Exploring 'Long-Stay' Male Service Users' Perception of their Physical
Healthcare in Forensic Mental Health Services

Samantha McCullough

Submitted: January 2022

A thesis submitted in partial fulfilment of the
requirements of the University of East London for the
Professional Doctorate in Clinical Psychology

ACKNOWLEDGEMENTS

ABSTRACT

Aims: To explore the experiences of Service Users detained in a High Secure Forensic Mental Health Service relating to their physical healthcare, including their attitudes toward physical wellbeing, and access and quality of service provisions.

Background: Several factors affect the physical wellbeing of those detained in mental health services or forensic services. People with a severe and enduring mental health diagnosis are more likely to have physical health comorbidities, often because of antipsychotic medication. Those in forensic services are more likely to have greater physical health needs due to historic trauma and social factors and restricted access to health promoting resources once detained which can worsen with longer detentions. It is therefore important to explore and understand the needs of this group as they will experience a greater number of mediating factors that influence physical health.

Methodology: Nine semi-structured interviews were conducted with adult males detained within secure services for over eight years who currently resided in a high secure service. A critical realist epistemological framework was adopted to explore and generate themes.

Results: A thematic analysis identified three main themes; 'The Meaning of Wellbeing', 'Being in a High Secure Forensic Environment', and 'The Role of Staff and the System'. The largest theme was the secure environment and participants' views on restrictions and impositions to their daily life. Participants were thoughtful about aspects that impact their health such as medication, individual responsibility, and diet. All agreed they were offered activities and access to healthcare; however motivation and staff availability could affect uptake amongst participants. These are explored further within the research.

Conclusion: The themes offered an opportunity to hear and understand service user's perspectives on an area that is becoming more considered. Recommendations discussed include integration of physical health and mental health services, staff training and employment of psychological approaches to physical healthcare.

ABBREVIATIONS

BCW	Behaviour Change Wheel
BPS	British Psychological Society
CI	Chief Investigator
CJS	Criminal Justice System
COM-B	Capability, Opportunity and Motivation model of Behaviour
CPA	Care Planning Approach
FMHS	Forensic Mental Health Services
GDPR	General Data Protection Regulation
HBM	Health Belief Model
HRA	Health Research Authority
LC	Local Collaborator
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
QOL	Quality of Life
R&D	Research and Development Teams
REC	Research Ethics Committee
SEMHD	Severe and Enduring Mental Health Diagnosis
SU/SUs	Service Users
UK	United Kingdom
WHO	World Health Organisation

LIST OF TABLES AND FIGURES

CONTENTS

Appendix C: Consent Form

Appendix D: Demographics Questionnaire

Appendix E: Debrief Sheet

Appendix F: Interview Schedule

Appendix G: Coding Transcript

Appendix H: Coding Table

Appendix I: Thematic Maps

Appendix J: NHS Ethics Letter

1.0 INTRODUCTION

Within the United Kingdom (UK) mental health services have historically struggled with underfunding and lack of resources compared to physical health services (Docherty & Thornicroft, 2015). To increase awareness and support for mental health services the UK government public health strategies committed to a 'parity of esteem' between mental and physical healthcare – aiming to reduce this discrepancy in funding, access, and quality between the two areas of provision (NHS England, 2014). Funding cuts and service commissioning has continued to impact mental health services disproportionately although there is growing pressure for a more equal system (Docherty & Thornicroft, 2015). Underfunding of mental health services can result in poorer access and facilities for physical healthcare and the nature of forensic services can create barriers to attending community based physical healthcare as well. The real-world impact is poorer health outcomes and a lower life expectancy for individuals diagnosed with a serious mental health condition (NHS England, 2016; Smith et al., 2007). However, the NHS Long Term Plan (2019) also outlines the importance of health across the lifespan. It issues key priorities of making sure everyone gets in the best start in life, delivering healthcare for major health problems and supporting people to age well. The aim of the present study is to explore the perception of physical healthcare for service users (SU) in a high secure mental health hospital and provide greater context to their experiences.

1.1 Defining and Giving Context to Forensic Services

This chapter presents an understanding of key concepts as well as summarising the UK legislative landscape relating to Forensic Mental Health Services (FMHS). The definitions and summary of relevant legislation is discussed with my own perspective and experiences of their interaction with the systems they influence as this has informed my approach and interest in the research.

1.1.1 Legislative Context

Within FMHS there are a number of legislative acts which direct service delivery and policy, namely; Human Rights Act 1998, the Mental Health Act 1983, and

the Equality Act 2010. These have implications for physical health treatment and care such as rights to access and capacity. Services are responsible for meeting these needs, failing to do so can constitute neglect of care and breach standards. Further context for the legislative acts named can be found in Appendix A.

1.1.2   Forensic Services Definition

This research has been conducted within and focused on UK services and discussed with this context in mind. FMHS operate for the treatment of individuals with a diagnosed mental illness who are assessed as posing a risk to themselves or others. Although other services operate to support mental health and the Criminal Justice System (CJS) this paper will refer to the National Health Service (NHS) commissioned services with that purpose. The management of risk is also provided within prisons along with some mental health provisions; the core differences being the mental health needs and treatment options, a therapeutic environment, mental health trained staff and management of risk which would necessitate someone to be detained in a secure hospital (JCPMH, 2013).

Within the literature FMHS may be referred to as; Forensic Mental Health Hospitals/Service, Secure Forensic Hospitals, Secure Hospitals, Forensic Inpatient Units/Service, Secure Psychiatric Services/Hospitals and Forensic Psychiatric Services/Hospitals.

This study will also be focused on high secure forensic services which provides care for those that need mental health input but present a "grave risk of harm to others" and cannot be managed at lower security levels, such as medium and low secure forensic services (NHS England, 2021).

Due to their responsibilities and position in UK services FMHS may have many legal obligations and restraints compared to mental health services, physical healthcare services and forensic services as they sit between and provide care in each of these domains.

1.1.2.1. Patients or Service Users: Although there is wider use of the word 'Service User' amongst mental health services and research as it offers neutral and global implications it is often rejected by people within forensic services for the preferred term 'patient' (Shaw, 2014; Völlm et al., 2017). This reflects their coerced engagement with and detention to forensic services rather than imply a choice they have made. These terms have both been used throughout the research to reflect the wider literature; the preferred term was used with patients when discussing their experience.

1.1.3 <u>Physical Health</u>

The World Health Organisation (WHO) defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." (World Health Organisation [WHO], 2014, p. 5). In 1948 this definition included a broad acceptance that it was not just the absence of negative health but having positive contributions to enrich life. In a post-war world this was encouraging however has since faced criticism. Huber et al. (2011) summarised the criticism as the requirement for "complete" health would be an impossible standard as the changing demographics and ageing population means more people are living with the impact of chronic illnesses, therefore using complete means the measures and classification systems WHO uses are based upon this concept and flawed. Despite criticism there are challenges to redefining and rebuilding an already existing system.

The World Health Organisation's (WHO's) aim of defining health was to provide a concept of universal health coverage, underpinned by access to all (World Health Organisation Maximizing Positive Synergies Collaborative Group [WHOMPSCG], 2009). Universal health coverage will be met when services are accessible, affordable, and acceptable (Evans et al., 2013). Within this however are groups who are marginalised or experiencing inequity (such as poverty) which limits the accessibility, affordability, or acceptability of healthcare available (Fukuda et al., 2005; World Health Organisation, 2014). While defining the term has uses and merits, it being applied to unequal systems can cause difficulties.

Attainment of the highest level of health is included within the Universal Declaration of Human Rights and States must provide the means to achieve healthcare and social needs (i.e., clean water, housing) (World Health Organisation, 2014). The Right to Health is not just being healthy or well it also offers protections from interference and bodily autonomy that may be limited within vulnerable populations.

Contextually and historically these definitions and directions were associated with a time of considerable change. The recognition of indeterminate rights followed World War Two, with great loss, mass atrocity & genocide, and migration & displacement (Higgins, 2012). The development of more progressive and protective guarantees for humans and health came from these difficulties and the Anglo-American viewpoint (Bhurga et al., 2015). These rights may be confined to individualistic needs and dominant narratives of diagnostic models, physical health, mental health, or disease at the time.

1.2 Forensic Services

1.2.1 Forensic Mental Health Hospitals

Forensic Mental Health Hospitals (FMHH) or Secure Hospitals are directly commissioned by the National Health Service (NHS) England as a specialist national service. There are four tiers of security including high, medium, and low secure inpatient and outpatient services with an integrated care pathway to support movement throughout. Secure hospitals follow security guidelines (such as those set by the National Offender Management Service and NHS England), and different security levels may require different physical, relational, and procedural restrictions to mitigate risk (JCPMH, 2013). Many of their service objectives and outlines are specified by the Adult High Secure Services Specifications (NHS England, 2021) including population needs, integration with other services, and quality and care responsibilities.

Most patients will enter forensic services from the Criminal Justice System under a Mental Health Act 1983 (MHA) section. This can be after an offence has been committed or may be following deterioration in their mental health. Other pathways a patient may be admitted through is a referral from other mental health services, transfer from prison, transferred from an existing secure

hospital or recalled from the community (Edge et al., 2017; Edworthy et al., 2016).

The number of FMHHs is not known fully; within England there are three high secure hospitals and an estimated 65 medium secure units in England and Wales (Davies et al., 2014). NHS England (2013) estimated 7719 inpatient beds are commissioned annually (795 high secure beds, 3192 medium secure beds and 3732 low secure beds). The Adult High Secure Mental Health Guidelines, outlined by NHS England (2013) state the overall aim is to "provide a therapeutic psychiatric service for individuals with a mental disorder – mental illness, personality disorder, neuro-developmental disorders who present a grave risk of harm to others". Other factors (i.e., bureaucracy and impact of offending) can lead to an overestimation in risk which means some patients may not necessarily reflect their assigned security level; dynamic risk factors such as completion in therapeutic programmes and clinician view of recovery may aid movement between secure levels more to reduce overall capacity (McCullough et al., 2020; Shaw et al., 2001; Völlm et al., 2016).

FMHS can straddle different objectives and requirements; providing care and treatment to improve mental health and wellbeing on one hand and detention, managing risk and reducing recidivism for public protection on the other (NHS England, 2013). This can mean clarity over treatment goals, psychological input, staff objectives and whether treatment is 'punishment' is often harder to achieve (Adshead & Davies, 2016; Livingston et al., 2012; Völlm & Nedopil, 2016). There is little research that evaluates the effectiveness of FMHH however discharged patients have lower rates of recidivism than comparative groups (Fazel et al., 2016).

1.2.1.1. Length of Stay in Forensic Mental Health Services: The reform of mental health services towards community-based treatment has led to fewer inpatient beds and services and a drive to reduce long stays in inpatient hospitals; though patients in FMHS have a greater risk of increased LoS (Davoren et al., 2015). The current aim for LoS in UK medium secure hospitals is two years, with an average exceeding six years (Shah et al., 2011). As LoS can be dependent upon clinical judgement or treatment 'success' this can lead

to some individuals remaining in a FMHH for a significant length of time beyond a criminal sentence (Edworthy et al., 2016).

1.2.1.2. Power Imbalance and Coercion: Coercion within FMHHs is widely acknowledged due to the inherent power imbalance between the service, staff, and patients within them and can be through persuasion, relational pressure, intimidation, threats, and structural imbalances (Adshead & Davies, 2016). Coercion is experienced as isolating, shaming, traumatising and punitive by patients and has a negative impact on therapeutic gains (Adshead & Davies, 2016; Sequeira & Halstead, 2002; Völlm & Nedopil, 2016). Due to the environment, there is a loss of autonomy and imposed power structure that dominates daily life which affects choice, freedom, and control over many decisions (i.e., food, clothing, personal belongings, freedom of movement, living environment and many more).

1.2.2 Prison Service

The UK Prison Service comprises adult prisons operating at four security categories, young offenders' institutions, secure training centres and secure children's homes with a total capacity of 96,000 (although occupied at a lower number) (Sturge, 2020). There has been improvement to the mental healthcare within Prisons over the last 15 years which includes a stepped care approach, psychologically informed environments, mental health in reach teams and improved staff training (Durcan, 2017). The prevalence of mental health needs within prisons remains high, with estimates that 45% of prisoners meet the diagnostic criteria for depression and anxiety, 66% of prisoners meet the diagnostic criteria for personality disorder, 60% have experienced a brain injury and 45% will meet the criteria for drug dependency (Parsonage, 2016; Singleton et al., 1998). Although many of these vulnerabilities may be explained by early life trauma and adverse childhood experiences which are common amongst the population, the prevalence indicates a higher need for support (Armour, 2012; Facer-Irwin et al., 2019).

Providing good physical healthcare is not only a right, but prevents communicable diseases, is economical and reduces the impact on community services longer term (Kinner & Wang, 2014). Furthermore, ageing within the

prison service is increasing, mirroring the general population - in a UK based prison over 90% of older prisoners had a physical health condition (Hayes et al., 2012). Whilst stakeholders are recognising the increased need for mental health support in prisons care under a FMHS is considered when the nature of distress, need for specialist mental health support in a therapeutic environment and multi-disciplinary care is necessary to support someone's mental health.

1.2.3 Relevant Guidelines

The High Secure Mental Health Commissioning Guidelines (NHS England, 2013) outline that individuals should have their physical healthcare needs met through primary care interventions, including health promotion and screening as well as reducing inequalities in access to provide integrated care.

1.2.3.1. NICE Guidelines for the Physical Healthcare of People in Prisons: The NHS became responsible for commissioning all healthcare for people in prisons in 2013 and noted unmet health needs compounded by poor access and inconsistent quality compared to the general population (NICE, 2016). In response the National Institute for Care and Excellence (NICE) produced guidelines in 2016 regarding the assessment, treatment, and maintenance procedures for physical healthcare of people in prisons; aiming to address health needs, reduce inequalities, create a pathway of care, and prevent health deterioration or premature death due to poor health (NICE, 2016). Identified methods to improve health were increased information, screening services, access to primary care and round the clock healthcare, regular reviews with a primary care clinician and screening for past traumas (NICE, 2016). In contrast there is no national clinical guidance for physical healthcare provisions in FMHS.

1.2.3.2. Managing Weight in Secure Services: Managing Weight in Adult Secure Services (2021) outlined practice guidance across all secure services to support maintaining a healthy weight for patients. It acknowledged the impact of comorbidities and interlinked drivers for weight gain and outlined guidance of accessible information, physical health checks, physical health monitoring and a commitment to embed policies for healthy eating and lifestyle in all services.

This should include provisions for and address aspects of weight management including diet, exercise and education.

1.3 Physical Health: Mediators and Ways of Understanding

1.3.1 Physical Health and Wellbeing

Wellbeing and the application to health, mental health, legislation, and guidelines has been a growing area of research and consideration, particularly in recent decades (La Placa et al., 2013; Seligman, 2011). There are often differences in both what it includes and deficits of definitions, which have made it 'hard to measure' and harder to have a clear idea of psychological wellbeing in an applicable sense (Thomas, 2009). Early attempts to define it have included life satisfaction, alignment with goals, the presence of pleasant affect or happiness, the absence of negative affect, or functional capacity (Dodge et al., 2012).

Dodge et al., (2012) looked at existing wellbeing literature and understandings holistically and defined it as "the balance point between an individual's resource pool and the challenges faced" (p. 230) with resources and challenges in the psychological, social, and physical domains.

The definition encompasses equilibrium or homeostasis that individuals can move between and what can aid movement (the resources and challenges faced) which has been identified in previous research as an important element of wellbeing. Whilst there is still debate in the application of wellbeing, this goes some way towards its understanding.

1.3.2 Physical Health and Quality of Life

Similarly, research within Quality of Life (QoL) has faced similar challenges when trying to define the concept as wellbeing, often with overlap between them (Hickey et al., 2005). This stems from the broad construct or multidimensional factors that QoL involves and can include many aspects of daily living, values, and life (such as satisfaction, social relationships, health & morbidity, mobility, functional ability, work and impact of treatment) which leads to a lack of a clear definition (Gladis et al., 1999; Katschnig 2006).

Often research involving QoL will investigate specific domains or use measures that fit the aims and direction of the research itself (Katschnig, 2006). However, how we define and use QoL has implications for policy, practice and aspects of our daily life so understanding where to make those changes matters (Ryan & Deci, 2001).

Whilst there is no agreed upon definition or core dimensions two areas research agrees should be present are subjectivity and multidimensionality (Hickey et al., 2005). Subjectivity relates to an individual's judgement and perception of an experience and multidimensionality refers to the domains or dimensions of life being asked about (WHO, 1998).

QoL has been conceptually relevant to medical and physical health literature since the 1960s and was introduced into medical literature databases in 1975 (Post, 2014). Healthcare and physical health is considered a core facet of QoL within the literature and poor health outcomes, both mental and physical, can impact QOL (Naylor et al., 2012; Guyett et al., 1993; Michalos, 2017; Whoqol Group, 1995).

Health related QoL and general QoL may include different dimensions as they are often considered different constructs by patients; and health related QoL may refer to a response to a medical or mental health need or QoL response to a medical need (Smith et al., 1999). Overall QoL has been found to be a useful construct for considering the needs of individuals with SEMHD (Lehman, 1988).

1.3.3 Biopsychosocial Model of Wellbeing

Engel's (1977) biopsychosocial model highlights the effect of psychological factors on physical health conditions and vice versa; suggesting that biological, psychological, and social processes have a simpatico relationship to physical health and illness (Suls & Rothman, 2004). There have been criticisms of the application of the biopsychosocial model to mental health services, where the psychological and social factors can be ignored in understanding distress or a reliance on the biological causes for mental health difficulties (Read, 2005). The central tenet is one of interaction between all elements.

The comorbidity of psychological and physical health can impact an individual's psychological, physical, and social wellbeing. It is understandable that individuals with physical health conditions can also have diagnosed and undiagnosed mental health conditions above the prevalence within the population. Estimates range from 25-35% of individuals admitted to hospital will have a diagnosed mental health condition, and 41-60% will have experiences of low mood or anxiety, with factors such as age, socioeconomic status, and sociocultural issues increasing the likelihood (Confederation NHS, 2009).

1.3.4 Behaviour Change Wheel

Meeting systemic health challenges requires effective interventions that target behavioural change. Often behaviour change is considered within domain specific categorisations, such as smoking cessation and weight management, however health related change behaviours are complex and do not occur in isolation of psychological, social, environmental, economic, political and cultural relationships (Ogden, 2016). As these processes can influence and interact with individual health related and motivated behaviour models that identify the antecedents for behaviour within the context of the wider mediating factors provides an opportunity to explore and address health and wellbeing (Michie et al., 2016; Michie et al., 2011).

The Behaviour Change Wheel (BCW) is a model of behaviour that brings together broad frameworks for understanding behavioural change and developing interventions. The core of the model comprises of sources of behaviour, based on the Capability, Opportunity and Motivation model of behaviour (COM-B) (Michie et al., 2011). The COM-B model proposes that individual health behaviours are enabled or limited by three factors; a person's Capability (e.g., psychological and physical capacity to engage in necessary processes), Motivation (e.g. the evaluations and plans and perception of their ability to engage with them), and Opportunity (e.g. the physical opportunity provided by the environment). Each individual category may influence adherence to the behaviour, however opportunity and capability may also moderate motivation as well (Michie et al., 2011).

In the context of FMHS, capability factors such as the capacity to plan and adapt to lifestyle changes may be mediated by environmental restructuring and restrictions. Additionally, factors such as executive function affected by medication, mood and historic injury may interfere with motivation. Similarly physical and social opportunities in FMHS such as access, social support, hospital culture, and patient-staff relationships may also mediate or moderate engagement and motivation. The model can help consider broader context of engagement with health-related behaviours and environmental factors that hinder and encourage individual engagement.

While the COM-B model is the core of the BCW which supports understanding of behaviour change, the further layers of the wheel are external factors that can be targeted to promote or remove barriers to engagement (Michie et al., 2014). The next layer identifies intervention that can be applied to enact change within the behavioural taxonomies and the final layer promotes development and understanding of policy changes and support that deliver the interventions (as seen in figure 1).

The BCW is popular in designing and implementing behavioural change interventions, however it often addresses the individual changes and may not develop the necessary clinical or relational skills required within a heavily restricted environment which has limited capacity to adjust. Characteristics such as empathy, alliance and therapeutic milieu are vital within FMHS and should be considered alongside other mediating factors (Hilton & Johnston, 2017).

