainees come to regulate their own behaviour and that 'hard power' techniques, such as commands or physical restraint, are less necessary. This may be further complicated in forensic hospitals by the almost ubiquitous use of medications, which enforce less-visible, chemical restraints upon detainees' bodies, particularly in terms of sexual expression (de Boer, 2014; Kneegtering et al., 2008; Serretti & Chiesa, 2011). Instilling an ethics of self-governance may further serve to protect staff from reliance upon more forceful exertions of institutional control, which they might experience as the infliction of further punishment upon vulnerable patients. Engaging with government in the carceral context thus becomes concerned with psychologically transforming detainees' desire to engage in particular acts, or seeking *"to shape conduct by working through our desires, aspiration, interests and beliefs, for definite but shifting ends and with a diverse set of relatively unpredictable consequences, effects and outcomes."* (Dean, 1999; p. 11).

The immersion of forensic staff in an (in)formal culture of risk serves to perpetually remind them of the potential dangers that working alongside detainees might entail. Moreover, professionals' possibilities for acting are themselves subject to neo-paternalism, by which the institutional culture seeks to modify their conduct through technologies of social control, including monitoring of their surveillance practices, supervision, and incident reviews (Holmes, 2005; Holmes & Federman, 2006). Failures to conform to the risk narrative can thus represent personal, professional, and legal shortcomings (Holmes, 2005; Jacob & Holmes, 2011). The physical structure of forensic inpatient settings, and spaces of detention more broadly, including double sets of locked doors, frequent alarms, and 'ligature-proof' furniture may similarly foster a culture of risk that understands detainees as inherently

vulnerable and dangerous (Bierie, 2012; Reavey et al., 2019a) Consequently, professionals' engagements with forensic policy and practice may threaten their perceptions of themselves as 'carer' and the detainee as 'person', as they struggle to simultaneously care for and control detainees (Holmes & Murray, 2011). Forensic staff may reconcile these competing imperatives by re-constructing detainees' unwanted desires and behaviours as rooted in mental health difficulties, justifying psychological modification of these as part of treatment (Brown et al., 2014).

1.3 Forensic Practice and Human Rights

1.3.1 Detainee rights and autonomy

At present, all UK citizens are afforded protection under the European Convention on Human Rights (ECHR), the rights within which are ratified in the Human Rights Act 1998 (HRA). Persons detained for offences by the UK state retain, in theory, all rights excluding their right to liberty. As Rule 2 of the European Prison Rules (Council of Europe, 2006) states: *"Persons deprived of their liberty retain all rights that are not lawfully taken away by the decision sentencing them or remanding them in custody"* (p. 6). This document specifies: *"Life in prison shall approximate as closely as possible the positive aspects of life in the community"* (p. 7). Similarly, the right to liberty of persons detained under the Mental Health Act 2017 is suspended until their Section is rescinded, but states are required to ensure that, in the absence of evidenced security concerns, all other rights are preserved. However, everyday practice within forensic institutions may frequently fall short of this requirement, particularly with regards to the preservation of detainees' privacy and family lives (Perlin, 2016; Ward, 2011). Moreover, the application of human rights law to detained individuals presents a greater degree of complication than in relation to the wider population.

Where states' duty to protect the rights of persons in society frequently requires negative action, or non-action (e.g. choosing not to interfere in communications), ensuring that the rights of detainees are met often rests upon positive obligations (e.g. implementing robust systems of communication in detention facilities) (van

Kempen, 2008). We may thus understand the role of the state with regards to the human rights of detainees as not merely being concerned with *protection*, but also their *promotion*. This may present particular difficulties in healthcare settings, where professionals may be unaware of their obligations to promote the rights of detainees, and whose routine practice may obstruct these (Patel, 2003; Sugarman & Dickens, 2007; Woogara, 2005).

Governments may interfere with detainees' access to human rights if this is demonstrably in the interest of national security, public safety, prevention of crime, protection of health, or protection of the rights of others (HRA, 1998). Article 8 of the ECHR, the right to respect for private and family life, home and correspondence, is qualified in the same manner, enabling institutions governing detention to impede relationships if this is justified. In mental health settings the obstruction of relationships may prominently feature a failure to promote sexual rights, as highlighted by one British study of service users' sexualities which found that none of their respondents were even aware of these (McCann, 2000). Detention in forensic units significantly limits detainees' and their relatives' opportunities to utilise their rights to respect for a private life (including their right to sexual expression), family life, and the possibility to start a family (Dein et al., 2016; van Kempen, 2008). At time of writing, no forensic detainees in the UK have access to conjugal suites, are allowed in one another's bedrooms, or are permitted to have visitors in their bedrooms, a markedly more conservative stance than adopted elsewhere in Europe (Tiwana, McDonald & Völlm, 2016).

Although conjugal visits may be considered a fulfilment of the obligation to provide humane living conditions and treatment of prisoners, the European Court of Human Rights (ECtHR) has historically made no demand of states to ensure that denial of these complies with the law, serves a legitimate aim, or is necessary in each individual instance (van Kempen, 2008). As such, states bound by the ECHR are not presently obligated to ensure that detainees have access to sexual contact, nor to demonstrate that prohibition is proportional to risk. However, a blanket prohibition of sexual expression and intimacy in forensic spaces without consideration of how this meets qualifying criteria under the ECHR in each instance is likely in violation of Articles 8 and 10 of the ECHR and Article 14(1) of the Convention on the Rights of

Persons with Disabilities 2006, and may be considered punitive rather than therapeutic (Dein et al., 2016; Perlin, 2016; Perlin & Lynch, 2014). Moreover, the instatement of this ban as the norm for all detainees, rather than considering proportionality in each case, may violate Article 14 of the ECHR, which offers all persons enjoyment of all Convention rights without discrimination.

Where rights to intimate relationships are presently included in forensic hospital guidance, they tend to be addressed only superficially. For example, forensic detainees in the UK are permitted to marry but not to consummate that marriage (Bartlett et al., 2010). Furthermore, the prohibition does not necessarily apply to reproduction, but rather specifically to engagement in sexual acts. Procreative freedom does theoretically exist for convicted persons in the UK, but exclusively relies upon the use of artificial insemination technologies, a position that the ECtHR has historically adopted to justify the UK's barring of conjugal visits as not being in violation of the ECHR (*E.L.H. and P.B.H. v United Kingdom*, 1997). Detainees who wish to procreate with their (married) partners may apply for permission from the state, which is reviewed on a case-by-case basis. However, such applications are usually rejected due to apprehensions regarding potential social disadvantage to the child and populist concerns regarding offenders being permitted to reproduce. Sutherland (2003) terms this routine limiting of detainees' reproductive freedoms in response to public concern "*the new eugenics*" (p. 5).

When examined in a European context, British forensic hospitals may currently enact some of the most prohibitive practices concerning sexual expression amongst EU member states (Tiwana, McDonald & Völm, 2016). Notably, Tiwana and colleagues identified a relatively unusual tendency for UK professionals to regard the ward as existing entirely within the public domain, suggesting that sexual expression by forensic inpatients has the potential to be experienced by staff as a deviant breach of the social contract (Ravenscroft & Gilchrist, 2009). UK-based research has confirmed that this understanding may be used as justification for prohibition (Dein et al., 2016). Moreover, forensic professionals may regard safety rationales as mechanisms by which detainees' dignity is protected, while possessing a limited understanding of what active promotion of their rights might entail (Sugarman & Dickens, 2007).

1.3.2 Staff attitudes and dilemmas

Staff attitudes towards the promotion of detainees' sexual rights may be influenced by their routine exposure to untoward incidents of a sexual nature. A recent Care Quality Commission (CQC, 2018) report identified 1,120 'sexual incidents' taking place on NHS mental health wards between April and June 2017, including 273 instances of sexual assault and 29 allegations of rape. 95% of these reports named patients as the alleged perpetrators, and they were also the most likely to be the affected party, comprising two thirds of the population. Despite roughly 27% of all incidents featuring sexual assault or rape, staff classified 97% of their reports as resulting in 'no' or 'low' physical or psychological harm to those affected, possibly representing an under-reporting of severity. The report further highlights that: *"Clinical leaders of mental health services do not always know what is good practice in promoting the sexual safety of people using the service and of their staff"* and *"many staff do not have the skills to promote sexual safety or to respond appropriately to incidents"* (CQC, 2018, p.14).

The recommended solutions to these issues are broadly structured around increased surveillance of patients on wards, making activities available to keep patients occupied as often as possible, and managing patients' use of communications technologies to mitigate the possibility of verbal sexual abuse and harassment. Where the report does allude to *"creating a culture that is ... open in encouraging staff and patients to report and discuss sexual wellbeing"* (p. 13), the few suggestions offered to facilitate this are centred on *"providing accessible information"* (p. 16) and responding to (rather than initiating dialogue around) the needs of LGBTQ+ patients (CQC, 2018). Maintaining the safety of persons detained on wards is of paramount importance, and both detainees and staff should not feel at risk of sexual violence in hospital. However, this document provides insight into how expressions of sexuality might be 'driven underground' by policy and recommendations that attend only cursorily to the promotion of rights while emphasising potential safety concerns (Brown et al., 2014). Conversely, prioritising

surveillance and prohibition may paradoxically produce “*exaggerated frustration and elevation of risk levels*” on the wards (Tiwana, McDonald & Völlm, 2016, p. 7).

Despite a broad tendency for forensic professionals to promote the wellbeing of those in their care (Morgan & Rees, 2018; Sugarman & Dickens, 2007), some staff in longer-term psychiatric inpatient settings may exhibit controlling behaviours including coercion, threats, emotional intimidation, and bullying (Cook, 2000; Gildberg, Elverdam & Hounsgaard, 2010; Gildberg et al., 2012). Where these occur, they present a significant barrier to forensic detainees’ ability to develop and maintain intimate relationships (Bartlett et al., 2010; Quinn & Happell, 2015). Moreover, they represent a series of human rights violations, and mental health services’ tendency to enact control over every aspect of service users’ lives (Dein & Williams, 2008; Simpson & Penney, 2011). Although the HRA 1998 introduced the right for detainees to respond to such treatment in UK courts, there is little indication that the number of legal challenges has increased as a consequence (Bowen, 2004; Sugarman & Dickens, 2007).

The ratification of the HRA 1998 raised concerns within the psychiatric community as to whether some aspects of long-term inpatient practice, such as lengthy seclusion, forced administration of medications, and the absence of conjugal visits, could be considered inhuman and degrading treatment (MacGregor-Morris, Ewbank & Birmingham, 2001). The latter of these highlights how risk-averse practices interfere with private and family life, protected by Article 8 of the ECHR. Article 8’s broad scope results in its being one of the most broadly interpreted provisions of the ECHR (Curtice & Sandford, 2009), though blanket prohibition of sexual expression chimes poorly with its protections and thus produces professional dilemmas (Patel, 2003; Ruane & Hayter, 2008; Sugarman & Dickens, 2007). Working in forensic institutional spaces necessarily involves the management of individuals with histories of significant sexual offending, whose desire for intimacy must be weighed against their potential to inflict harm on others (Völlm, 2019; Völlm et al., 2019). As such, the promotion of conjugal rights may risk infringing upon the rights of others.

The preservation of detainees’ rights to privacy and family life are particularly difficult within the forensic hospital, and in terms of sexuality may be understood as

protecting both those who wish to be expressive in private and those who do not wish to observe sexual behaviour. Many of those detained in forensic settings have experienced some form of sexual abuse and/or childhood abuse occurring in the context of familial relationships, and so exposure to the relational pursuits of their cohabitants may produce significant distress (Dolan & Whitworth, 2013; McKenna, Jackson & Browne, 2019). Moreover, engaging with detainees' sexualities at the relatively superficial level of routine inquiry and discussion may provoke moral concerns in staff whose personal beliefs regarding 'appropriate' sexualities might chime poorly with detainees' own relational ontologies (Krumm, Kilian & Becker, 2004). Some staff may alternatively view detainees as recipients of just punishment who should not be permitted to enjoy sexual aspects of their lives (Dein et al., 2016).

Professionals' ability to support detainees' sexual rights is further impeded by the scarcity of formal policy and training concerning sexualities in many forensic hospitals. In the absence of robust guidance, there is little to disrupt the influence of ward cultures and personal beliefs, resulting in professionals often constructing detainees' sexualities in terms of problematic and 'pathological' behaviours (Cole, Baldwin & Thomas, 2003; Dobal & Torkelson, 2004). The lack of guidance regarding sexualities produces uncertainties as to the extent that detainees are permitted to express their sexualities, including conversations about past relationships, seeking relationships with other detainees, and wearing clothes that allow them to feel sexual (Brown et al., 2014; Ravenhill et al., 2019).

Staff may experience uncertainties regarding the extent to which they are permitted to promote detainees' rights by allowing such expressions to take place without suffering negative consequences themselves (Ravenhill et al., 2019). Forensic professionals may experience their work as routinely overshadowed by the potential risks of professional and legal liability in the event of untoward incidents, incentivising them to not promote detainees' rights when they feel they could have to explain these decisions in future (Morgan, 2007). This could be of particular salience to forensic mental health nurses and healthcare assistants, who may view the primary function of risk assessment and intervention as being a means of abrogating liability for decisions (Mason, Worsley & Coyle, 2010). Forensic staff at managerial and directorate levels may feel subject to further scrutiny by the UK tabloid media,

which tends to depict forensic detainees as undeserving of human rights, and professionals themselves as not sufficiently managing risk (Cross, 2014; Exworthy & Wilson, 2010).

1.4 Forensic Sexualities

1.4.1 Sexuality, wellbeing, and distress

Within dominant Western healthcare discourses, human sexuality has historically been constructed in a similarly moralistic manner to issues of mental health and incarceration, with non-procreative sexual desires and acts framed as negative, non-productive and 'perverse' (Foucault, 1990). As with madness and offending, the presence of perverse behaviours may elicit attempts by societies and institutions to enact strategies of control so that the power held within dominant discourses may be maintained. This 'psychiatrisation of perverse pleasure' represents states' and institutions' outlook shifting towards 'power-over-life', becoming concerned with their role in preserving the lives and reproduction of their constituents, and consequently re-situating sexualities within health discourses (Foucault, 1990).

The World Health Organisation (2006) presently conceptualises sexuality as inherent to a person's wellbeing, arguing for a holistic construct that *"encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction"* (p. 5). This understanding moves beyond historical conceptualisations of sexual 'health' as concerned with purely biological structures and processes and towards a broader viewpoint, incorporating one's psychological and social wellbeing in relation to sex. Within this frame, sexual health can be understood as *"not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence"* (WHO, 2006, p. 5). As such, the roles and responsibilities of health professionals with regards to patients' sexual health can be understood as including engagement with their experiences and expectations of relationships, intimacy and self-esteem (Graugaard, 2017; McCann et al., 2019).

Contemporary psychological discourses concerning sexuality increasingly construct a broad range of sexual desires and acts as 'healthy', with 'health' conceived of as a socially-desirable, normative state to be pursued (Anderson, 2013; Greenhalgh & Wessely, 2004). Despite this perspective's potential to normalise sexualities that may have historically been perceived as deviant, it is often reliant upon neoliberal discourses which position people as individually responsible for their sexual expression and wellbeing, regardless of their level of access to community resources (Ludwig, 2016). Within these, individuals are subject to the expectation that they will be knowledgeable regarding their personal sexual needs and will use this knowledge to limit potential health risks that are of concern to society (Grant & Nash, 2017).

This positioning of individuals as personally and morally culpable for unwanted consequences of their sexualities in wider society (e.g. Watts & O'Byrne, 2019; Martins et al., 2016) conflicts with forensic mental health discourses, which tend to position detainees as lacking capacity to anticipate unwanted consequences of their actions (Bartlett, 2010). As such, responsibility for forensic detainees' sexualities and their consequences may fall, in part, to those institutions and professionals responsible for their treatment, particularly at higher levels of secure care. Further complexity arises when considering the index offences underpinning some detainees' ward stays, with a distinction to be drawn between those whose detention inhibits the expression of a socially acceptable sexuality and those who are detained because their sexual expressions present a risk of harm to others. For the latter group, exploration of sexuality (within a programme of harm reduction) will feature as a component of therapeutic intervention during their time in detention, typically emphasising the individual's role in self-monitoring and the identification of 'early warning signs' (Mann & Fernandez, 2006).

Clinical research narratives concerning sexualities predominantly focus on their undesirable outcomes, such as the spread of infection, unintended pregnancy, sexual dysfunction, and sexual violence (Carpenter, 2010; Dixon-Mueller, 1994; Higgins & Hirsch, 2007; Philpott, Knerr & Boydell, 2006; Pick, Givaudan & Kline, 2005; Dein et al., 2016). The prospect of discussing sexualities outside of these acceptable discourses may provoke anxiety in mental health professionals due to

uncertainties regarding their professional remit, a lack of knowledge, and subscription to 'conservative' attitudes and beliefs (Cort, Attenborough & Watson, 2001; Katz, 2002; Shield, Fairbrother & Obmann, 2005). Clinicians may thus exclusively engage with patients' traumatic sexual experiences or constructions of present and future sexual risk, omitting discussions regarding pleasure, satisfaction, and other salient 'positive' or relational aspects of sexuality (Brown et al., 2014; Quinn & Browne, 2009; Urry, Chur-Hansen & Khaw, 2019). Engagement with sexual activity specifically is further complicated by a legacy of social Darwinism and eugenics, whose warnings against permitting the propagation of the 'defective' genes responsible for 'insanity' maintain a powerful if quiet background influence in modern day psychology and psychiatry (Joseph, 2003; Pilgrim, 2008; Read, Bentall & Mosher, 2005), and continue to underpin some professionals' concerns regarding sexual contact between forensic detainees (Dein et al., 2007; Dein et al., 2016).

Conversely, those with mental health difficulties experience as strong and regular a need for sexuality and intimacy as anyone else (Deegan, 1999; Perlin & Lynch, 2014), though they often rate their experiences of satisfaction in these as the lowest of all life domains (Ostman, 2014). Though intimate relationships between forensic detainees have historically been found to be similar in nature to those elsewhere (Davison, 1999), aspects of psychological distress and accompanying structural marginalisation of those considered 'mentally ill' may present barriers to the formation and maintenance of these (McCann, 2003; Perry & Wright, 2006; Quinn & Browne, 2009). Particular manifestations of distress, in tandem with side-effects of psychotropic medications, may feature social withdrawal, diminished enjoyment of sex, and difficulties in becoming physically aroused, which may in turn produce conflict with intimate partners (Bella & Shamloul, 2013; Urry & Chur-Hansen, 2018). Similarly, societal constructions of the 'mentally ill' and offenders more broadly may result in socially exclusionary practices and economic disadvantages that are equally detrimental to a person's ability to pursue intimacy (Blalock & Wood, 2015; de Jager et al., 2017; Mills & Codd, 2008; Wright et al., 2007). Distress and sexual marginalisation can be understood as mutually constituting, with structural barriers to the pursuit and maintenance of intimacy affording some service users less opportunity to safely negotiate sexual boundaries, and consequently rendering them

more vulnerable to traumatising experiences such as unwanted sexual outcomes, exploitation, and violence (Higgins, Barker & Begley, 2006a; McCann et al., 2019).

Intimate relationships have a demonstrated positive impact on mental wellbeing in the wider population (Kawachi & Berkman, 2001; Keitner & Grof, 1981). Relationship satisfaction is positively associated with self-reports of global happiness and self-esteem (Proulx, Helms & Buehler, 2007), and sexual satisfaction is positively associated with measures of autonomy, self-esteem, and empathy (Galinsky & Sonenstein, 2011). Women who describe themselves as 'always' comfortable with their sexualities have been found to be almost four times more likely to be sexually satisfied than those who describe themselves as 'never', 'rarely', or 'sometimes' comfortable (Menard & Offman, 2009). Of note is that these notions of 'comfort' and 'satisfaction' are unlikely to simply represent sets of internalised states held by individuals, but rather speak to people's relationships with the properties that characterise their sexualities, including their (non-)conformity to social roles and expectations, and the subjectivities produced by these interactions (Sprecher & Cate, 2004).

We may assume that issues of sexuality are of particular salience to forensic detainees due to the majority of detainees being between 20 and 40 years of age, constructed within both lay and academic discourses as a critical period of sexual development. Within this age range, both (cis) men and women in the Global North are anticipated to experience 'peaks' of both sexual desire and satisfaction, and relatively open engagement with sexual skills development and experimentation are considered acceptable by society (Barr, Bryan & Kenrick, 2002; Brown et al., 2014; Wood et al., 2017). Moreover, many detainees experience lengthy periods of detention, with 24% of those in high-secure settings remaining for over 10 years, and 17.4% of those in medium-secure for over 5 years (Duke et al., 2018). A small literature base has found improvements in the rehabilitation and recovery of forensic detainees, and reduced likelihood of recidivism in convicted persons more broadly, when permitted to participate in relationships (Hales et al., 2006; Klepfisz, Daffern & Day, 2017; Tapp et al., 2013). Detention may be understood as having far-reaching consequences for the lives of detainees and all those within their relational networks, including their partners, family members, and hospital staff, each of whom possess

some ‘ownership’ of forensic sexualities in terms of their ability to transform detainees’ possibilities for living.