Figure 1

The Behaviour Change Wheel (Michie et al., 2011)
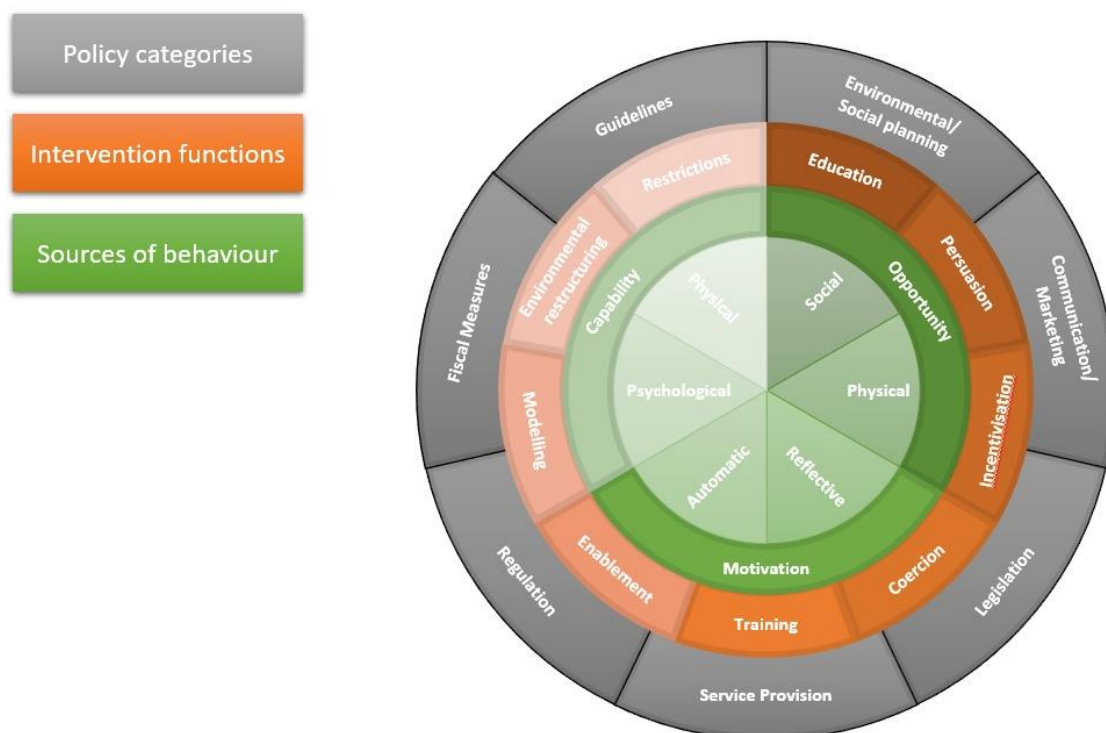
1.3.5 Health Belief Model

Developed in the 1950's the Health Belief Model (HBM) has often been used to evaluate the effectiveness or likelihood of engaging in preventative health behaviours for those with chronic health conditions or as part of public health strategies (Janz & Becker, 1984). The model outlines modifying characteristics, such as demographic and psychological variables, interact with individual health motivation, perceptions of illness (namely susceptibility and severity) and perception of engagement (namely benefits and barriers) which determine the action. Cues to action, including triggers or prompts, can also affect engagement in health promoting behaviours. These cues may be internal or external and this is often the target of public health campaigns.

The advantages are the model can be used to predict likelihood to engage by examining the self-efficacy of change (Rosenstock, et al., 1988). If individuals feel they cannot change their circumstances (low value of health or impeding individual psychological factors, more perceived barriers and less cues to action) then it may be unlikely someone will engage even with high perception

of severity and susceptibility. This may be more prevalent within FMHS where there may be knowledge of health-related factors but less individual control.

1.3.6 Physical Health and Recovery

Recovery emanates from two constructs; the biological approach where recovery means a change to a diagnosis, 'disorder', brain functioning, and/or chronic conditions and the psychosocial recovery which is more closely aligned with wellbeing and a meaningful life (Braslow, 2013; Slade, 2009; Slade et al., 2014). Physical health and wellbeing may form part of an individual's construct of their recovery, although may be at odds with systemic goals of recovery aligned with biological factors such as symptom reduction, functioning and standardised measures.

Recovery and personalised care pathways are an important part of mental health services and personalised recovery plans, such as the Care Planning Approach (CPA) policy, is one-way mental health services may support individual goals with the ideals of recovery (Department of Health, 1990). They are often aligned with biological discourses of mental health, and the social, political, and systemic agendas that impact individuals are largely ignored (Duff, 2016; Harper & Speed, 2013; Hunt & Resnick, 2015; Price-Robertson et al., 2016). As noted, there are numerous social, political, and systemic determinants for recovery ideals in health care provision, education & employment, and family & social support which positively impact mental health outcomes (Allen et al., 2014).

The intersection between individual determinants and mental health may be stronger within forensic services due to societal perspective on individualism and criminality; if crime and mental health is viewed as an individual issue of accountability then recovery may also be held at these levels rather than a wider structural response.

While recovery often refers to a medical model of recovery – where a return to a usual or standard level of symptoms, experiences or functioning is attained – there is a growing movement within recovery to include meaningful and more functional activities as part of construct (Whitely & Drake, 2010). Whitely and

Drake (2010) proposed physical health as one facet of recovery (alongside clinical, existential, functional, and social) while many definitions of recovery have previously omitted this. Physical recovery can refer to improvements in health and wellbeing and acknowledges a structural impact on physical health for individuals with a mental health diagnosis (Bartles, 2004; Whitely & Drake, 2010).

1.3.7   Other Psychological Barriers to Engagement

Non-engagement with services is a prevalent issue in physical and mental health and is associated with poorer health outcomes, lower wellbeing, and lower levels of patient care (Doyle et al., 2014; Kardas et al., 2013; Martin et al., 2005; Walsh et al., 2019). Whilst the benefits of engagement in positive behaviours for physical health like exercise, healthy eating, attending primary care appointments, and compliance with treatment regimens there are many factors that can affect how likely individuals are to engage in health promoting behaviours. These include accessibility, available support, fear, transport, service delivery costs, coercion & choice, information, influence & relationship to the care provider, incentivisation, and motivation (Sangelaji et al., 2017).

The communication of health promotion and information can often impact engagement. Messages that are perceived are controlling, coercive, and a threat to an individual's freedom or autonomy reduce engagement and intention towards change behaviours in many aspects of health (Reynolds-Tylus, 2019). When freedom is threatened individuals seek autonomy and freedom restoration; this is termed 'psychological reactance' where the psychological, emotional, and cognitive responses lead to behavioural and cognitive attempts to regain autonomy (Dillard & Shen, 2005; Rosenberg & Siegel, 2018). This can include engaging in the threatened behaviour further, denigrating and dismissing the source of the threat or overestimating the worth of the threatened behaviour or the severity of the threat (Reynolds-Tylus, 2019; Shen & Dillard, 2005). This response can be seen in many health outcomes but is particularly relevant for FMHS where there is an existing power imbalance.

Whilst it can be difficult to isolate and identify all contributors to poor health due to the broad nature of its definition some aspects of health research have

focused on individualised health risk behaviours to classify what increases likelihood of disease and poor health. These commonly include; current smoking, excessive alcohol consumption, physical inactivity, poor dietary habits and excessive weight, stress, non-engagement with health check-ups, use of illicit drugs, 'risky' sexual behaviour, and poor sleep (Kwan et al., 2013; Carr-Gregg et al., 2003; Fukunda et al., 2005). It is likely that an excess of these health determinants leads to poor physical and overall health.

1.4 Physical Health & Mental Health

The idea that physical wellbeing impacts mental wellbeing and vice versa is firmly rooted within societal narratives and literature. There is good evidence to suggest more common mental distress (i.e., depression, anxiety, anger, and stress) has negative outcomes on physical health and similarly there is also evidence for the beneficial effects of positive mental states (Veenhoven, 2007).

1.4.1   Prevalence and Impact of Physical Health Conditions in Mental Health

Physical health conditions are consistently more prevalent for SUs with a mental illness diagnosis, with even higher rates for individuals with a diagnosis of schizophrenia (Robson & Gray, 2006; Phelan et al., 2001). Those diagnosed with schizophrenia, or a Severe and Enduring Mental Health Diagnosis (SEMHD) often take antipsychotic medication, are more sedentary, use tobacco, have financial difficulties which can contribute to poor health, a poorer diet, and a history of or active use of harmful substances which can contribute to physical health conditions (Phelan et al., 2001). 'Symptoms' and social factors (i.e., isolation, cognitive impairments, and suspicion) can contribute to difficulties seeking help and diagnostic overshadowing; this can lower the prioritisation of physical health for individuals and healthcare providers (Phelan et al., 2001; Thornicroft et al., 2007).

Developing integrated support is considered preventative for long term conditions and cost effective therefore benefitting the NHS. Current aims are for those with a SEMHD to have an annual physical health check; however, this varies across the UK and an estimated 31% of service users with a SEMHD receive annual physical monitoring (NHS England, 2016; Smith et al., 2007). Improving physical health training for staff has been recommended as poor

physical health checks and monitoring contribute to poorer awareness of physical healthcare needs for SUs (NHS England, 2016; Phelan et al., 2001).

1.4.1.1. Severe & Enduring Mental Health Diagnoses: It is well recognised that compared to the general population individuals diagnosed with a SEMHD or severe mental illness are more likely to have poorer health outcomes, higher rates of comorbidity, have unrecognised physical health needs and higher rates of morbidity related to their health complications (Barr, 2001; Lawrence et al., 2001; Naylor et al., 2016; Phelan et al., 2001; Miller et al., 2006; Smith et al., 2007). A SEMHD often refers to diagnoses of Schizophrenia, Bipolar, Psychosis and Personality Disorder, however there is no acknowledged definition amongst the literature or what defines 'serious mental illness', 'severe mental illness' or other used terms; for the purposes of this review literature that refers to severe mental health difficulties of a persistent nature has been included under the SEMHD umbrella (Goldman & Grob, 1999; Zumstein & Rises, 2020).

Despite the higher risk of premature death and comorbid physical health research suggests physical healthcare resources are underutilised by SUs, in part due to the relationships between healthcare providers and SUs, access and SU related issues (Felker et al., 1996; Lawrence & Kisely, 2010). Life expectancy estimates for those diagnosed with Schizophrenia and Bipolar are between 14-20 years lower than average with an increased risk of mortality from some diseases such as cancer (Kisely et al., 2013; Laursen et al., 2014; Miller & Bauer, 2014). Poor detection and treatment of physical health conditions can treble mortality rates for people diagnosed with Schizophrenia (Brown et al., 2010).

Patients, carers, and healthcare professionals may experience anosognosia related to physical health, which means ignoring the symptoms that they may be ill which could account for lower rates of physical health concerns being recognised, treated, or monitored (Litschge & Vaughn, 2009). Lack of reviews can further contribute to missing signs of illness – for example, 33% of medical doctors and 50% of psychiatrists missing comorbid medical conditions at reviews, less than 75% of patients examined by a doctor for physical health when admitted to a mental health service and only a minority screened for

cardiovascular health (Hardy et al., 2013; Lawrence & Kisley, 2010; Osborne & Warner, 1998).

1.4.1.2. Comorbidity: A key facet of poorer health outcomes for individuals diagnosed with a SEMHD is the higher rates of comorbidity than the general population (Fleischhacker et al., 2008; Miller et al., 2006). There are higher rates of comorbid physical health conditions including obesity, hypertension, diabetes mellitus, hyperlipidaemia, smoking heart disease and tobacco use (Barr, 2001; Fleishchhacker et al., 2008; Lawrence et al., 2001; Phelan et al., 2001).

Obesity and diabetes rates are higher in patients with SEMHD than the general population. It is estimated 54% of individuals with a SEMHD meet the criteria for obesity compared to 33.9% of individuals in the general population and an additional 19% were indicated as being overweight, this figure increases to a 50% rate of obesity and 40% rate of metabolic syndrome in those diagnosed with Schizophrenia (Flegal et al., 2010; Kennedy et al., 2005; Wirshing, 2014). Furthermore 27-37% of individuals are likely to have raised blood pressure levels reaching hypertension and 13% have hyperlipidaemia (De Leon & Diaz, 2005; Kennedy et al., 2005). Rates of diabetes are also significantly higher, with glucose intolerance rates of up to 25%, hyperglycaemia rates of 7% and diabetes mellitus (type 2) in 14-18% of those diagnosed with a SEMHD compared to 6% of the general population (Cohen et al., 2006; Kennedy et al., 2005).

Heart disease is the leading cause of death for individuals with a SEMHD, similarly to the general population, however health conditions that increase risk of heart disease are more prevalent for individuals with a SEMHD (including obesity, diabetes, and smoking) (Daumit et al., 2002; Miller et al., 2006). The increased rates of serious physical health conditions highlight an ever-growing problem and gap in the physical healthcare needs of those with a SEMHD.

1.4.2 Medication

Side effects of antipsychotic medication can also cause health related concerns, and these are commonly prescribed in forensic services and to those with SEMHD.

First-generation antipsychotic medications were introduced in the 1950s to treat positive symptoms (i.e., hallucinations and delusions) of schizophrenia. They reduce dopamine activity and thus slow the communication of neurotransmitters in the brain (Walker et al., 2004). They are associated with adverse side effects such as weight gain, metabolic syndrome, heart disease, dry mouth, hepatoxicity, osteopenia, impact to sexual functioning, cognitive impairment, sedation and neuromotor side effects (as dopamine activity positively affects neuron communication responsible and bodily movements) (Solmi, 2017; Stoup & Gray, 2018).

In the 1980s second-generation antipsychotic medication was introduced due to the adverse effects of the previous generation. This targeted other neurotransmitter receptors to limit neuromotor side effects; however side effects of weight gain and metabolic syndrome are far more common. Metabolic syndrome is characterised by increased waist circumference (central obesity), elevated blood pressure, cholesterol disturbances, hypertriglyceridemia, and hyperglycaemia; having three of these characteristics will classify as a metabolic disease (Centorrino et al., 2012; Solmi, 2017).

Weight gain can be associated with the side effects of the medication directly, with increase in appetite and decrease in movement being a feature, but also lifestyle and socioeconomic factors associated (i.e., poor diet) which can cause difficulties maintaining wellbeing and health (McCloughen & Foster, 2011). Unfortunately, the effects of weight gain and metabolic disease are strongly linked with cardiovascular health.

1.4.2.1. Engagement: As prior research noted non-engagement is a prevalent issue across both mental health and physical health services, however individuals with a diagnosis SEMHD are more likely to have a physical health condition as well. Both the lack of detection and engagement with healthcare

may play a part in worsening an already existing issue. For individuals with a SEMHD frequent use of unplanned care and emergency services is also more predominant with treble the attendance to emergency departments and five times unplanned inpatient admissions compared to a matched population sample and 80% of occasions relates to physical healthcare issues (Dorning et al., 2015). In many cases, for individuals with SEMHD their interaction for physical healthcare is through the psychiatric treatment team and they may not report physical healthcare concerns, or they can be overlooked because of the mental health focus of their care (Goldman, 1999; Kennedy et al., 2005).

Research suggests that difficulty communicating healthcare needs, underutilised health care, lower engagement with help-seeking behaviours, less compliance with recommendation and treatment, resource constraints and lack of integration between mental health and physical health services are factors that affect engagement for those with long term mental health conditions (Bright et al., 2015; Docherty & Thornicroft, 2015; Graffigna et al., 2017; Koponen et al., 2017). Furthermore, coercion and lack of control also predict less engagement whilst healthcare providers feel coercion increases compliance (Jaeger et al., 2013; Tessier et al., 2017). Power imbalance and issues of control and coercion are central amongst mental health services and FMHS however exertion of control can negatively affect therapeutic engagement and is not helpful longer term (Danzer & Rieger, 2016; Hotzy & Jaeger, 2016).

1.5 Physical Healthcare in Forensic Mental Health Services

As discussed in 1.2.1 many people detained in forensic services will be diagnosed with a severe and enduring mental health condition and will have a higher physical healthcare risk associated and a similar profile of comorbidities previously covered (Meiklejohn et al., 2003). Some issues that may be more unique to a FMHS relating to physical health are discussed below.

1.5.1   Early Life Events

Prisoners and people detained within FMHS are often acutely unwell, have complex needs, historical trauma and behaviour that challenges and are one of the more vulnerable populations (Barr et al., 2019; Durey et al., 2014). The Adverse Childhood Experience study and subsequent research indicates a

positive relationship between childhood trauma and long-term negative health outcomes and physical health problems such as cardiovascular disease, diabetes, and obesity (Harris & Fallot, 2001; Hennessey et al., 2004; Morrison et al., 2003; Muskett, 2014; Stein & Kendall 2006). The research indicates that individuals in forensic services are more likely to be exposed to abuse, neglect, and family trauma in childhood. A sample of inpatients from high and medium secure services in the USA found 29% had been exposed to four or more adverse childhood experiences (three times more than the general population) (Maguire & Taylor, 2019; Muskett, 2014).

1.5.2 Forensic Events

Violence and aggression are often higher in inpatient mental health services – with 73% of staff reported being threatened and 45% assaulted, and, whilst lower, 31% of patients reported being threatened and 15% reported experiencing assault (Barr et al., 2019; The Healthcare Commission, 2008). This increases within forensic services, with estimates of 62% experiencing direct aggression (Barr et al., 2019; Dickens et al., 2013). The impact of experiencing this can impact physical health – both directly through physical harm or indirectly through damage to relationships, negative staff attitudes and avoidance of seeking help.

1.5.3 Forensic Environment

1.5.3.1. Physical Activity, Weight Gain & Lifestyle: The link between antipsychotic medication, weight gain and reduced physical activity has been discussed; this is particularly prevalent within a forensic inpatient population due to higher rates of antipsychotic use, restricted movement, and limited dietary choice.

In a forensic inpatient sample of overweight or obese patients 78% reported they had been more active within the community or in the prison system and felt their physical activity had decreased due to lower motivation, medication, and opportunity (Every-Palmer et al., 2018). In the sample 75% were concerned and attempting to lose weight and they viewed institutional constraints as the main barrier to living a healthier life (Every-Palmer et al., 2018). Oakley et al., (2013) found that over half of medium secure units do not have effective strategic

management for obesity and recommended health promotion and education. Trying to balance health management against coercive and restrictive practice around access to food which would violate individual rights can create discord within health professionals, although a systematic review of weight reduction programmes (such as regular weight assessment, behaviour change intervention, education for staff and patients, being implemented in medium secure units yielded some positive changes (Jerome et al., 2009; Johnson et al., 2018). More generally, those with a SEMHD reported the symptoms of their mental health condition often affected their activity levels (Jerome et al., 2009).

Smoking is also a prevalent issue within forensic services. In 2006, prior to the indoor smoking ban a survey in a forensic inpatient unit found 76% were current smokers (Dickens et al., 2006). Garg et al., (2008) looked at staff views on smoking during the implementation of the indoor smoking ban and found opposition to a total indoor smoking ban due to concerns about security and risk management, increased anxiety and aggression amongst patients, and time and medication resources. This would suggest some health behaviours also form part of the culture of forensic services.

Lower levels of activities have been linked to lifestyle and mental health experiences, such as hallucinations, low cognitive functioning and thought disorder (Jerome et al., 2009; Robertson et al., 2000). Social isolation and high hospitalisation rates are also associated with a poorer diet (Compton et al., 2006; Henderson et al., 2006). Whilst this is experienced in the community by individuals with SEMHD the lack of access to information, facilities, equipment, and choice combined with the effect of antipsychotic medications would appear to affect those in FMHS to a greater degree.

1.5.3.2. Length of Stay: LoS is positively correlated with poorer health outcomes, such as increased weight gain and risk of metabolic disease (De Hert et al., 2006; Meiklejohn et al., 2003). Detention within a forensic service for treatment can exceed predictions and service aims leading to an increased risk of poor health for long stay patients. In this context long stay is defined as a stay of five or more years; however some literature will use eight or more years to define long stay (Völlm et al., 2016).

1.5.3.3. Ageing in Forensic Services: Research within High Secure FMHS have found the total population of older adults was around 8.5% in 1995 and reached 20% in 2017 (Wong et al., 1995; Di Lorito et al., 2018). The age patients are considered an 'older adult' can vary, the widely accepted age is 55+ years but for some may be 50 or 60+ years old (Snyder et al., 2009). There are often two distinct groups of older adults in forensic services, those who offend when young and age while detained and individuals who offend as an older adult and there may be different unmet health needs in each group however little research has been done to explore this (Das et al., 2012).

Older forensic patients often have at least one health condition and may have more complex health needs such as neurological disease & dementia, heart disease, stroke, and hypertension (Di Lorito et al., 2018; Lewis et al., 2006). Older adults in FMHS have reported positive feedback around physical health but experienced barriers to engagement caused by social isolation, services not being set up for their age-related needs and feeling unmotivated to engage, however those in high secure services reported more 'unmet' health needs compared to lower secure settings (Das et al., 2011; Völlm et al., 2016).

Additionally, older adults within forensic services comprise around 30% of the long stay population and older patients have a LoS that evidently above that of younger patients in FMHHs and older adults in the prison population (when matched with a similar offending history) adding to the complexity of physical healthcare needs within a forensic mental health population (Völlm et al., 2016; Di Lorito et al., 2018).

1.5.4   <u>Masculinity in a Male Environment</u>

Statistically men are more likely to suffer premature death or a debilitating injury, have difficulties with alcohol and substance use and have a heart condition than women therefore understanding health engagement behaviours and the role gender and masculinity holds importance (Creighton & Oliffe, 2010; Gough, 2006; Sesso, Paffenbarger, & Lee, 2010). Risk taking and reduced help seeking are theorised as a product of hegemonic masculinity or stereotypical masculine traits (Creighton & Oliffe, 2010; Gough, 2006). This is supported in

some areas of research and media; with themes of 'winning', 'competitiveness', 'strength' and not being vulnerable interfering affecting health seeking or engagement noted as a barrier (Lohan, 2007; Ricciardelli, Clow, & White, 2010; Verdonk, Seesig, & De Rijk, 2010). Gough (2006) noticed men's health discourse, particularly in media, does not accommodate a wider range of meaning and difference amongst groups of men which can lead to the perpetuation of the belief (or something like that) that men are disinterested in their health. A restrictive definition of masculinity within the public sphere harms choice, policy, and service development (Lee & Owens, 2002).

The intersection of socioeconomic background, class and gender when thinking about men's health can create a more complex understanding of health seeking behaviours. For example, where masculinity and class position meet and create a sense of physical and emotional toughness, achievement, and authority certain 'risky' behaviours (such as remaining in a physically demanding job avoiding the GP, etc.), are more likely (Dolan, 2011). Within forensic settings this hierarchy of masculinity can be performed by individuals, staff and through the practices of the system which will reinforce masculine ideals.

1.6 Aims and Rationale

1.6.1 <u>Rationale</u>

Patients in FMHS are at a greater risk of developing health conditions as well as having restrictions placed upon them that can affect health engagement. With these challenges held in mind, the research will prioritise the voice of the patients and their experiences to gain a greater understanding of physical health in high secure services. High secure services and long stay patients were selected as patients in these services may be at greater risk of developing physical health needs and have more unmet health needs (Das et al., 2011; Völlm et al., 2016). Therefore, exploration of their view should yield an interesting and valuable perspective.

1.6.2 <u>Parity of Esteem</u>

The improvements in awareness campaigns and policy (i.e., WHO's "No health without mental health") have led to greater understanding of mental health difficulties individuals can face and recognises that poor mental health can lead

to greater physical health issues, injury, preventable diseases, disability, and poverty (Prince et al., 2007). Such attention has shone a light on the importance of mental health for public health however stigma and accessibility still mean many people do not receive treatment (Henderson, Evans-Lacko, and Thornicroft, 2013; Prince et al., 2007). It also highlights the inequalities in funding, access and lack of integration which leads to inequitable health outcomes for everyone.

1.6.3   Aim

The broad aim is to generate an exploratory account of patients' experience of access and quality of physical healthcare and physical wellbeing whilst in a FMHS. By focusing on both access and quality over time it is hoped to understand and identify changes felt by patients that may offer guidance for future research and practice where applicable.

1.6.4   Research Questions

The following research questions were developed to understand patient's experiences of their physical healthcare in high secure FMHS:

1. How do male patients in forensic settings experience their physical healthcare and wellbeing?
2. What, if any, challenges do patients experience when accessing physical healthcare provisions in forensic settings?
3. What would patients like to change, or think would improve their physical health?
4. Have patients observed or perceived a change in their access and physical healthcare provisions in forensic services over time?

2.0 METHODOLOGY

This chapter outlines the methodological details, rationale and philosophical underpinnings that shaped the present study. It provides details on how the study was conducted, ethical approval and considerations, participant selection, recruitment, data collection and the analysis. Steps to ensure the safety of participants and the researcher are also considered.

2.1 Epistemology

The proposed research takes a critical-realist epistemological stance. This means that participants' accounts are based on the events they have experienced, however these experiences are constructed by the individual within a context and retold from their subjective position that also sits within a context (Harper, 2012). While constructively formed from individual experiences, it takes the position of ontological realism where the phenomena exist regardless of perception. This is relevant for FMHS and those detained within the setting whereby there are consequences beyond the simply subjective experiences. The researcher acknowledges the concepts of 'wellbeing' and 'healthcare' will exist, but will be mediated by their construction, context, and environment and ramifications of their reality which are influenced by the historical, cultural, political, and social perspective.

The critical realist position needs an acknowledgement of the assumptions of the researcher and researcher's perspective which can further impact the analysis and conclusions based on the data. While the aim of the study has been to understand the individual perspective, both the participant's and researcher's interpretation of events can impact a true reality or reflection of the events (Willig, 2012). The interview data and responses given reflect the person's perspective and demand characteristics of the situation, alongside their understanding of what information is sought. The researchers' interpretation of this data reflects their own knowledge and practice and is analysed through the lens of their experiences.

2.2 Design & Procedures

A cross-sectional qualitative interview method was used, seeking to explore the experiences of service users in FMHS of physical healthcare treatment.

Qualitative research methods were considered to be most appropriate for addressing these aims as they are concerned with the meaning making and experiences of the individual in relation to a specific event, using a framework to understand the range of responses (Alderfer & Sood, 2016; Harper & Thompson, 2012; Willig, 2008). Quantitative research would benefit from larger numbers, and therefore potentially capture a wider range of perspectives; however a small-scale qualitative sample reflects the purpose and aim of the study. In qualitative research samples of six to fifteen are more usual and consistent themes are present as early as 6 interviews and significant numbers of new codes are usually not found beyond 12 interviews (Guest, Bunce & Johnson, 2006). As recruitment was from a small population in an under-researched area obtaining rich and useful data should be possible using small-scale qualitative methodology.

2.2.1 Research Setting

A High Secure Hospital situation within Mental Health NHS Trust was used as the recruitment site. Initially, a total of four teams were contacted within four NHS Trusts. Of these two did not respond to the research request and one was unable to continue with the research request due to staff changes at a later point in the research. These FMHHs were of medium and low security. These hospitals have various levels of engagement with staff, space, access to the community and local services. Initially it was hoped to recruit participants from across a range of secure services (such as high, medium, and low security) to ensure findings were not service specific. However, high secure services offered more participants who met the inclusion and exclusion criteria, and it was felt there would not be enough participants within the one medium secure hospital to adequately examine a difference between experiences in different settings. Therefore, the research focuses on High Secure Services. The High Secure Service offered support in the identification of participants and orienting the clinical teams towards the study.

2.2.2 Recruitment

The process for identifying and recruiting participants.

1. When ethical approval was granted by the NHS Research Ethics Committee (REC), Health Research Authority (HRA) and Research and Development teams (R&D) in the NHS Trust, the Local Collaborator (LC) then identified 'suitable' participants. 'Suitable' is based upon the clinical judgement of the LC, with the inclusion criteria acting as a guide. It was acknowledged that the 'suitability' of the service user may change depending on their context (i.e., if they or a family member became seriously ill during the research period) and the importance of clinical team and LC involvement and communication with Chief Investigator (CI) enabled this to mitigate any distress (suitability will be discussed in 2.2.3 as it relates to the inclusion and exclusion criteria).

2. Local Collaborators spoke with potential participants and gained verbal consent to be contacted by the CI.

3. The CI sent the participant information sheets with an invitation letter and awaited their contact or made direct contact (if requested by the LC) with potential participants to inform them of the research.

4. Potential participants could then contact the CI through their clinical teams to indicate interest. If no contact was made indicating interest in participating or requesting further information within two weeks of the invitation letter being given it was assumed the Service User did not want to participate.

5. An interview time was made and confirmed (either in person or via letter).

During recruitment participants were offered monetary compensation of £10 to reimburse them for their time. All participants who took part received this through the hospital account system once their interview was completed. The decision to offer £10 was reached as a reflection of what they could earn in work placements within the hospital for the same time contribution.

2.2.3 Inclusion and Exclusion Criteria

All participants had to be Adult (18 years or older) male service users within FMHS. Services users were not specifically sought on the basis of any specific clinical or demographic characteristics.

The principal inclusion criteria were:
- They must have been in receipt of FMHS for a total of 8 years or more at any level of security.
- They could have transitioned through security levels (i.e., moved between high, medium, or low) in any order.
- They had the capacity to consent to research on their experiences of physical healthcare, as determined by a member of their clinical team.
- They had been in the current FMHS for a minimum of 3 months.
- The team did not feel that participation in the study would impact negatively on their mental wellbeing.
- They could speak and read English.

The inclusion criterion of eight years was chosen as it is above the average length of stay in high secure services. It was felt their experiences would be important as they are most affected by longer term restriction, and it is thought physical health changes would be more likely. This means that any outcomes or ideas would benefit those most affected and all new service users moving to or from high secure services. The ability to read and understand English was necessary due to the practical and financial constraints of having an interpreter present, and that the experience of non-English speaking Service Users may differ significantly more (this will be discussed further in the limitations of the research under chapter 4.0).

The principal exclusion criteria were:
- If it would be traumatising to discuss physical healthcare provisions due to life threatening or ongoing physical health conditions. The possible impact will be discussed with the Service User and clinical team before participating.
- Those felt to be 'high risk' by their clinical teams where it may affect the safety of the researcher or staff.

2.2.4. Participants

Single semi-structured interviews were conducted with Service Users in a High Secure FMHH in a West London NHS trust. Thirty-five suitable participants

were identified from nine wards, three wards did not respond to the research request.

Of the suitable participants identified nine were unsuitable at a later point due to an increase in risk identified by the clinical teams and LC, eleven declined to participate, four agreed to participate but declined or were unavailable at the scheduled interview time, one was transferred to another hospital and ten took part in the research. Following the research one participant was identified as unsuitable as he had spent time in a prison between hospital stays. He was compensated for his time and his interview was not included within the analysis.

The participants in this study resided on different wards within the hospital, with five participants on a rehabilitation ward and three on a high dependency ward. One participant was recruited from the intensive care ward; however, this type of ward is not consistent across all high secure services. From the nine participants, seven identified their ethnicities as white, white British or white English, one identified as black Caribbean and one identified as Italian. For the purposes of the study a breakdown of patient demographic information for individual participants has not been provided to protect the anonymity of participants due to the small sample size. See Table 1 for further demographic information.

Table 1

Table illustrating length of stay and age of participants

	Minimum	Maximum	Average
Length of Stay in a High Secure Forensic Mental Health Service	2 years, 8 months	25 years	13 years
Length of Stay in all Forensic Mental Health Hospitals	10 years	40 years	18 years, 11 months
Age of participants	31 years	67 years	45 years

2.2.5 Data collection

1. At the interview the CI discussed participant information and gained informed consent via the consent form (see Appendix B & C). The

participant was also asked to complete the short demographic questionnaire (see Appendix D). The debrief information sheet (see Appendix E) was also discussed as a precaution in case the interview was terminated early. At this time participants were informed any risks identified would be communicated with the LC of their clinical team.

2. When informed consent was obtained the interview proceeded using the interview schedule and was audio-recorded. Interviews were 60 minutes in duration to reduce the possibility of distress, fatigue or feeling overwhelmed. If requested the interview was conducted in smaller portions (i.e., two interviews of 30 minutes or three interviews of 20 minutes). This was requested by four participants. The total meeting time (including consent, interview and debrief) did not exceed 1 hour and 45 minutes and no more than five meetings.

3. At the end of the interview the participants were reminded of the debrief information sheet, given an opportunity to ask any further questions and the CI identified any risk issues (i.e., disclosure of significant risk to self or others). If risk issues were identified the participant was made aware the CI would speak with the LC or the clinical team to ensure their safety, however no risks were identified throughout the research.

4. Interview audio recordings and all documents were then stored securely. All paper documents were kept in a locked location (on site where possible and moved to a locked location offsite when necessary) and were not stored with identifiable information to maintain anonymity. More details regarding audio recordings are provided in 2.2.6.

2.2.6. Interview Schedule

Semi-structured interviews were selected as they allow participants to speak freely and flexibly about their experiences by providing a loose structure (Smith, 1996). The development of the questions can bias the information being sought as it shapes the discussion and may imply to participants that there is an expected or desirable response, however it also allows the participant to choose what information they share and maintain their individual boundaries with the researcher (Hammersley & Gomm, 2008).

The interview schedule was developed based on the research questions, initial literature reviews and consultation with clinicians and services (see Appendix F). A pilot interview was conducted with a lay person to ensure that the proposed questions promoted a natural conversation and the language used was accessible. The interview schedule was also reviewed by the Local Collaborators for their professional opinion on the suitability and structure of questions. The interview schedule was reviewed regularly for language, question structure and ease of understanding.

It was decided to include general questions to obtain the participants' understanding of wellbeing and other concepts rather than providing a definition. The reason for this was to see how this differed between participants, both in relation to the existing literature and to facilitate a deeper understanding of the experiences they spoke about. To facilitate discussion of such broad concepts, participants were asked for examples.

The interview schedule was used as a tool for the interviews, rather than a fixed set of questions, to allow for flexibility in the participants' responses and facilitate collection of rich data.

2.2.7 Recording and Transcription

All interviews were recorded using a Dictaphone approved by the hospital. The audio recording was then uploaded to a computer on the NHS Trust network for transcription, the file was password protected and not saved to any Virtual Private Network to comply with the security of the hospital. Participants were informed that the interviews would be audio recorded to support the transcription process as part of the consent to participate. The interviews were transcribed by the CI on site. Thematic analysis does not necessitate detailed transcription methods, so the transcription was at a semantic level (Braun & Clarke, 2006). All potentially identifying information was removed during transcription and names were omitted. Once anonymised the transcripts were stored securely using encryption and password protection, on a secure Virtual Private Networking System.

2.2.8 Thematic Analysis

The data was analysed using thematic analysis. Thematic analysis can be conducted with different epistemological positions as it broadly seeks to identify themes within the data (Braun & Clarke, 2006). As the research takes a critical realist stance, the themes and analysis presented does not form an absolute truth and will be one interpretation of the data and experiences told. Furthermore, there have been few studies exploring the impact of physical healthcare within a high secure forensic hospital; therefore thematic analysis was selected due to the novel nature of the research and flexibility of the method. Other theories, such as grounded theory and interpretative phenomenological analysis, were considered but the primary focus of data gathering was to broadly explore the individuals' perspective rather than deriving theory or interpretation of the experiences.

Themes and patterns across the data were identified using Braun and Clarke's (2006) method:

1. Familiarisation with the data through the process of reading and re-reading the data
2. Generating initial codes within the data using a coding framework.
3. Searching for themes within the codes. Braun and Clark (2006) identified a theme as a coherent and meaningful pattern that summarises the data relating to the research question, therefore noticing unifying features that came together to create an initial set of themes.
4. Reviewing and refining themes against the coded extracts and entire dataset to show a relationship between and within them.
5. Defining and naming themes to capture their meaning.
6. Reporting the themes using extracts and quotes which represent the theme well

Themes can be inductive and derived from data or deductive and derived from theory. As a research method it is flexible and applicable to a range of research questions and uses by the researcher. An inductive approach was used in this study as it was not felt there was a strong theory to deduce themes from and it was intended that the data would serve as the basis for the research. Data was

transcribed and analysed at a semantic level, using the participants' words directly to illustrate the themes more richly.

See Appendix G & H for an anonymised extract of the transcript illustrating the initial coding and coding table. Appendix I shows the development of themes using thematic maps using the coding table.

2.3 Ethics and Safety

Ethical approval was sought and obtained from the NHS Research Ethics Committee and HRA (see Appendix J). The research was carried out in line with guidelines from the British Psychological Society's (BPS) Code of Ethics and Conduct (BPS, 2009) and the NHS HRA guidelines.

2.3.1 Participant Wellbeing

Although the study was not expected to cause harm it was considered that discussing physical healthcare may cause emotional distress for some participants. The researcher sought to minimise harm and distress by collaborating with the LC and clinical teams in the identification and ongoing assessment of suitability due to distress or risk. The participants had the right to withdraw at any stage and during the informed consent participants were given a clear understanding of what questions might be asked. Questions were asked in a sensitive manner, and an assessment of risk and their wellbeing was conducted at the end of the interview. Participants were also provided with sources of information and support via the debrief form.

2.3.2 Participant Involvement

Involvement of service users, carers and members of the public were thoroughly considered as an ethical and valuable element of research; however, it was felt this would not be possible within this research. It was thought that only service users within a FMHS could truly support the design of this research, as this is a novel area these are the participants we are seeking to recruit. It was not possible to identify any service users at the research sites due to needing ethical approval and length of the study.

Furthermore, there is no funding for training and supervision for the active involvement of service users, carers, or members of the public to be involved. For participants it was thought they may have strong reservations concerning other service users participating in the research due to confidentiality and anonymity. As the timescale of the project would not accommodate the groundwork of breaking down these barriers and establishing trust it was decided that this would not constitute meaningful collaboration.

2.3.3 Power

Due to the nature of forensic services, the physical environment and structures and policies there is an inherent power imbalance between service users and staff. Research within forensic services will hold some imbalance of power, such as the role of chief investigator and service user is one of imbalanced power. Therefore, truly informed consent will be difficult due to the coercive environment. To minimise this service users will be given multiple opt-out points and informed the research will not affect their care or progress.

2.3.4 Informed Consent

An information sheet (See Appendix C) was given to all participants and was verbally explained to them to ensure their understanding and comprehension. This included information about the project, their right to withdraw participation, data management, recording, and storage. Participants were reminded of their right to withdraw before and after the interview.

The impact of learning, education attainment and comprehension were also considered when obtaining informed consent. This is particularly important in forensic services due to literacy levels and educational attainment often hindering understanding, which may impact access to physical healthcare. Faulkner (2007) identified small changes, such as replacing the word "consent" with "agree or disagree", which impacted understanding positively. Patenaude (2004) reports that academic language can harm rapport in prison due to the use of words that may imply inequality between groups, or due to use of words such as 'informant', which may hold a different meaning within forensic settings. Also, how individuals are referred to can affect engagement; Shaw (2014) found that the preferred term for the majority of people within secure mental health

services was patients rather than service users, despite this being the widely accepted academic term. For the purposes of the research the term Service User was used when applying for ethics and in academic writing, but if a participant expressed wanting to be called 'patient' then this was adhered to.

2.3.5 Data Collection, Management & Storage

The study was conducted in line with the Data Protection Act 1998 and General Data Protection Regulation (GDPR) using a protocol to ensure the safety and anonymity of participants and their data. All electronic data was stored using encryption and password protection, on a secure NHS server or Virtual Private Networking System (such as the University's cloud-based storage). Data recordings did not leave the hospital site and, once transcribed and anonymised were deleted. Any personal or contact information was destroyed unless a summary was requested. This will be destroyed following examination of the research project. Anonymised transcripts will be kept for up to three years after the research has been completed before deletion.

2.3.6 Anonymity

To protect participants identifying characteristics and personal information (i.e., name) was changed or redacted in the transcripts. After interviews participants were given a number to identify them for the body of work and any dissemination. Any information that has not been analysed was not disclosed to the hospital or care team and participants were informed, once collated and analysed a summary would be produced for the hospital. If any risk issues were identified participants were informed this would break their right to anonymity as it would be shared with the clinical team to ensure their safety.

Interviews took place on inpatient wards in interview rooms and service users may be reluctant to engage due to the fear of others seeing their engagement or staff knowing of their engagement. Participants were informed of where the interview would take place and whether the entrance, door or room was visible. This may have affected true anonymity and is a consideration of research within forensic settings.

2.3.7 Safety of the Interviewer

As part of the recruitment and participant criteria risk to the researcher was considered and only 'suitable' participants were invited to take part. Due to the nature of the service the researcher had to undergo safety training including physical breakaway tactics and maintain personal safety on inpatient wards. Participants may view the researcher as aligned to the forensic mental health hospital or mental health services, which may hold negative connotations or hostility due to their experiences. The procedures and communication between the CI, LC and clinical teams aimed to minimise any potential risk.

2.4 Reflexivity

Reflexivity is imperative to the reflective practice of the research during and after research is conducted and was implemented to maintain as much objectivity as possible. As acknowledged the researchers hold their own position and view within the world, and the research will be conducted through this lens and shape how their conduct and interpretation of the data (Braun & Clark, 2006). This bidirectional relationship between research and participant needs a reflective and interpretative response by the researcher, resulting in reflexivity (Alvesson & Sköldberg, 2000). Reflexivity allows the researcher to consider the impact of them within the research outcome.

To ensure the integrity of the research process, transparency and introspection are needed to examine pre-existing and influential relationships (Willig, 2003). Reflexivity is key when using a critical realist epistemological stance to safeguard as much objectivity as possible, although true objectivity will not be possible, it is better when these biases are acknowledged. As a critical realist stance was adopted this research offers one perspective and interpretation and does not seek to make generalisable truths about patients' experiences of physical healthcare in a FMHS. This is through my context, as someone who has worked in FMHS and a Trainee Clinical Psychologist.

At the start I considered my own biases and influences. I have previously worked in forensic mental health services, as a healthcare worker, rehabilitation worker and assistant psychologist, across low, medium and high secure services, and the prison service. I felt this experience placed me in a

knowledgeable position of the services and how they operate which would help me navigate and approach the research. My experiences growing up, of my father who was a prison officer, showed me the inherent power imbalance and a negative view that often exists about people in forensic services. This was a motivating factor for me working within the field but also for wanting to conduct research. Seeing difficult professional practices and cultural milieu deepened my desire to want to create change and empower SUs.