1.4.2 Conceptualising forensic sexualities

Little formal policy presently exists concerning UK forensic detainees’ sexual expression and intimate relationships (Buckley & Robben, 2000; Dein & Williams, 2008). Where policies are present they are specific to individual wards and often bear little resemblance to one another (Bartlett et al., 2010). Issues of sexuality in inpatient spaces have historically received little attention in both clinical practice and the academic literature (Bartlett et al., 2010; Brown et al., 2014; Collins, 2001; Hunter & Ahmed, 2016). However, absence of oversight does not preclude the practice, and as many as 30% of service users report participating in some kind of sexual activity during their time as psychiatric inpatients, often when such contact is prohibited (Warner et al., 2004). In one study of UK forensic detainees, all participants had either participated in or were aware of shared sexual activity on their respective wards (Ravenhill et al., 2019). Guidance currently available to professionals suggests that each psychiatric unit:

“must have developed an accepted philosophy, with ensuing policy and procedures, to cover the appropriate expression of sexuality among inpatients. The policy will address human rights, legality, capacity and consent, contraception and cultural variances” (Royal College of Psychiatrists, 2007, p. 6).

This document further endorses the provision of privacy and condoms, where appropriate, in response to emerging sexual relationships between detainees, framed within on-going multidisciplinary programmes to ensure staff knowledge, awareness and confidence in engaging with such issues. Recent CQC guidance concerning relationships and sexual activity in adult care services emphasises the need to encourage and demonstrate active institutional support for sexual expression, including policy and accessible information for patients (Care Quality Commission, 2019). There is, however, little evidence to suggest that these recommendations have been implemented, with many forensic hospitals in the UK

prohibiting or actively discouraging sexual expression (Bartlett et al., 2010; Ravenhill et al., 2019).

Sexuality can be described as involving “*the totality of being a person*” (p. 134) and essential to the human condition (McCann, 2000). The fields of psychology and medicine have contributed to the construction of sexuality as essential and individualised, being situated within the biology, neurology, and sensation-making processes of bodies (Hines, 2006; Potts, 2004). Contemporary lay and social science discourses surrounding sexuality support this anthropocentric understanding, emphasising sexuality’s role as a socio-political symbol of internalised agency, free will, and identity, and the individual subject as where sexuality takes place (Clough, 2008; Plummer, 2003; Weeks, 2007). However, this perspective does not necessarily account for how sexualities might be constructed and experienced within institutional settings, where its ‘more-than-human’ aspects may contribute equally to sexuality’s becoming on the ward (Allen, 2015b). For instance, the current prohibition of conjugal visits within UK forensic settings produces a reliance on communications devices for the preservation of intimate relationships, and so sexualities can be conceptualised as existing within the relationships between these objects and their users, as well as in their being projected beyond the physical boundaries of the hospital. Crucially for this research, hospital cultures and accompanying (in)formal policies and practices can be understood as part of the network of heterogeneous elements constitutive of forensic sexualities involving hospitals, staff and detainees, ultimately shaping each actors’ possibilities for thinking and acting (Clarke et al., 2015; Mellard & van Meijl, 2017).

For instance, Ravenhill and colleagues (2019) outline an occasion on which two cohabitants of a forensic unit pursued an intimate relationship with one another, which ward staff responded to by permitting this to exist in concept, but forbidding any physical contact. This culminated in the detainees in question no longer being allowed to sit with one another, though they continued to consider themselves to be in an intimate relationship despite this intervention. The institutional response may be revealing of the conflict experienced by staff in their dual desires to facilitate the relationship and limit any threat that it might pose to the stability of the ward, and also the manner in which they found themselves holding a responsibility for these

detainees' sexualities. The result of these subjectivities is a relationship that would likely appear peculiar in most cohabitant spatial contexts other than the psychiatric unit, with both women continuing to be in a relationship with one another despite being barred from physical proximity. The possibilities for living of all involved in this intervention can be viewed as having been shaped by institutional discourses, with staff simultaneously unable to wholly permit or deny the relationship, and both detainees having to proceed in a fashion that was less than desired. We may also consider some of the unintended transformations emerging from this instance: Detainees may now consider defiance and subversion to be valuable aspects of intimacy; new staff may be initiated into a normative culture of observation and obstruction; and the transmission of professional concern through the institution may have resulted in the research in question.

We may, therefore, understand forensic sexualities as being neither individualised, arbitrary, nor 'natural', but instead actively produced by moral and political practices on the wards. These practices may manifest as a series of interventions intended to cultivate a particular set of behaviours viewed as socially acceptable within the confines of the forensic unit, broadly omitting 'natural' sexual expression (Brown et al., 2014; Weeks, 2011). Vital experiences of sexual desire for others may be re-situated within psychiatric discourses concerning, for example, the pathologisation of the pursuit of sexual intimacy by those with diagnoses of Emotionally Unstable Personality Disorder (Nehls, 1998). Similarly, ward-based practices such as regular room checks and strict regulation of pornography and masturbation aids may disrupt opportunities for detainees to be sexual beings in private (Brown et al., 2014; Ravenhill et al., 2019). The spatial structure of the hospital itself, including the interweaving of public and private spaces and ongoing processes of surveillance and risk assessment, lends itself towards sexualities that are owned in part by all members of the network, yet safe for none. Any expressions that might be viewed as sexual, perhaps excluding narratives of trauma taking place in therapy rooms, become transformed into 'signs' of potential vulnerability or predation, transmitting anxieties concerning liability and professional failure throughout the institution and beyond (Brown et al., 2014).

1.4.3 Amputated sexualities

The prohibition of sexual relationships in forensic inpatient spaces may rely upon the assumption that detainees' sexualities can be temporarily abandoned until a future point in time when expressing them carries minimal risks to themselves or others (Brown et al., 2014; Deegan, 2001). Moreover, some hospital policy-makers may consider detainees' desire for intimacy as a distraction to the treatment that the institution is ostensibly concerned with providing (Hunter & Ahmed, 2016). This presumed asexuality is experienced as problematic and confusing by some detainees, who do not necessarily share these views (Brown et al., 2014; Higgins, Barker & Begley, 2006). Moreover, little attention is paid in the research literature and clinical practice more broadly as to what impacts the prohibition of sexual expression while inside might have on a detainee's sexuality once they are discharged back into the community. The organisation of the forensic hospital and its accompanying positioning of sexualities within discourses of vulnerability, predation, and misbehaviour may be anticipated to generate a novel kind of relationship with one's own sexuality that persists following detention. Brown et al. (2014) summarise this as follows:

"The territorialisation of sexuality in the unit extracts particular expressions from service users' embodied acts, isolates and disconnects the expressions from how service users understand them in the context of their own mental health, recontextualises them in terms of a discourse of vulnerability/predation, and reinserts and distributes them anew as sexualised signs of mental health" (p. 249).

This territorialisation may be scaffolded by the influence of psychiatric medications, which can instil a kind of asexuality in up to 70% of users by way of their side-effects. These include significant reduction in sexual desire, erectile and ejaculation difficulties, penile and clitoral priapism, diminished vaginal lubrication, anorgasmia, and diminished subjective enjoyment of sex (Bella & Shamloul, 2013; de Boer, 2014; Knegtering et al., 2008; Serretti & Chiesa, 2011). Where individuals using medications may still retain their sexual functioning, other side-effects can disrupt conformity with socially normative understandings of a sexually desirable body. These include difficulties in expressing emotion, shuffling gait, weight gain, breast

enlargement and lactation (in all sexes), bulging eyes, and dribbling (Kelly & Conley, 2004; Mackin, Watkinson & Young, 2005; Sullivan & Lukoff, 1990). Patients who experience these side-effects report significant reductions in quality of life and treatment adherence as a consequence (Finn et al., 1990; Haddad & Sharma, 2007; Olfson et al., 2005). Patients are unlikely to spontaneously report sexual side-effects of medications to mental health staff (Montejo et al., 2010), and prescribers may in turn be unlikely to discuss these with patients prior to or following administration (Brill, 2004). Exploration of potential sexual side-effects of medications may present a challenge to those professionals who would otherwise strive to construct patients as asexual beings, resulting in a 'hierarchy of prioritisation' in which *"the sexual side-effects were always at the bottom"* (Higgins, Barker & Begley., 2006, p. 443).

For staff, the territorialisation of sexuality within the forensic unit may serve as an act of reconciliation between the 'care' and 'control' discourses that serves to offset, if not assuage, discomfort regarding their dichotomous roles. The consequences for detainees, however, are unpredictable and myriad, and further complicated by the impermanence of the forensic hospital, whose structure is permeated by discourses concerning future lives to be had, exploration of which may be central to therapeutic techniques intended to foster a sense of hope and accompanying adherence to treatment plans (Tucker et al., 2019). Moreover, the outside community can be understood to regularly intrude upon the hospital in a number of ways, including visitation, communications technologies, and exchange of goods, further clarifying detainees' potential futures. In this sense, sexualities are restricted to neither body, place, nor time, instead existing across innumerable anticipated futures. Where some professionals may regard these anticipations as an opportunity to confine sexual expression to detainees' prospective lives following discharge, detainees might conversely view the hospital as an ideal testing ground for intimacy, supported as they are by ever-present care teams (Ravenhill et al., 2019).

Forensic detainees may find narratives concerning treatment and hopeful futures to be at odds with their experiences of being physically and chemically confined and controlled (Brown et al., 2014; Ravenhill et al., 2019). This dissonance manifests as detainees' experiences of the hospital as 'anti-life', in which the removal of both both public freedoms and private comforts distances detainees from their own sexualities

and obscures a broader sense of meaning in their day to day lives (Brown et al., 2014). Forensic detainees may consequentially regard their sexualities as 'amputated', both by the obstructive organisation of a ward that limits opportunities for embodied sexual experiences, and by the discursive re-positioning of sexualities as matters of public concern (Lowson, 2005). To engage in one's sexuality in a manner that contributes to a felt sense of vitality may have disastrous repercussions for detainees, including the rescindment of earned privileges and the lengthening of their detention under Section. Brown and colleagues (2014) conceptualise 'amputated' sexualities as a kind of 'Psychologically Modified Experience' (PME), by which individuals are required to engage in a process of self-categorisation in order to conform to psychologically informed discourses:

"Psychological practice makes its own theories real by modifying experiences such that they become what now passes for reality, and then demonstrates this by pointing to their presence in the social world – a 'self-fulfilling prophecy'. Like GMOs, releasing PMEs into the ecology makes it impossible to ever go back, to separate out supposedly naturally occurring experiences from ones that have been modified by psychological practice" (p.256).

In the forensic institutional environment, sexuality is confined to a far more narrow range of potential expressions than elsewhere, not featuring in assessments upon admittance to hospital, discussions initiated by staff, nor in socially acceptable conversation with other detainees. Moreover, guidance on supporting forensic detainees in re-engaging with life in the community does not typically address sexualities or intimate relationships (e.g. Wolfson, Holloway & Killaspy, 2009), instead offering a more sanitised account of the value of 'social ties' (Brown et al., 2014). Of concern is that those patterns of behaviours considered socially and morally acceptable on the forensic unit are not necessarily representative of those that might be considered 'normal' or 'natural' in wider society, bringing into focus the enduring role that models of psychological treatment, and the hospital's treatment of detainees more broadly, may hold in maintaining this amputation post-discharge.

1.5 Research Rationale

This study serves as a continuation of a series of investigations into key stakeholders' understandings of sexual rights and practices in the largest provider of forensic inpatient psychiatric services in the UK. Previous research at this site has engaged with detainees', ward staff's, and multidisciplinary team (MDT) members' understandings of sexualities within the hospital (Brown et al., 2014; Ravenhill et al., 2019). Research regarding service users' sexualities is largely concerned with issues of risk and unwanted sexual outcomes, and broadly omits the experiences of those working in forensic settings. The scarce literature examining forensic inpatient sexualities in the UK has yet to account for the sense-making practices of policy-makers at the directorate level, whose understandings of sexualities may materialise as guidance that shapes the lives of staff and detainees alike (Bartlett et al., 2010; Tiwana, McDonald & Völlm, 2016).

1.5.1 Relevance to clinical psychology

Problematizing the issue of forensic detainees' sexualities is of relevance to clinical psychology, which may presently be positioned within mental health services as the discipline most concerned with patients' sexual pasts and futures (Ussher & Baker, 1993). Incorporating the importance of detainees' felt sense of connection to their sexualities into treatment planning may result in their feeling more committed to therapies and less likely to commit harm while subject to detention or following discharge, and may contribute to their being less likely to need mental health service input in future. This is evidenced by literature concerning the positive impact of intimate relationships on treatment adherence, psychological wellbeing, and criminal recidivism, and by reports from forensic inpatient professionals working elsewhere in Europe (Deegan & Drake, 2006; Fals-Stewart, Birchler & O'Farrell, 1999; Newcomb, 1994; Overbeek et al., 2006; Tiwana, McDonald & Völlm, 2016; Tucker et al., 2019; Whisman, Uebelacker & Bruce, 2006). Moreover, clinical psychologists' roles are frequently concerned with understanding interpersonal dynamics within care organisations, the development of shared understandings of complex issues, and the

facilitation of multidisciplinary teamwork (Reiss & Kirtchuk, 2009). Developing a deeper understanding of the processes at play within forensic psychiatric institutions when conceptualising forensic detainees' sexualities is supportive of these roles.

Engagement with relationships and sexualities in forensic inpatient settings is consistent with contemporary trends in national guidance which, despite not yet having coalesced into more concrete policy, increasingly positions psychiatric patients as deserving of opportunities to lead fulfilling lives (Care Quality Commission, 2019). Moreover, the promotion of detainees' sexual rights is an ethical issue in keeping with psychological practice that supports patients' human rights. Engaging with this research topic as an issue of relevance to clinical psychology is consistent with the ethical obligations put forward by the British Psychological Society (BPS), and the profession's broader claims to be concerned with ethical practice (BPS, 2018; Butchard & Greenhill, 2015; Kinderman, 2007).

1.6 Research Aim and Research Question

1.6.1 Aim

This study aims to develop an understanding of how policy-makers at the directorate level conceptualise forensic inpatient sexualities, and how these understandings contribute to their vision of a policy governing these.

1.6.2 Research question

- How do hospital policy-makers make sense of forensic detainees' desire for intimate and sexual relationships?

2. METHOD AND METHODOLOGY

2.1 Overview

This chapter provides an account of the epistemological, ontological, and methodological positions orienting the thesis research, including an overview of thematic decomposition analysis (TDA) and the concept of 'subject position'. Research procedures, including participant sampling, data collection, and method of analysis are specified. Considerations concerning ethics and research quality are explored. Finally, the chapter presents a reflexive account of the research process and the researcher's position within the study.

2.2 Epistemology and Ontology

Epistemological positioning refers to one's theory of knowledge, or the underlying philosophical position that orients a work's methods and approach to collecting and interpreting data (Chamberlain, 2015). The present research adopts a social constructionist epistemology. It is concerned with the ways in which policy-makers engage in meaning-making with regards to forensic detainees' sexualities, and understands discourse as not simply expressing or reflecting these meanings, but rather as being the manner through which meanings are constructed (Potter & Wetherell, 1987). These discourses can be understood as formed by extant socio-historical contexts and the relational, conversational and social practices emerging from these (Stam, 1998). Implicit in this stance is the imbalance of power in the forensic hospital, in which particular narratives are felt to *warrant voice* and thus attain positions of local dominance (Burr, 1995).

Social constructionist epistemology positions participants and researchers as discursive, contextual, and socially constituted persons, and as such neither can be considered extricable from their socio-historical contexts (Raskin, 2002). Discourses through which our realities are constructed will consequently shape the research data and ensuing interpretation. Inherent in this is the notion that researcher,

participants, and those referred to during the research procedure are not necessarily in possession of a particular 'personhood' or 'personality'. What might traditionally be conceptualised as relatively coherent and stable personal ontologies are instead constituted by culture, context, and ways of communicating, and persist in a state of flux (Sampson, 1989). Subjects, objects, and their possibilities for the production of experience are positioned through discourse as fulfilling different social roles at different times (Willig, 2013).

Subject positions may be understood as persons within a story (including those telling and hearing it) being assigned 'parts' or temporary roles by the manner in which the story is told. These positions may be generated by processes of reflexive positioning, in which people's use of language produces their own subject positions, and interactive positioning, in which people's use of language produces the subject positions of others (Davies & Harré, 1990). The presence of dominant local discourses can be understood as limiting the possible subject positions that persons may adopt, potentially resulting in their inhabiting unwanted social roles (Parker, 1992). This in turn shapes the rights and obligations ascribed to them, and their capacity to ascribe rights and obligations to others (Moghaddam & Harré, 2010). Specifically, this research is concerned with processes by which policy-makers' discursive realities concerning forensic sexualities transform detainees' and professionals' possibilities for living via their materialisation as hospital culture and praxis (Deleuze & Guattari, 1988).

2.3 Methodology

This study utilised qualitative methods in order to develop a 'thick' understanding of hospital policy-makers' sense-making around forensic inpatient sexualities (Geertz, 1973). This approach aimed to attend to participants' conceptualisations of sexualities and the forensic institution, and the accompanying subject positions they ascribe to themselves, other members of hospital staff, and detainees (Davies & Harré, 1990). Given that a significant quantity of the extant literature positions detainee sexualities as problematic or dangerous prior to analysis, there is limited

research examining the ways in which these meanings are made, which a qualitative approach could serve to address. Qualitative methods were felt to be of further relevance to this research due to the small pool of potential participants represented by the hospital directorate, who would be unlikely to constitute a ‘representative’ sample using alternative methods.

2.3.1 Thematic decomposition analysis

Thematic decomposition analysis was chosen as the qualitative research framework due to its explicit concern with socially constituted meaning. Despite its being ‘thematic’ in scope, in that it seeks to identify themes emerging from research data, TDA is not a form of thematic analysis, but rather a kind of ‘thematic’ discourse analysis. This differs from a constructionist thematic analysis in its understanding of patterns, themes, and stories within data as being representative of ‘underlying systems of meaning’, and the identification of these as relying upon a more fluid and organic analytic process than would be more commonly utilised within thematic analysis (Braun & Clarke, 2006; Reavey et al., 2017; Stenner, 1993). It is, therefore, of value when seeking to examine in detail the processes by which particular domains of experience are understood by others. Of specific interest to this approach is the extent to which the ‘socially sedimented’ (Berger & Luckmann, 1966) themes and stories shared by participants may offer us insight into “*trans-individual, historically localised, culturally specific formations of language-in-use*” (Stenner, 1993, p. 94).

Thematic decomposition analysis is not so much concerned with whether a participant’s storying of an experience is ‘true’, but rather what might be achieved or created by that story’s use. This approach understands themes as being representative of subject positions that have been allocated to or adopted by a person, consequently reflecting the broader structures of shared social meaning by which participants’ narratives are constructed (Ussher & Mooney-Somers, 2000). These themes are generated both inductively, through ‘decomposition’ of the transcripts, and deductively, through understanding extant literature as containing

pre-existing narrative themes that have been arranged for our use (Sarbin, 1986; Stenner, 1993).

2.4 Participants

2.4.1 Inclusion criteria and recruitment

Participants in the study were identified and recruited opportunistically by contacting the research site, to whom I was already known through prior studies conducted there. Inclusion criteria required that participants were members of the hospital directorate and were involved in policy-making. Directorate members were already aware of the broader project examining the ways in which sexualities are presently engaged with within the hospital. They were notified of the current study by emails containing copies of the study information sheet (Appendix B) and the researcher's contact details, sent by the hospital's research department. All directorate members were contacted regarding the research and 10 agreed to participate in interviews, which were scheduled by the research department and took place at various hospital sites.

2.4.2 Sample characteristics

A total of ten participants were recruited based on their being directly involved in policy-making within the hospital. These included eight members of the hospital's clinical directorate (five specialising in psychiatry; two in clinical psychology; one in nursing) and two members of the personnel and development team, both of whom specialised in diversity and inclusion. The age of participants ranged from 32 to 58 years ($M=42.9$, $SD=6.62$). Five participants were male and five female. Participants' ethnicities included five White British, four Asian British, and one Black British.

Due to the total population of potential participants being very small, and their all being familiar with one another, members of the sample have not been numbered or pseudonymised here or in the analysis. Should one participant identify a particular excerpt as belonging to another, through espoused beliefs or patterns of speech, they will not then be able to identify all of the latter participant's contributions.

2.5 Data Collection

2.5.1 Interview Procedure

Participants were presented with another copy of the information sheet and a consent form to read (Appendices B and C). The parameters of the research were discussed and participants were given the opportunity to ask questions and voice concerns. Participants were informed of their rights to confidentiality, to end the interview at any time, and to withdraw their participation in the study at any point until three weeks following the interview date. Demographic information was requested and recorded. All interviews took place in offices and meeting rooms at the hospital sites, and were recorded using a digital voice recorder. All those met for interview agreed to participate and provided signed consent. Interviews typically lasted for roughly one hour. Following the interview, participants were provided with a debrief sheet (Appendix D) and the researcher's contact details. Their right to withdraw was explained again and they were invited to ask any questions they might have.