In my roles in these services before I often feel helpless, powerful and powerless, anxious, angry and dejected when hearing about individuals' experience, this was alongside times of hope and connection as well. I considered my position as someone outside and within the service, as someone with knowledge but no longer a part of the system and not someone who is directly affected by the system as SUs are. This led to how I wanted to approach the research and develop it with the SUs voice centred, as well as the topic which is something that relates intricately to human rights and quality of life. My ultimate hope was to open up discussions on treatment within these services and attitudes that may exist and damage the people residing in them.

3.0 ANALYSIS

This chapter presents the themes generated from the participant interviews regarding physical healthcare in forensic services.

3.1 Key Themes and Analysis

The themes have been organised within Table 2.

Table 2

Themes and Sub-Themes

Theme	Sub-Theme
"As the saying goes, a healthy body is a healthy mind": Wellbeing and the Individual	Meaning of Wellbeing
	Physical and Mental Health Link
	Individual Aspects of Wellbeing
"It has its own rules": Being in a High Secure Forensic Mental Health Hospital	Restrictions
	Living In High Security
	Medication and Side Effects
"It is pretty poor if you're in a psychiatric hospital and you went down with a physical illness": The Role of the System and Staff	Expectations
	Integration with Primary and Secondary Care
	Staff Approach

3.2 "As the saying goes, a healthy body is a healthy mind": Wellbeing and the Individual

This theme summarises participants' general understanding and engagement with wellbeing as it relates to physical and mental health. Their meaning of wellbeing was elicited at the start of the interview to draw out a broad understanding amongst patients within a high secure FMHH. As interviews

progressed physical healthcare concerns, challenges engaging with physical healthcare due to their mental health, and the interaction between physical and mental health and individual mediators of engagement emerged that added to their experience of wellbeing.

3.2.1 Meaning of Wellbeing

Participants generally characterised wellbeing as an overall positive feeling or absence of negative impacts in multiple areas.

> *Wellbeing, to me, stands for how well is someone's mental state, their physical state, their psychological, spiritual, even, that's what I think wellbeing means to me. It's how well and how good do you feel in yourself. (P8)*

> *Free from ailments. (P3)*

> *Just how you feel, how well you feel, in all areas of your life probably. (P9)*

P3 characterised wellbeing in negative terms – the absence of ailments leading to wellbeing – whereas most other participants saw it as having a good feeling or adding to their life. Many participants mentioned physical and mental health specifically to mean or be associated with a state of wellbeing.

> *Well it means how you feel inside, both physically and mentally. Just like general day to day how you feel. (P6)*

> *Well, it comes in 2 forms physical and mental. Mental being emotional and um essentially positive, and healthy, and physical as in physically well, and nothing untoward or different from what is the norm. (P2)*

> *Wellbeing is a mark of surviving successfully, so if you're physically well and you are mentally free from abuse, that is what I would describe as a happy state, that is wellbeing. (P5)*

P10 linked this to behaviour, such as a healthy diet, which creates a sense of comfort and wellbeing. Many participants linked behaviours to health, health living or physical wellness but did not directly link or think of these behaviours when discussing the concept of wellbeing. It was often hard for participants to elaborate on their initial explanation to define wellbeing, however some would give examples of what would bring them wellbeing such as being looked after, being well comparatively to others, being able to handle psychological pressures. When asked if other areas of life contributed to their sense of wellbeing common responses included spirituality, contentment, and relationships as adding to this although it was not in their initial interpretation of the word.

> *Wellbeing meaning being comfortable how you are, a healthy diet, healthy mind and that, sort of, seeing yourself outside looking thinking 'oh, is he fit, is he well?'. (P10)*

There could be several reasons why participants found it hard to elaborate further; generally, it is difficult to define abstract concepts for most people and the circumstances of an interview can add to this, such as confidence to express thoughts or not wanting to be wrong. Additionally, the impact of language within in a mental health service where wellbeing may be spoke of as a goal (i.e., good mental health, recovery, being well). This may leave less room to acknowledge the challenges to wellbeing or more personalised views.

3.2.2 Physical Health and Mental Health Link

Although there was some uncertainty of what wellbeing meant many felt psychological or mental wellbeing was linked to physical wellbeing and they would impact each other. This was sometimes seen in the way it was compared or connected to the participants.

> *I think they are interlinked, I think they are interlinked and one affects the other, you know you can be unwell inside and still be physically fine, or you could be well inside and physically bad. (P6)*

There's a connection between the various stated of body […] as the saying goes, a healthy body is a healthy mind, so um, if you have psychological damage or trauma it can have influence on your muscles, tension in your muscles, and erm, that's just one example yeah. (P8)

I suppose if you are not feeling that good mentally, you are probably not doing,- take your health maybe that seriously and if you are feeling good about yourself in your mind, you are probably more healthy and fit. And I think vice versa, the opposite as well if you not, you know not healthy or feel fit you probably, your mind isn't that good so it all links up. (P9)

Those who felt physical and mental health were more balanced in their influence of each other referenced historical trauma and physical trauma specifically, with one participant speaking about his experiences of violence and harm during an event that caused great physical and psychological distress and another who had had major surgery within the last year.

Yeah, even negative emotions can have an impact on the physical body […] Some people suffer from PTSD, post-traumatic stress disorder, even I- I, um suffered from PTSD many years ago because I was assaulted a few times and it left me scarred with bad emotions, you know. Sometimes we- the psychological damage that we incur within parts of our lives can lead to tensions in the muscles, that can lead to trapped nerves, so I've been told, yeah. (P8)

3.2.2.1 Mental Health Facilitating Physical Health: Most participants felt their mental health had a greater impact on being able to engage with physical health. A few linked this to talking therapies and psychological input directly, by reducing anxiety and feeling calmer it improved their physical health.

I have done so many different therapies, it is untrue, for 4 weeks to 22 months to 9 and half years, so I have done a fair amount of therapies which helps me psychologically, and I suppose in that effect it helps me physically as well so I can do more […] If you are physically unsettled

chance are you are going to be psychologically and emotionally unsettled as well, the two go hand in hand sort of thing. (P2)

If your mental wellbeing is good you tend to focus on the physical side as well. (P7)

If you don't have your mental health you wouldn't have your physical health. (P8)

Participants also felt having psychological support if physically unwell was useful to improve mood or worries, and whilst they had engaged with all staff psychological input was valued or identified as being helpful in managing physical health.

When I feel unwell I get depressed and go into my shell. (P3)

I talk to [psychologist][…]I told her last week and she was very concerned, I told her how I was feeling[…] knowing it can end your life, that's why I'm worried. (P4)

As a mental health hospital there may be a focus on psychological and emotional wellbeing that prioritises the impact of mental health on overall wellbeing and increases access to psychological support.

3.2.3 Individual Aspects of Wellbeing

As participants explored personal experiences of health and wellbeing they spoke about individual factors that influence their engagement with physical healthcare.

3.2.3.1 Ageing, Health Concerns and Institutionalisation: Some participants, when asked if they worry about their physical health, reported they were and the impact this had. Often this was for individuals who have had or have ongoing physical healthcare needs. Some of the worries related to the hospital not supporting them adequately, a health condition worsening or developing a health condition.

Not worried maybe a little bit concerned, one of the dieticians said I was borderline diabetic, so that something to think about, some nasty things can happen to you if diabetic, it is not worth the chocolate and biscuits. (P2)

Yeah I worry, I feel weak, I feel light-headed, I feel tired, aches and pains in my body. I had [health condition], and I'm worried about it coming back or it has come back. I feel worried right now, something is not right. (P4)

Yeah, yeah I was very scared I would get diabetes and now I've got it you know. (P8)

While others acknowledged they have worries but felt relieved by making efforts to be healthy.

I don't think about it too much, but occasionally if you see something on TV or in the paper it reminds you […] everything is unhealthy you know isn't it... It is bloody difficult, you try your best but you can't be perfect. (P9)

A few participants expressed not being worried about their physical health at all due to not holding enough value for their life and not viewing physical health needs seriously compared to his mental health needs.

I am not worried about my physical health because, I mean I would like my lungs to be fine, if I am not over exercising they are relatively okay. But I don't value life, not my life, so if I were to die of a physical complication it wouldn't bother me. (P5)

You have to grin and bear it. I broke my foot a while ago and had to have a cast on my leg and just came through without complaint. (P3)

Both expressed the impact of being detained affected their views. P5 expressed the deprivation of enjoyment meant his life was not worth valuing as highly as

gaining freedom where his quality of life and its value. P3 linked his approach to being resilient and not showing pain to others, including staff. Both of these participants would like good physical health though and still felt it contributed to wellbeing, however the motivation to adopt those behaviours is lower when psychological wellbeing declines.

Concerns about physical health, ageing and being in FMHS for long periods of time were articulated as contributing to their concerns. Some attributed some of their health concerns to their age, such as diabetes and muscle aches, and others expressed concern their health may change.

Well when I first came here I was quite young, so there wasn't really much wrong with me physically, but am I getting old I get these issues like eyesight issues, potential diabetes situations and going to hospital for a few operations sort of thing. (P2)

I am generally physically well, I don't know if that will change. (P3)

Well normally it's nice to be physically healthy, you don't think about what is going to happen in 10 years […] but there are tragedies, there is conflict, changing circumstances, changing realities which affects you mentally. (P5)

Concerns about ageing and length of stay within FMHS were mostly articulated with older participants or those who had remained in High Secure Services for most of their detention. Younger participants, despite being detained for an extended period, had moved between levels of security more and referred to their health changing once they left so may not view themselves as ageing or part of the long stay population as readily.

3.2.3.2 Motivation and Barriers: Many participants were aware of what the hospital offered and what would improve good health (i.e., attending the gym, good diet and sleep). This was met with a desire to engage, such as "trying", "wanting" and intention towards these actions that indicated a motivation to be healthier.

I haven't exercised now since May 2018, which is just over a year ago since I last exercised… I do intend to start exercising again, but it's tough to start really, once you are off to a start it is not too bad, it's getting that start. (P2)

I try to walk, go for a walk everyday although sometimes I don't manage it. (P9)

I try to eat more healthily, and um, I'm going to restart going to the gym very soon. (P8)

If you are interested in exercise you can do it, or you can do it by yourself (P5)

When asked what got in the way of their intent some said it can depend on how they are feeling each day or difference in their mood and the schedule which resulted in inconsistent engagement.

Sometimes I do and sometimes I don't, it just all depends, what, how I am feeling in terms of energy and stuff you know, I do take medications which affect my,- not so much my mental wellbeing but my physical, medication does have an effect on that. (P6)

Barriers to acting in line with participants' motivations and desires were largely viewed to be internal such as viewing change as necessary, self-talk and self-encouragement. Largely, staff were reported as being encouraging and positive when offering exercise and dietary changes. A few participants explicitly stated their mental health could get in the way of going to activities, such as feeling low or anxious.

When I first came I was going to the gym like 5-6 days a week, it wasn't just like weights, it was swimming, it was cricket, it was football, it racquetball, it was like, I used to do it all, and then my mental health took quite a big dip […] my confidence and my anxieties gone quite high, my

confidence has gone quite low and my anxieties is quite high, so it's something I'm working on. (P7)

I think for me like, you know, I kind of fluctuate with my mood […] so I might spend like, I might start spending, I do this quite a lot, I might start spending like 12 hours laying on my bed watching TV, because I'm not motivated to do anything because of my depression and that you know. (P6)

They've tried to improve dietician input, they've tried to involve the gym a lot more, so I think they have improved, they have the [weight reduction] programme, I've asked for it but there's a waiting list for that, they did offer but then I said no as my mind wasn't ready either (P7)

Importantly participants suggested this is variable and at times motivation and the barriers can be more present or wane. Factors that enable access can both help and hinder motivation, with the schedule of activities being fixed on some wards or areas and fluid depending on staffing in others. Some participants cited flexibility and/or structure as being helpful to engagement and building motivation. In FMHS fluctuation in motivation and mood can be common and may hinder how they are perceived to be engaging.

3.2.3.3 Individual Responsibility: Whilst FMHS were identified as having responsibilities and a duty of care, the notion that individuals have a responsibility for their health was prominent amongst some of the participants. This was linked to engagement (as in choice and free will), building motivation or living with the consequences of choices.

I spent years blaming other people but eventually you have think 'well get a grip of your life, take some responsibility, if you're going to eat pudding and crisps everyday you're going to put weight on'. If you're comfortable with that, you're comfortable with that. It doesn't affect anyone else, it affects yourself. So like, yeah. (P10)

Some linked their responsibility to their own healthcare and wanting to change how they feel physically.

> *I decided that I much rather be a lesser wright than I am now so I stopped doing it. (P2)*

> *Well after I had smoked for 10 years I said 'it is getting dangerous now' so I put down cigarettes. (P5)*

> *Motivation? Just to keep my weight down and bit of exercise really, I am not massively into lots of exercise but I did use to do a lot of exercise when I was younger, but it sort of er, I over did it, so, but a small amount of exercise is good I think. (P9)*

Engagement with health initiatives on offer was viewed as a choice; at times this was linked to who holds the responsibility for healthcare being a balance between both the hospital and individual (offer and acceptance), however as the hospital cannot force engagement the individual ultimately decides and has responsibility for their health in this way.

> *I think it comes from the patient internally and the hospital could go "arrrr why don't you do this, why don't you do that", cos they can't say "you are going to do this, you are going to do that", they can't do that because that wouldn't be right, but they, so they say, they word it like "why don't you do this, why don't you do more of that" and then it is down to the patient then, the patient can go like "yeah" or "whatever", you know, or just "nah I'm aright thanks", you know. So they might come say to my door for a gym sessions, "Do you want to attend the gym session?" and I will be like "nah I'm alright thanks". Do you see what I mean they can bring it but,- you can lead a horse to water but you can't make them drink it (P6)*

> *So then it comes a time when you can stop blaming other people and take responsibility and make changes in a positive way rather than thinking 'well I'm just going to eat this and do that because I feel good*

right now' it's not really thinking of your future, your family, or whatever you know. (P10)

They can't force you to. It's up to the patient whether they want to do or not […] I think it is alright as it is, they come on the ward and ask patients if they want to do things. (P4)

3.3 "It has its own rules": Being in a High Secure Forensic Mental Health Hospital

The biggest theme to arise during discussions was the impact of being in a secure mental health hospital on physical health and wellbeing. This theme encompasses the challenges of being in a high secure FMHH and how patients view the hospital environment.

3.3.1 Restrictions

Within a FMHH patients are restricted in many aspects of daily life and will have many infringements to their physical being and psychologically. Participants spoke of blanket restrictions in place for security, safety, routines and diet that impact their physical wellbeing. There was an acknowledgement that some people will have different experiences depending on their ward and individual care needs.

I think it is personally, you know, but it is restricted to a point because we are in a high secure environment and there is only so much, you know that they can permit safely like […] everything here is risk assessed [...] my experience of the hospital might be very different to somebody else's you know. (P6)

Some spoke about the hospital restrictions in terms of preference, with acknowledgement for the reasons behind security and restrictions but if in lesser security or the community with greater freedom life and health would be better.

Perhaps in the environment,- as this environment is quite restrictive, we do get a choice., we get a choice of meals but I would much rather do my own cooking and eat healthier that way[…] It would be a lot easier on the outside. (P2)

Participants commented on the restrictive nature of the hospital increasing overtime.

Erm, I think it is not too bad, but over the years it is slowly becoming more restrictive, so it is quite restrictive, err, well it's not too bad, it depends what you want from life really. (P9)

3.3.1.1 Diet: Diet was noted amongst most participants as being something restricted, limited or lacking freedom which impinged on daily life. To improve physical health, restricting access to unhealthy foods has been changing gradually.

The food has been changing gradually. As for physical health care in gym and all that, it used to be less formal and when they try and regiment everything, create slots for everything it loses it spontaneity, I much prefer a free and easy system. (P5)

Many years ago the shop canteen was great, it was better than any shop canteen I'd ever been to but over the course of 8-7 years it's been very limited, restricted as to what we can buy and so on. (P8)

This has meant limits of 'unhealthy' foods such as chocolate and crisps, which some did not mind and others.

I have heard the limit, of what amount and it seems quite, not too restrictive it is quite, it is more than I would eat but, I think they try to be, you know, it is an NHS hospital I can understand they need to try and do something. (P9)

It's poor, there's not a lot, 'cause of this obesity epidemic, crisis or it's what they call it, that why the hospital has limited us as patients to what we can and cannot buy. (P8)

The source of these changes was often seen to be the dietician and the hospital, whilst acknowledging it may be to tackle obesity, many felt it was too strict and took away simple enjoyment for patients.

In [hospital] when it comes to food it's all down the dietician really, a lot of power they have, the dietician, she's too strict. They come in here, they have all these rules, the shop gets scared, dietician is involved, the café gets scared, the dietician is involved, every time you ask the shop "have you go this?" they say "no, the dietician said we can't sell it anymore". So it all comes back to the dietician. (P4)

They always have some idea up their sleeve, because you have these larger guts [hits stomach] they say they want a healthy diet so they stopped us having extras, you can't have extras now. More recently, the last couple of months they stopped puddings, you have small round yoghurt that is about all, and I got someone to ask at the food forum why they were not doing puddings, we had puddings reinstituted, and they said it was to keep you healthy, it's a load of, they just try and punish you anyway they can. And if it's not a whole meal, you don't enjoy the food the same way, simple they can just have a random meal they use to. So I don't know what you can do, it's pretty hard. (P5)

The restrictions indicate the role the hospital have in promoting wellbeing along with offer choice and respecting individuals' decision making.

3.3.1.2 Routine: The routine of the hospital was identified as detracting from spontaneity and freedom of participants. Spontaneity and flexibility were coveted as adding to quality of life and wellbeing overall, as well as creating more opportunities to engage with healthcare in an individualised way.

Erm, well all of sudden I'm tempted to eat supper in the evenings, because I've just eaten an hour or two before, can you imagine tea at 5 finish at 5.30, they normally do supper here about 10 o'clock which I would normally partake, but I have stopped doing it now, plus I have been trying to eat more fruit. (P2)

You know there is that element of you know spontaneous, spontaneity, there is that like, there is nothing much spontaneous here everything's like you know, this is your food at this time, you know, this is where you go to work at this time, everything is kind of set out. (006)

Some felt the sedentary, repetitive nature of the hospital added to feelings of lethargy and disengagement. Lacking control in aspects of daily life, such as routine and food was seen as boring, frustrating and encroaching on joy.

Outside there is not that sterile control it is a bit more fluid, yeah it is a bit more interchangeable and all that, lots different things can happen, but mostly on here it is like you pretty much know what is going to happen from day to day, so I wouldn't quite say it is Groundhog day, but it is not far off, we live the same day, I wouldn't say I live the same day but I live the same week, cos it's my same routine every week, so I kinda live the same week you know. (P6)

Some participants linked routine and flexibility to motivation, however it also seemed to be a feature of a FMHH that felt restrictive additionally. Harmonising choice, control and flexibility appear to be challenges within FMHS whilst affecting patient engagement.

3.3.1.3 Availability and Choice: All participants indicated the hospital offered ways to engage with physical exercise and health, which was a positive reflection of the hospital.

They offer a lot here, [hospital] are very good with that, they encourage everyone to exercise, [hospital] are very good like that when it comes to exercise, so that's one positive attribute. (P4)

There is a gymnasium, they encourage us for that. And just generally cos we are like on assertive rehab ward, we are expected to have a certain amount of activities that we do, cos we are getting prepared to move on you see (P6)

Further, the hospital also provides information about healthy eating and menus to encourage decision making.

The menus say, they tell people what's healthy and what's not healthy and the calories of that meal so you know what you're eating is healthy or not, that's good, some patients won't change how they think though. (P4)

They've started putting in calories and healthy options on the menus, so it has got a lot better. So when you look it at you can see the calories and stuff, because I'm trying to lose weight, I'm trying to have less calories. (P7)

All participants recognised engagement with the offers was presented as a choice if available. The concept of 'choice' within a FMHH can feel limiting to the patients who may be presented with set options. This could affect how likely someone is to engage if the choices presented do not meet their personal interests or not wanting to engage with a service or system they feel is punitive.

The activities that they do would suit some people more than others you know, you might get some people that like the amount of activity that they are offered, like going to the gym you know like going out on the terrace all the time. Then you got the people that don't like that, are not interested in that you know. (P6)

You get OT coming round or training instructors asking if you want to attend. We actually had a timetable I was given, I threw it away as I never use it. It said all the different sessions they had. (P5)

They do physical health checks once a week […] only about a third of the ward have it done, not even that. (P10)

This may be experienced as a barrier and some felt there is less choice available now than historically which could discourage individuals who have been detained longer or lead to unhealthy choices through perceived lack of options. This particularly related to changes in food available at the shop and hot food to buy at the café. The reasons for this are linked strongly to hospital restrictions however many participants were dissatisfied with these changes and would therefore choose food based on what they liked or desired rather than health.

I think there is a lot less choice, exactly less choice it does seem to, not the best stocked shop, certainly when I first came here back in 1995 they, you could buy more or less anything. (P9)

I just mark down what I fancy, I don't go by the calories to tell you the truth, it's not really in big print, it's hard to see. (P4)

Inherent within these views is the notion that the hospital has to offer and encourage physical healthcare, but individual determinants also make a big difference. This highlights the aspects of power, coercion and fairness that may be balanced precariously within FMHS.

What the fact that you are detained, er, well I would like to do more, more movement and exercise yeah. Because I don't do much to be honest, but at the same time I don't believe it is good to go to the gym, lots of impact exercise it can damage your joints things like that, so that is a downside. (P9)

3.3.2 Living in High Security

Challenges to living in a FMHH impact wellbeing and health; particularly the environment of a High Secure hospital. This theme discusses barriers to access physical healthcare created by the environment, the lifestyle and emotional effect of detention.

3.3.2.1 Accessing Healthcare: Barriers to accessing and engaging with healthcare were a common threat throughout the interview, this encompasses those barriers that relate to the hospital environment itself. Systemic factors, such as integration of healthcare and staff attitudes that may also limit access, are discussed in 3.5.

While some participants were motivated and wished to engage in activities to improve health the restrictions and security measures are a prevailing force within their lives. All participants reported a range of services and facilities available, accessing the gym or facilities depending on staff training and availability.

> *You can't get to the gym as freely, you can't to the little off ward gym too as none of the ward staff are trained […] I don't go to the gym much anymore anyway, there's been times I've just wanted to go sit on the bike and just use the bike but I can't […] It's a little bit more difficult, it's lot more restricted. (P7)*

> *It would be quite good if they do have a little gym just off the ward, they do have actually the paddock gym on this ward, I was going quite regularly, but it was a bit inconsistent, they just didn't have a set time to come, so I just sort of stopped doing it really. But if it is regular or a particular routine of it I will go. (P9)*

Participant 7 resided on the intensive care ward with the highest level of security and restriction within the hospital; this may increase awareness of restrictions.

> *Yeah I had more access on other wards because the risk is a lot less, you can go to the place and there are other patients that do go but it's, again for me personally it's probably the anxiety. (P7)*

Compared to community services people did feel they had less access to care in a FMHS and being detained meant they were not provided the physical healthcare needed.

I use to believe that hospitals were there to help, so I accessed help and discovered it is written off condemned, and I don't see anyone hardly at the peak of physical fitness. (P5)

I don't think people are getting the right care here, when they're unwell. (P4)

If you hit something and it's really swollen, you go to A&E, here they wait, they play a waiting game. If that's community advice to go A&E why has it got to be that way for a high secure service, so that something that does change in, not just here, in prisons and other secure services as well. So I think sometimes the GP cares, I wouldn't say the GP cares a little bit less that some of the ones in the community, not all, not all, I can't fault the care that they've given me personally but sometimes I think I would be better off in the community. (P7)

Limits to access may mirror the limits they have to the outside world more generally as this is monitored, restricted and risk managed. However, participants did reflect that by being in a high secure hospital it changes the nature of care they receive and access to care on the outside world.

3.3.2.2. Fear and Loss: Many participants spoke about the environmental toll on emotions such as anxiety, loss and isolation which affect their engagement with physical healthcare. One prevalent theme was the fear and anxiety caused by meeting other patients and incompatible relationships which prevented them from attending the gym or activities.

They have a gym here which is only certain times of the week, and it is multiple attendance, there's not just the one ward, it is multiple wards in one go. Unfortunately there's a few people I don't get on with, so rather than risk it I don't go. (P2)

I went a while ago, erm, I did enjoy it, but it is just the, I don't like going in groups of people I don't really know, so er, but I mean when, I'm going to

*be moving to the new hospital at some time in the future, and apparently
I have heard that each ward has its own little gym, if that is the case I
will do more regular exercise. (P9)*

On many wards gym staff would collect groups of people from different wards to
attend the gym facilities, the participants reflected this was easier for them to
manage and meant more people could be offered sport and leisure facilities;
however, for some the feelings of worry or not wanting to engage with people
outside of their ward meant they would decline. This was reflected in other
comments about the patient group and the need for resilience to cope with the
environment.

*High Secure is different to a Medium Secure, trust me, in a lot of ways.
It's high security and the patients it holds here, I don't know but it has its
own fucking rules, a high secure hospital has its own rules. (P4)*

*I am a resilient sort of person. It helps me cope in an environment like
this. It's harder for other people. (P3)*

Another common emotional thread was a sense of loss – of relationships, small
joys and control that creates a barrier toward engagement with all aspects of
physical health.

*Yeah I suppose it was quite nice as you are locked up, you are detained
you don't have your freedom, so it is nice to have little treats and things.
I hope they don't take everything away, as we are detained so we need
to have a little bit of something. (P9)*

*Well when I had hope and I had friends I use to find that helped greatly in
my physical wellbeing, but isolated and alone and misrepresented at
times you feel, a lethargy, a loss of energy, I think the words inertia, and
obviously it effects how you function. (P5)*

3.3.2.3 Lifestyle: A high secure environment changes the pace and nature of daily life. Some of the quotes below illustrate how the lifestyle of being in a high secure was viewed.

> *I would say very little changes at [hospital], very little changes, you know it's been the way it's been for a long time, you know, so yeah I would say over a 5 year period there probably isn't any change at all. (P6)*

> *It's quite a sedentary lifestyle that is the only concern, but they do have the gym and stuff so, I am going to make more of an effort in the future. (P9)*

> *You know this is an extremely sterile controlled environment. (P6)*

Many would link this to motivation for physical health, getting in the way of goals for the future and affecting how they felt day to day which created barriers for them.

3.3.3 Medication

All participants mentioned medication in the interviews. This was something that impacted their health directly, they had witnessed side effects in others, or having to live with them to move forward. Many of the participants either had a health condition such as diabetes, metabolic syndrome or obesity or were being monitored for this. Some identified these as common health conditions as well as the risks of taking antipsychotics long term.

> *The only common ailments are side effects of drugs, but I feel my resistance is broken down now, it has got really bad in my intellectual functioning is breaking down. I used to have a clear head, a very good memory now I don't. (P5)*

> *There is one extreme in that it can kill me, that is one extreme, and the reason why it can kill me is because, Clozapine has a habit in the system of killing white blood cells, and white blood cells is your immune system so you know if it was to turn against me so to speak, and start eating my*

white blood cells I could die from a common cold. But it is extremely, extremely rare […] and you got weight gain and another big thing as well is it, it can contribute to someone becoming diabetic, it puts you at a higher risk and also puts you at a higher risk of heart problems, so them are the downs, but what can you do though you know, they have made it as best they can. (P6)

Whilst many participants spoke about the common side effects, acknowledging the risks and severity of these medications is important for the physical health of patients which was often viewed as the main reason for poor physical health.

Yeah, yeah but they're missing the main thing which is medication, medication is the key pivotal thing in all this, it's the reason why we put on weight and getting illnesses, physical illnesses, do you know what I mean, but they won't admit it. (P8)

In addition, some found it more challenging to address their physical health and overall wellbeing with the physical and psychological impact of the medication.

I would say my physical health is problematic, but a lot of us have wound up with spiritual and psychological pressures. I can handle psychological pressure, but not when combined with drugs. (P5)

3.3.3.1 Tiredness: Tiredness had a detrimental effect on participants feeling able to engage with healthcare or aspects of healthy living such as exercise.

It makes it worse, every day I have racing thoughts. I take medication but it makes me fucking tired. (P4)

For the majority of people, because most people are on medication they don't want to do a lot of exercise, you know. (P8)

Some felt the effects of antipsychotic medication last for many years and can create unhelpful cycles of medication changes, trying to do exercise and struggling which leads to weight gain.

*Most of us are on medication so we don't have the motivation to do
exercise or we feel too lethargic, or, um yeah, some do, some persevere
but every time they change someone's medication round it takes months
on end, sometimes even years on end to get accustomed to that
medication inside your bloodstream, inside your body and then to start
exercising again, yeah (P8)*

Tiredness combined with a sedentary lifestyle can make physical exercise
harder to engage with and perpetuates poor physical health.

3.3.3.2 Weight Gain & Hunger: Participants said hunger and subsequent weight
gain greatly affected their health and wellbeing. Increased weight was
observable amongst the hospital patients.

*Yeah a lot of us are on Clozapine, you will see some big lads like me on
the wards, you know cos, cos of the medication we take. It's not like we
are greedy and just you know, it's not about that, it's not greed it is about
we feel hungry a lot, you know. (P6)*

*I think, possibly patients have become more overweight, certainly more
incidences of diabetes, only from what I hear from other people. (P9)*

The hunger and appetite increase the medication causes was often cited as one
reason, as they found this difficult to manage and created an impossible goal.

*Difficult [laughs], very very difficult, I get so hungry sometimes I can't get
to sleep at night, but I am getting used to it. (P2)*

*Also medication increases appetite so you eat more than what you would
do if you weren't on medication. So of course you're going to put on
weight, because you're going to overeat, and it slows down your
metabolism some of the drugs so it's an uphill struggle to maintain a slim
figure or your original weight from when you first come into the hospital.
(P8)*

It's not easy, especially with the medication […] I'm on olanzapine, so I just wanna keep eating, so where I've been trying to focus on the physical side, so instead of eating junk I've been buying fruit, so I eat a lot more fruit. (P7)

But yeah medication, it makes you hungry as well which means you put on weight, which is then not good for your heart, you know, so that is another way as well, but they encourage us to go outside down there on the terrace, go for a walk and that you know. (P6)

Participants 7 and 6 specifically mentioned the increase in medication and impact this had on their weight, wanting to find a balance between mental and physical health.

I was, so I was on an injection every 4 weeks when I was aiming to control my weight and control my eating, then it got increased, the dose of it, and it got increased to every 3 weeks and I was on a higher dose as well and that was about 6 weeks 2 months ago and I've put on a stone since it's been increased, I was losing it but now I've put it back on. (P7)

What's changed for me again is my weight, I have put on a lot of weight again […] I was on Clozapine for 7 years there, and I put on a lot of weight, then they got us in to the medium secure unit and they wanted me to lose some weight, and they took me off the Clozapine, and I did lose a lot of weight but I started to deteriorate mentally and I have ended up back here and the doctors here put me back on Clozapine, which has resulted in me putting on more weight again […] but the trade-off for that is like inside I am feeling better, you see what I mean, so it is either stay off the Clozapine and be healthy, slim, whatever but feel like shit inside, or be happy inside and be overweight. Me and the doctors have decided together that it is better that I am happy inside you know […] I think what they were trying to achieve was probably unachievable, you know which is to have me like both physically well and mentally well, at the same time which was their ideal, but it didn't work, you know. (P6)

Overall some felt the medication was the predominant factor in their physical health and felt a sense of anger this was not acknowledged more widely by the hospital as a cause.

> *Yeah, I never hear the hospital managers or doctors say 'well we understand because of your medication you're putting on weight' they always blame the food the food the diet the diet and it's not necessarily that. (P8)*

This brings back to the balance FMHS have to ensuring good mental healthcare and physical healthcare when antipsychotic medication is used.

3.3.3.3 Diabetes: Of the participants interviewed, three disclosed they had diabetes and all others said they were being monitored or taking medication to prevent diabetes developing. When asked about medication side effects many discussed diabetes and their health concerns.

> *It wrecks you, wrecks you in here, gives you diabetes lots of things. I am borderline diabetic. (P5)*

> *I'm not diabetic, and I am quite a lot of points under being diabetic, I think I am 32, and I think diabetic is 38 or 39, but I get prescribed a drug called Metformin […] I take 1 tablet every day, and this is to prevent me getting diabetes before it actually, it is like a pre-emptive strike sort of thing. (P6)*

> *It has not prevented me from not getting diabetes […] so, I think it's the medication because the olanzapine converts food fast into sugar or into fat one way or another, or that's what I've heard. (P8)*

Some participants expressed their frustration over forced medication that causes health concerns and diabetes specifically.

> *Which is wrong they shouldn't give you diabetes, diabetes affects you in the long term, and they think that everything, the chaps got to be on*

drugs and they are forced in mass doses of these drugs they know they are not helping but they enjoy seeing you decline, and I'm here to psychiatric self-ignorant carriers. (P5)

Overall medication was deemed by all to have some impact on their physical health which was not always shared by the hospital or their care team. FMHS have a responsibility to ensure good care for both physical and mental health; the ethical and moral dilemma of giving medication with causation of physical health concerns is vague which creates mistrust for patients.

It is not good enough but that's because of the effect of psychiatric drugs, so there is nothing I can say that is going to alter it, nothing they can do to change it. (P5)

3.4 "It is pretty poor if you're in a psychiatric hospital and you went down with a physical illness": The Role of Staff and the System

This theme identifies what expectations patients have of physical healthcare, their experience of the integration between tiered physical healthcare services and the role and impact of mental health staff on their care.

3.4.1 Expectations of Care

Expectations encompass the patient's perspective of the dual role the hospital holds as a secure mental health hospital and the responsibilities to their physical health.

A few expressed they felt the role of the FMHH was to care for only their mental health, whereas secondary care services provided physical health.

A physical hospital looks after your body, mental hospital looks after your mind. They keep a close eye on me and stop me getting manic. (P3)

In general, most saw it as the responsibility of the hospital to look after both and could give examples such as regular monitoring, diet, exercise and accessing the healthcare centre as part of the physical healthcare package.

Because of the nature of the hospital, whilst this is a psychiatric hospital they all take of your physical as well and therefore you get looked after both physically and psychologically. (P2)

There's mental wellbeing and physical wellbeing, my overall health is being looked after that's what I understand it to be. (P7)

They all felt it was important that physical health was offered by their mental health care team as well as physical health staff specifically. Some saw the procedures and individual care planning as a holistic approach that ensured physical health monitoring happened regularly and was part of their overall care.

Because, when we have a CPA I suppose it is an opportunity then for them to give you an MOT so to speak and give you a once over, make sure you're alright, it is pretty poor if you're in your in a psychiatric hospital and you went down with a physical illness, sort of fly's in the face of what they do really. (P2)

Being an NHS hospital was often linked to their responsibilities or duty of care in managing physical health concerns such as diet and weight gain. Some understood that restrictions may be necessary and felt overall health is a priority.

I mean alright we have a responsibility to ourselves, but ultimately it's them that have you know, they have the legal kind of position that they have look after us physically. (P6)

It does, it does have a duty of care […] people are putting weight on are given money to buy food, they're pushing it, they're enforcing it, they're tolerating it. (P10)

I have heard the limit, of what amount and it seems quite,- not too restrictive it is quite, it is more than I would eat but, I think they try to be,

you know, it is an NHS hospital I can understand they need to try and do something. (P9)

Overall, the clarity with which patients felt physical healthcare was part of the care they received in a FMHH came through. Whilst this may be in opposition to other themes, such as individual responsibility, there was an acknowledged duty of care towards them.

3.4.2 Integrated Physical Healthcare

When speaking about the integration of physical healthcare some distinctions in roles and focus were discussed. This theme aims to explore how patients view the integration of services and care within a high secure mental health hospital.

3.4.2.1 Health Monitoring: All participants said they were offered regular health checks provided by ward staff, aligning with monthly monitoring or bi-annually as part of their care planning.

> *We have a health check once a month, basic health check, weight, temperature, blood pressure. The every six months we have a CPA and staff over medical come take your blood test for testing, they sort out your cardiovascular graph, stuff like that. (P2)*

Participants also mentioned monitoring in other ways, such as staff observation and awareness of patient needs and wellness.

> *Yes, well generally they notice, I don't go to staff complaining of things but when I vomited a couple of months ago, they heard me vomiting and they asked, and so I told them and assistance of help was very quick, and I felt almost at one point that I just wanted a bit of space and not to be crowded, but they are quite kind to you when you are physically ill. (P5)*

As health checks were part of care planning there were regular conversations regarding physical health which some felt helped staff focus on and deliver physical healthcare.

It is always in the fore front of their minds, you know cos obviously we have to discuss it all the time, so it is never neglected or brushed under the carpet, you know it is dealt with. I think it is very many things, you know that come together. (P5)

Monitoring helps identify health conditions early and is vital to maintaining good physical health for those with a SEMHD or in a mental health service. While health checks are offered the individual can choose to engage with them or not, however by making this a part of care planning it helps give some responsibility. One patient spoke positively about the care planning experience giving him input and accessibility to his care.

Better understanding, more self-input into care plans and decisions about yourself, I am involved in my care quite a lot, it depends what, I'm going to be honest with you, how well you are at the time (P7)

While care planning is one way to achieve regular monitoring and input, patients also identified caring staff, regular communication (see 3.4.3.1), and primary care facilities as other ways to meet this need.

3.4.2.2 Primary Care Facilities: Participants felt there was a good provision of primary physical healthcare services, including a GP, dietician, physiotherapist, optician, dentist and podiatrist, available at the on-site healthcare centre.

I can see dentistry, podiatry, opticians that is about it I think, and GP did I say. It's easy indeed, perhaps not, depends if they are on, OK the opticians was not bad, they only turn up when they have a few people to visit, so they don't turn up for one, only if three or four. So if you put a request in it could take a few weeks. (P2)

Many said it was easy to attend the healthcare centre if the ward could facilitate this. Another concern raised by one participant was the sharing of information and not feeling they afforded the same privacy or consideration as someone in the community.

> *Yes I have, the doctor, all the GP's are nice, but I was put down to see him as I was complaining about these drugs […] I said no I'm not seeing them, because when they start delving, they write down things in your notes and they stick with you forever. I am not being nasty or inconsiderate it's just I know what it's like something written down in the notes sticks. (P5)*

Most participants felt having the healthcare centre onsite improved access, one participant felt this eased the burden or his mental health compared to a medium secure unit, and another said they would not attend the GP regularly in the community but they attend here regularly.

> *Probably not as good if I am honest because, you know because we were going out on leave so we, the lads who were going out on leave, we were expected to make our appointments outside, so register with a GP, or go to the opticians ourselves, you know like Specsavers on the high street. So yeah it is geared up differently, here is geared up for everything to be self-contained, in the medium secure unit it is not all self-contained some of it they expect you to go out and do yourself. (P6)*

> *It's a lot less, when I was in [MSU] they didn't have a site doctor that came in, if you had a temperature or something they had to come from all around the county, there would be one doctor for the counties, there was no dentist there, no physical healthcare there, you had to go into the community for it. (P7)*

> *I go there [physical healthcare centre] every 6 months, I have a diabetic check-up for blood sugar, it's good. (P3)*

However, one participant felt the treatment he would have got in the community would be better. Participant 4 discussed a lack of treatment options and asking for a Second Opinion Doctor to review his case to get the physical health treatment he needed. When discussing what his experience may have been like in the community, he said:

> *I would have had more control, whereas in here things are out of my control, in the community things are in my control. It bothers me a little bit […] if they had seen me quicker it wouldn't have spread […] I do feel that the NHS have let me down. (P4)*

Many could list ways physical healthcare needs are met and how it was already integrated into the FMHH, and it was difficult to consider further ways to integrate or improve physical healthcare. This may be because of the security of high secure hospitals when leaving to attend primary healthcare – as would happen in a medium secure unit - is logistically more challenging and therefore integration of services is necessary.

3.4.3 Staff Approach

Participants reported the important role staff had in their physical healthcare. Overall many noted the staff, and ward staff in particular, cared which helped them engage positively. Within this theme participants discussed their perception of staff attitudes, the communication they receive and their experiences of being cared for by staff in a FMHH.

3.4.3.1 Communication: Participants reflected that having timely and regular communication about the physical health was important for their health and wellbeing, especially if this tied in with healthcare monitoring.

> *Erm, not really just to be, as well communicated as possible, things to be communicated to patients. You always need to keep an eye on that. (P9)*

Some felt these conversations with staff were helpful and gained more information and knowledge of how to approach their healthcare.

> *Staff, they encouraged, and I've always known those tips and stuff but there's a couple of staff I get on with and know really well and they give lots of advice and support so it's nice having them around, and like, the*

help with diet plans and exercise plans and just things like for future not here and now (P7)

When asked about communication and how it can make a difference to health, many noted the support they felt and linked it to care. Some noted that coming together with staff and discussing physical health can lead to change, such as keeping them on track with health goals of weight loss. Participant 10 noted that education and staff involvement with this can lead to wider changes across the hospital.

More education and more talking about physical health, more talking really more about physical health and what not. I'm sat here right now, I'm not really overweight, I'm quite fit, but if I know that if I don't take responsibility and know that I'm going to stay the same weight or keep improving then I've lost before I've even started you know. (P10)

While participants broadly felt communication from those providing physical healthcare services are vitally important to the engagement and accessibility of healthcare, none linked this to training or staff skills and felt staff were skilled enough to approach the topic of healthcare. This would suggest a bias within the culture of the hospital rather than feeling the hospital is not suited to addressing physical health concerns.