2.5.2 Interview Approach

A semi-structured interview schedule was used (Appendix E). This approach was intended to strike a balance between eliciting themes relating to the research questions and literature review, and affording space for participants to freely share their understandings of the topic (Rabionet, 2011). Interview questions were generated based both on salient topics that had arisen during the literature search, and on issues that had arisen in interviews with detainees and ward staff in prior

research at the site (Ravenhill et al., 2019). Non-essential prompts were included to probe for particular topics if they did not arise during the course of the discussion. Given the study's intent to capture participants' own understandings of sexualities, a preamble was used to emphasise that 'sexuality' may be subject to a multiplicity of personal and professional definitions, and participants were reassured that they were not expected to take an 'expert' position. The researcher adopted a responsive stance during the interviews in order to promote a more 'natural' communicative event, for example joining with smiling and laughter where it occurred (de Fina & Perrino, 2011). This was intended to disrupt the experience of the interview as a professional encounter which may be subject to scrutiny by the hospital, potentially limiting what participants felt able to say (Holmes & Federman, 2006).

2.6 Analytical Approach

2.6.1 Individual readings

All recordings were transcribed verbatim (excluding anonymisations) by the researcher, which served to enhance familiarity with the data (Braun & Clarke, 2006). Following transcription, individual transcripts were subjected to a 'decomposition', a close reading attempting to identify themes or stories emerging from the text. Where the process of coding within thematic analysis may be *descriptive* of data or *interpretive* of participants' *intent* when speaking, a reading within thematic decomposition dispenses with the notion of any outside truth against which it may be measured (Stenner, 1993). As such, a reading is always *situated* (Haraway, 1988) and must be understood as inherently incomplete and incapable of contributing to an analysis that illuminates any kind of universal 'reality'. Rather than seeking themes that are indicative of phenomena taking place in such a location, this process is concerned with understanding the discourses by which different actors' social realities are produced.

These may in turn be indicative of those socially sedimented narratives upon which participants rely in order to make sense of their worlds, and of the parts that

participants and others have to play in these stories (Stenner, 1993). The decomposition process included repeated readings of the transcripts and a systematic, line by line thematic coding of the data (Ussher & Mooney-Somers, 2000). Where codes were identified, their surrounding text was retained in order to provide context at later stages of the analysis (Braun & Clarke, 2006). Transcripts were recorded in standard orthography, with notable interruptions and physical actions (e.g. laughter; prominent gestures) simply recorded in brackets. The reading process combined both a literal reading of written data and listening to the original audio, so that content would not be lost during the analysis. An excerpt from a coded transcript is included as Appendix F.

2.6.2 Cross-transcript readings

Following the coding of individual transcripts, individual narratives were compared and codes grouped together in order to produce emergent themes. Homogenous narratives appearing in multiple transcripts were afforded particular attention due to their being potentially indicative of dominant discourses that had become socially sedimented within the forensic hospital. Competing narratives were similarly scrutinised for their being revealing of contested subject positions, through which participants attempt to negotiate which discourses warrant voice in the production of meaning (Stenner, 1993). The generation of codes and later organisation of themes was partially grounded in the research literature, which was referred back to following an initial reading of the data to produce 'analytical directives' to guide subsequent readings (Reavey et al., 2017). However, an inductive stance was also retained insofar as codes and subsequent themes were produced from close readings of the transcript data rather than fixed presumptions regarding what they would ultimately be. Codes were collated and a thematic map was produced (Appendix G) to assist in their grouping into sub-themes (Braun & Clarke, 2006).

2.6.3 Reviewing themes

Following the identification of sub-themes, the transcript data was read once again to establish if these fit with each participant's storying of the subject. Where particular sub-themes were found to not fit participants' narratives following a re-reading they were collapsed into their constitutive codes and re-organised, followed by further readings of the data (Braun & Clarke, 2006). These readings further sought to establish internal homogeneity and external heterogeneity, or that themes were specific enough to represent discrete constructs and broad enough to illustrate stories told across multiple transcripts (Patton, 1990). Following a number of readings and re-organisations of sub-themes, a further thematic map (Appendix H) was used to group them into themes. Transcripts were re-read to examine these themes' representation of participants' narratives, and themes were compared to avoid overlap.

The data was not read for saturation due to this research's reflexive analytic stance, which understands readings of the data as revealing of particular constitutive discourses rather than an 'excavation' of all possible meanings. As such, meanings are understood as being generated between the situated and subjective relationship between data and researcher, with the question of 'how many' data items will produce similar findings thus being impossible to answer (Braun & Clarke, 2019). Excerpts felt to evidence each sub-theme were identified for use in the write-up of the analysis. These are included alongside my own narrative regarding the purposes of these stories and the positioning of those within them in a form of jointly-produced meaning between myself and participants. Particular excerpts were selected for a number of reasons, including opportunities to unpick particular meanings for the reader, to illustrate and explain concepts using experiential accounts, and to give voice to competing discourses within the institution, particularly those that are typically silenced (Corden & Sainsbury, 2006).

2.7 Ethical Considerations

2.7.1 Ethical Approval

Ethical approval was obtained from the University of East London Research Ethics Committee (Appendix I). This was accepted by the research site, who provided an honorary research contract for the duration of data collection (Appendix J). This study did not require NHS ethical approval due to the research site being a charitable organisation.

2.7.2 Confidentiality

Participants were assured that their transcripts would be anonymised using pseudonyms and the removal of all identifying information. Given that the participants were all colleagues and that the hospital directorate represented a very small population, maintaining confidentiality presented some challenges. It was decided that demographic information would not be linked to pseudonyms, and that if any participants referred to their own demographic information (in particular, indicators of their specialisms) in the data then this would be anonymised. Excerpts chosen to be included in the analysis were examined carefully in terms of their potential to reveal the participants' identities to their colleagues. Details of names corresponding to pseudonyms and consent forms were stored separately from audio recordings and transcripts.

2.7.3 Participant Considerations

The topic of sex and sexualities has historically been shrouded in taboo, which may result in exploration of this producing distressing emotions such as guilt and shame (Macklin, 1976). This may be further magnified for those professionals who feel caught between conflicting professional and personal belief-sets, risking moral distress in discussions that are revealing of this (Shield et al., 2005). Moreover, forensic professionals are often positioned by both justice and mental health structures as possessing a kind of expert certainty regarding the detainees they work

with (Vivian-Byrne, 2001). Exploration of sexualities, a topic which receives little attention in training programmes across disciplines, may present an unwelcome challenge to this standpoint (Astbury-Ward, 2011; Nnaji & Friedman, 2008; Shaw, Butler, & Marriott; 2008).

These issues were addressed in interviews by naming that sex and sexualities are not often spoken about and so can feel quite challenging, and by emphasising that the multiple definitions of sexuality can produce a variety of perspectives.

Participants were assured that they were not expected to take an 'expert' stance on the topic and that their personal feelings and opinions were of equal value to their professional understandings. The researcher sought to build a good rapport with participants, listened carefully, and attended to signs of personal conflict with validation when they emerged (Dempsey et al., 2016). All participants had personal supervision structures that they could rely on if the interviews proved challenging for them. No significant distress was observed to arise as a result of the interviews.

2.8 Reflexive Statement

Social constructionist epistemology emphasises the importance of the role of the researcher in relation to participants, quality of research techniques, reporting of findings, and reflexivity. Each of these requires a critical stance on the part of the researcher with regards to their own relationship with aspects of the study and, in particular, 'taken-for-granted' knowledges that they may incorporate into the understandings that are generated (Hosking & Pluut, 2010). This study's ontological positioning of its participants as not necessarily 'real', but rather as revealing of relational processes and localised realities, also extends to myself. The findings presented in the next chapter should thus be understood as constituted by my own relationship (and emerging subjectivities) with the literature and the research data, rather than representing an objective, empirical account of what was observed (Haraway, 1988). The purpose of this reflexive statement is not, then, to offer an account of how bias was reduced and objectivity maintained throughout the research process, but rather an insight into the ongoing dialogues and multiple re-

constructions of self through which I sought to evaluate my own position in relation to the study (Gergen, 1994; Hosking & Pluut, 2010).

2.8.1 Relationship with the topic

I am a 31-years old, white British man from a working class background. I am the first person in my family to receive a higher education. My upbringing was subsumed by narratives of my family's being coerced and oppressed by higher class Others, who continue to be framed as simultaneously ignorant, immoral, and destructive. My family's storying of sexuality is remarkably open in some respects (e.g. talking about sex is quite common), and conservative in others (e.g. marginalised sexualities are constructed in derogatory terms). I find my own sexual orientation to be quite difficult to define. My family has a lengthy and enduring history of mental health service use, though this is not discussed in any depth or detail. I identify as mad, having lived experience of paranoia, unusual beliefs, a psychotic episode, and intense periods of low mood and embodied anxiety. The former of these inform my understanding of realities as localised storytelling practices, rather than based upon a definitively 'real' world.

Throughout my upbringing, criminality and psychological distress were both frequently positioned by my relatives within discourses informed by eugenics, particularly with regards to sex offenders. Conversely, victims' and survivors' accounts of sexual violence in the media were routinely dismissed, typically perceived as evidence of women's manipulative natures and men's subjugation. My adolescence was marked by sexual promiscuity and sexual trauma, much of which I continue to discover does not fit with dominant understandings of a 'healthy' or 'normal' development. I am prone to adopting a subjugated position and regarding institutional forces as oppressive, and this extends to my relationship with the discourses of my youth. During my history of employment in mental health services I have been subject to stigmatising responses to my experiences of distress. Most prominent of these was an instance in which a psychosis researcher informed me that *"We must think very carefully about letting people like you have children"*.

My interest in working with forensic detainees' sexualities doubtlessly stems from these experiences. The positioning of justice and mental health services as facilitators of social control chimes well the storying of institutions in my childhood. Much of the present research is concerned with the paternalism inherent in mental health service provision, and I worry that my own positioning of forensic inpatients (including my choice to term them as 'detainees') risks contributing to this by omitting some of the agency they possess despite their detention. I was not detained when I experienced psychosis, and I wonder if this may incentivise me to construct those who are as suffering injustice, so that I might position myself as fortunate. Simultaneously, I am prone to positioning the detainees referred to throughout this study as 'like me', which may invoke a protective urge on my part when conceptualising their treatment and its relationship with human rights law. However, I am not 'like them'. I am a researcher and a psychologist with no criminal history. I wield power and influence that they do not.

2.8.2 Relationship with the institution

I first visited the hospital as a research associate prior to training. Its spatial layout, ostentatious buildings laid across acres of sculpted green space, struck me as strange. Prior to this I had exclusively been employed by hospitals in South East London, whose sites tend to be cramped and quite drab. My first experience of walking up the long, winding driveway to be greeted by the sight of elderly patients, clad in all-white and playing croquet on a manicured pitch, seemed more in keeping with those asylums I had seen in films than my lived understandings of them. This feeling became more pronounced within the main hospital building, whose aesthetic featured thick carpets, old portraiture adorning most walls, and an abundance of creaking, richly varnished wood. Each sensory aspect of the space contributed to an unsettling feeling of unreality. The wards themselves were markedly clinical and thus more familiar to me, producing a sense of dissonance between my understanding of what the hospital was and what it presented itself as. I later came to wonder if this veneer served to mask the realities of life in the hospital, and if so, for whom? I recall

some ward staff I spoke to during this time privately mocking detainees in conversation with one another, at one point assuming that I would join in.

My early experiences of the institution featured meetings with male senior staff, now no longer employed there, who would be asked questions by my female supervisor and direct their responses to myself or another male colleague. I interviewed for a research post at this hospital several months later, and was subjected to what I experienced as quite a bizarre masculine performance, involving one of the interviewers slamming his hand on the table and aggressively berating me for suggesting that the commute could be manageable. This gesture was repeated more recently, in a preliminary meeting to discuss the present research, by a current member of senior staff. His hand hit the table as he loudly informed us that “*These are people with mental illnesses, and those illnesses make them* do things.” Working in mental health services ensures that I am regularly exposed to descriptions of people like me as less-than-human, but this instance was particularly hard to hear. I maintained a courteous, professional dialogue in this moment, trying to preserve my colleagues’ sometimes-strained relationship with the hospital. Upon reflection, I wonder if I had become transformed to better suit the institution, my calm demeanour in the face of this violence representing little more than so much creaking, varnished wood.

I do not understand the aim of holding these experiences and their relationship with the organisation and outputs of the current research as ensuring that a kind of objective knowledge is produced (Haraway, 1988). Doubtless, those experiences outside of my cognisance, which I can acknowledge here only by their absence, will have a greater influence on the finished product than any I might try to manage or control. Rather, I wish to attend to the fact that as researcher I have reciprocally influenced and been influenced by the story I am telling. In this thesis I attempt to situate detainees’ sexualities within multiple local-sociohistorical realities constructed by the relationships between themselves, the study participants, myself, and any number of subjects (Hosking & Pluut, 2010). In this way, reflexivity is not the act of reducing myself within the research, but an opening up to multiple, complex possibilities for living (Hosking, 2008).

3.0 ANALYSIS AND INITIAL DISCUSSION

3.1 Overview

This chapter presents a thematic decomposition analysis of the data, organised as overarching themes and their subthemes (see Table 1). The first theme, *Risk and Uncertainty*, explores policy-makers' understandings of themselves and other professionals in relation to forensic sexualities. The second, *Artificial Realities*, examines participants' sense-making around the interactions between detainees' sexualities, the forensic institution, the outside world, and extant legal frameworks. The third, *Detained Bodies*, is concerned with participants' positioning of forensic detainees across the treatment trajectory, addressing the capacity for the hospital to take part-ownership of sexualities and transform these to better fit with institutional discourses. 'Thick' descriptions of themes are included in Appendix K.

Table 1: Themes and subthemes

Theme	Subtheme
Risk and Uncertainty	The knowing professional
	Risking discomfort
	Responsibility and silence
Artificial Realities	The hospital's purpose
	Distance and 'the community'
	The deferral of dignity
Detained Bodies	Dangerous pasts, fragile futures
	Discoursing health
	Bodies transformed

3.2 Risk and Uncertainty

3.2.1 The knowing professional

Participants often constructed their own and colleagues' roles as mental health professionals as being largely concerned with ensuring that no harm was inflicted by or upon those detained in the forensic hospital. In order to accomplish this, clinicians relied upon robust systems of risk assessment, record keeping, and overt behavioural surveillance strategies such as routine observations and room checks to ensure that detainees were behaving 'appropriately' (Ravenhill et al., 2019). The setting up of safety in this way emphasised a need for professionals to 'know' detainees to the fullest possible extent, both in terms of their histories and their current activities, in order to maintain ward security (Chester & Alexander, 2017):

P: They were the doctor and social worker for both of the patients so they were acutely aware of the histories of both individuals and so they were able to make a balanced judgement in terms of what are the triggers that they should be looking out for to ensure the relationship doesn't become a one-sided or an aggressive-, to ensure that one of the individuals isn't disadvantaged or hurt or distressed or harm is caused to them.

The role of staff within forensic services was thus understood as being largely concerned with developing and maintaining ongoing systems of behavioural surveillance, with little consideration of these methods' potential to produce unwanted outcomes. Lack of privacy, both in terms of regular observations and constant proximity to other detainees, is understood to be a key source of enduring distress for those within spaces of detention (de Viggiani, 2003; Douglas, Plugge & Fitzpatrick., 2009) and of dissatisfaction with mental health treatment more broadly (Fortney et al., 2004; Reavey et al., 2017), and as such could be conceptualised as a site from which risk is produced. Despite this, participants tended to construct the removal of detainees' privacy exclusively in terms of its capacity to *reduce* the potential for harm, with their ability to perform a tolerance of intrusion, including a

willingness to self-report feelings and intentions, constructed as an indicator of their increasing 'wellness' (Crewe, 2009; Crichton, 2009):

P: So when they have leave, the purpose of the leave is one of the things that's discussed quite a lot. A lot of the patients know that when they meet up with people on leave, the team needs to know about it to make sure that that's an appropriate use of their leave. So the majority of patients, if they're in a relationship, will just be quite open and honest about that.

Despite the above excerpt's characterisation of intimate relationships taking place on leave as generally 'known' quantities, forensic sexualities were broadly constructed as producing a number of uncertainties within the institution. In keeping with previous research with ward staff, policy-makers felt unsure as to the extent that the topic could be discussed openly with detainees, or the avenues available to the hospital with regards to facilitating relationships (Ravenhill et al., 2019). In the absence of clear policy and guidance, some felt that each new relationship could necessitate a re-negotiation of professionals' roles:

I: Do you have any thoughts on existing policy at [the hospital] that addresses this [sexualities]?

P: It's kind of muddled. People think they know what it is and then you get an incident or a couple of patients want to have a relationship and everybody sits around scratching their heads going, "Oh, what do we do?"

Further magnifying the lack of policy within the hospital, a number of participants raised the issue of training as foundational to their ability to know how to engage with sexualities, both in terms of practical, conversational skills and the boundaries of clinicians' professional remit. Consequently, where the topic was engaged with on the wards it could lack consistency between staff members:

P: I've seen some absolutely awesome role-modelling for sexual behaviours, sexual questions, sexual preferences by HCAs [Healthcare Assistants]. I've also seen some really pathologising behaviour, and I think, in terms of training, HCAs need to be supported with training, but I would also see that other professions whose training you'd think would have much more common sense views also need some training.

The above excerpt suggests a need for training across all levels of the hospital hierarchy and makes reference to a perception of detainees' sexualities as evidence of 'pathology' (Brown et al., 2014). Understanding detainees as bearers of individual pathology positioned them as being 'knowable' under professional expertise, providing a basis for feeling that their behaviours were predictable and explainable (Gottschalk, 2000). These discourses also served as a rationale for why detainees were detained in mental health institutions and not prisons, with pathology rather than knowing intent often constructed as the reason why they had committed offences. Though this framing was useful in terms of professionals' ability to view detainees as separate from their crimes, it could also risk their otherwise 'natural' sexual behaviours being understood as intrinsically linked with pathology, and thus requiring treatment (Brown et al., 2014):

P: I have heard it talked about to a HCA who's said, "Talk to your therapist about that," say if they've expressed something sexual. "Well don't talk to me about it. Talk to them about it." But I think that goes back to a sort of association that it's to do with their mental health, for me, like you can't have a human conversation about that but they could tell you that they liked this colour or they like to do this as a hobby, but as soon as you want to say, "Well I think I might be gay", or whatever it is, "Well talk to them about that."

Constructions of pathology varied between participants, with some alluding to supposedly concrete states defined by particular diagnostic labels, and others subsuming particular relationship behaviours within the concept:

I: Do you have any thoughts on patients trying to start or maintain intimate relationships with people on the outside?

P: It's generally encouraged, as long as it isn't pathological, and by pathological I mean whether there's coercion, abuse, which there very often is. People are often here for those reasons, or it's part and parcel of why they're here.

Of interest in the above extract is the participant's attribution of coercion and abuse as belonging to pathology, part of what marks forensic detainees as different from others. Though some detainees' index offences are related to these behaviours, they may also be understood as somewhat commonplace in UK relationships, with their perpetration lacking a clear association with underlying mental health needs (Dixon et al., 2007; Office for National Statistics, 2019; Rongqin et al., 2019). This is, of course, not to say that the hospital should not be concerned with the prevention of harm in detainees' relationships, but rather an acknowledgement that an overt focus on this prevention may result in sexual desires being read as signs of 'pathological' vulnerability or predation (Brown et al., 2014). In particular, the presence of some detainees whose offending involved coercion and abuse within relationships may contribute to these behaviours' being broadly understood as evidence of a mental health problem to be treated, where they may not be elsewhere:

P: It's difficult because out there in the general public there are lots of relationships where there are unequal relationships, and people do have the right, I guess, to engage in a relationship that is not healthy, perhaps, or whatever, whereas here it becomes part of our responsibility to ensure that while they're in our care that they're not subject to harm.

The construction of abusive relationships themselves as pathological serves to re-situate sexualities within the remit of formal psychological and psychiatric knowledges. Management of intimacy was, therefore, viewed as falling within

professionals' roles as agents of care, with propensity to abuse or be abused understood as evidence of illnesses to be treated (McDonald, 2005). However, the situation of sexualities within pathology discourses sat uncomfortably with some participants due to the lack of space afforded by the hospital to incorporate them into the treatment approach:

P: I think sometimes people focus on safe as opposed to healthy. I think when you focus on safe you focus on being restrictive, whereas if you ask the question, "How do I keep this healthy?" then you think more about therapeutic opportunity. I guess the obvious group of people to kind of pull up would be around sexual offending, but I think then again it's a live opportunity to kind of assess ongoing risk or to assess people's ability to form healthy attachment, because a part of what keeps people healthy in the community with sexual offending is that ability to self-monitor and self-recognise early warning signs.