3.4.3.2 Mental Health Focus: A FMHH is set up to support individuals' mental health and this can create a divide in services. Many participants noted that physical healthcare falls within the remit of the health centre and, while trained, mental health staff focus on their mental wellbeing primarily.

Some identified the role of the psychiatrist as being central to this focus, even when raising concerns about side-effects.

Like I said the GP is pretty good […] those responsible for physical health are not to blame, it's when talking about drugs and treatment and effects what have you it is a different ball game, and that means meeting with the psychiatrist which is impossible. (P5)

The psychiatrist don't usually deal with physical health, that is more the GP. Every ward gets assigned a doctor for them to come if we need them. The psychiatrists they are just all about the MI you know, that's their remit. (P6)

Many would attend the healthcare centre for matters relating to physical health and monitoring, and while they spoke positively about ward staff, saw this as two distinct areas of specialism.

I don't, a lot of the staff that come here, like the HCA's, well HCF's now, staff nurses and that are more mental health, they are trained in physical health but a lot of them train in mental health side, that's why you have the healthcare centre and they know their stuff so it's pretty good, plus you have the SHO's and they're quite good and will send you to the healthcare centre for a check-up, plus the GP's there (P7)

This mental health focus can lead to physical health conditions being missed or blindness to physical health conditions as a side-effect or related to their mental health, adding to the risk of developing physical health conditions within a FMHH.

3.4.3.3 Attitudes: Finally, the attitude of staff was discussed as something that can help facilitate good physical health and made participants feel cared for. On the whole, many participants reported feeling supported and treated well by their care team.

So, my self-harm […] when I did that I'd have to go to hospital and stuff, they'd panic, and they'd do this, strip my room, do that, but now it's not so much panic, they don't go to hospital straight away, they'll just try and keep me here, check I'm okay, unless I can't pass urine or there's hypertension, then I have to go […] it's more supportive than punitive, that kind of thing. (P7)

> *They care, they're professional. They have a humane attitude to patients. (P3)*

Some reported that outside services, such as the local hospital, held a negative view of those detained in forensic services and this impacted their treatment.

> *They have a strange attitude towards [hospital] patients, they think of us as expendable, you never get proper service. (P5)*

> *Sometimes you'd go to the dentist and you were handcuffed, so that was great, so if I go here I don't need that. (P7)*

When asked whether this had affected how likely they were to seek support, P5 said it was as he did not enjoy the experience. Others who had visited outside acute physical healthcare hospital said the staff were neutral but most of the interactions were still with staff from the high secure service due to escorting.

In the attitudes of staff, listening was felt to be a big part of being cared for. One participant recalled feeling ignored when reporting physical healthcare concerns and felt "neglected" by the hospital due to his experiences.

> *I told HSH I have [health condition] 2 years ago and they wouldn't believe me. I was passing blood, and they said "I am 110% sure you don't have [health condition], you're too young and your bloods are okay"[...]Neglect, it's neglect. (P4)*

P4 said some staff had listened and cared for him but he felt let down by this experience which resulted in a serious change to his physical health. Overall, this encompasses the care attitude that is needed to prevent diagnostic overshadow and preventable health conditions.

4.0 DISCUSSION

This chapter aims to summarise and discuss the findings from the analysis and relate this to the research questions and implications of the study.

4.1 Summary of Findings

4.1.1 The Meaning of Wellbeing

As a research question was to explore wellbeing and the perception of this in FMHS the interview guide opened and directly asked about participants' understanding, definition and views - therefore it is not surprising this generated a theme. While there were differences in the definition for individuals, there was a collective resonance on its importance, a strong impact between physical and mental wellbeing and individual responsibility. Despite services maintaining separatism in the commissioning and provision, previous research shows higher physical health needs within mental health and FMHS (Brown et al., 2010; Meiklejohn et al., 2003).

The theme further explores this relationship as those who had physical health comorbidities or concerns about their physical health valued physical health closer to or equally as important as their mental wellbeing. In a service with a strong focus on mental health and recovery, physical wellbeing was often something people saw for their future or not valued as highly their care team. Masculinity and the environment could perpetuate this further and may stifle conversations between participants and the system if it is viewed through the lens that men are disinterested in their health (Gough, 2006). It seemed more prevalent within higher restrictive wards in the hospital, as mental health recovery acts as the benchmark for movement. However, this doesn't diminish how it's valued by the participants. This may fit more widely with the recovery agenda within mental health services, where physical health is included within this but not a focus in and of itself.

When defining wellbeing some saw it as an absence of negative effects whereas others viewed it as having positive actions associated. The effect of optimism and pessimism is considered small for outcomes related to

psychological wellness but holds a larger role within physical health, with a pessimistic view affecting physical performance (although not significant) (Kubzansky et al., 2004). In a high secure service this may contribute to views that mental health, or optimism, contributes to greater physical health but not vice versa. Gender, class and early life experiences may mean wellbeing is an unfamiliar concept as well or one that has been shaped by mental health services. As a concept wellbeing is hard to define so a focus on what it is or is not provides a way of communicating this to an outsider. Furthermore, the definition proposed by Dodge et al., (2012) described a balance point between available resources and challenges faced. Considering this definition within a FMHS a balance or equilibrium may not feel attainable, their psychological, social and physical resources are limited due to the nature of the service and they may perceive and experience greater challenges to wellness. Defining a concept that may not be attainable and has not been for many years means a focus on what they can or cannot achieve within the environment could shape this definition.

As the population in FMHS ages there are greater unmet healthcare needs (Völlm et al., 2016). Many participants reported a positive view of healthcare available similarly to the literature, however identified a change in their physical healthcare needs. This was often in the form of needing greater access to care or self-care through exercise and healthy eating. As articulated in section 3.2.2, P3 felt he was healthy at this stage but this could change as he continues to age in FMHS and shows the concerns of this population. This vulnerability may be sensitive to address in a FMHS and meeting the needs of the whole service can mean some groups' needs may not be met. Reducing length of stay has been one way to reduce an ageing psychiatric population and recognises long detentions in forensic services for minor crimes was more detrimental and increased institutionalisation than aided risk management or recovery (Margetic et al., 2012). Services for older adults detained in forensic settings have been suggested due to the complexities that sit between older adult and forensic care alongside an ageing general population that may lead to more first-time older adult offenders (Nnatu et al., 2005).

Asking about the challenges and barriers towards accessing healthcare highlighted individual factors that affected engagement. Low feelings of motivation and desire to engage were often seen as barriers, with a few exceptions. Motivation was largely diminished due to mood and mental wellbeing, medication, and existing poor health. Considering the COM-B model reduced capability due to mental wellbeing and reduced opportunity due to environmental factors such as routine and restrictions of movement would affect motivation negatively. The literature indicated difficulty communicating healthcare needs, lower engagement with help-seeking behaviours, less compliance and lack of integration between mental and physical health services impacted engagement (Bright et al., 2015; Docherty & Thornicroft, 2015; Graffigna et al., 2017; Koponen et al., 2017). While a lot of these are interactions between the external world and internal processes, what participants spoke of when discussing motivation were internal (i.e. not feeling like exercise, ignoring healthy food choices, knowing it should happen, a responsibility for their health). The effect on two of the core aspects of the COM-B model would indicate that more may be needed from the service to build motivation and engagement.

The responsibility individuals hold for their choices was a more divisive but prominent theme, with some stating they felt responsible for their health, wellbeing and recovery and others felt this control had been lost. Being detained involuntarily is difficult to accept and can lead to a withdrawal from services offered, however regaining a balance of responsibility, and having some decisions over care was found to be helpful for those moving to a lower secure FMHS (Tapp et al., 2013). Having no perceived autonomy could feel like a further lack of control and devaluing of individual responsibility in favour passivity to a powerful system. Within the participants those who valued individual responsibility also spoke more of moving forward in their care pathway and a sense of hope or collaborative care could increase the balance of responsibility, however this may not be felt within a long-stay population who have had setbacks in progress or remained in FMHS for many years.

4.1.2 <u>Being in a High Secure Hospital</u>

The restrictions of the environment were the main way participants felt their physical health impacted. The environment affected all aspects of daily life and engagement with individual ideas for wellbeing, such as diet and exercise. Regarding diet there were differing views on the restrictions, with some feeling it was too far and other feeling there was still access to many 'unhealthy' foods through shopping. They did speak about the limited choice available for food and cooking as something that discouraged adopting a healthy lifestyle. Meals and menu options are overseen by the dietician; participants did not indicate how they engage with this process. There is a convincing argument for improving choice and patient engagement; it is ethical to do so, improves therapeutic outcomes, and improves the quality and accessibility of the service and the validity in the eyes of the SUs (Livingstone et al., 2013). Therefore, improving choice may improve engagement with diet and healthcare, true engagement and collaboration can be difficult to achieve within the forensic services though due to the inherent power imbalance that exists. These restrictions are often paternalistic in their implementation, whilst it shows the dilemma the hospital faces in balancing healthcare improvements with the rights of individuals; wanting to offer free choice but knowing this can lead to health problems is a growing concern. The impact of these changes on the individual experience may not be fully accounted for and leads to growing tension amongst the patient population towards the hospital who they feel unfairly brandishes authority in an environment where they have already lost power.

The balance between choice and engagement was also present. Many participants felt choices were given in many aspects of daily life, however this choice was limited by environmental constraints which eliminated complete choice. This was often summed up as wanting to eat healthy foods but cook it themselves so they could have variety or being offered choices of exercises but preferring something else that is not available. While participants felt they had choice, meaningful activities seemed missed. Enforced compliance with care through coercion and lack of control does predict less engagement with activities (Jaeger et al., 2013). Antoniou (2007) summarised this as "There are two sorts of 'boring' on the ward. One is caused by having lots of hours to fill and not having the things one usually has to fill them up with because one is not

at home. The other is a side effect, or a series of side effects from the medication(s). It is possible to be bored on the ward even when there are activities planned every hour, and not to be bored when doing nothing." (p. 33). In a long-stay population boredom with routines and the same available activities would not be uncommon. Although FMHS have a responsibility to offer choice and activities to promote health the engagement and choice to decline is up to SUs. Hospital and service restrictions were a prominent mediating factor for individuals' engagement with exercise, healthy eating and physical health promoting behaviours. Balancing safety and wellbeing are always fraught and this study highlighted the impact and felt experience for those in FMHSs.

Participants reported health concerns and negative effects from long term antipsychotic medication use and detention including weight gain, diabetes, and tiredness. This is consistent with the literature that shows a higher prevalence of comorbidities for those with a SEMHD and in forensic services (Meiklejohn et al., 2003). The coercive or enforced nature of medication and the prevailing medical model influences medication as a crucial part of recovery. Participants spoke of trying to find a balance between their mental health and physical health, but this often meant a balance between medication and absence of symptoms versus the impact medication has on their health. Participant 6 spoke about the benefits he saw in his mood from medication; however this meant he had to accept the debilitating physical effects including weight gain and diabetes. Many patients were aware the medication caused diabetes, and this was a source of anger for some and reinforced the power the hospital has over their choices.

Bringing mental health detention and laws in line with human rights and ethics is fraught, the medical model of mental illness can reinforce this separatism, stigma and at times abuse of power (Duffy & Kelly, 2017). The broader policy frameworks derived therefore prioritise and comply with a bio-medical model and treatment for mental health, this leaves less room for psychological and social aspects of understanding and alternatives to medication (Read, 2005; Spandler & Calton, 2009). Greater incorporation of human rights and identifying explicit power imbalances that lie within policies and the conceptualisation of mental health could bring alternatives for treatment that are currently secondary

and complimentary (Spandler & Calton, 2009). Due to the isolated and restrictive nature of FMHS it widens the gap between these alternatives and medical treatment and the power imbalance that lies between, which makes a move towards a biopsychosocial model more challenging. The reliance, therefore, on medication as the main treatment option continues to create physical health comorbidities for SUs.

Feelings of isolation and loss were also common for participants, in particular loss and isolation of community and social relationships. An impact of being in a FMHS and mental health services more widely is institutionalisation and disconnection from family and community. Loved ones may function as carers and offer many forms of support; however both carers and SUs can feel powerless and intimidated by the system and fall into a pattern of institutionalisation (Ridley et al., 2014). Although beds in FMHS have declined over the years and moved towards care outside of FMHS, many will have more short-term admissions or struggle with re-engagement in the community (Pendersen & Kolstead, 2009). This rise and fall of de-institutionalisation and re-institutionalisation are due in part to the reliance of the medical model and pharmacology, reducing costs and negative views of 'asylum' style care. Within a long-stay population reengagement with the community can be more difficult and reflect feelings of loss.

4.1.3 The Role of Staff and the System

Most participants understood the duty of care the hospital had to physical health. Whilst primary care services were identified as part of the hospital, these were often on a part-time basis. P4 and P7 had both accessed local and specialist hospital support and viewed the role of healthcare within the hospital as covering basic care, this could be due to their experience of specialised physical healthcare services. The dual role held by FMHS is difficult to manage at a service and policy level and aspects of service provision and care may be missed or side-lined, such as staff having broad physical health knowledge when trained with a mental health background would be hard to achieve. This is being considered in the training or new staff where a division between mental and physical health still exists (such as nursing) (Gourney, 2005).

Whilst mental health services are underfunded, alongside wider issues of funding across the NHS, parity of esteem has led to directives in the NHS five year forward view for greater integration of primary care services in mental health. Stigma is cited as one of the main barriers in accessing mental health care; however this can prevail within physical healthcare too. The division between mental health and physical health services creates barriers and stigma for individuals with SEMHD in accessing physical healthcare due to being seen as timewasters, physical health concerns being labelled as mental illness related or past poor treatment (Happell et al., 2012). Additional stigmas associated with the forensic environment, masculinity and fear were also expressed; P3 expressed needing to "grin and bear it" when in pain whilst others said going to shared spaces for exercise created a barrier of seeing others or feeling under threat. The prevalence of a mental health focus was also noted in 3.4.3.2. and the divide between services consistently noted which can add to stigma.

Improved staff communication and attitudes encouraged engagement with physical healthcare for participants. This is consistent with the view that staff attitude can create barriers as well. Many participants reported staff were helpful, offered regular monitoring and cared. This is reflected in the literature, which indicates that most forensic mental health staff hold positive views of SUs, however there are negative beliefs about their ability to recover (Lammie et al., 2010). That feeling may be amplified for the longer-stay population who have not 'recovered' and who may notice more negative attitudes towards aspects of their care. Some felt training could be improved so staff were more knowledgeable about mental and physical health to improve engagement, by knowing more about mental health they would be able to understand and encourage engagement more effectively. The relationship with the GP and their primary care provider was also viewed as important, with one participant in particular speaking of negative experiences and poor health outcomes as a result. Of note, they reported not being listened to and diagnostic overshadowing as the main cause of the relational breakdown, this is consistent with the research that shows routine health conditions can be misappropriated to mental health side effects or symptoms or have a low priority (Phelan et al., 2001; Thornicroft et al., 2007). The divide between physical and mental health

care services can contribute to this further, with a lack of joined up care or understanding from primary care services and mental health services. In their case the relationship with the GP affected their sense of trust and being cared for.

4.1.4 <u>Summary of the Research Questions</u>

The first research questions sought to gain a greater understanding of how adult men detained in a forensic mental health hospital experience their physical wellbeing. In this study, while there was some variance, common themes and ideas emerged of being concerned about their physical wellbeing and the environmental factors or psychological factors that encroach. This was not held as strongly by everyone and was more prevalent for those who experienced poor physical health, however the main counterpoint was the individual responsibility held.

The second research question aimed to identify challenges in accessing physical healthcare. Nearly all participants felt they had access to services for physical health and this is provided in a timely way. The main challenges arose from the environment, such as restrictive settings, limited time windows, staff availability, and staff responses. The third question sought to explore what changes participants felt would be beneficial for their wellbeing, many identified changes to their day-to-day experiences such as staff attitudes and greater flexibility in the environment. The final angle of the research was looking at changes over time, this question did not gain an informative response and the main focus of the analysis has been on their experiences and barriers.

4.2 Implications for Practice

It is hoped that by exploring the understanding of SUs is begins further exploration into the area of physical health. Below are some of the implications from the research and link to the wider literature.

4.2.1   <u>Clinical Implications</u>

Overall, the interviews provided ideas of how participants saw and engaged with their physical healthcare and offered insights into how we may better engage with them.

4.2.1.1 Individual Understanding Wellbeing: An aspect explored throughout the study was the importance of both physical and mental health for participants, and how this creates a sense of wellbeing. Many were thoughtful and eloquent about the link between them, and particularly how good mental health can facilitate engagement with physical healthcare. This echoes other models, such as the bio-psycho-social model and model of wellbeing which suggest a holistic and balanced approach to different domains (biological, psychological and social, and challenges and opportunities respectively). As mentioned this may be at odds with other models within mental health such as the attainment of wellbeing through recovery. This highlights the importance of SUs voices and how this could influence practice and research. Changing cultural and service views on what is important or valued takes time and raising awareness is a first step.

All participants indicated a value and worth of their physical health, which would indicate a level of individual motivation (i.e. motivation or health motivation within the COM-B and HBM model respectively). Often, when individuals do not engage in healthy behaviours it may be seen as a fault of individual. What this research shows is external mediating factors more greatly affect engagement, and the perception of barriers and susceptibility is understood by patients. Many showed great insight into their health risks and health promoting behaviours, therefore addressing service barriers such as accessibility and relationships may promote more cues for action.

4.2.1.2 Assessment & Integration: The findings suggest that not all participants have been asked about their physical health as it relate to their wellbeing. However the findings suggest that greater integration of physical and mental health would support more holistic care. It could be advised that mental healthcare workers directly ask about physical health and the impact this has on the individual, and also spends time ascertaining individual sources of behaviour to tailor care planning. The COM-B model outlines motivation, opportunity and capability as mediators of behaviour change, which could be integrated into initial and ongoing assessments as part of healthcare promotion. While this may not change structural and social determinants that influence

healthcare policy, it may support identification or barriers at a local and individual care level and changes that can be made.

4.2.1.3 Healthcare Promotion: Initiatives that both monitor and promote positive health designed for FMHS are needed as there is a currently a paucity of specific protocols (Ferrera et al., 2015; Völlm et al., 2016). Creating something deliberate, where individuals can make choices about their health, and incidental, where healthy living is a part of the routine, can build a culture of engagement and wellbeing for positive health outcomes (Every-Palmer et al., 2018). Small scale studies have shown success when introducing structured exercise programmes and weight reductions programmes which were tailored for the population, however this can create challenges of being too punitive and balance with individual rights and choice (Oakley et al., 2013; Tetlie et al., 2008).

Regular monitoring and engagement with healthcare has been highlighted as a key factor in continued wellbeing (Hickey et al., 2005; NHS England, 2016; Phelan et al., 2001; Smith et al., 2013; Whitely & Drake, 2010; Völlm et al., 2016). Screening and monitoring informed by behaviour change theory have also been suggested which would include more psychological determinants of engagement and addressing resource constraints that may prevent this alongside training and support for staff (Kisely et al., 2013).

4.2.2   Implications for Services

Although service level changes were not explored or identified by participants they were able to recognise and identify the impact of the service on their experiences and this offers an insight into changes that may benefit.

4.2.2.1. Providing Services for Long-Stay: The concern showed by individuals relating to their health and the impact on long detentions on their lifestyle was noted, particularly when thinking about the future. It is acknowledged that while a small group within FMHS individuals who remain in hospital for a longer period of time are more likely to have detrimental effects to their health. Participants concerns about aging within services and feeling physical healthcare was a goal for the future may reflect the short-stay aims of the

service, which could adversely be affecting health. Long-stay provisions within services or pathways of care to support transitions would benefit this group of patients' holistic care more readily (Davoren et al., 2015). This also fits with wider policy such as the NHS Long Term Plan (2019) which wants to support people to age well, including greater independence and physical mobility.

4.2.2.3 Service User Involvement: Many of the service users identified that decisions were made about aspects of healthy living, such as dietician input into the menu or Occupational Therapy led sports activities. They often spoke about the impact the service decisions had on their wellbeing or limited access or choice. It may be that robust SU involvement is in place within the service but was not identified by this participant group and there was dissatisfaction at the availability or decisions, however wider SU involvement can reduce feelings of powerlessness and lead to greater involvement in their care (Ridley et al., 2014). This may also reduce perceived barriers or improve factors such as motivation and opportunity as involvement and support in healthcare often leads to stronger outcomes and engagement (Michie et al., 2016).

4.2.3 Implications for Staff

The division of roles between physical and mental health staff was apparent throughout the research, although this has been an artificial distinction. Research indicates that improving staff training in areas of physical and mental health improves the knowledge, confidence, and attitudes of staff (Haddad et al., 2009). The changing role of mental health or psychiatric nurses has been recognised to include more training and knowledge of physical health needs, particularly of the forensic population (both prisons and FMHS) which is steadily growing (Gourney, 2005). This would indicate that integration may mean reducing the division of specialisms amongst staff groups, but also specialist training for FMHS and the physical healthcare needs of the population is necessary. This can be at a professional level, such as core training, and service level to ensure delivery and applicability.

Communication was often a mediator for adherence, which is supported by the COM-B model. Within FMHS communication may be more important given the history of trauma and adversity experienced by the population. Higher alliance

with healthcare professionals has been indicated for professionals who have engaged with trauma informed communication training and improved engagement with healthcare (Green et al., 2016). Without addressing service level changes, increased knowledge and awareness among staff to support understanding of SUs perspective and experiences could aid changes in individual factors such as motivation. However, when the services design is mismatched with the reality of the clinical needs and skills within the patients, professionals, and services suffer (Blount et al., 2007).

4.2.4 <u>Implications for Further Research</u>

This study has contributed to a growing body of work within mental health services and clinical psychology more broadly as integrated care between mental health and physical health becomes more necessary and prevalent. Whilst this research focuses on a unique sample, future research of SUs perspectives across FMHS and mental health services about their experiences and needs should inform service development moving forward. As highlighted many SUs face difficulties with their physical healthcare needs associated with treatment and detention and future research could focus on these groups to add to the understanding of the patient experience. To add further depth to this staff and carer interviews would also be useful to broaden understanding. In particular, research around the staff experience of offering physical healthcare, balancing the demands of security versus care, and confidence in delivering this care would all serve to understand potential barriers staff may feel and expand on the current study.

It would also be useful to understand the integration of physical healthcare across FMHS, this study focused on high secure services however medium secure and low secure services are more prevalent within FMHS and can support broader service development. Integration of services is another key theme within the professional guidelines and literature to improve service provisions. Often more positive outcomes happen when the approach to physical health is integrated with primary care and is multidisciplinary *(*Ferrera et al., 2015*)*. Improving coordination between primary care services and secondary or tertiary care has constraints (data sharing, access, and resources) but is a necessary step to allowing continuity of care (NHS England, 2016;

Naylor, 2016; Smith et al., 2007; Working Group for Improving the Physical Health of People with SMI, 2016). As services become more integrated clarification of staff roles and boundaries may become more necessary (Every-Palmer et al., 2018). This may pose challenges to FMHS, particularly High Secure Services that often have restrictions on access to the environment and data for those outside of the service. These fears are rightfully concerning for the hospital but can create barriers for integrated and specialist physical care.

More practically, measuring uptake of offers for physical healthcare and health promotion in FMHS would be essential to understanding barriers to engagement and making substantive changes to consistent engagement. NICE has developed guidelines for the physical health monitoring and admission criteria for the prison population and weight management guidelines for FMHSs, however further guidelines could integrate this as part of care. Many of the participants reported this is currently being held by the CPA process, which can ignore individual needs and concerns if they do not align with hospital policies or approach (Duff, 2016). Further, research around the culture of physical healthcare within mental health services would serve longer lasting results of policies and practices put in place.

Considering the psychological impact poor physical health has on the emotional and mental wellbeing of individuals, psychologists have an ethical argument and duty for being more involved in this care and the development of services. This is especially relevant to FMHS where the environment and application of practice can reinforce or create further power imbalances and coercive practices which present further barriers to wellbeing.

4.3 Ethical and Methodological Considerations

Conducting research within a forensic mental health service, with its inherent power differential, means consideration of the ethical and methodological impact is important. This section aims to highlight some of the challenges and strengths of the present research.

4.3.1 Methodological Strengths

Methodological strengths of the present study include research in an underrepresented but growing area of psychology, also with an underrepresented but highly impacted sample group. There is a novel aspect to this research which offers tentative but appropriate implications. It also adds to the body of qualitative research within FMHS.

4.3.1.1 Thematic Analysis: Thematic analysis (TA) was employed which offers a broad overview of the participants' experience and patterns across the data, without a strong focus on interpretation of individuals words or generating theoretical data which could offer further insight into individuals' experiences. It was thought this offered the most valuable and appropriate data for the research questions explored.

4.3.2 Ethical Approval

Conducting research within the NHS was a challenging endeavour. NHS Ethics was sought along with trust and service level ethical agreements. NHS ethical approval was unfamiliar with forensic services and the procedural security that limits aspects of research (i.e., data storage). This unfamiliarity with the context, population and service meant there were misunderstandings as to the nature of the research and suggestions made for improvement. This reflects the limited understanding of FMHS services within the NHS and psychological research and reinforces the need for this research to be more prevalent.

4.3.3 Ethics of Forensic Research

Research within forensic services raises complex moral and ethical dilemmas around the nature of the research, its use and application, and value to services and patients. Although research is presented as voluntary many aspects of research can obfuscate this, the decision to offer fair payment for time over bribery of a group with limited financial control highlights the challenges and consideration needed. Altruistic consent, coercive language in research and capacity decisions are factors that can impact truly informed consent within forensic services and ultimately tangle the intention of the research and researcher (Adshead, 2004). These dilemmas and approaches need careful consideration to avoid reinforcing coercive systemic practices.

4.3.4 <u>Issues of SU involvement in Research</u>

Whilst efforts were made to involve staff at the hospital in the development of the research, it was challenging within time constraints to involve SUs in a meaningful way within forensic services. Volm et al., (2017) completed a systematic review that identified themes related to issues of research and service user involvement in forensic settings. They noted considerably less information available for forensic service user involvement in research than for mental health in general. Many recommendations for forensic services were similar to mental health services, which relate to a broader group of people taking part. Overall, they highlighted issues of power relations, tension with staff, interview specific challenges, adequate support and supervision, inclusion being tokenistic, recruitment, employment and payment, training, and confidentiality in relation to involving service users in research in forensic settings. Whilst it is acknowledged that research will not truly benefit the population it aims unless forensic patients are an integrated part, the practical and cultural constraints continue to exclude them (Adshead, 2004).

From professional experience research requests can be received with hesitation, as often research projects focus on offending behaviour or medical testing and may hold negative connotations for service user involvement. From conversations with SUs, they were hesitant as they mistrusted those involved in research or why it was being conducted. There is an inherent power imbalance that can create tension when implementing collaborative working as well as many procedures and policies (some for the protection of service users) that creates additional barriers to true collaboration, and substantive groundwork in cultivating and fostering positive relationships and safety is necessitated. This should be a consideration of future research within the area, both of FMHS and physical health, to strive towards meaningful collaboration.

4.4 Limitations of the Research

As with all research there are methodological and ethical limitations, some acknowledged within earlier chapters. Discussed below are some of the reflections and considerations that arose in the research and analysis.

4.4.1 <u>Sample Limitations</u>

The participants for the research were self-selected once they had been given information about the research. Within the sample black men are underrepresented, as were those on a high dependency ward, compared to their representation within FMHS. The sample size was also smaller which limits the scope of study. Whilst twenty-six participants were approached, eleven declined to take part in the research and five were unable to take part or later declined after initial agreement. The inclusion of more interviews, and particularly interviews for more ethnic backgrounds, would have provided a broader and more representative sample for the dataset.

As participants chose to take part, the data may represent participants who consider or value physical health greatly, and not necessarily reflect all views held within the hospital. Further, patients who are more distrusting of professionals, research and services due to previous experiences may not have volunteered to take part and this may reflect the under-representation (i.e., individuals from ethnic minority backgrounds and high dependency wards) who may have more negative experiences with institutions. Due to the practical and financial constraints of the research interpreting services were not possible, however non-English speaking SUs face additional barriers in accessing physical healthcare and their experience may be different compared to the sample recruited.

Self-selection was decided upon to prevent further coercion within an environment that has many coercive elements, however it should be acknowledged that this can lead to an 'unheard' group within forensic services and service decisions should reflect this. Epistemologically this data is considered within this context and is hopefully to add to the wider understanding of physical health within FMHS rather than seeking to offer directive or definitive answers to the questions.

Prior to being approached, clinical teams and/or local collaborators would identify and approach participants using the inclusion and exclusion criteria. Judgement on suitability, whilst guided, was made by clinical teams and some decisions may have been more subjective that others (i.e., a decision on

capacity or risk to participate versus age). It is also important to note that three wards did not respond to requests to take part nor identify any participants. This was often due to staff availability to assess suitability, for example two wards did not have a psychologist or psychiatrist in post at the time. This is significant in terms of representation across the hospital setting and incorporating the perspective across different ward types particularly. On reflection, there were both advantages and disadvantages to being an 'outsider' however it meant reliance upon the knowledge, relationships and availability with local collaborators during recruitment.

4.4.2 Interview Schedule and Process

The interview schedule was meant to guide conversation; however, the aim was for participant led data. Some of my concerns prior to starting were the language used and the exploratory nature of the interview. During the information and consent I would often indicate participants could interrupt, ask for rephrasing or decline to answer to prepare them, however further discussions around the exploratory nature and language may have helped to mitigate this in earlier interviews and on reflection this was added to encourage participants to speak freely.

When drafting questions trying to have several closed and open questions felt important to prevent guiding or driving participants to answer in a certain way. Closed questions were followed with requests for more information. I noticed in early interviews some phrases such as "Why…?" in response were often met with "I don't know" or a decline to answer. I reflected that this may be due to requests they often have to share personal information from professions and phrases such as 'why?' may represent this, however requests for more information in some form (i.e., 'that interesting, can you tell me more') would create a much richer and deeper narrative of their experience. Language within FMHS, particularly when building a relationship and collaboration during an interview, can lend itself to maintain the inequality and power imbalance that exists in many other aspects of their experience.

The interview questions were designed with input from local collaborators along with the literature to reflect the topic and research questions. Service user

collaboration at this stage would have been invaluable to supporting language development. Similarly completing a pilot interview and reviewing issues to adapt would have helped. I think this would be beneficial for future research in this area.

Furthermore, the interviews took place on ward-based locations with their clinical teams aware of their participation. Whilst efforts were made to maintain anonymity (such as participant numbers and omission of individually identifiable experiences) this could have affected their decision to take part but also engagement during the interviews. The environment limits privacy through windows and viewing methods to every room; with regular security and location checks for all individuals. Staff would regularly look through and other patients, depending on the ward, could do the same which limits their privacy when taking part. Some may be reluctant to share negative experiences of healthcare or their care team on the ward if they felt they could be identified or overheard. Unfortunately, only ward-based interviews were possible and future research may consider other logistical possibilities to enhance the interview process for participants.

4.5 Research Quality

Lincoln and Guba (1985) highlighted the value of qualitative research being based upon 'trustworthiness' and attention given to the extraction of data. 'Trustworthiness' is related to the rigour with which the research is conducted and defined using the criteria of credibility, transferability, dependability, and confirmability to build upon the constructs of validity and reliability often used within research. Yardley (2008) suggested coherence, transparency, rigour and impact create a universal standard for qualitative research. Spencer and Richie (2013) argued the constructs of reflexivity, auditability and defensibility make up the reliability of qualitative research. As these strongly map onto each other and the concept of trustworthiness, they have been considered when reflecting upon the data.

Credibility seeks to ensure the research is plausible and recognisable to the reader, and the findings are representative of the data itself (Guba & Lincoln, 1989). The researcher has addressed credibility by prolonged exposure,

immersion and engagement with the data, and referring back to the data when drawing conclusions.

Transferability related to generalisability. This is an often-difficult concept within qualitative research. It's acknowledged that the sample and focus of the research is within a specific population and service within FMHS and clinical psychology. This may affect generalisability to forensic services and populations, however the rationale for exploring these views was the multiple areas of systemic impact they have on their physical health. Approaching the research from a critical-realist position has sought to contextualise the research and my positioning within this. Using transparency and rigour has helped ensure this further. It is hoped the research is positioned within this small part of wider systemic issues, but by focusing on those more affected conclusions and suggestions will be of benefit more widely and support transferability of the ideas although not all the experiences.

Dependability related to the decisions and robust documentation of these by the researchers, making sure the research process is logical and systematised (Lincoln & Guba, 1985). Good record keeping practices of the raw data, field notes, transcripts and reflexive journaling helps the researcher in the methodical approach to the data. To ensure dependability of the study the researcher maintained organised records of the data, notes and literature, generated coding using a framework table and used thematic mapping to develop themes and links. This allows a reflexive and evolution of the data as seen previously in Appendix J.

Confirmability refers to the interpretations being clearly linked to the source data which is achieved through credibility, transferability, and dependability (Guba & Lincoln, 1989). Similar to coherence (the consideration and definition of themes at a micro and macro level) it alludes to the interpretations being clear, robust and well-grounded within the data. By checking the data through supervision and reviewing the data and different times in the process I was able to consider how the interpretations and analysis were linked to the source material.

Whilst quantifying true validity within research is a difficult task, the extent to which it offers useful and important information is an important measure or research quality (Yardley, 2007). I believe this research offers a voice to the experiences of patients who have been detained for a long period of time and offers opportunities to be heard. This is an important mark of usefulness and value, which highlights implications for the wider field.

4.6 Reflexivity

Throughout the research process I noticed and reflected upon my own frustrations; the difficulty navigating ethical and service requirements for access was, at times off- putting, and other times detrimental (and led to the project scope changing). I tried to maintain an awareness of my position, as someone outside of the service but also within the system and the view that may project for participants. I concluded that this mixed position held a duality within research in FMHS, offering protection, distance and detachment in the relationships formed. As interviews progressed and interactions with possible participants, I felt more comfortable outlining my position fully as I understood it more – I think this was helpful for the participants to make a more fully informed choice. Changes that I made based on reflections often related to language and questions that elicited information well. I also made changes to the ending of interviews when someone has spoken about some difficult physical health experiences, offering them time between the endings and debrief to engage in their soothing behaviours. I continued to offer this as I wanted to approach the research with sensitivity and validate their challenges.

Some of my reflections at the end of the research were related to feelings of emptiness, concern and burdened. Participants often reflected they had not been asked about this before which strengthened the need and usefulness of this experience. By noticing these feelings and addressing them it is hoped some objectivity remained through the analysis.

4.7 Conclusion

Concerns about physical healthcare within mental health are steadily growing, however few studies focus on FMHS, fewer on long-stay populations, and even

fewer explore SUs perceptions of this which is a vital part of making changes within this area.

This population is at a far greater risk of developing physical health issues and comorbidities due to their experiences, medication and the environment. Further research and resources in this area is vital. The stigma and social perceptions of these services and individuals within them, alongside the balance of risk and safety, makes this a harder journey than most.

REFERENCES

Adshead, G. (2000). Care or custody? Ethical dilemmas in forensic psychiatry. *Journal of Medical Ethics*, *26*(5), 302-304.

Adshead, G., & Brown, C. (2003). *Ethical issues in forensic mental health research.* Jessica Kingsley Publishers.

Adshead, G., & Sarkar, S. P. (2004). Ethical issues in forensic psychiatry. *Psychiatry*, *3*(11), 15-17.

Adshead, G., & Davies, T. (2016). Wise restraints: Ethical issues in the coercion of forensic patients. In *The use of coercive measures in forensic psychiatric care.* Springer.

Alderfer, M. A., & Sood, E. (2016). Using qualitative research methods to improve clinical care in paediatric psychology. *Clinical Practice in Pediatric Psychology, 4*(4), 358–361.

Allen, J., Balfour, R., Bell, R., & Marmot, M. (2014). Social determinants of mental health. *International Review of Psychiatry, 26*(4), 392–407.

Alvesson, M., & Skoldberg, K. (2000). *Reflexive Methodology: New Vistas for Qualitative Research.* Sage.

Antoniou, J. (2007). Bored on the ward. *Experiences of mental health in-patient care. Narratives from service users, carers and professionals*, 33-40.

Armour, C. (2012). Mental health in prison: A trauma perspective on importation and deprivation. *International Journal of Criminology and Sociological Theory, 5*(2), 886-894.

Attride-Stirling, J. (2001). Thematic networks: An analytic tool for qualitative research. *Qualitative Research, 1*, 385–405.

Barr, W. (2001) Physical health of people with severe mental illness. *British Medical Journal, 2,* 323:321.

Barr, L., Wynaden, D., & Heslop, K. (2019). Promoting positive and safe care in forensic mental health inpatient settings: Evaluating critical factors that assist nurses to reduce the use of restrictive practices. *International journal of mental health nursing*, *28*(4), 888-898.

Bartels, S. (2004). Caring for the whole person: integrated health care for older adults with severe mental illness and medical comorbidity. *Journal of the American Geriatrics Society, 52*(12), 249–257.

Bhugra, D., Campion, J., Ventriglio, A., & Bailey, S. (2015). The right to mental health and parity. *Indian Journal of Psychiatry*, *57*(2), 117.

Blount, A., Schoenbaum, M., Kathol, R., Rollman, B., Thomas, M., and O'Donohue, W. (2007). A Summary of the Evidence Professional Psychology. Research and Practice. Vol. 38, No. 3, 290–297. Braslow, J. (2013). The manufacture of recovery. *Annual Review of Clinical Psychology, 9,* 781-809.

Braun, V., & Clarke, V. (2006). Using Thematic Analysis in Psychology. *Qualitative Research in Psychology, 3*(2), 77–101.

Bright, F. A., Kayes, N. M., Worrall, L., & McPherson, K. M. (2015). A conceptual review of engagement in healthcare and rehabilitation. *Disability and rehabilitation*, *37*(8), 643-654.

British Psychological Society. (2009). *Code of ethics and conduct.* Leicester: The British Psychological Society.

Brown, S., Kim, M., Mitchell, C., & Inskip, H. (2010). Twenty-five year mortality of a community cohort with schizophrenia. *The British journal of psychiatry*, *196*(2), 116-121.

Brown, J. (2016). Managing Physical Health Concerns in patients with Severe Mental Illness: an extended Clinical Audit. *Centre for Academic Primary Care.*

Carr-Gregg, M. R., Enderby, K. C., & Grover, S. R. (2003). Risk-taking behaviour of young women in Australia: screening for health-risk behaviours. *Medical journal of Australia*, *178*(12), 601-606.

Centorrino, F., Masters, G. A., Talamo, A., Baldessarini, R. J., & Öngür, D. (2012). Metabolic syndrome in psychiatrically hospitalized patients treated with antipsychotics and other psychotropics. *Human Psychopharmacology: Clinical and Experimental*, *27*(5), 521-526.

Chambers, M., Gallagher, A., Borschmann, R., Gillard, S., Turner, K., & Kantaris, X. (2014). The experiences of detained mental health service users: issues of dignity in care. *BMC medical ethics*, *15*(1), 1-8.

Clarke, V., & Braun, V. (2013). Teaching thematic analysis: Overcoming challenges and developing strategies for effective learning. *The Psychologist, 26*(2), 120-123.

Cohen, D., Stolk, R. P., Grobbee, D. E., & Gispen-de Wied, C. C. (2006). Hyperglycemia and diabetes in patients with schizophrenia or schizoaffective disorders. *Diabetes care*, *29*(4), 786-791.

Compton, M. T., Daumit, G. L., & Druss, B. G. (2006). Cigarette smoking and overweight/obesity among individuals with serious mental illnesses: a preventive perspective. *Harvard review of psychiatry*, *14*(4), 212-222.

Creighton, G., & Oliffe, J. L. (2010). Theorising masculinities and men's health: A brief history with a view to practice. *Health Sociology Review*, *19*(4), 409-418.

Danzer, G., & Rieger, S. M. (2016). Improving medication adherence for severely mentally ill adults by decreasing coercion and increasing cooperation. *Bulletin of the Menninger Clinic*, *80*(1), 30-48.

Das, K., Murray, K., Driscoll, R., & Nimmagadda, S. R. (2012). Assessment of healthcare and placement needs in an older forensic psychiatric population in comparison to a younger forensic psychiatric population. *International psychogeriatrics*, *24*(7), 1188-1190.

Daumit, G. L., Pratt, L. A., Crum, R. M., Powe, N. R., & Ford, D. E. (2002). Characteristics of primary care visits for individuals with severe mental illness in a national sample. *General hospital psychiatry*, *24*(6), 391-395.

Davies, A., Mallows, L., Easton, R., Morrey, A., & Wood, F. (2014). A survey of the provision of family therapy in medium secure units in Wales and England. *The Journal of Forensic Psychiatry & Psychology*, *25*(5), 520-534.

Davoren, M., Byrne, O., O'Connell, P., O'Neill, H., O'Reilly, K., & Kennedy, H. G. (2015). Factors affecting length of stay in forensic hospital setting: need for therapeutic security and course of admission. *BMC Psychiatry*, *15*, 301.

De Hert, M. A., van Winkel, R., Van Eyck, D., Hanssens, L., Wampers, M., Scheen, A., & Peuskens, J. (2006). Prevalence of the metabolic syndrome in patients with schizophrenia treated with antipsychotic medication. *Schizophrenia Research*, *83*(1), 87-93.

De Leon, J., & Diaz, F. J. (2005). A meta-analysis of worldwide studies demonstrates an association between schizophrenia and tobacco smoking behaviors. *Schizophrenia research*, *76*(2-3), 135-157.

Department of Health. (1990). *The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services*. Department of Health.