Here the participant outlines how forensic sexualities produce a conflict between her knowledges concerning care and institutional discourses concerning control. Where monitored, positive risk taking would typically be viewed as an important aspect of a holistic forensic treatment agenda (Boardman & Roberts, 2014), she finds little opportunity to do so with intimacy. This conflicts with unwanted relational experiences being "*part and parcel*" of detainees' pathologies, and produces uncertainty as to what her role might be with regards to promoting rehabilitation. The framing of what is 'safe' as opposed to what might promote a 'healthy' sexuality is revealing of a tension in her position as a knowing professional. This knowing is divided between a need to predict and prevent risk in the present moment and a need to provide enduring, holistic care for detainees (Holmes, 2005). We may surmise from the excerpt that those discourses concerning sexualities' potential to result in harm are presently felt to warrant voice over those concerning long-term treatment. We may also read the participant's storying of her role as assessing detainees' 'health' and enhancing their ability to self-monitor as somewhat omitting others' rights to not be subject to harm. Given that the institution lacks the ability to inform detainees' potential partners as to their offending histories, or other risks that

they may present within sexual relationships (Ravenhill et al., 2019), the *live opportunities* referred to by the participant may be understood as necessitating an underlying calculus as to ‘how much’ harm upon another may be risked in order to more holistically assess and treat a detainee.

3.2.2 Risking discomfort

For most participants, the possibility of opening up discussions concerning sexuality and emotional relationships on the wards raised concerns regarding possible impacts on staff members’ professional relationships with detainees. The ambiguities that conversations concerning sex and relationships might produce, including the potential for detainees and other professionals to misread clinicians’ intentions when initiating them, were felt to represent a risk to ward staff. Participants offered occasionally contradictory accounts that positioned hospital staff as sometimes unwilling and sometimes unable to initiate or participate in conversations about sex and relationships. In the absence of clear boundaries, many staff felt that discussing sexuality risked punitive responses from elsewhere in the hospital hierarchy:

P: So if a patient’s talking to you about that [sex] and someone overhears it, do they then think you’re having an inappropriate conversation with someone? That could put you at risk, having a conversation. A conversation could get you in trouble and you could lose your job.

The potential for discussing detainees’ sexualities to result in reprimand was felt to extend beyond intimacy’s positioning as taboo, and participants voiced anxieties concerning its dangerous linkages with other identity constructs such as gender. The recent implementation of diversity and inclusion projects in the hospital had raised concerns among professionals regarding their possibly being viewed as bigoted by detainees and colleagues should they try to engage with these issues. Without clear

policy governing these interactions, staff were left with uncertainties as to the personal consequences they might suffer should they get it wrong:

P: Staff are petrified of getting it wrong, of getting into trouble for saying something that's politically incorrect. So I think also making those safe spaces for staff to say how they feel but also give people permission to get it wrong. I think that fear of getting it wrong and them being labelled as bigoted is a massive fear.

The question of being 'politically correct' represented staff members' being subject to normalising judgement³ regarding their roles, within which they were expected to consistently engage with patients as beings unfettered by ideas now viewed as bigoted by the institution (Bradbury-Jones, Sambrook & Irvine, 2008; Tyrer et al., 1990). As illustrated by the above excerpts, failure to conform to the normative, socially sedimented understanding within the hospital of forensic professionals as asexual beings who are never politically incorrect was anticipated by staff to result in punishment, both from detainees and colleagues who may then define them as 'bigoted', and by supervisors and managers who may terminate their employment. For policy-makers, the institution was further subject to normalising judgements from external social institutions such as the media and government, who were felt to position the hospital as a place in which experiences of (sexual) enjoyment were simply not permitted to happen. Sensationalist headlines in the Daily Mail, in particular, were voiced by a number of participants as possible negative outcomes of deviation from these viewpoints in the form of policies and practices regarding sexual expression that might be viewed as too liberal by conservative media (Cooper & Cross, 2017). Conversely, one participant was concerned that more progressive political ideologies could take precedence over harm prevention, in the form of transgender detainees being afforded the right to be placed on wards matching the gender with which they identify:

³ Foucault (1977; 1990) describes 'normalization' as the construction of an idealised form of conduct for particular groups of people (e.g. soldiers; nurses) and consequently rewarding or punishing persons for conformity to or deviation from these behaviours, with the intended aim of asserting social control with minimal use of violence.

P: I'm talking about the transgender lobby. People who seek to politicise things for whatever end [laughs], rather than-, you know, people who believe in ideology over people. People should be assigned to units based on risk. Physical risk. We've had people who go onto the gender of unit with the sex they identify with rather than they're born with, but that has been after, you know, "Are these a threat?" If the answer's no, then-, if the answer's yes, that's a more difficult question.

Despite these concerns, the majority of participants felt that the incorporation of detainees' sexualities into treatment planning, including the opening up of conversations on the wards, could improve relationships between staff and detainees. The factors underpinning this improvement included detainees feeling more appreciated by staff, that their human rights were protected, and feeling a greater degree of normalcy during their time in hospital. These views are consistent with perspectives from forensic professionals internationally whose treatment settings permit sexual contact (Tiwana, McDonald & Völlm., 2016). However, a broadening of detainees' possibilities for expressing themselves sexually in hospital was often juxtaposed against the wellbeing of staff. Participants' positioning of ward staff with regards to forensic sexualities often placed exploration of sexual issues in opposition to professionals' personal beliefs. For some, the expectation that detainees should be free to discuss their sexualities was unfair to staff members who may not feel comfortable participating in such conversations:

P: I think a lot of our staff would feel quite uncomfortable with that and would need quite a lot of support and training. I think we've got to be mindful of the cultural aspects of the interaction as well, both from staff and from patients. If you take my ward for example, I've got a lot of quite chronic patients who are of a particular faith, and they probably wouldn't welcome those conversations with anyone else who wasn't of their gender and their faith, so I think that's something that we've got to tackle, being culturally sensitive. I think a lot of the staff would find it deeply uncomfortable.

As illustrated by the above excerpt, policy-makers' positions within the forensic hospital ensure that their considerations of policy and training must be balanced in terms of protecting both staff and detainees. The issue of sexuality is representative of taboos across numerous cultures, any number of which may be featured among the detainees and professionals inhabiting the institution at any given time (Quinn & Browne, 2009). Histories of abuse, potential future dangers, and distressing behaviours might be easily situated by clinicians within discourses concerning pathologies to be treated in hospital, positioning these uncomfortable topics as acceptable to discuss on the wards. Those aspects of sexuality that are not so simply subsumed within a framework of mental illness, however, may be experienced by staff as not sharing the same justification for discussion, and may thus provoke greater uncertainties regarding their relationship with treatment and appropriate professional boundaries (Hook & Andrews, 2005; Stevenson, 2010).

3.2.3 Responsibility and silence

Some participants highlighted that detainees' attempts to talk about sexualities could be silenced by professionals, either through overt rejection or by changing the subject. This was predominantly attributed to a lack of staff knowledge, personal discomfort, and fear of disciplinary procedures. For some, the 'quality' of ward staff was invoked as a primary facilitator of detainees' being afforded the opportunity to explore their sexualities through dialogue. These policy-makers drew a distinction between those who are personally interested in enacting care and others who understand their roles as predominantly being facilitators of institutional control, with the latter group perceived as prioritising their continued employment over detainee wellbeing:

P: I think it's level of maturity. I don't think somebody has got to go to university to be able to have a mature, meaningful conversation. I think it's kind of general

knowledge. I think it's people who are quite integrated in society. I think it's also people who have a true passion to be here, to help patients get better, as opposed to it's the biggest local employer and it's a job. I think there's quite a big difference there.

Those staff viewed as being of high quality were not necessarily the most qualified or experienced, but rather were seen as being thoughtful about the importance of their relationships with the detainees they worked with:

P: My whole view is that the conversations that happen on the wards need to be a better quality. Not just to keep somebody calm, but that they need to be engaging in conversations that enrich people and help them. What you might end up finding is that you might raise the issue that do you have the right quality and skill of healthcare assistant that can have a meaningful conversation with the patient.

Despite the prevalence of discourses within the hospital positioning detainees as not necessarily able to make decisions regarding unwanted sexual outcomes, more enjoyable aspects of their sexualities tended to be subject to a neoliberal ethics of self-governance. As such, detainees were broadly considered responsible for governing and promoting those features of their sexualities that did not produce institutional concern regarding risk. Given the lack of opportunity for sexual expression while in hospital, this largely took the form of their being anticipated to raise any difficulties with experiencing sexual pleasure through masturbation. As in other inpatient settings, staff were viewed as only initiating conversations regarding sexual pleasure where a need for containment of unwanted behaviours was identified (Bartlett et al., 2010), such as with care planning to avoid their witnessing masturbation. This was believed to disproportionately affect women on the wards, who were described as broadly less likely to feel able to volunteer issues regarding preferred aspects of their sexualities such as experiencing desire or pleasure:

P: I think with girls-, we've had a bit of a laugh, not in a nasty way, but with a patient who told us that she was experiencing [laughs] a clenching feeling down below, and it was like, "I think we know what she's talking about." But it's interesting that for us that was unusual. It's not my general experience that females talk a lot about whether they orgasm and I've never, ever had a female ever say to me, "I'm having a problem masturbating. I'm not getting that clenching feeling down below."

For some participants, this silencing of women's sexualities was consistent with broader, patriarchal societal tendencies permeating the institution, and was thus not viewed as something that professionals could reliably address (Hafford-Letchfield, 2011). Interestingly, the framing of detainees as agentic facilitators of their own sexual pleasure often resulted in them, rather than professionals, being positioned as responsible for counteracting these cultural scripts. The failure to initiate the conversation was thus often understood as belonging to the detainees. Conversely, male detainees were often positioned as less responsible for the management of unwanted sexual outcomes, and received less scrutiny as to their awareness regarding safe sexual practices. Where conversations regarding contraception took place across the hospital, this was often in relation to medication guidelines concerning the prescription of sodium valproate to women of childbearing age, rather than in terms of a detainee's intentions or likelihood of having sex. In the absence of explicit linkages between the promotion of sexual wellbeing and mental health treatment, initiating discussions concerning sexual pleasure tended to not be seen as the hospital's responsibility:

P: I wouldn't know where to even start with that one [feeling sexual pleasure], I'll be perfectly honest with you. I mean, I guess this is more about patients' awareness of their own emotions, and that could be explored in terms of various aspects of their psychosocial care plans, I guess.

Policy-makers who wished to engage in dialogue regarding sexualities with detainees could be similarly silenced by colleagues who adhered to more traditional

hospital practices. Several participants referred to historical instances in which detainees had been sexually abused while in hospital, with one such occasion involving a staff member. These histories were felt by some to underpin the risk-averse hospital culture, which could perceive such conversations as opening up possibilities for untoward incidents, such as the formation of sexual relationships between staff and detainees:

P: I imagine lots of staff who have negative views, or different views from me, in this area would say, "If staff and patients start discussing sexuality they're going to end up having sex together or they're going to end up trying to have a relationship."

For the participant in the above excerpt, the silencing of sexualities places staff in a precarious position in which conversations with detainees may be recognised as signs of vulnerability or predation on the part of both detainees and themselves (Brown et al., 2014). The primary responsibilities of hospital staff were understood by all participants to include the maintenance of 'appropriate' boundaries, against which their own and detainees' behaviour could be evaluated and governed by the institution. However, in the absence of formal policy and training, the acceptable parameters of these boundaries were generally unclear, limiting professionals' capacity to bring sexual aspects of the work to supervision:

P: I don't think it's abnormal to look at a patient and think they're sexually attractive, but it's then not ok to have a sexual relationship with that patient for lots and lots of reasons, and I think there isn't a space for staff to be able to acknowledge those attractions, or even those fleeting thoughts, which are going to affect your interactions with that person. Whether you avoid them more or whether you overcompensate and you're around them more.

The above excerpt illustrates one way in which the silencing of sexualities in the hospital may serve to impede therapeutic relationships and produce risk. Detainees

and professionals both become positioned by the institution as essentially asexual beings whose desires will not impact upon the hospital's goals of treatment and discharge (Hunter & Ahmed, 2016). However, as highlighted by the participant, the silencing of these experiences does little to reduce them, and so their consequences may be transmitted into relationships on the ward as staff come to "*overcompensate*" in response. For detainees, who may view their keyworkers as the only people for whom they feel any significant attraction or attachment (Brown et al., 2014; Ravenhill et al., 2019), any changes in behaviour resulting from avoidance or overcompensation will likely be strongly felt. Such events may produce any number of uncertainties and emotional responses which may then elevate risk on the wards as, in the absence of dialogue, these feelings and accompanying frustrations manifest as undesirable behaviours (Tiwana, McDonald & Völlm., 2016).

3.3 Artificial Realities

3.3.1 The hospital's purpose

The hospital was understood by many policy-makers as being intrinsically 'unreal', lacking the qualities that might situate it within the 'natural' world, yet whose aim was to ultimately yield 'recovered' individuals who could one day return there. The facilitation of any kind of activity on the part of detainees thus tended to primarily be measured against its utility in the treatment of mental illness and the prevention of harm. Policy was understood to shape detainees' lived realities through the modification of professionals' behaviour, though many participants voiced doubts as to the likelihood of new policies being read or enacted by ward staff. For them, previous difficulties had emerged from failures to make treatment and harm reduction rationales explicit to professionals. This had resulted in some hospital staff disregarding new guidance as unnecessary additions to their roles, and unrelated to treatment:

P: Often in our training and in our discussions we say, “Pride is important”, we say, “Sexuality is important and we must allow people to be proud of where they’re from,” but we miss the bit that explains why it’s important. So we miss the part of explaining that people who have a more diverse sexual interest are probably more at risk of developing certain kinds of pathologies affecting wellbeing, marginalisation, discrimination.

Here the participant outlines how practices intended to safeguard detainees may be interpreted by staff as emerging from political ideologies, adherence to which was felt to run counter to dominant understandings of what the hospital was for. She further described “backlash” to the recent development of Gay Pride celebrations in the hospital. The ‘politics’ she refers to are thus of particular interest in terms of professionals’ legal responsibility to protect the human rights of those under their care, which may sometimes contradict their understandings of how detainees are to be managed while in hospital (Perlin & Lynch, 2008). For some participants, these tensions were somewhat resolved by their engaging in a re-envisioning of the hospital as being primarily concerned with detainees’ skills-based rehabilitation rather than the treatment of discrete pathology constructs:

P: I think ultimately all of the patients are going to be discharged from the service at some point. Everybody gets discharged eventually, and rehabilitation is about imparting skills that were lost through illness, and a big part of people’s lives is intimacy, sexuality and relationships. So we really ought to be supporting people with that part of their lives, and we’re not doing that at the minute.

Some participants drew a distinction between what they considered to be the more ‘traditional’ and ‘conservative’ functions of secure care, which were concerned with removing offenders from the natural world as punishment or to ‘cure’ their illnesses, and newer modalities emphasising rehabilitation (Crichton, 2009; Havard & Watson, 2017). These latter understandings emphasised that institutional life should resemble, as closely as possible, life on the outside. Where ‘natural’ sexual drives

and desires were viewed as a poor fit with more traditional understandings of what might be acceptable in hospital, some participants saw recent national movements towards more progressive styles of secure care as opportunities to incorporate these into the hospital's remit (CQC, 2017; CQC, 2019; Havard & Watson, 2017).

However, this ideological transition was not foreseen to be a simple process:

P: So I think the institution is built on a very conservative kind of bedrock, and I think there is always a tension when you get that ... So there is a tension between bringing in those modern ways of working and the organisation. Having said that, I think it's made a lot of surprising changes and headway in diversity and inclusivity, equality, which I think comes back to sexuality as well.

Where these inclinations to shift hospital practice towards promoting detainees' sexualities to a greater degree had produced more opportunities for a flexible approach on the wards (Ravenhill et al., 2019), little movement had occurred in terms of policy and guidance. This was viewed by some participants as an ethical failing on their part and seemed to produce moral distress in those who found themselves positioned as inhibitors of detainees' preferred lives:

P: "We're going to recognise that you have sexual urges or needs or whatever, but we're not going to do anything about it, because we don't know what to do." That for me I don't think is acceptable, and I'm not saying that's what we do, but if we're not facilitating your ability to have relationships or to have meaningful, intimate relationships, or to have a normal sex life, or whatever, if we're not doing that then almost by default we're saying, "Well we're just going to push that away to one side and focus on all these other things, because these are the things that we can actually do something about." I don't think that would be correct. That's what we tend to do, I guess.

The above excerpt highlights the possibilities for the hospital to stand as an ethical facilitator of care, within whose purview lies the opportunity to ensure that detainees' lives are as fulfilling as possible, despite the deprivation of their liberty. Rather than the realisation of this ideal, we witness the participant's painful coming to terms with the present realities of the hospital as he speaks, shifting from a position of *"not saying that's what we do"* to one of acceptance as his narrative unfolds. Of note is that by not incorporating intimacy into its function, the institution overtly says nothing, yet through this silence communicates a clear and powerful message to detainees as to whether their sexualities might be considered valuable, safe or relevant (Brown et al., 2014).

3.3.2 Distance and 'the community'

'The community' was invoked by most participants as a signifier of multiple relational opportunities and risks inherently separate from life in detention, and was positively contrasted with being detained. One of the hospital's primary functions was understood to be the separation of those confined within from aspects of the community that could be damaging to or damaged by their presence. Detainees' nearness to the community was thus used as an indicator of their approaching rehabilitation. The community was thus constructed as a space in which wellness happens, and the traditional site of 'healthy' sexualities that function separately from histories of pathology or offending (Brown et al., 2014). However, a number of participants described difficulties in trying to maintain this delineation, as aspects of the community routinely intruded upon the institution (Quirk, Lelliot & Searle, 2006; Tucker et al., 2019). This was of particular salience for those policy-makers involved in low-secure settings, where the availability of unescorted leave rendered boundaries especially porous, enabling a trickling through of detainees' sexualities:

P: So my most common dilemma is, so I typically run [service] wards, either medium- or low-secure. When they get to low-secure they tend to have a fair amount of leave. They tend to then meet people from the [other service] on the grounds of

the hospital or in the community. They say, "I want to start a relationship with person X."

The above excerpt frames the community's opening up of detainees' potential for intimacy as a dilemma belonging to the participant, positioning forensic sexualities as being owned in part by the institution. The complexities produced by these occurrences is described elsewhere by this participant as clashing and overlapping with the concept of safeguarding, as all of those detained in the forensic hospital are situated within legal frameworks as vulnerable people (Georgiou, Oultram & Haque, 2019). Without policy to inform professionals' roles in facilitating intimacy, the community's intrusion into the forensic hospital may present concerns for professionals who are liable for any negative consequences which may arise (Ruane & Hayter, 2008). Contrasting with the silence surrounding sexualities, safeguarding policies concerning violence and harm are an everyday presence, possibly ensuring that intimacy's potential risks are experienced as more salient than its possible benefits. Of further interest is how the community's increasing nearness necessitates the extension of these professionals' jurisdiction outside of the hospital, where limited opportunities for surveillance produce a reliance on detainees' self-governance, particularly their willingness to report their relational intentions:

P: They're using leave, they could be meeting anybody. We have got two patients currently on the site who are in a relationship when they leave the hospital, so that's something that both teams have had to be really aware of to manage and make sure that that is an appropriate relationship. Both patients are very close to being discharged, they both have capacity to make that decision, but we also have to think about how that would impact upon their time on the site as well and how we have to manage that. We pretty much rely on patients telling us.

The relationship described here illustrates forensic sexualities' capacity to cause the artificial reality of the forensic hospital and more 'real life' aspects of the community to collide. Despite both detainees' residence within the hospital, their relationship is

perceived as existing outside of it, raising questions as to the extent that these connections are viewed as 'real' while within the institution. Moreover, the role of staff is identified as being the management of what realities might be *brought back* to the hospital from the outside following the opportunity to be intimate, a concern that is in part mitigated by both detainees' nearness to discharge. Where relationships were facilitated by the hospital, they were perceived by participants as being imbued with some of its artificiality:

P: I assumed it was something they'd given permission to or allowed to happen, as in, "We'll let them say that they're boyfriend and girlfriend and we'll let them go through a meetup for a coffee or something like that." That's how it was put across. In a way that you might do with young children, like with little kids. Like, "That's his boyfriend, blah blah blah. That's the girlfriend." You know what I mean.

The above excerpt illustrates a paternalistic prohibition of sexual contact that, for the participant, reduces the relationship to something childlike and ultimately less real (Ravenhill et al., 2019). By situating 'real' intimacy as something that happens in the community, or at least off of the wards, detainees' potential to actually re-join reality and enact sexual agency was felt to be unnecessarily impeded. However, this framing contradicted many participants' own experiences of reality within hospital, where unsanctioned sexual contact occurred on both the wards and the grounds. The absence of conjugal suites ensured that detainees' sexual connections with other wards and the wider community could not be brought back into the hospital in a way that was acceptable for policy-makers. For participants, and ward staff in other research (Ravenhill et al., 2019), these 'less-than-real' relationships were the only form in which intimacy might conceivably exist within the hospital. This, however, may also be understood as the most conservative set of forensic practices in Europe with regards to sexualities (Di Lorito et al., 2020; Tiwana, McDonald & Völlm, 2016).

3.3.3 The deferral of dignity

Many participants understood the promotion of sexualities as relevant to the preservation of detainees' dignity and human rights, and consistent with professionals' desire to maintain similarities between the community and life on the wards. In particular, detainees' rights to privacy and family were raised as areas of concern with regards to their being denied sexual contact by the institution, with these often viewed as aspects of real life that could not be successfully replicated. Detainees' rights were often constructed alongside wellbeing as standing in opposition to safeguarding frameworks intended to protect society from harm. As such, policy-makers often found themselves unwillingly positioned as authoritarian arbiters of detainees' rights and dignity during their admissions, a role that focused on establishing which of these could be deferred until a future point in time. The qualification of Article 8 of the ECHR was invoked by one policy-maker as supporting this postponement:

P: We know that right to family life, et cetera, is enshrined in the Human Rights Act, but it's also qualified, and making sure people understand that so we get the correct balance of what's right for the individual but it also protective and also encompasses that duty of care we have to everybody. I suppose it's that idea that we don't do anybody any harm. One set of people's freedoms don't negatively impact on somebody else's to any significant extent.

Detainees' lack of access to privacy while detained was considered to be an unavoidable, if unfortunate, consequence of the manner in which the hospital was set up, both in terms of ward layouts and traditional ideologies concerning 'appropriate' behaviours (Ravenhill et al., 2019). Rather than viewing professionals as impeding detainees' rights, participants tended to conceptualise the physical bedrock of the hospital as hindering possibilities for supporting sexual expression. Participants could not foresee how intimacy could be permissible with the interweaving of public and private space on the wards, routine observation practices, and the absence of conjugal suites (Brown et al., 2014). For many, masturbation was

the only appropriate means of sexual expression, with governance only required if it took place publicly. However, surveillance practices such as regular room checks ensured that no spaces could truly be considered private:

P: One of the big issues around observations and staff observing, so I've worked with patients in the past where it's actually been part of their care plan, where they've identified to staff that that's what they're going to do then their care plan is a little more lenient in terms of observations to allow them privacy, so it's not embarrassing for them and it's not embarrassing for the staff, but also so that patients aren't deliberately doing it when they know that staff are going to observe.

The institutional attempt to preserve dignity described above was echoed by a number of participants as being key to promoting detainees' rights to *private* sexual expression, and is revealing of how privacy might be conceptualised on the wards. In order to have "*been part of their care plan*", these detainees' desire to masturbate will have been discussed by a number of professionals involved in their treatment. The decisions arising from this dialogue would then be codified into a written document, with a copy stored within the detainee's electronic record accessible by all those involved for the duration of their admission. This document will then be revisited and reviewed by hospital staff at least once monthly (Georgiou, Oultram & Haque, 2019). Though this procedure succeeds in obfuscating detainees' bodies at particular times so that they have the opportunity to be sexual, it does so by subjecting their sexualities to routine institutional scrutiny that is beyond their capability to limit or control. The provision of masturbation aids such as pornography and sex toys was subject to further levels of care planning, which some participants viewed as barriers to dignity:

P: The only way I know those conversations come up is via two routes that are quite humiliating for patients. One is requesting access to pornography, which I think we need to have a better way of doing without people coming to ward round and

asking for it. Can you imagine being at home and having to ask your parents? It's just not ok.

Here the participant positions hospital staff as being like detainees' parents, implying an assumption of paternalistic powers or rights that run counter to the preservation of dignity (Glaser, 2003; Ward, 2011). By their being detained in a forensic hospital, detainees' preferences or goals may be easily overridden in a manner that is constructed by the institution as being in their best interests, or in the best interests of those with whom they share the ward space. The imperative to "*not do anybody any harm*" necessitates a sacrifice of the detainee's dignity in order to preserve the dignity of all. The detainee is thus made responsible for interpreting routine surveillance and management by ward staff as protective of their dignity, rather than impeding it, so that the intervention might be perceived as harming no one (Crichton, 2009). The alternative responses available to detainees, including anger and resistance, may result in disastrous consequences subjecting them to further deprivation of liberty, including a reading by the institution of these behaviours as evidence of pathology (Brown et al., 2014; Ravenhill et al., 2019). However, even those permissive of intrusion could be subject to these outcomes:

P: Suppose our policy said it's ok for people [to have sex], if they've had a capacity assessment and they're capacitous, to have a consenting relationship, which it could well say, I think the barriers might be that everybody decides they're not capacitous, because they don't like it. People would struggle with the concept that you could have a right to make an unwise decision, so I think there's a risk that people would decide-, it would sway people's capacity assessments.

The above excerpt implies that capacity assessments may sometimes be used by professionals in order to assuage paternalistic concerns as to whether detainees are making unwise relational decisions, a right to which is enshrined in the Mental Capacity Act 2005 but which may routinely be poorly implemented in mental health services more broadly (Lepping, 2008). These processes may be understood as

affording little opportunity for detainees to express their sexualities in a dignified manner, with safeguarding frameworks intended to prevent unnecessary restrictions on detainees potentially generating further prohibitive outcomes. Rather, these procedures may sometimes serve an additional function of re-constituting controlling acts as elements of caring practice (Wilson & Daly, 2007).

3.4 Detained Bodies

3.4.1 Dangerous pasts, fragile futures

Participants' knowledges regarding how to support detainees' sexualities were complicated by histories of abuse and offending. Maintaining confidentiality presented particular difficulties for policy-makers when considering relationships between detainees who had experienced sexual abuse and those with histories of inflicting sexual violence upon others (Glaser, 2003). Participants voiced concerns regarding their inability to inform detainees that they were pursuing a relationship with potentially dangerous individuals, with some noting instances in which offending histories had been accidentally disclosed by staff. These ethical dilemmas raised questions as to the hospital's ability to safeguard those detained within while also ensuring that their rights were promoted:

P: Say for example one common dilemma is to what degree, if somebody is a registered sex offender, on the sex offenders register, and has a history of offending against various groups, including children, to what degree does the person that they're in a relationship with have the right to know about that, and at what point?

Beyond the obvious risk of violence in relationships with detainees who had previously inflicted harm, histories of sexual offending were also understood to render (particularly male) detainees vulnerable to unwarranted allegations:

P: So when we're having our MDT meeting they'll often get told that, "This woman has a history of making various allegations against staff and other patients around being touched inappropriately, or saying this, doing that," and obviously I have to take that into account to say, "Well if you're here, you're in secure care, you've got a sexual offending history. You want a relationship with this woman but if they start alleging something and there's no witnesses you're in serious trouble whether it happened or even if it didn't happen."

Of further concern to policy-makers was the extent to which detainees' past exposure to grooming or abuse in relationships might make this more likely to reoccur in future. Detainees (particularly women) who had previously been victimised were positioned by policy-makers as especially vulnerable and requiring extra oversight and protection. The issue of these detainees' ability to consent to relationships was raised by a number of participants, as prior experiences of abuse were felt to constitute a part of pathology and thus could be reasoned to inform capacity assessments. As such, the histories of these women often formed the basis of a safety rationale ensuring that the hospital could not serve as a site for them to develop relationship skills via mechanisms of positive risk taking and exposure, such as the ability to recognise abusive patterns of behaviour (Higgins, Barker & Begley, 2006; McCann et al., 2019). Similarly, access to potentially supportive community resources, such as peer support groups, could be blocked by staff due to fears that therapeutically engaging with detainees' experiences of violence in relationships could be 'triggering' of their dangerous pasts:

P: I think there's a lot of well-meaning clinicians, like we did an event around domestic violence for victims of sexual assault, you know? We went around and told staff that it was an event for staff and patients because there's a lot of support groups in [the local community] that patients could access and there's a lot of clinicians going, "Oh, we can't really talk to our patients about that. It's going to trigger something."

Where detainees may regard the forensic hospital as an ideal base from which to experiment with potentially ‘triggering’ experiences, inpatient staff may alternatively invite detainees to engage in a process of emotional displacement by which painful phenomena are always to be avoided (Reavey et al., 2017). Despite learning to manage one’s own emotional states being commonly viewed as a primary intended outcome of mental health interventions, particularly those models made available in forensic settings such as dialectical behaviour therapy (Chapman, 2006), those emotional states connected to prior experiences of intimacy were positioned as unfit for discussion in hospital (Ravenhill et al., 2019). For some participants, this divestment of detainees’ relational selves during their time in detention risked placing their sexualities in a kind of stasis, from which they would one day emerge to discover that the world had moved on in their absence (Reavey et al., 2019a). The lack of opportunities to practice relationship skills in the context of hospital admission was featured prominently in these accounts, with some noting that particularly lengthy admissions without exposure to relationships would likely be detrimental to detainees’ future attempts to reintegrate into their communities (Brown et al., 2014).

P: If you’ve been in hospital for ten years then you haven’t been in a sexual or romantic relationship for ten years, and you’re discharged from hospital and you’re in the community, you’re going to be at sea, I think. How do you manage that?

Where detainees’ futures following discharge had not historically been viewed as a part of the institution’s remit, the sociocultural re-positioning of the forensic hospital as a site of rehabilitation necessitated consideration of these. This new understanding of forensic detention was viewed by some participants as one part of a broader societal turn that had similarly re-constructed notions of ‘healthy’ sexualities in a manner incorporating a more expansive range of sexual expressions (Mercer et al., 2013). The changing ways in which sexualities could be expressed in wider society were raised as further evidence of detainees’ future vulnerabilities, with technologies such as dating apps viewed as particularly representative of the skills deficit that many would experience following discharge.

P: If you consider that 95% of dating is online anyway now, so say you come here and it's not like that and then you leave and everyone's on these apps. A lot of them are quite sexualised anyway, what's acceptable, what's not, how to communicate with people. It's like learning, isn't it? It's like learning dating. When you start dating it's as if it's a learning curve of what sort of person do I like, what do I need, what sort of person is right for me? It must be a shock. How do you meet anyone without that? How do you get into that? How could people abuse that, because you don't know how to read the signs of what you might get?

This wider cultural shift was felt to be permeating the hospital both from above, in the form of guidance from the CQC (2019), and below, in the form of the induction of new, young staff (particularly HCAs) whose personal politics and willingness to talk about sex and relationships were viewed as more progressive:

P: I've sat in meetings where they've [psychiatrists] tried to ban relationships. You can't ban a relationship, and if you do you're just going to make it so much more interesting and the person's going to want it more. So I accept that we need training for our HCAs, but our HCAs are often younger and more open-minded and more dynamic than some of our older, qualified staff, if I'm honest. I think when we had Pride Week in the [service] two years ago and the younger HCAs were more on board than some of the older staff.

Despite the influx of new ideologies, the hospital's conservative bedrock, in tandem with its demarcation from wider society and prior experience of untoward incidents, seemed to constitute its own dangerous past that policy-makers perceived as interfering with their desire to facilitate relationships. Moreover, the historical lack of promotion of detainees' sexualities nationally, in other secure settings and on the part of governing bodies, had produced a stasis from which the hospital now found itself awakening.

3.4.2 Discoursing health

Where sexualities were discussed in practice, this tended to be concerned with establishing whether detainees' sexual desires and expressions were consistent with dominant institutional discourses regarding what is 'healthy'. For policy-makers, healthy sexualities tended to be understood as incorporating an understanding of safe sexual practices and omitting previous relationship behaviours that might be considered part of the reason for detainees' admissions. The latter consideration tended to position detainees as inherently bearing 'unhealthy' sexualities by way of their having experienced or perpetrated abuse in the past (Classen, Palesh & Aggarwal, 2005; Moser, 2001). Detainees' limited opportunities to demonstrate more socially acceptable tendencies during their admissions ensured that this discourse often went unchallenged.

This was further magnified by the hospital's separation from the wider community, which ensured that the only relational opportunities available to most detainees were with other vulnerable people (Ravenhill et al., 2019). Extant legal frameworks' positioning of both people in a relationship as vulnerable served to reinforce professionals' position as responsible for ensuring no harm would occur, further problematising their roles when these instances occurred. The construction of abuse as an issue of pathology fostered a linkage between risk and treatment discourses, particularly for those detainees whose offences were sexual in nature (Glaser, 2003), and situated the management of intimacy as a function of both care and control. However, the hospital possessed no formal guidance as to how exactly this management was to be assessed or enacted, necessitating a re-invention of procedure on a case-by-case basis:

P: We have sexual offenders, for example, whose victims of choice are vulnerable, learning disabled women, and they say, "I met this person, I want to be in a relationship," and they're a vulnerable, learning disabled woman from the LD ward. You've got that judgement as to what extent this is normal drive and this is

essentially the pool of people that this person has to interact with and therefore they're going to interact with other vulnerable people.

The issue of healthy sexualities produced tensions in terms of whose responsibility it might be to ensure that health could be preserved while in hospital and following discharge. The ongoing development of a broader sociocultural conceptualisation of 'mental health' as incorporating, for example, spiritual and occupational wellbeing (e.g. Karban, 2017), highlighted for some participants that forensic practice may produce insecurities for detainees in its attempts to alleviate particular 'pathologies' (Wilson, McDonald & Pietsch, 2010). This concern manifested, for some participants, in conflicts between their personal perspectives and what they understood to be a more medical set of knowledges. Women's sexualities were particularly contested arenas in the sexual health debate, particularly with regards to framings of 'personality disorder' as underpinning relational lives that were viewed as inherently unhealthy (Nehls, 1998; Warner & Wilkins, 2004):

P: I think because we work with so many people with personality disorder, I think most people who work in places like this are so used to how tentative romantic relationships can be, and how ephemeral [laughs].

I: Could you expand on that a little bit?

P: Well we treat a lot of people with emotionally unstable personality disorder, and a core feature of that disorder is instability in relationships. You know, they're madly in love one second, thirty seconds later they're trying to kill someone [laughs], and you have to take into account the fact that that's the disorder people are here to be treated for. So that just adds another layer of complication to whether something's a practical arrangement or could be considered to be romantic.

Constructing difficulties in managing relationships as belonging to "the disorder that people are here to be treated for" fosters an individualised and pathologised understanding of these problems, positioning them as illnesses that exist within women's 'unwell' bodies (Player, 2016). This in turn enables the institutional gaze to

turn away from harmful societal tendencies outside of clinicians' control, such as the infliction of harm upon women within intimate relationships that is prevalent in UK society (Khalifah et al., 2013; Ussher, 2011), and possibly alleviates feelings of threat that the inability to directly intervene with these may instil (Warner & Wilkins, 2004). Situating relationship difficulties within detainees may further limit professionals' possibilities for examining how the forensic hospital's attempts to manage or prohibit intimacy may reproduce these women's prior experiences of being controlled in the context of coercive relationships (Pollack, 2007). Women with diagnosis of emotionally unstable personality disorder were thus understood as simultaneously at risk of unstable relationships, and responsible for managing that risk. The hospital's role with regards to 'treating' this pathology was thus concerned with fostering an ethics of self-governance:

P: One of the core pathologies is patients having very dysfunctional relationships with those around them, and we spend a lot of time trying to help people be more effective in interpersonal relationships.

Women's physical sexual health needs, particularly in terms of contraception, produced similar tensions as to the relevance of psychiatric knowledges in supporting female detainees' wellbeing. The risk of birth defects arising from pregnancy while taking sodium valproate had resulted in a number of women being informed by male psychiatrists that they would be administered hormonal contraception. This was regarded by one female participant, and a number of female detainees referred to by her, as male medical expertise's positioning of women as solely responsible for preventing pregnancy (Wigginton et al., 2015):

P: They didn't feel that the doctor was coming at it from the same perspective as them, because they were male and it was very much about contraception rather than the bigger conversation around, "Actually, I don't want to take contraception. I want my medication changed because I don't want to take contraception," whereas the discussion from the medical point of view was, "You're on valproate. You need to

take contraception”, even though they weren’t thinking of engaging in a sexual relationship.

The above excerpt raises questions as to whose health the described medical intervention was intended to protect. The “*bigger conversation*” referred to here is, in part, concerned with the histories of sexual abuse that many of these women experienced prior to admission, and what meanings taking contraception may produce in terms of their felt level of agency over their sexualities (Williams, Larsen & McCloskey, 2008). The salient issues for “*the doctor*” may conversely be understood as following safe prescribing guidelines, preventing harm to detainees, and avoiding professional liability, issues which were voiced by male psychiatrists interviewed in this study:

P: You’ve got the complication of does the pregnancy then limit the treatment you can give that mental health condition? Will that then worsen or not improve? If they carry that baby through to term you’ve got the risks to the child, the mother’s parenting ability. Does that child get adopted?

However, an insistence upon contraception for those who stated no intention to have sex may alternatively be read as professionals’ tacit acknowledgement that these women are untrustworthy, or that they be subject to sexual violence in the future. Through this lens, female detainees may understand this intervention as the institution potentially being unwilling or unable to protect them, as evidenced by its privileging the health of a hypothetical foetus over theirs. This positioning of women’s desire to have sex as secondary to their capacity for reproduction may be further representative of enduring medical and lay discourses constructing the value of women’s bodies as their being sites for the production of children, and may be read, again, as a reproduction of the gendered marginalisation contributing to the distress underpinning admission to hospital (Chesney-Lind & Hadi, 2017; Ussher, 2011).

3.4.3 Bodies transformed

All participants acknowledged that, despite a lack of formal engagement with the issue, detainees' sexualities were likely to become transformed as a consequence of their detention. The side-effects of medications were broadly acknowledged to produce unintended, embodied changes for detainees, and were considered to be an unavoidable consequence of medical treatment:

P: If people didn't come into [the hospital] or any other hospital with sexual dysfunction in a way that stops them gaining pleasure, they're probably going to have it when they go out or while they're here.

The prevalence of sexual side-effects of medications ensured that their monitoring was one of the few aspects of sexuality covered by existing policy within the hospital, and were intended to be a routine part of medication reviews. However, some policy-makers were unaware of this and did not necessarily inquire about these in their own practice:

I: Is it usually patients who initiate that conversation or is there some sort of routine inquiry?

P: No, there's not really. There are tools you can use but there's not prompting. I think you've brought up a very important point. The patients are normally the ones who would bring that to you. I don't normally ask about that.

Side-effects that interfered with the physical functioning of genitals were most likely to be raised in medication reviews or by detainees themselves, with this taking place more reliably for male detainees. This was explained as male detainees being more likely to raise concerns, and also as properly functioning penises being more visible than vaginas in terms of their developing erections and ejaculating:

P: There's a cultural belief, isn't there, that women are less likely to masturbate than men, but also definitely less likely to climax, to orgasm, than men. It's more visible, isn't it, to ask men in some ways [laughs]. So I work with learning disabled patients, and you can ask, "Do you ejaculate?" "What are you talking about?", and you have to get very nitty-gritty to explain what it is you mean, and then they'll go, "Oh god, yeah", or "No!" [laughs].

Embodied sexualities' visibility on the wards received contradictory responses from participants, at times constructed as vital to ensuring that detainees' sexual needs could be supported, and at others as problems to be managed and contained. Given the inherent dangers of being viewed as too open to the idea of exploring sexualities, both detainees' and professionals' desire to reverse unwanted bodily transformations could risk their becoming discursively transformed into an object of threat (Brown et al., 2014). Just as female detainees' bodies were often positioned as sites at risk of reproduction, men's were frequently constructed as where risk of sexual harm in the hospital originated, though the responsibility for managing this danger was more widely dispersed:

P: When we have our big patient party a lot of our patients do like to dress up for it but we then have to say, "Actually, there's some of the men who may be quite vulnerable and the way you're dressed may make you quite vulnerable to those men," and it's not about, "You can't go out looking like that." It's just about making sure that they're aware that while to them it makes them feel sexually attractive, it could be quite intimidating to other people or it could be quite difficult for other patients to manage that and how we sort of manage that across the site.

The above excerpt highlights some detainees' desire to feel sexually attractive in hospital, which may manifest as particular clothing choices when attending social events that include detainees from multiple wards. Of interest is the participant's double usage of the word "*vulnerable*", which appears to serve two different functions: For women, this vulnerability may be understood in a more traditional,

patriarchal sense as representing their perceived likelihood of being harmed should they wear clothing that men (and staff) might consider to be sexually provocative (Keller, Mendes & Ringrose, 2016). Men's vulnerability, however, appears to refer to their propensity to inflict sexual harm, an understanding that may emerge from discourses constructing their harmful behaviours as produced by pathology rather than intention. Although both 'vulnerabilities' are of concern to the participant, the proffered solution is the transformation of the female detainee's body into a less sexually desirable object.

This may be read as an enacted silencing that positions the detainee in question as responsible for maintaining the health and safety of others at the party, and her sexual expression as of less importance than the potential for harm to occur (Keller, Mendes & Ringrose, 2016). Moreover, despite these constructions of male and female sexual vulnerability by the participant being presented to us in a decontextualised manner, they are revealing of the extent to which the forensic hospital is permeated by patriarchal power. For many of the women referred to in the excerpt, their detention is likely deeply entangled with prior experiences of sexual violence in which control over their embodied sexualities was taken from them by men (Dolan & Whitworth, 2013; Phipps, 2010), a process which is reproduced by an institutional demand to abstain from wearing clothes that make them feel sexual, one of the few avenues of sexual expression and control available to them. Societally, women's perceived failure to de-sexualise their bodies is commonly implicated as a cause of male-inflicted sexual violence, serving to resituate fault for the infliction of this oppression away from male perpetrators and, consequently, increasing its permissibility (Loughnan et al., 2013). As outside of the hospital, female detainees may find this same oppression reproduced by a system that censures their performing a preferred embodied sexuality via their clothing choices, with the stated aim of 'protecting' men from the need to curtail their own sexual desires framed within a discourse of vulnerability purportedly intended to keep women safe. Where detainees' bodies were not purposefully transformed, this could often occur as an unintended consequence of medications:

P: You're kind of saying, "Although this keeps you well, this may reduce your attractiveness and therefore ability to get a partner, and therefore fulfil a really important part of your life." I think that's just a bit too much for people to bite off, and maybe that's cowardice, but that's something we need to work through.

Detainees' desire to feel sexually attractive was typically conceptualised by participants in relation to their experiences of trauma and low self-esteem. The impact of medications upon one's ability to inhabit a sexually desirable body, particularly in terms of weight gain, was viewed as a salient issue for detainees, but one that received little attention in medication administration or review. The participant in the above excerpt identifies this as an issue of "cowardice", linking the hospital's historical lack of engagement with sexualities to the fear and uncertainty that they generate among staff, while also acknowledging that this is insufficient reason to inhibit detainees' access to fulfilling lives. One policy-maker, however, suggested that medication reviews may often omit inquiry regarding sexual side-effects and, disturbingly, that sexually inhibiting side-effects of medications might be perceived by some as useful to the successful running of the hospital:

P: I don't think the checklist for sexual impact of medications, one, consistently happens. I've not seen an audit on that and I have never, in ten years, seen it inform care planning. I think what I would say is sometimes, and I could think of at least one patient who has committed sexual offences, including since he's been in [the hospital], and I suspect the side-effects of his antidepressant on lowering his libido is viewed as a positive. I'm not suggesting we prescribe antidepressants as backdoor anti-libidinals, but I don't think it would be seen as a bad thing that we would need to address.

This excerpt refers to the utility of particular medications in suppressing harmful sexual behaviours within the hospital, noting their potential to produce side-effects that, while not necessarily intended by staff, are not necessarily unwelcome. The participant's qualification of this statement is understandable, given that prolonged

chemical restraint used for clinical convenience is unlawful under the Mental Capacity Act 2005, though this may be routine practice in other mental healthcare domains (e.g. Branford et al., 2019). Moreover, the use of pharmacotherapy to suppress sexual urges without detainees' explicit, non-coerced consent is likely in violation of Articles 8 and 12 of the ECHR, and may be considered to be torture, or inhuman or degrading treatment, under Article 3 (Rainey & Harrison, 2008). Despite the acknowledgement here that the medication in question was not intended to be used in this way, this excerpt highlights professionals' profound capacity to transform detainees' bodies into forms that are more easily managed by the hospital.

4.0 FURTHER DISCUSSION

4.1 Chapter Overview

This chapter discusses the themes emerging from the analysis with regards to the research question and existing literature. The relevance of the findings for clinical practice and policy, and accompanying recommendations, are explored, followed by suggestions for future research. Finally, limitations of the research are reviewed.

4.2 Summary of Key Findings

The aim of this study was to understand how UK forensic hospital policy-makers make sense of detainees' sexualities, and how this manifests as institutional policy and practice. The findings suggest that forensic sexualities present policy-makers with a broad spectrum of uncertainties, particularly in terms of how they are to fulfil their responsibility to prevent harm to detainees, staff, and the public if sexual expression is to be permitted in hospital. The prioritising of safety rationales in this way is consistent with views expressed by UK forensic ward staff in previous research (Dean et al., 2016; Ravenhill et al., 2019; Di Lorito et al., 2020) and national guidance concerning the operation of forensic hospitals (Allen, 2015a; CQC, 2018). These findings further highlight that, despite a broad societal turn emphasising sexualities as intrinsic to psychological wellbeing (WHO, 2006) and the human rights of those in care settings (CQC, 2019), little movement has occurred in terms of the promotion of these as aspects of forensic hospital policy or treatment planning.

4.2.1 Harm and rehabilitation

Despite increasing movements towards conceptualising sexual expression as a relevant aspect of the mental health treatment agenda (WHO, 2006; CQC, 2019), the findings of this research highlight an ongoing absence of formal forensic hospital policy governing this. A limited conceptual framework underpinning policies that

govern detainees' relationships already exists in the form of relational security, though institutional engagement with this tends to be neglected in comparison to physical and procedural security (Aitken & Noble, 2001; Exworthy & Gunn, 2003; Parry-Crooke & Stafford, 2009; Tighe & Gudjonsson, 2012). Where policies that relate to sexualities do exist, they tend to focus on staff members' responsibility for maintaining professional boundaries and safety rather than recognising opportunities to promote detainees' wellbeing and human rights. Moreover, where policies permitting sexual relationships are put in place, they may be ignored by ward staff (Ruane & Hayter, 2008), possibly due to a fear of personal liability, should untoward incidents occur (Cole et al., 2003; Mason, Worsley & Coyle, 2010; Morgan, 2007).

The uncertainties produced by forensic sexualities were revealing of a tension between two dominant discourses concerning the hospital's role in society and the accompanying function of mental health treatment, both of which were operating across the hospital sites to differing degrees. The first of these, concerned with 'harm', positioned the forensic institution as a centre of enclosure responsible for protecting society and other detainees from the predations of those contained within (Deleuze, 1995; Foucault, 1990), with treatment constructed as the elimination of pathologies and the modification of detainees' behaviours to ensure that the chances of criminal harm are significantly reduced (Brown et al., 2014; Ravenhill et al., 2019). This discourse was explicitly concerned with protecting the wellbeing and human rights of others in society, including staff members and other detainees, which might be infringed upon should detainees be afforded the opportunity to discuss or enact their sexualities (Holmes & Murray, 2011). As such, this discourse often maintained a sense of ambiguity around sexualities which could paralyse staff, resulting in a silencing of detainees' sexual expression (Ravenhill et al., 2019).

Meanings produced within the 'harm' discourse were understood by policy-makers in terms of their being 'traditional', 'conservative', and primarily concerned with risk. Detainees were positioned, in gendered terms, as the physical sites from which sexual risk was produced, with male bodies defined by their potential to enact sexual violence, female bodies as instigative of male sexual violence and at risk of unwanted pregnancy, and transgender bodies as disruptive to traditional harm-prevention strategies on the wards (see also Dein et al., 2016). The hospital's role

was primarily concerned with reducing risk in the present moment through strategies of monitoring and containment (Ravenhill et al., 2019). Clinicians were sometimes positioned within this discourse as at risk of sexual misbehaviour, both in terms of this actually occurring and in their being fearful of being misinterpreted as such (Holmes & Federman, 2006).

The second, competing discourse, concerned with 'rehabilitation', positioned the hospital as a potential facilitator of enduring care, whose propensity to lessen detainees' experiences of their lives as 'real' must be actively worked against. Treatment was constructed as the promotion of a range of skills and opportunities that did not necessarily fit with traditional understandings of 'curing' discrete mental illness. Rather, this discourse was concerned with the promotion of individual detainees' rights and the facilitation of a 'real life' in hospital and following discharge, both of which were felt to necessitate engagement with sexualities (Hunter & Ahmed, 2016; Sugarman & Dickens, 2007). Concern with 'equality', 'open-mindedness', and 'opportunity' were primarily understood as supporting detainees' prospective futures in the community, within this discourse (Brown et al., 2014). Detainees were positioned as presently unhealthy individuals whose sexualities could be restored to a 'natural' state using holistic approaches promoting sexual health and intimate relationship skills. These were viewed as foundational to reduced interpersonal distress and accompanying risk in future (Hales et al., 2006; Kepfisz, Daffern & Day, 2017; Tapp et al., 2013).

Equity was of concern within the 'rehabilitation' discourse. Areas of inequality included the uneven construction of male and female bodies as sites of potential vulnerability and the distribution of responsibility for safe sexual practices across genders, the acceptance of marginalised sexual orientations within the hospital, and the right for transgender detainees to be placed on wards consistent with their gender identities (Mercer, 2013). Clinicians' propensity to promote equity was framed in terms of their 'quality', referring to their intent to provide care to detainees rather than control their behaviours (Holmes, 2002). High quality was felt to be derived from personal life experiences that formed progressive sexual politics, rather than level of educational attainment. This discourse often served as a rationale for staff to disrupt prohibitive forensic praxis in the hopes of producing better outcomes for detainees.

Of interest is that those qualities that were understood to pierce the wider paralysis were understood as coming from outside of the hospital, rather than belonging to any kind of disciplinary knowledge or training. To promote detainees' sexual rights thus required staff to adopt a precarious and conflictual position that could challenge their professional legitimacy in its departure from traditional forensic practice.

Sexuality's apparent point of intersection between the 'harm' and 'rehabilitation' discourses was its construction as an issue of the 'health' that the hospital aims to support, or a mechanism by which wellbeing can be promoted. By framing sexuality as relevant to health, it may then be understood as within professionals' remits and thus contributing to recovery (Ruane & Hayter, 2008; Bartlett et al., 2010). This conceptualisation's utility to the 'rehabilitation' discourse is obvious, framing sexualities as another opportunity for the hospital to produce positive outcomes for detainees that could endure following discharge. Sexuality's relevance to the 'harm' discourse, however, necessitated a positioning of detainees as subject to pathology, and pathology as the driver of the sexual risks that the hospital's interventions were intended to prevent. Given that these latter understandings are already prevalent within forensic practice (e.g. Holmes & Murray, 2011; Tiwana, McDonald & Völlm., 2016), the failure to reconcile these discourses, as voiced by a number of participants in this study, may represent sexuality's being conceived of by professionals solely in terms of being indicative of pathology to be contained, rather than as an avenue for rehabilitation (Brown et al., 2014; Ravenhill et al., 2019). Forensic practice may thus benefit from extending conceptualisations of sexuality beyond its being a site of risk and towards its utility as a rehabilitative resource.

The conflict between the 'harm' and 'rehabilitation' discourses is central to the findings of this work, and highlights the dichotomous roles of forensic hospital policy-makers, who are positioned as simultaneously responsible for ensuring that meaningful mental health treatment takes place and that harm does not occur. Sexual expression's sociohistorical construction as taboo, particularly for convicted persons and psychiatric patients, presents barriers to its being positioned as a 'well' behaviour and thus subjects staff members to normalising judgement from colleagues and wider society should they attempt to position intimacy as relevant to rehabilitation (Foucault, 1990; Macklin, 1976). As such, sexuality presents

professionals with a complex tangle of dangers. These include those that may be more comfortably standardised within existing risk assessment frameworks (e.g. predicting likelihood of physical harm to the public), and those of a more ontological nature, such as the moral value ascribed to particular sexual acts. The manner by which risk is constructed within the hospital (primarily as an issue of personal; professional; legal; moral failings) leaves little room for the sophisticated and thoughtful engagement that a human rights-based approach to detainees' sexual expression necessitates (Morgan, 2007). This difficult position does not, however, justify a tendency towards a complete silencing of detainees' sexualities, and resolution of this conflict may only arise from an acknowledgement of intimacy as fundamentally important to wellbeing at an organisational level.

4.2.2 The hospital in society

Policy-makers' framings of the 'harm' discourse as being representative of 'tradition' speaks to its being a socially sedimented narrative whose historicity lent it the ability to warrant voice within the institution (Berger & Luckmann, 1966; Burr, 1995). Other traditional narratives that impacted upon the way that participants conceived of detainees were evidenced throughout the analysis, some of which were felt to have been brought into the hospital from the outside. For instance, despite a significant body of evidence demonstrating that the female forensic detainees are as likely as men to inflict harm in detention (e.g. Nicholls et al., 2009; Wilson et al., 2015), interventions intended to reduce risk of harm tended to be more restrictive for men. Conversely, policy-makers described male sexual dysfunction as being of higher concern and more actively engaged with by the hospital. This stemmed from a prevalent, gendered construction of women as vulnerable both in terms of their being viewed as potential victims of their own fertility and male sexual predation, while simultaneously dismissing their need for sexual pleasure and agency as less relevant than men's (Mercer, 2013; Warner and Wilkins, 2004). These phenomena were broadly attributed by female participants to the hospital existing within a wider society in which women's sexual health concerns and agency are marginalised, within both medical and lay discourses (Mercer, 2013; Ussher, 2018).

The 'rehabilitation' discourse's concern with 'open-mindedness' and 'equality' lent itself towards a socio-political transition occurring in the outside world. British society's views concerning healthy sexualities had recently experienced a significant shift towards a more neoliberal, permissive agenda emphasising personal choice and agency (Ludwig, 2016; Mercer, 2013). Accompanying developments in national guidance for those in care settings had caused this to intrude upon the hospital (CQC, 2019). Moreover, academic interest from elsewhere in Europe had positioned the UK as particularly conservative with regards to the promotion of detainees' sexualities (Di Lorito et al., 2020; Tiwana, McDonald & Völm., 2016), serving to challenge the rationales underpinning traditional strategies of harm prevention. However, hospital staff were aware of this discourse's roots lying outside of traditional practice, and this knowledge could enable them to avoid the difficult topic of sexuality, and accompanying moral distress, by dismissing it as politically-driven rather than of relevance to treatment. British society's understanding of forensic detainees being deserving of sexual rights had not necessarily changed either, and policies that might be perceived as too permissive were feared for their potential to produce a populist backlash (Cooper & Cross, 2017; Cross, 2014). The presence of both conservative and progressive ideologies within wider society ensured that both prohibition and promotion of sexualities were felt to risk negative consequences for the hospital, such as harmful media representation and increased government scrutiny.

Crucially, where framing the promotion of sexualities within the hospital as an intervention explicitly concerned with detainees' health might gain traction within the hospital, this may very well not be the case in wider society. Discourses produced by mainstream British media tend to construct (particularly sexual) offenders in generalised, offensive, and fear-inducing terms, producing a national sense of moral panic that may result in the public feeling that these people are not deserving of wellbeing (Cooper & Cross, 2017; McCartan, 2010) or the right to reproduce (Sutherland, 2003). The hospital's being beholden to government and, consequently, media oversight positions the institution itself as at risk of harm should it become public knowledge that sexual intimacy is facilitated for detainees (Pilgrim & Rogers, 1993). Policy-makers' use of silence may be understood as a protective response to this which trickles down into ward practice, transforming detainees' possibilities for

living as sexual beings. Moreover, the ECtHR's waiving of the legal requirement for institutions to demonstrate proportionality in each instance of sexual prohibition may be read as a tacit acceptance of silencing as acceptable practice more broadly (van Kempen, 2008).

As such, the institution's failure to concretely prohibit or promote detainees' sexualities may be produced by a paralysis caused by the conflicting 'harm' and 'rehabilitation' discourses, and the resulting influence of multiple actors both within and outside the hospital (Reavey et al., 2019b). Consistent with previous research, detainees' experiences of sexual desire were understood by professionals to be 'natural' to the point of being obvious, yet hospital practice afforded few ward-sanctioned opportunities for sexualities to be expressed (Brown et al., 2014; Ravenhill et al., 2019). Where sexualities were perceived to manifest in the hospital, this occurred in the forms of personal intimacy and same-sex relationships on the wards, and in more myriad arrangements at cross-ward hospital parties and during leave on the hospital grounds. Opportunities for sexualities to be transmitted from the hospital and into the community were only present for detainees towards the end of their treatment trajectories, who were constructed as likely to present less potential for harm to themselves, the public, and the institution's image.

Sexuality's becoming in each of these arenas was reliant upon silencing. This could manifest as the hospital's transforming bodies and understandings into new, controllable forms, such as with the use of anti-libinal medications, or the production of 'supervisable' relationships that were viewed by some as child-like in their lacking physical intimacy. If detainees without unescorted leave wished to have sexual relationships as they would in 'real life', they were required to avoid the institutional gaze to do so, ensuring that their unobserved actions were situated within the 'harm' discourse as 'misbehaviour' (Brown et al., 2014; Ravenhill et al., 2019). Although certain aspects of these practices, such as sexually inhibiting side-effects of medications and sexual contact on the hospital grounds, were not *formally* considered tolerable by the institution, they were very much in keeping with policy-makers' understandings of how the hospital traditionally functions. Crucially, the vulnerabilities that these produced were viewed as governable by the hospital, rather than being transmitted into the community and resulting in outcomes that render the

institution itself vulnerable to the predations of tabloid media and government (Cross, 2014; Exworthy & Wilson, 2014).

4.3 Critical Review

4.3.1 Quality assurance

There is presently a lack of consensus regarding how to best assure the quality of qualitative health research, with the field traditionally relying upon adherence to output-oriented, positivist constructs intended to produce an 'objective' kind of knowledge, as markers of quality (Reynolds et al., 2011; Stige, Malterud & Midtgarden, 2009). This research, however, adopts a stance that positions its outputs as being produced by the subjective, situated relationship between researcher, participants, and narrative (Haraway, 1988). Quality may thus be understood as a process-oriented construct derived from my consistently engaging with and providing theoretical justification for the methods employed during the research procedure, emphasising continuous methodological awareness and transparency over the use of quality 'checklists' (Reynolds et al., 2011; Sanjek, 1990). In keeping with this, I have described my epistemological and reflexive positions in previous chapters, and included evidence of analytic procedures (Appendices F, G and H) and 'thick' descriptions of themes (Appendix K) (Lincoln & Guba, 1985). I also maintained a reflective field journal during data collection, an excerpt of which is included as Appendix L.

The quality of this research could have been further assured by the implementation of a robust audit trail to record methodological considerations during the course of the research procedure (Bowen, 2007; Reynolds et al., 2011). This was not included due to the intensity of this approach, the time demands and my own inexperience with research audit. Similarly, participatory methods such as member-checking could have ensured that the study's findings were relevant to the participants, limiting my own influence over the research output (Mays & Pope, 2000). This was not implemented due both to my own time constraints and those of the participants,

many of whom struggled to make time to take part in interviews. As such, my own relationship with the data may be better represented here than participants’.

4.3.2 Thematic Decomposition Analysis

Use of Stenner’s (1993) analytic approach enabled a reading of policy-makers’ narratives concerning forensic sexualities, and the manner in which participants ascribed roles to themselves and others as their stories unfolded. This methodology allowed for a theorising of the subjectivities inherent to occupying particular positions within the narrative, be they the fears and uncertainties evoked by playing the ‘paternal’ part of forensic clinicians or demands for containment in response to detainees’ inhabiting ‘predator’ or ‘vulnerable’ roles. This approach also made relevant a historical account of the forensic hospital within British society, so that the relationships between those discourses and sense-making practices revealed by the analysis and their present-day socio-historic contexts might be better understood.

As with all qualitative methods, the findings of this research are not generalisable to the wider population, though may be revealing of broader societal and legal discourses that influence policy decisions elsewhere. Similarly, the analysis did not engage with the relationship between forensic practice and human rights law to a significant extent, due both to my own inexperience in this field and some participants’ reticence to discuss detainees’ care in these terms.

4.3.3 Alternative Analytic Approaches

A number of alternative approaches could have been applied to this research, perhaps the most appropriate of which are narrative analysis and Foucauldian discourse analysis (FDA). As with TDA, each of these methods rely upon social constructionist epistemology and are concerned with the manner in which meaning is produced by discourse. Narrative methods would have offered the research a broader scope in terms of storying the issue of forensic sexualities and how this storying spoke to policy-makers’ constructions of the hospital and their own identities

(Sharp, Bye & Cusick, 2019). Specifically, narrative interviewing techniques typically rely upon open-ended questions that allow the discussion to be narrated by participants to the extent that the resulting data almost entirely consists of those topics that they consider to be relevant (Wellin, 2008). Providing participants with the opportunity to more completely narrate their sense-making around forensic sexualities may have provided a more accurate answer to the research question. However, this approach was discarded following consideration of the sample, whose disciplinary knowledges may tend to privilege more structured interviewing procedures that invoke a sense of certainty in the appropriateness of one's answer (Drogin et al., 2012). Given that the subject matter of this research already bore the potential to be experienced as threatening to participants' sense of professional expertise, TDA was chosen over narrative methods for the likelihood of its being experienced by participants as more familiar and comfortable.

FDA offers opportunities to speak to the flow of discourses within the socio-cultural context of the forensic hospital and beyond, in particular constructions of forensic patients and psychiatric expertise within wider society. However, FDA's specifically 'top down' approach was not felt to be consistent with this study, which aims to take advantage of policy-makers' unique position within the institution to present an account of meaning-making that bridges both the socio-cultural and the individual (Brunton et al., 2018). Similarly, the need for this research to both serve as a thesis and be of use to the research site resulted in TDA being preferable to Foucauldian discourse analysis. Despite being a form of discourse analysis itself, TDA offered an opportunity to produce research findings that are overtly 'thematic' in form, and thus consistent with qualitative outputs more commonly seen in health and social science literature (Braun et al., 2019). Analysis and findings presented in this form would likely be more acceptable to the research site, and thus more likely to result in recommendations being considered.

4.4 Implications for Policy and Practice

The absence of systematic and clear guidance concerning sexual expression results in feelings of insecurity for detainees, whose everyday freedoms and prospective futures are dependent upon their ability to demonstrate their adherence to an ethics of self-governance by successfully following the hospital rules (Crewe, 2011; Ravenhill et al., 2019). Moreover, the historical silencing of sexuality within the institution is experienced by staff as highly problematic. Ward staff in particular feel that their actions around sexuality are subject to considerable institutional scrutiny and feel afraid to engage with the topic, irrespective of their view on whether or not it is an important part of recovery (Ravenhill et al., 2019). This fear of repercussions feeds a culture of risk-averse practice in which impeding detainees' pursuit of sexual expression and/or intimacy becomes the norm, despite this being in violation of CQC (2019) guidance and Article 8 of the ECHR. Detainees experience staff obstruction of sexual expression as a generic application of behavioural norms in which sexuality is considered to be 'misbehaviour'. This produces a self-fulfilling prophecy in which detainees may then use 'misbehaviour' as a strategy of resisting these norms, and thus cyclically provide justification for further interference by staff (Ravenhill et al., 2019).

The following section outlines general recommendations for a policy governing forensic sexualities, alongside recommendations for existing policy and practice governing the domains of risk assessment, induction and training, and ward practice. Further recommendations are offered for the implementation of trauma-informed approaches within the hospital based on salient issues that have emerged from this research.

4.4.1 Sexualities policy recommendations

- Policy should clearly state that sexual expression by detainees is permissible while in hospital and on leave, in accordance with CQC (2019) guidance and

international human rights law⁴. It must be made clear that human rights law supersedes local policy and national law.

- A 'baseline' of permissible sexual expression while in hospital should be established for all detainees. This may include openly talking about past, current and future sexual relationships, dressing in ways that facilitate feeling sexual, masturbating in private without interference, and possession of one's own sexual aids (rather than being stored in contraband lockers).
- The boundaries of permissible sexual expression beyond the 'baseline' must be determined by hospital staff for each individual detainee and regularly reviewed at ward rounds and in care planning. This may include having sex when on leave, or forming intimate relationships with other detainees.
- Policy should clearly state that initiating sexual reviews, including discussion around masturbation and intimate relationships, are a routine professional responsibility. The onus must not be placed on detainees to initiate discussion around issues of sexuality (Montejo et al., 2010).
- The onus should not be placed on particular professional disciplines to engage in discussion around issues of sexuality. If it is ceded to one particular specialism then this is likely to reinforce that sexuality is a taboo subject, rather than restoring its links with rehabilitation.
- Devolvement of policy to local service levels is likely to place greater burdens on particular services (e.g. CAMHS; Learning Disabilities). Policy should be generated at an organisational level and then tailored to meet the needs of these services.
- The implementation of a sexualities policy would benefit from being supported by the development of a Sexualities Working Group within the hospital, who

⁴ In particular, that obstructions of detainees' right to privacy and family under Article 8 of the ECHR, including their right to enjoy (un)married relationships without interference, must be qualified **in each individual instance** on the grounds of a demonstrable risk of harm to society.

will be responsible for ongoing monitoring, audit and review of the implementation of policy changes across all hospital sites.

- Any sexualities policy must be co-produced with forensic detainees, partners and ward staff, including HCAs (who presently engage in a substantial proportion of this work), in order to meet their needs. Subsequent tailoring of this policy to local services (e.g. CAMHS; Learning Disabilities) must also include parents and carers.
- A sexualities policy must make clear the organisation's stance in opposition to marginalisation of detainees and staff on the grounds of sexual or gender identity, and that it is the responsibility of all staff to ensure that such instances are not tolerated.
- The formation of this policy, and the changes to practice anticipated following its implementation, must be coherently communicated to all staff and detainees through training events, supervision, and ward discussions.

4.4.2 Risk assessment recommendations

- Separate relationship risk assessment procedures should be developed for those who have historically presented a risk of (sexual) violence to others and those who do not. The presence of some detainees whose index offences entail the infliction of sexual harm is not sufficient justification for the denial of intimacy to those whose do not.
- Staff across the hospital presently possess significant experiential expertise in nuanced, proportional decision-making regarding the sexual risk presented by particular detainees. Policy would benefit from collating this expertise within a working group in order to produce formal sexual risk assessment procedures, both for those detainees with histories of violent/sexual offending and those without.

- Risk assessment procedures should take into account the increased likelihood of sexual revictimisation by those detainees who have themselves experienced sexual violence in the past (Classen, Palesh & Aggarwal, 2005), and that this likelihood necessitates increased monitoring and support by staff rather than obstruction. These procedures should further assess the likelihood of particular kinds of treatment by the hospital being experienced as a reproduction of past sexual violence and/or relational abuse (e.g. restraint; forced contraception).
- The Sexualities Working Group should regularly audit sexual risk assessments across services to ensure that interference with sexual expression is not disproportionately experienced by particular patient groups, as is the case for male and female detainees in this research and elsewhere (Ravenhill et al., 2019).

4.4.3 Induction and training recommendations

- Induction materials should incorporate an ownership of forensic sexualities by the organisation, by clearly stating that an openness to initiating and engaging with sexual discussion as required is an expectation of working in clinical roles.
- A discrete sexualities training should be developed. This must not be subsumed into other trainings concerning sexual/gender identity, or relationships more broadly, as this risks the uncomfortable topic of sexual expression being omitted (Brown et al., 2014).
- Training materials should acknowledge that sexualities are frequently under-addressed in UK-based training programmes for psychiatry, clinical psychology, occupational therapy, mental health nursing, and social work (Couldrick, 2005; McCann, 2003; Rele & Wylie, 2007; Schaub, Willis & Dunk-West, 2017; Shaw, Butler & Marriott, 2008). As such, they should not assume

a level of knowledge based on disciplinary background, and should aim to empower staff who might wish to develop local policy and procedures.

- Training materials should conceptualise sexuality as being ‘natural’, or something belonging to life prior to inpatient care that cannot simply be abandoned while in hospital (Brown et al., 2014). They should emphasise that sexual behaviours are not inherently related to ‘pathology’.
- Training materials should acknowledge that discussions around sexuality may evoke feelings of discomfort or arousal in staff, and that feelings of sexual attraction to detainees is normal. They should make clear that these experiences are appropriate to discuss in supervision.
- Training materials should make explicit the linkages between sexual wellbeing, enduring psychological wellbeing, reduced risk on the wards, and reduced recidivism (Deegan & Drake, 2006; Gilbert, Rose & Slade, 2008; Overbeek et al., 2006; Whisman, Uebelacker & Bruce, 2006) in order to re-situate sexualities within a holistic treatment approach, rather than purely as an issue of risk. Emphasising this may serve to challenge staff who view the training as politically-motivated rather than relevant to their professions.
- Training materials should acknowledge historic gender differences in engagement with sexual issues across services. For instance, that female detainees are rarely asked about masturbation or sexual pleasure, and that men may be unfairly constructed as presenting high sexual risks.
- Training materials should offer forensic professionals an opportunity to reflect upon their exposure to historic discourses that may produce prejudice regarding forensic detainees’ right to engage in intimate relationships (Dein et al., 2016).
- Engagement with sexualities should be a routine component of training refreshers. The Sexualities Working Group will be responsible for identifying

Continuing Professional Development (CPD) needs at all staff levels, and for ensuring that ongoing CPD sessions are provided to meet these.

4.4.4 Ward practice recommendations

- Detainees' sexual needs may be addressed proactively via their consideration in routine assessments, including ongoing assessment and monitoring of capacity to form and remain in relationships (Dein et al., 2016).
- The organisation must acknowledge that particular staff groups (particularly younger HCAs) presently carry the burden of managing patient sexuality. These represent the most junior and least securely employed staff, and may be most subject to normalising judgement from the hospital hierarchy. These staff members' labour should be supported with training, supervision and guidance.
- Ward teams and MDTs should acknowledge that engagement with sexualities may produce feelings of discomfort and/or arousal in detainees and staff, and foster a culture of acceptability both in supervision and team discussions that permits open engagement with these experiences.
- A streamlined process should be developed by which detainees may obtain pornography and other sexual aids should they choose to. Provision of these items must be risk assessed as appropriate, but detainees should no longer be subject to exposing and embarrassing assessment practices (Ravenhill et al., 2019).
- Medical staff must routinely inquire about sexual difficulties during medication reviews. They should be made aware that detainees are unlikely to volunteer this information on their own, and are unlikely to have been asked at previous points in their treatment trajectories (Brill, 2004; Montejo et al., 2010).

- Medical staff must fully disclose the potential sexual side-effects of medications to detainees prior to administration.
- Medical staff should afford female detainees prescribed sodium valproate or other medications that bear teratogenic risks the opportunity to choose between using contraception or changing their psychotropic medication. Detainees should always be afforded the opportunity to discuss this decision with a female member of staff.
- Where intimate relationships may occur between individuals detained on different wards, staff from both services must meet regularly to ensure information sharing and ongoing monitoring and support of the detainees in question.
- Sexual education programs should be implemented on all wards. Further, educational literature and audio recordings must be made accessible to detainees without having to request them from staff. These should cover a broad range of sexual topics, including consent, sexual identity, the physical mechanics of sex and masturbation, and sexual health.
- As requested by a number of detainees during data collection focus groups in Ravenhill et al.'s (2019) study, informal discussion groups should be established on each ward so that detainees and staff have structured opportunities to engage in discourse concerning sex and sexuality. These groups should be facilitated, rather than led, by staff.
- Ward staff must foster an awareness of community resources that may benefit detainees who have experienced sexual violence and/or abuse in relationships, and support them in accessing these should they choose to. The hospital represents a space in which detainees can safely engage in particularly difficult therapeutic work, and this should not be delayed until post-discharge for fears of producing 'triggers'.

- Detainees who have experienced sexual violence and/or abuse in relationships must be afforded equal opportunity to participate in education and discussion around sexualities and relationships. They must be afforded opportunities to express sexual identities outside of pathologising frameworks.

4.4.5 Trauma-informed care recommendations

- Policy and training materials should acknowledge that experiences of (sexual and relational) trauma underlie many detainees' forensic inpatient admissions (Dolan & Whitworth, 2013; McKenna, Jackson & Browne, 2019). These should emphasise that trauma is widespread across society, and that experiences of violence and abuse are not indicative of 'pathology'.
- Policy and training materials should recognise the potential for inpatient practices to re-traumatise detainees who have historically experienced sexual violence and/or abuse in relationships (e.g. constant observation; seclusion; restraint; physical violence) (Sweeney et al., 2018). Evidence-based alternatives to these approaches, such as Safewards (Bowers et al., 2015), should be developed and promoted throughout the organisation.
- Staff should be made aware that their actions may be experienced as re-traumatising by detainees should they inflict a sense of betrayal, boundary violation, objectification, powerlessness, vulnerability, and/or lack of agency (Butler, 2011).
- Trauma-informed treatment approaches that may facilitate the exploration of issues of embodiment and bodies in relation to sexual experiences should be made available to all detainees (Procter et al., 2017).
- Staff at all organisational levels should be made aware, through policy and training, of how trauma-informed approaches overlap with existing good practice approaches such as shared decision-making, cultural competency

and service user involvement (Elwyn et al., 2012; Grundy et al., 2016; Schouler-Ocak et al., 2015).

- Staff should be supported in, recognised for, and assessed on their ability to communicate detainees' basic humanity to them and, through this, engage with subjects that transcend the boundaries of the hospital such as love and intimacy. There is evidence to suggest that staff-patient relationships of this kind constitute a form of therapy (eg. Priebe & McCabe, 2008; Reavey et al., 2017).

4.5 Implications for Future Research

Despite a growing evidence base indicating beneficial impacts of intimacy upon psychiatric patients and persons subject to criminal detention (e.g. Fals-Stewart, Birchler & O'Farrell, 1999; Newcomb, 1994; Overbeek et al., 2006; Stevens, 2013; Whisman, Uebelacker & Bruce, 2006), the effects of permitting sexual expression for detainees in forensic psychiatric settings have not yet been studied. Moreover, the question posed by a number of detainees in previous research, as to how they would be able to embody socially acceptable sexualities in the community following their transformation by forensic psychological praxis, remains unanswered (Brown et al., 2014; Ravenhill et al., 2019). Though it may be tempting to assume that detainees may resume their relational lives unimpeded upon return to the community, this 'rehabilitation' period features an ongoing degree of observation and intrusion by mental health services, who may continue to predominantly position former detainees' behaviours within narratives of risk and 'pathology' (Brown et al., 2014; Sullivan, 2005). Further research is needed with those who have been discharged from UK forensic inpatient services to fully understand the implications of Brown and colleagues' (2014) 'amputated sexualities' construct and, crucially, to identify areas of development in community forensic mental health practice to support the relational rehabilitation of detainees post-discharge.

Given that risk of harm was the most commonly raised concern in this study, forensic practice would benefit from establishing whether permissiveness of sexual

expression in hospital bears an association with untoward incidents both during and following detention. Though this avenue is presently unavailable in the UK, forensic professionals elsewhere in Europe have voiced a belief that facilitating sexual expression has reduced the likelihood of harm occurring (Di Lorito et al., 2020; Tiwana, McDonald & Völlm, 2016). Further research at these sites may be of benefit for de-constructing risk-averse British institutional discourses voiced in this study and elsewhere (e.g. Dein et al., 2016; Ravenhill et al., 2019), though must necessarily be accompanied by a cross-cultural comparison of legal frameworks in each country. Given that the notion of risk in this study was regularly linked with personal and professional liability, an international comparison of relevant legal frameworks could further establish whether more significant structural barriers to promoting detainees' rights are present in the UK than elsewhere.

The impact of public opinion's linkages with perceived risk and liability, as voiced in this research, could also be better understood with an international comparison. Previous work has highlighted that moralistic British tabloid journalism penetrates and shapes political discourses concerning marginalised groups to an extent rarely seen elsewhere in the Global North (Welch & Schuster, 2005), yet no cross-cultural research presently exists comparing media portrayals of forensic hospital detainees. The moral panic produced by media depictions of these people in the UK, particularly those who have committed sexual offences, may be found to similarly contribute to the presently conservative attitude towards sexual expression while in hospital (Cross, 2014; Cooper & Cross, 2017). However, previous research highlights that the stance adopted by British tabloids towards offenders is likely more punitive than that of the wider public (Allen, 2008). As such, further examination of the relationship between media representations of forensic detainees and actual public opinion may be of use for establishing a genuine understanding of the political ramifications of the hospital's engagement with sexualities. Given the institution's positioning of tabloid media as a (substantial) perceived threat in this study, developing an understanding of its actual capacity to inflict harm upon the hospital via the modification of public opinion may be crucial to support the implementation of human rights-based practice.

4.5.1 Recommendations for co-production

Co-production of mental health research is beneficial in fostering service development and understanding the relationships between institutions and those they serve (Boyle and Harris, 2009; Realpe and Wallace, 2010). These methods may serve to challenge the position of dominance held by reductionist, positivist epistemologies within health research and, in doing so, redress power imbalances that emerge via the privileging of these kinds of knowledge as warranting voice over lived experiences (Haraway, 1988; Pinfold et al., 2015). Co-production in forensic settings is comparatively under-utilised due to risk management concerns and constraints upon open communication between detainees and professionals, attributed both to relationships with staff and the physical nature of secure environments (McKeown et al., 2016).

Despite this study's participants being staff rather than patients, experiential expertise could have been utilised in the research design, particularly in terms of developing interview questions for policy-makers and producing the analysis (Pinfold et al., 2015). This was not done due to time constraints and my distance from the research site, with regards to the added layer of complexity presented by recruiting and consulting with patients who have limited access to communications technologies. A significant critique of attempts by health services and researchers to engage in co-production is their only affording limited participation to experts by experience, resulting in their contributions being little more than tokenism (Beresford, 2013; Martin, 2008; Trivedi, 2009). Given the limited resources available to this project, I felt that any attempt to engage in co-production would likely result in limited, tokenistic opportunities for experts by experience, and so opted not to pursue this. This decision was further informed by my history of working as an expert by experience, including feelings of invalidation and disempowerment when entering into poorly thought-out spaces of co-production.

4.6 Conclusion

This is the first study to explore UK forensic hospital policy makers' sense-making around detainees' sexualities, and provides an understanding of this with implications for policy, practice, and further avenues of research. The provision of sexual expression to forensic detainees is consistent with policy-makers' understandings of a rehabilitative and human rights oriented treatment approach. However, policy-makers perceive significant barriers to doing so, including negative public perception of forensic detainees and institutions, a need to overcome 'traditionally' prohibitive hospital practices, a gendered tendency to position detainees as intrinsically predatory and/or vulnerable, and the belief that permitting sexual expressivity will produce risk of harm. A lack of policy does not prevent sexual contact from occurring, and policy-makers are presently quite resourceful in developing informal, *ad hoc* or informal procedures for managing detainee relationships when they develop. The restrictiveness of current practice may not be proportional to actual risk, and forensic hospitals may not presently be meeting their obligations to promote detainees' human rights under the ECHR.

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APPENDIX A: LITERATURE SEARCH

The guiding questions for the literature search were:

- How have intimate relationships and sexuality been conceptualised in forensic inpatient treatment?
- What linkages are there between intimate relationships, sexuality and mental health treatment more broadly?

The following search terms were used concurrently with the terms “sex”, “sexuality”, and/or “relationships” with the Boolean operators ‘AND’ and ‘OR’:

- Forensic
- Offender
- Mental Health
- Policy

The following terms were included later due to their regular appearance in salient literature:

- Governmentality
- Article 8
- Human rights
- Relational security

Limiters included:

- Title and abstract only
- English language only

The following databases were used for the search:

- Science Direct
- PsycINFO
- PsychARTICLES
- PubMed

- SCOPUS
- Academic Search
- Google Scholar and open-source research repositories including ResearchGate, Academia.edu, and the UEL Research Repository were also used.

468 articles were initially found. Titles and abstracts were reviewed for relevance to this research. Further, subject-specific limiters were applied. For instance, those papers concerning policy and legal frameworks were only deemed relevant if specific to UK-based forensic services. The literature found to specifically address sexuality in forensic inpatient settings was found to be extremely sparse, and so was included regardless of:

- Date of publication
- Country of origin
- Quantitative, qualitative or mixed methodology
- Participant population (e.g. staff, detainee)

The majority of articles identified were explicitly concerned with the treatment of forensic detainees who had been convicted of sexual offences. These were largely omitted from the review due to their being concerned with sexual violence rather than sexual expression.

The literature search identified 16 articles, comprised of 15 pieces of experimental literature and 1 review, that were directly related to sexuality and intimate relationships in forensic inpatient care. Each of these were included in the review.

APPENDIX B: INFORMATION SHEET



PARTICIPANT INVITATION LETTER

You are being invited to participate in a research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

Who am I?

I am a postgraduate student in the School of Psychology at the University of East London and am studying for a Professional Doctorate in Clinical Psychology. As part of my studies I am conducting the research you are being invited to participate in.

What is the research?

I am conducting research into policy-makers' understandings of forensic inpatients' pursuit of sexual contact and intimate relationships while in hospital.

My research has been approved by the School of Psychology Research Ethics Committee. This means that my research follows the standard of research ethics set by the British Psychological Society.

Why have you been asked to participate?

You have been invited to participate in my research as someone who fits the kind of people I am looking for to help me explore my research topic. I am looking to involve professionals who are involved with the development and implementation of secure unit policies in *[the hospital]*.

I emphasise that I am not looking for 'experts' on the topic I am studying. You will not be judged or personally analysed in any way and you will be treated with respect.

You are quite free to decide whether or not to participate and should not feel coerced.

What will your participation involve?

If you agree to participate you will be asked to take part in an informal, one-hour interview at your place of work. You will be asked questions regarding your thoughts on current patient and institutional practices, and the issues that prospective policy would need to cover. The interview will be audio recorded, and all identifying information will be removed prior to publication.

I will not be able to pay you for participating in my research but your participation would be very valuable in helping to develop knowledge and understanding of my research topic

Your taking part will be safe and confidential

Your privacy and safety will be respected at all times. You will be asked to choose a pseudonym prior to interview and any identifying information will not be included in

the interview transcript, on any written material resulting from the data collected, or in any write-up of the research material.

You will not have to answer all questions asked of you and can cease your participation in the interview at any time.

What will happen to the information that you provide?

Audio recordings and transcripts will be stored on a password protected computer to which only I have access. Transcripts will be anonymised, including any names or other identifying information being changed during the transcription process.

Anonymised excerpts from the transcripts will feature in publications following this research and may be used as presentation or teaching materials. The anonymised transcripts may be shared with supervisors during the analysis.

Participant contact details will be immediately destroyed following interview. Audio recordings will be destroyed immediately following examination of this project by the University of East London. Transcripts will be retained for two years and then destroyed.

What if you want to withdraw?

You are free to withdraw from the research study at any time without explanation, disadvantage or consequence. You will be given three weeks following the interview to fully withdraw your participation from this study, after which any data you have provided will be included in the analysis.

Contact Details

[Omitted for submission]

APPENDIX C: CONSENT FORM



UNIVERSITY OF EAST LONDON

Consent to participate in a research study

HOW DO HOSPITAL POLICY-MAKERS MAKE SENSE OF FORENSIC INPATIENTS' DESIRE FOR INTIMATE AND SEXUAL RELATIONSHIPS?

I have read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw, the researcher reserves the right to use my anonymous data after analysis of the data has begun.

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Researcher's Name (BLOCK CAPITALS)

.....

Researcher's Signature

.....

Date:

APPENDIX D: DEBRIEF



UNIVERSITY OF EAST LONDON

Debrief Information

EXPLORING HOSPITAL POLICY MAKERS' UNDERSTANDINGS OF FORENSIC INPATIENT SEXUALITIES

Thank you for participating in this research. I hope that considering these issues in depth has been a useful experience. This form provides some background information regarding the study. Please feel free to offer any comments or questions you might have.

This study is designed to examine senior hospital staff members' perspectives when considering forensic inpatients' pursuit of sexuality and intimate relationships. Previous work conducted within *[the hospital]* has found that both service users and ward staff consider sexuality and relationships to be prominent issues within secure wards, but that both groups may feel under-equipped to explore these topics outside of dominant discourses of risk and psychopathology. Here, my interest was in how these same issues are viewed by senior staff, and the manner in which these considerations translate into the development and implementation of policy.

The write-up of this project will be submitted to the University of East London as my doctoral thesis. Following this it will be edited with a view to disseminating as a journal article. Your participation in this research is voluntary, and you may withdraw your consent to participate at any time for the next three weeks. If you choose to do so, all data obtained from this interview will be destroyed. Given the small pool of potential participants for this project, I would appreciate it if you did not discuss your experience of participation with colleagues until the data collection phase has concluded.

If you have any questions or comments about this research, please ask now or contact me at any point in the future:

Name: [Omitted for submission]
Email:

APPENDIX E: INTERVIEW SCHEDULE

Introduction by interviewer (*to be communicated to participant*): I'm going to ask you some questions about your perspective on forensic patients' sexualities, in particular in relation to having intimate relationships while in hospital. I'm going to use 'sexuality' as a broad term that does not have a single definition. When I ask you to think about sexuality, I mean how people might feel as sexual beings, which includes things like: feeling and being intimate with themselves and others; feeling and being romantic; feeling sexually attractive; feeling sexually attracted to others; feeling desire; feeling sexual pleasure; and experiences of sexual relationships. There are no right or wrong answers and everything you say will be anonymous. You can stop the interview at any time, and you don't have to answer a particular question if you don't want to.

Question 1: To begin with, could you please give me some background on your role?

Prompts: Could you tell me how your role is related to the development of policy?
To what extent are you involved in implementing policy once it's been developed?

Question 2: Does [*the hospital*] currently have a hospital policy concerning sexual contact or intimate relationships on the secure units?

YES Prompt: Could you tell me about the issues you feel are important when considering patients' sexualities?
Do you feel that the policy currently covers all of the important issues?

NO Prompt: What are your thoughts on a sexuality policy not existing?
Could you tell me about the issues you feel are important when considering patients' sexualities?

Prompts: What are your thoughts on implementing a sexualities policy on the units?
Can you foresee any barriers to a sexualities policy being implemented on the secure units?

Do you feel that each ward would implement such a policy in the same way?

Question 3: What are your thoughts on patients from the secure units having sexual contact or intimate relationships?

Prompts: Do you feel that there's any difference between your personal and professional views on this?
Do you have differing views on patients having romantic relationships versus sexual relationships?
What are your thoughts on patients attempting to maintain romantic relationships with people on the outside?
Are you aware of sexual contact or relationships having happened on the secure units in the past?
How do you feel the hospital currently responds to these instances when they occur?

Question 4: What are your thoughts on sexual relationships being allowed to happen on the wards?

Prompts: If not there, where should they happen?
If forensic patients were allowed to have sexual relationships, at what point in their treatment trajectory do you feel permission should be given?
Are patients in low-secure units permitted to have sexual relationships while on leave? What does seeking permission look like?
Are there different considerations for male and female patients?
What about transgender patients? Different ages?

Question 5: What impact, if any, do you feel that being a forensic inpatient has on a person's sexuality?

Prompts: Are there any aspects of the way secure units are set up that you feel impact upon a patient's sexuality?
What impact, if any, do you feel that medication has on patients' sexualities?

Do you think that staff and patients feel able to talk to one another about sexual issues? Whose professional responsibility do you feel this should be?

If I go back over the aspects of sexuality I mentioned at the start of the interview, could you briefly give me your thoughts on how they work in a secure unit?

- *Feeling and being intimate with yourself.*
- *Feeling and being intimate with others.*
- *Feeling sexually attractive.*
- *Feeling sexually attracted to others.*
- *Feeling desire.*
- *Feeling sexual pleasure.*

Question 6:

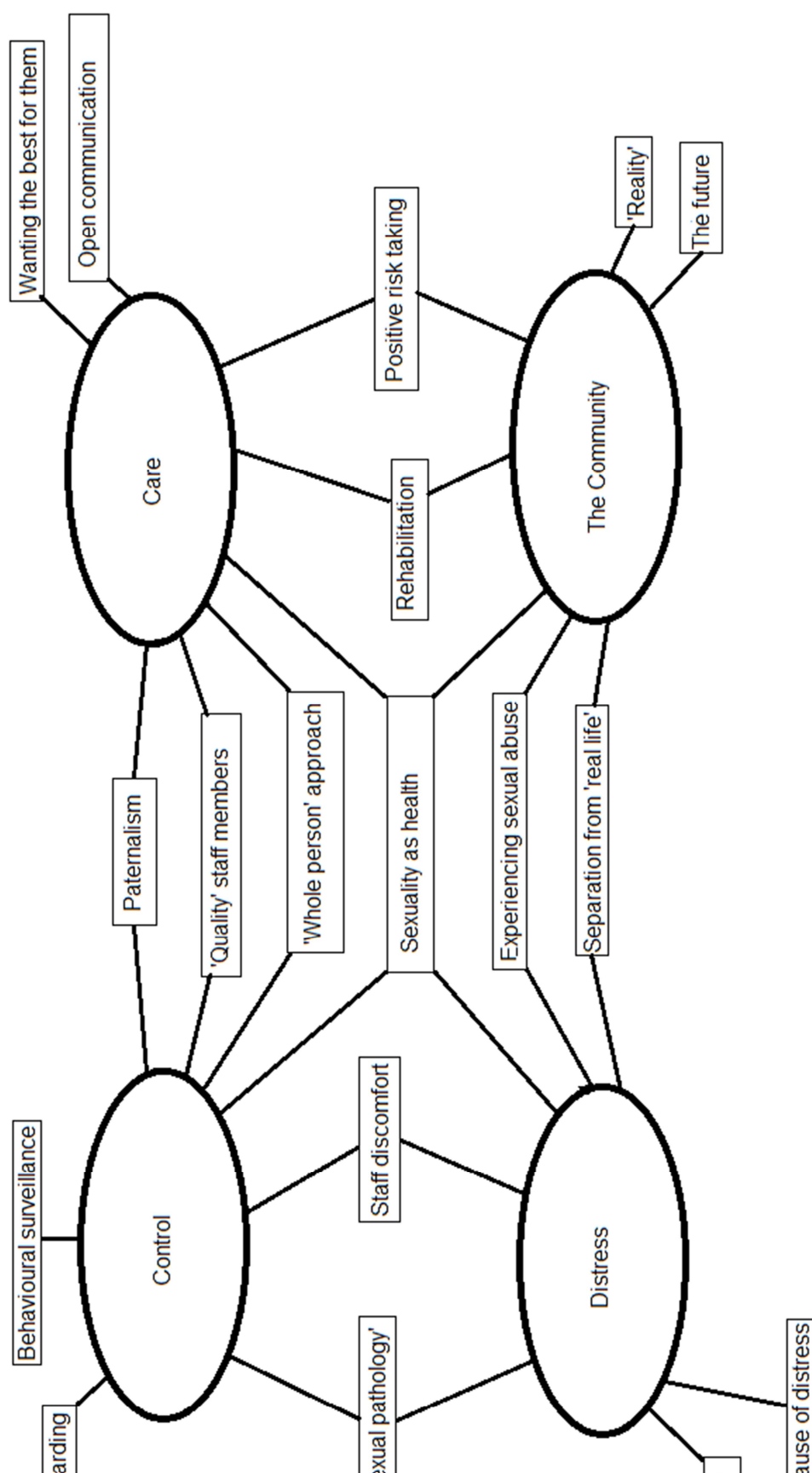
We're coming to the end of the interview. Just before we finish I'd like to ask, if you were in my chair what do you think would be the most important question I could be asking?

APPENDIX F: CODED TRANSCRIPT EXCERPT

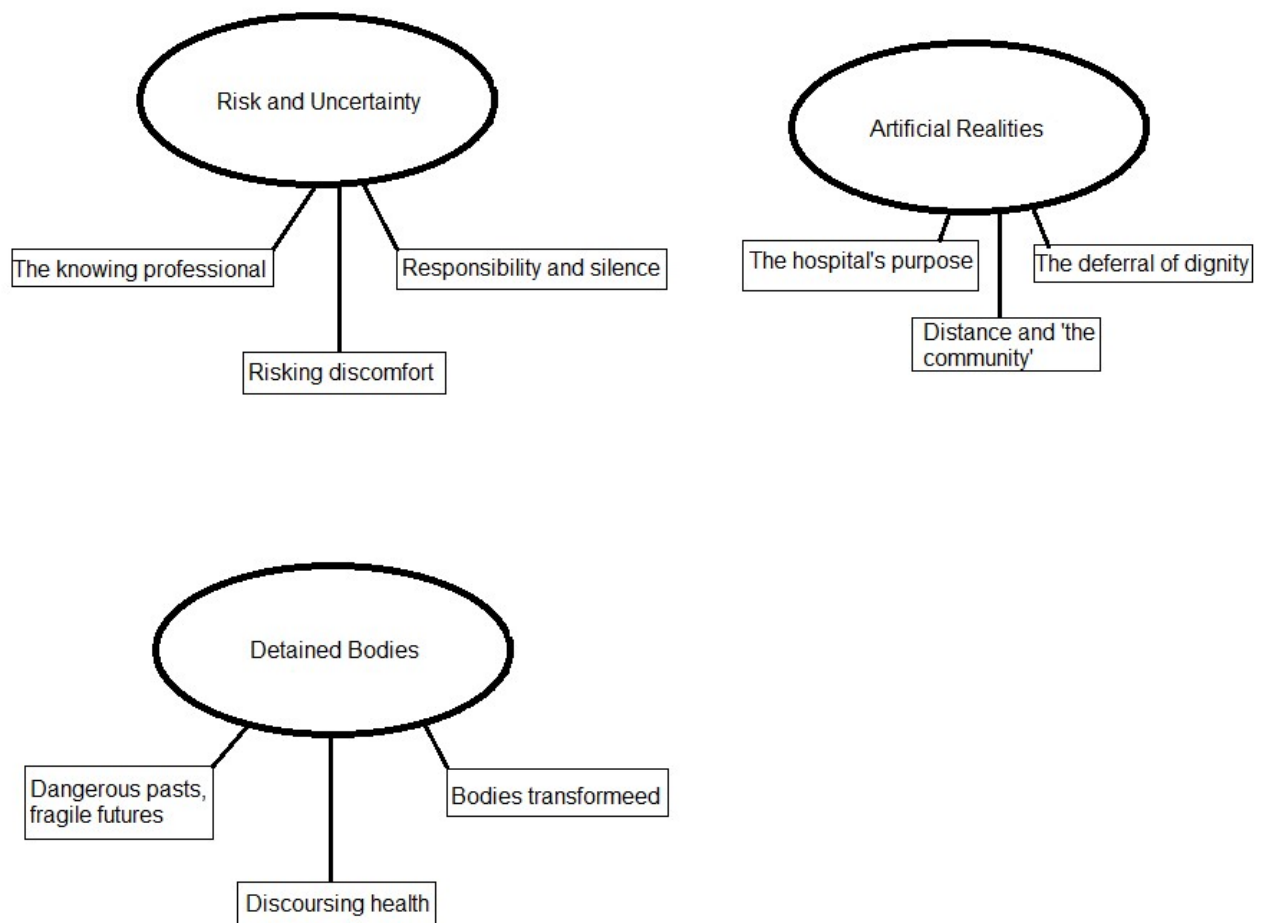
25	disorders, we probably haven't been as advanced in looking at how to fulfil or meet	Jason Poole Lack of professionalised knowledge
26	or even understand the sexual needs of our patients.	Jason Poole Patients 'belonging to' staff/hospital
27		
28	<i>That thing you said about the function of the hospital. Do you personally feel that one</i>	Jason Poole Whole person as 'treatment'
29	<i>of the functions of the hospital is to engage with that?</i>	Jason Poole Sexuality as vital
30		Jason Poole Professionalised knowledge (conflict w. holistic approach?)
31	If you believe, and I certainly do, and we are doing this to some extent, that if we	Jason Poole Sexuality as ephemeral
32	treat an individual holistically based on the sum totality of their needs, and that will	Jason Poole Psychological knowledge producing itself
33	include their sexual needs. However, I think we recognise that our expertise is	Jason Poole Sexuality as 'need' – essential?
34	probably more geared towards the treatment of the more tangible, concrete	Jason Poole Appropriateness and boundaries – staff in trouble?
35	elements, because there are very clear assessments and treatments, I guess.	Jason Poole Boundaries
36	Whereas when it comes to sexual needs, et cetera, well it seems there are probably	Jason Poole Sexuality as individualised; maintained via taboo
37	boundaries there that we shouldn't-, that we don't want to cross, or "That's	Jason Poole Nothing to do with the institution; taboo?
38	something that's personal to them. That has nothing to do with us", or "They'll sort it	Jason Poole Responsibilisation
39	out when they leave hospital," so up until then that sort of sets in an abeyance. It	Jason Poole Not now, later
40	shouldn't do but that's how things have traditionally been, and we're slowly starting	Jason Poole Silence; ambivalence
41	to move away from that now.	Jason Poole Moral distress?
42		Jason Poole Traditional silence
43	<i>Ok. So am I right in understanding that the things that you're saying, that that's the</i>	Jason Poole Traditional attitudes
44	<i>predominant attitude?</i>	Jason Poole Sexuality as vital to professionals
45		Jason Poole Lack of professional knowledge
46	It's the more traditional attitude, I think people would say "Yes, we absolutely need to	
47	consider it", but I think there's a lack of knowledge and procedure on how to do that.	

2

APPENDIX G: THEMATIC MAP 1: PRELIMINARY THEMES



APPENDIX H: THEMATIC MAP 2:



APPENDIX I: ETHICAL APPROVAL

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Matteo Martini

SUPERVISOR: Kenneth Gannon

STUDENT: Jason Poole

Course: Professional Doctorate in Clinical Psychology

Title of proposed study: How do hospital policy-makers make sense of forensic inpatients' desire for intimate and sexual relationships?

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below): In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below): In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY

(Please indicate the decision according to one of the 3 options above)

approved

Minor amendments required *(for reviewer):*

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students):*

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):*

Student number:

Date:

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES / NO

Please request resubmission with an adequate risk assessment

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐

HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☐

MEDIUM (Please approve but with appropriate recommendations)

☒

LOW

Reviewer comments in relation to researcher risk (if any).

Reviewer (*Typed name to act as signature*): Matteo Martini

Date: 15/04/2019

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

RESEARCHER PLEASE NOTE:

For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.



APPENDIX K: 'THICK' DESCRIPTIONS OF THEMES

Theme One: Risk and Uncertainty

Refers to the dominant, socially-sedimented discourse that emerged in interviews with all participants, in which sexuality is predominantly constructed in terms of its capacity to result in harm to detainees and others.

Sub-theme: The knowing professional

Refers to the subsumption of sexualities under formalised psychiatric and psychological knowledge-sets, and how this enables professionals to feel a greater sense of certainty while resulting in sexuality's being understood through a primarily problem-saturated lens.

Sub-theme: Risking discomfort

Refers to the manner in which 'risk' is constructed in the hospital, expanding the concept to incorporate staff members' experiences of moral distress and personal discomfort as untoward outcomes of detainees' sexual expression.

Sub-theme: Responsibility and silence

Refers to the application of an ethics of self-governance within the hospital in response to the perceived risks associated with sexual expression, and acknowledges the difficulties experienced by detainees in self-governing in the absence of clear guidance from the hospital.

Theme Two: Artificial Realities

Refers to a dominant understanding of the hospital as being separate from 'real life', and professionals' positioning as responsible for maintaining and disrupting the artificial reality in response to detainees' 'natural' sexual needs.

Sub-theme: The hospital's purpose

Refers to the sometimes-contradictory constructions of the hospital's purpose in relation to detainees' sexualities, both within the views of policy-makers and those staff, detainees, and members of wider society who they refer to in their narratives.

Sub-theme: Distance and 'the community'

Refers to the kinds of distance that separate life in forensic hospital from 'real life', including physical barriers and duration of detention, while acknowledging points at which the boundaries of the institution are more porous and intruded upon by the outside world.

Sub-theme: The deferral of dignity

Refers to detainees' sexual dignity and human rights, and the manner in which qualifications and lack of attendance to these allow them to become transformed by professional practice while detained in the forensic hospital.

Theme Three: Detained Bodies

Refers to the identity transformations experienced by detainees in their exposure to psychological and psychiatric knowledge sets, including the impact of psychotropic medications upon one's capacity to inhabit a sexual body.

Sub-theme: Dangerous pasts, fragile futures

Refers to discourses surrounding detainees' capacity to be victims of sexual violence or to victimise others, and how conceptualising their sexualities solely in terms of potential vulnerability and predation serves to produce anxiety and paralysis around sexual expression.

Sub-theme: Discoursing health

Refers to the subsumption of sexualities under 'health' discourses, and how doing so may bridge 'care' and 'control' discourses, providing a rationale for professionals to incorporate sexualities into the hospital's treatment agenda, while simultaneously producing new problem-positions in which detainees' 'unhealthy' sexualities may be situated.

Sub-theme: Bodies transformed

Refers to the capacity for forensic inpatient treatment to physically transform detainees into asexual beings via the use of psychotropic medications, whose efficacy in containing 'pathology' may be privileged over patients' capacity to live their desired lives.

APPENDIX L: REFLECTIVE JOURNAL EXCERPT

Interview 8 – Reflections

- This was a difficult interview to sit through. I didn't like how P would frequently laugh and joke about patients' distress, or construct them as essentially unable to ever participate in meaningful relationships due to the diagnosis that has been given to them. Need to think more on this as presently feeling quite biased against P. Maybe joking produced as defence against feeling worried in the interview?
- Body language and tone were odd. At times felt like they were being evasive – would physically turn when offering examples of past untoward incidents, would repeatedly refer to themselves as not directly involved. At other times joke-y – flirtatious? Odd references to 50 Shades of Grey. Do I make people feel like they're being investigated?
- Took place in a very cramped, busy office. Papers everywhere and bleep kept going off. Made the interview feel a bit urgent or like I was intruding on their time. This is becoming a running theme through these interviews – my presence very much feels like an inconvenience to the normal running of things. What can this tell me about teams sometimes having to sit down to reinvent their thinking about relationships?

- I might be privileging my own discomfort in inhabiting these spaces/talking to these people over their discomfort at being interviewed.
- P adopted a quite defensive position re. trans women being dangerous and tabloid media. No personal experience of things going wrong on wards but very concerned about the possibility – need to look up the newspaper story they referred to. Odd that they started the interview by referring to tabloids in derogatory terms, ended by telling me that they're actually right. Felt almost conspiratorial, very different from interviews with others. Maybe sees self as some kind of conservative lighthouse in a storm of progressive ideology?

APPENDIX M: TITLE CHANGE APPROVAL



University of East London Psychology

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed title change to an ethics application that has been approved by the School of Psychology.

By applying for a change of title request you confirm that in doing so the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed then you are required to complete an Ethics Amendments Form.

HOW TO COMPLETE & SUBMIT THE REQUEST

1. Complete the request form electronically and accurately.
2. Type your name in the 'student's signature' section (page 2).
3. Using your UEL email address, email the completed request form along with associated documents to: Psychology.Ethics@uel.ac.uk
4. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.

REQUIRED DOCUMENTS

1. A copy of the approval of your initial ethics application.

Name of applicant:	Jason Poole
Programme of study:	Professional Doctorate in Clinical Psychology
Name of supervisor:	Kenneth Gannon

Briefly outline the nature of your proposed title change in the boxes below

Proposed amendment	Rationale
Old Title: How do hospital policy-makers make sense of forensic inpatients' desire for intimate and sexual relationships?	I mistakenly submitted an incorrect title with my ethics application, so it differs

	from the registered title on PhD Manager.
New Title: Exploring Hospital Policy Makers' Understandings of Forensic Inpatient Sexualities	

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	✓	
Does your change of title impact the process of how you collected your data/conducted your research?		✓

Student's signature (please type your name):

Jason Poole

Date:

13/03/2020

TO BE COMPLETED BY REVIEWER		
Title changes approved	APPROVED	
Comments: All seems fine here		

Reviewer: Glen Rooney

Date: 19/03/2020