Di Lorito, C., Völlm, B., & Dening, T. (2018). Ageing patients in forensic psychiatric settings: A review of the literature. *International journal of geriatric psychiatry*, *33*(12), 1548-1555.

Dickens, G., Picchioni, M., & Long, C. (2013). Aggression in specialist secure and forensic inpatient mental health care: incidence across care pathways. *The Journal of Forensic Practice*, *15*(3), 206-207.

Dillard, J. P., & Shen, L. (2005). On the nature of reactance and its role in persuasive health communication. *Communication Monographs*, *72*(2), 144-168.

Docherty, M., Thornicroft, G. (2015) Specialist mental health services in England in 2014: overview of funding, access and levels of care. *International Journal Mental Health Systems, 9,* 34.

Dodge, R., Daly, A. P., Huyton, J., & Sanders, L. D. (2012). The challenge of defining wellbeing. *International journal of wellbeing*, *2*(3).

Dolan, A. (2011). 'You can't ask for a Dubonnet and lemonade!': working class masculinity and men's health practices. *Sociology of Health & Illness*, *33*(4), 586-601.

Dorning, H., Davies, A., & Blunt, I. (2015). Focus on: People with mental ill health and hospital use. *Exploring Disparities in Hospital Use for Physical Healthcare.* Nuffield Trust and the Health Foundation.

Doyle, R., Turner, N., Fanning, F., Brennan, D., Renwick, L., Lawlor, E., & Clarke, M. (2014). First-episode psychosis and disengagement from treatment: a systematic review. Psychiatric Services, 65(5), 603-611.

Duff, C. (2016). Atmospheres of recovery: Assemblages of health. *Environment and Planning, 48*(1), 58–74.

Durcan, G. The future of prison mental health care in England. London: Centre for Mental Health.

Durey, A., Wynaden, D., Barr, L., & Ali, M. (2014). Improving forensic mental health care for Aboriginal Australians: Challenges and opportunities. *International journal of mental health nursing*, *23*(3), 195-202.

Eckert, M., Schel, S. H., Kennedy, H. G., & Bulten, B. H. (2017). Patient characteristics related to length of stay in Dutch forensic psychiatric care. *The Journal of Forensic Psychiatry & Psychology*, 1-19.

Edge, D., Walker, T., Meacock, R., Wilson, H., McNair, L., Shaw, J., Wilson, H., McNair, L., Mitchell, H., Gutridge, K., Senior, J., Sutton, M., Meacock, R., & Abel, K. (2017). Secure pathways for women in the UK: lessons from the women's enhanced medium secure services (WEMSS) pilots. *The Journal of Forensic Psychiatry & Psychology*, 28(2), 206-225.

Edworthy, R., Sampson, S., & Völlm, B. (2016). Inpatient forensic-psychiatric care: legal frameworks and service provision in three European countries. *International journal of law and psychiatry*, 47, 18-27.

Engel, G. L. (1977). The need for a new medical model: a challenge for biomedicine. *Science*, 196(4286), 129-136.

Evans, D. B., Hsu, J., & Boerma, T. (2013). Universal Health Coverage and Universal Access. *Bulletin of the World Health Organization*, 91(8), 546.

Every-Palmer, S., Huthwaite, M. A., Elmslie, J. L., Grant, E., & Romans, S. E. (2018). Long-term psychiatric inpatients' perspectives on weight gain, body satisfaction, diet and physical activity: a mixed methods study. *BMC psychiatry*, 18(1), 1-9.

Facer-Irwin, E., Blackwood, N. J., Bird, A., Dickson, H., McGlade, D., Alves-Costa, F., & MacManus, D. (2019). PTSD in prison settings: A systematic review and meta-analysis of comorbid mental disorders and problematic behaviours. *PLoS one*, 14(9), e0222407.

Faulkner, A. (2004). *The ethics of survivor research: Guidelines for the ethical conduct of research carried out by mental health service user and survivors.* Policy Press on behalf of the Joseph Rowntree Foundation.

Fazel, S., Fimińska, Z., Cocks, C., & Coid, J. (2016). Patient outcomes following discharge from secure psychiatric hospitals: systematic review and meta-analysis. *The British Journal of Psychiatry*, 208(1), 17-25.

Felker, B., Yazel, J. J., & Short, D. (1996). Mortality and medical comorbidity among psychiatric patients: a review. *Psychiatric Services*, 47(12), 1356-1363.

Ferrara, M., Mungai, F., Miselli, M., Shiers, D., Curtis, J., Starace, F. (2015). Strategies to implement physical health monitoring in people affected by severe mental illness. *Journal of Psychopathology, 21*, 269-280.

Fleischhacker, W. W., Cetkovich-Bakmas, M., De Hert, M., Hennekens, C. H., Lambert, M., Leucht, S., Maj, M., McIntyre, R. S., Dieter N., Newcomer, J. W., Olfson, M., Osby, U., Sartorius, N., & Leiberman, J. A. (2008). Comorbid somatic illnesses in patients with severe mental disorders: clinical, policy, and research challenges. *The Journal of clinical psychiatry*, *69*(4), 514-519.

Flegal, K. M., Carroll, M. D., Ogden, C. L., & Curtin, L. R. (2010). Prevalence and trends in obesity among US adults, 1999-2008. *Jama*, *303*(3), 235-241.

Fukuda, Y., Nakamura, K., & Takano, T. (2005). Accumulation of health risk behaviours is associated with lower socioeconomic status and women's urban residence: a multilevel analysis in Japan. *BMC public health*, *5*(1), 1-10.

Gladis, M. M., Gosch, E. A., Dishuk, N. M., & Crits-Christoph, P. (1999). Quality of life: expanding the scope of clinical significance. *Journal of consulting and clinical psychology*, *67*(3), 320.

Goldman, L. S. (1999). Medical illness in patients with schizophrenia. *Journal of Clinical Psychiatry*, *60*, 10-15.

Goldman, H. H., & Grob, G. N. (2006). Defining 'mental illness' in mental health policy. *Health Affairs*, *25*(3), 737-749.

Gostin, L. O. (2008). 'Old' and 'new' institutions for persons with mental illness: Treatment, punishment or preventive confinement?. *Public Health*, *122*(9), 906-913.

Gough, B. (2006). Try to be healthy, but don't forgo your masculinity: Deconstructing men's health discourse in the media. *Social science & medicine*, *63*(9), 2476-2488.

Gournay, K. (2005). The changing face of psychiatric nursing: Revisiting Mental health nursing. *Advances in Psychiatric Treatment*, *11*(1), 6-11.

Graffigna, G., Barello, S., Bonanomi, A., & Riva, G. (2017). Factors affecting patients' online health information-seeking behaviours: The role of the Patient Health Engagement (PHE) Model. *Patient education and counseling*, *100*(10), 1918-1927.

Green, B. L., Saunders, P. A., Power, E., Dass-Brailsford, P., Schelbert, K. B., Giller, E., Wisslow, L., & Mete, M. (2016). Trauma-informed medical care: Patient

response to a primary care provider communication training. *Journal of Loss and Trauma*, *21*(2), 147-159.

Guba, E. G., & Lincoln, Y. (1989). *Fourth generation evaluation.* Sage.

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. *Handbook of qualitative research, 2*, 163-194.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods, 18*, 59-82.

Guyatt, G. H., Feeny, D. H., & Patrick, D. L. (1993). Measuring Health-Related Quality of Life. *Annals of Internal Medicine*, *118*(8), 622-629.

Hammersley, M., & Gomm, R. (2008). Assessing the radical critiques of interviews. In M. Hammersley (Ed.), *Questioning qualitative inquiry: Critical essays* (pp. 89-100). Sage.

Happell, B., Scott, D., & Platania-Phung, C. (2012). Perceptions of barriers to physical health care for people with serious mental illness: a review of the international literature. *Issues in Mental Health Nursing*, *33*(11), 752-761.

Hardy, S., Hinks, P., Gray, R. (2013). 'Screening for cardiovascular risk in patients with severe mental illness in primary care: a comparison with patients with diabetes'. *Journal of Mental Health, 22*(1), 42–50.

Harper, D., Gannon, K., & Robinson, R. (2012). Beyond evidence-based practice: Rethinking the relationship between research, theory and practice. In R. Bayne and G. Jinks (Eds.), *Applied psychology: Practice, training and new directions* (2nd ed., pp. 32-47). Sage.

Harper, D., & Speed, E. (2013). Uncovering recovery: The resistible rise of recovery and resilience. *Studies in Social Justice, 6*(1), 9–26.

Harper, D., & Thompson, A.R. (2012). *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (pp.83-97). John Wiley & Sons Ltd.

Harris, E. C., & Barraclough B. (1998). Excess mortality in mental disorder. *British Journal of Psychiatry, 173,* 11–53.

Hayes, A. J., Burns, A., Turnbull, P., & Shaw, J. J. (2012). The health and social needs of older male prisoners. *International journal of geriatric psychiatry*, *27*(11), 1155-1162.

Harris, M., & Fallot, D. (2001). Trauma-informed inpatient services. New Directions for Mental Health Services, 89, 33–46.

Henderson, C., Evans-Lacko, S., & Thornicroft, G. (2013). Mental illness stigma, help seeking, and public health programs. *American journal of public health*, *103*(5), 777-780.

Henderson, D. C., Borba, C. P., Daley, T. B., Boxill, R., Nguyen, D. D., Culhane, M. A., Louis, P., Cather, C., Evins, A. E., Freudenreich, S. M., & Goff, D. C. (2006). Dietary intake profile of patients with schizophrenia. *Annals of clinical psychiatry*, *18*(2), 99-105.

Hennessey, M., Ford, J. D., Mahoney, K., Ko, S. J., & Siegfried, C. B. (2004). Trauma among girls in the juvenile justice system. *National Child Traumatic Stress Network*.

Hickey, A., Barker, M., McGee, H., & O'Boyle, C. (2005). Measuring health-related quality of life in older patient populations. *Pharmacoeconomics*, *23*(10), 971-993.

Higgins, W. (2012). Human rights development: Provenance, ambit and effect. *mental health and human rights: vision, praxis and courage*. Oxford University Press.

Hilton, C. E., & Johnston, L. H. (2017). Health psychology: It's not what you do, it's the way that you do it. *Health Psychology Open*, *4*(2), 10.

Hotzy, F., & Jaeger, M. (2016). Clinical relevance of informal coercion in psychiatric treatment—a systematic review. *Frontiers in Psychiatry*, 7, 197.

Huber, M., Knottnerus, J. A., Green, L., Horst, H., Jadad, A. R., Kromhout, D., Leonard, B., Lorig, K., Loureiro, M. I., Van der Meer, J. W. M., Schnabel, P., Smith, R., Van Wheel, C., & Smid, H. (2011). How should we define health? *BMJ, 343,* 41-63.

Hunt, M.G., & Resnick, S.G. (2015). Two birds, one stone: Unintended consequences and a potential solution for problems with recovery in mental health. *Psychiatric Services, 66*(11), 1235–1237.

Jaeger, S., Pfiffner, C., Weiser, P., Längle, G., Croissant, D., Schepp, W., Kilian, R., Becker, T., Eschweiler, G., & Steinert, T. (2013). Long-term effects of involuntary hospitalization on medication adherence, treatment engagement and perception of coercion. *Social psychiatry and psychiatric epidemiology*, *48*(11), 1787-1796.

Janz, N. K., Becker, M. H. (1984). The Health Belief Model: a decade later. *Health Education Quarterly, 11(1), 1-47.*

Jerome, G. J., Young, D. R., Dalcin, A., Charleston, J., Anthony, C., Hayes, J., & Daumit, G. L. (2009). Physical activity levels of persons with mental illness attending psychiatric rehabilitation programs. *Schizophrenia research*, *108*(1-3), 252-257.

Joint Commissioning Panel for Mental Health (JCPMH). (2013, May). *Guidance for Commissioners of Forensic Mental Health.* https://www.rcpsych.ac.uk/pdf/jcpmh-forensic-guide.pdf.

Johnson, M., Day, M., Moholkar, R., Gilluley, P., & Goyder, E. (2018). Tackling obesity in mental health secure units: a mixed method synthesis of available evidence. *BJPsych open*, *4*(4), 294-301.

Kardas, P., Lewek, P., & Matyjaszczyk, M. (2013). Determinants of patient adherence: a review of systematic reviews. *Frontiers in pharmacology*, *4*, 91.

Kennedy, C., Salsberry, P., Nickel, J., Hunt, C., & Chipps, E. (2005). The burden of disease in those with serious mental and physical illnesses. *Journal of the American Psychiatric Nurses Association*, *11*(1), 45-51.

Katschnig, H. (2006). Quality of life in mental disorders: challenges for research and clinical practice. *World psychiatry*, *5*(3), 139–145.

Kinner, S. A., & Wang, E. A. (2014). The case for improving the health of ex-prisoners. *American Journal of Public Health*, *104*(8), 1352-1355.

Kinney, M. (2009). Being assessed under the 1983 Mental Health Act—can it ever be ethical?. *Ethics and Social Welfare*, *3*(3), 329-336.

Kisely, S., Crowe, E., & Lawrence, D. (2013). Cancer-related mortality in people with mental illness. *JAMA psychiatry*, *70*(2), 209-217.

Koponen, A. M., Simonsen, N., & Suominen, S. (2017). Quality of primary health care and autonomous motivation for effective diabetes self-management among patients with type 2 diabetes. *Health psychology open*, *4*(1).

Kubzansky, L. D., Kubzansky, P. E., & Maselko, J. (2004). Optimism and pessimism in the context of health: Bipolar opposites or separate constructs?. *Personality and social psychology bulletin*, *30*(8), 943-956.

Kwan, M. Y., Faulkner, G. E., Arbour-Nicitopoulos, K. P., & Cairney, J. (2013). Prevalence of health-risk behaviours among Canadian post-secondary students: descriptive results from the National College Health Assessment. *BMC public health*, *13*(1), 1-6.

Lammie, C., Harrison, T. E., Macmahon, K., & Knifton, L. (2010). Practitioner attitudes towards patients in forensic mental health settings. *Journal of psychiatric and mental health nursing*, *17*(8), 706-714.

La Placa, V., McNaught, A., & Knight, A. (2013). Discourse on wellbeing in research and practice. *International Journal of Wellbeing*, *3*(1), 116-125.

Laursen, T. M., Nordentoft, M., & Mortensen, P. B. (2014). Excess early mortality in schizophrenia. *Annual review of clinical psychology*, *10*, 425-448.

Lawrence D, Holman CJD, Jablensky AV. *Preventable Physical Illness in People with Mental Illness*. The University of Western Australia, 2001

Lawrence, D., & Kisely, S. (2010). Inequalities in healthcare provision for people with severe mental illness. *Journal of psychopharmacology*, *24*(4), 61-68.

Lawrence, D., Kisely, S., & Pais, J. (2010). The epidemiology of excess mortality in people with mental illness. *The Canadian Journal of Psychiatry*, *55*(12), 752-760.

Lee, C., & Owens, R. G. (2002). Issues for a psychology of men's health. *Journal of Health Psychology*, *7*(3), 209-217.

Lehman, A. F. (1988). A quality of life interview for the chronically mentally ill. *Evaluation and program planning*, *11*(1), 51-62.

Lewis, C. F., Fields, C., & Rainey, E. (2006). A study of geriatric forensic evaluees: who are the violent elderly? *Journal of American Academy of Psychiatry and Law*, *34,* 324–332.

Lincoln, Y., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage.

Litschge, C. M., & Vaughn, M. G. (2009). The mentally ill offender treatment and crime reduction act of 2004: Problems and prospects. *The Journal of Forensic Psychiatry & Psychology*, *20*(4), 542-558.

Livingston, J. D., Nijdam-Jones, A., Lapsley, S., Calderwood, C., & Brink, J. (2013). Supporting recovery by improving patient engagement in a forensic mental health hospital: Results from a demonstration project. *Journal of the American Psychiatric Nurses Association*, *19*(3), 132-145.

Livingston, J. D., Nijdam-Jones, A., & Brink, J. (2012). A tale of two cultures: Examining patient-centered care in a forensic mental health hospital. *Journal of Forensic Psychiatry & Psychology, 23*(3), 345-360.

Lockwood, G., Henderson, C., & Thornicroft, G. (2012). The Equality Act 2010 and mental health. *British Journal of Psychiatry, 200*, 182–183.

Lohan, M. (2007). How might we understand men's health better? Integrating explanations from critical studies on men and inequalities in health. *Social science & medicine, 65*(3), 493-504.

Margetić, B., Ivanec, D., Žarković Palijan, T., & Kovačević, D. (2012). Offender patients' opinions on placement in a forensic hospital. *Criminal Behaviour and Mental Health, 22*(5), 360-368.

Martin, L. R., Williams, S. L., Haskard, K. B., & Di Matteo, M. R. (2005). The challenge of patient adherence. *Therapeutics and clinical risk management, 1*(3), 189.

Maguire, D., & Taylor, J. (2019). A systematic review on implementing education and training on trauma-informed care to nurses in forensic mental health settings. *Journal of forensic nursing, 15*(4), 242-249.

McCloughen, A., & Foster, K. (2011). Weight gain associated with taking psychotropic medication: An integrative review. *International Journal of Mental Health Nursing, 20*(3), 202-222.

McCullough, S., Stanley, C., Smith, H., Scott, M., Karia, M., Ndubuisi, B., Ross, C. C., Bates, R., & Davoren, M. (2020). Outcome measures of risk and recovery in Broadmoor High Secure Forensic Hospital: stratification of care pathways and moves to medium secure hospitals. *BJPsych open, 6*(4).

Meiklejohn, C., Sanders, K., & Butler, S. (2003). Physical health care in medium secure services. *Nursing Standard, 17*(17), 33-37.

Michalos, A. C. (2017). Social Indicators Research and Health-Related Quality of Life Research. In *Connecting the Quality of Life Theory to Health, Well-being and Education* (pp. 25-58). Springer International Publishing.

Michie, S., Atkins, L., & Gainforth, H. L. (2016). Changing behaviour to improve clinical practice and policy. *Novos Desafios, Novas Competências: Contributos Atuais da Psicologia. Axioma-Publicações da Faculdade de Filosofia*, 41-60.

Michie, S., Atkins, L., & West, R. (2014) *The Behaviour Change Wheel: A Guide to Designing Interventions.* Silverback Publishing.

Michie, S., Van Stralen, M.M., & West, R. (2011) The behaviour change wheel: a new method for characterising and designing behaviour change interventions. *Implementation Science, 6* (1), 1.

Miller, C., & Bauer, M. S. (2014). Excess mortality in bipolar disorders. *Current psychiatry reports*, *16*(11), 499.

Miller, B. J., Paschall III, Ph D, C. B., & Svendsen, D. P. (2006). Mortality and medical comorbidity among patients with serious mental illness. *Psychiatric services*, *57*(10), 1482-1487.

Morrison, A. P., Frame, L., & Larkin, W. (2003). Relationships between trauma and psychosis: A review and integration. *British Journal of Clinical Psychology*, *42*(4), 331-353.

Muskett, C. (2014). Trauma-informed care in inpatient mental health settings: A review of the literature. *International journal of mental health nursing*, *23*(1), 51-59.

Naylor, C., Parsonage, M., McDaid, D., Knapp, M., Fossey, M., & Galea, A. (2012). *Long-Term Conditions and Mental Health: The Cost of Co-morbidities*. The King's Fund.

Naylor, C., Das, P., Ross, S., Honeyman, M., Thompson, J., & Gilburt, H. (2016). *Bringing together physical and mental health*. The King's Fund.

NHS Confederation (2009). Healthy mind, healthy body. How liaison psychiatry services can transform quality and productivity in acute settings. NHS Confederation. www.rcpsych.ac.uk/pdf/Healthmindhealthbody.pdf

NICE Guidelines. (2016, May). *Physical Health of People in Prison.* https://www.nice.org.uk/guidance/ng57/history

NICE Guidelines. (2014, March). *Psychosis and schizophrenia in adults: prevention and management*. https://www.nice.org.uk/guidance/cg178

NHS England. (2021). Adult High Secure Service Specification. NHS England. https://www.england.nhs.uk/wp-content/uploads/2021/02/service-specification-high-secure-mental-health-services-adult.pdf

NHS England. (2013). *High Secure Mental Health Service Specification*. NHS England. https://www.england.nhs.uk/wp-content/uploads/2013/06/c02-high-sec-mh.pdf

NHS England. (2014). *Five Year Forward View*. NHS England.

NHS England. (2016). *Improving the Physical Health of People with Serious Mental Illness.* NHS England.

NHS England. (2019) *The NHS Long Term Plan.* NHS England. https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

NHS England. (2021) *Managing a Health Weight in Adult Secure Services – Practice Guidance.* NHS England. https://www.england.nhs.uk/wp-content/uploads/2021/02/B0121_Managing-a-healthy-weight-Adult-Secure-Services-practice-guidance-090221.pdf

Nnatu, I., Mahomed, F., Shah, A. (2005). Is there a need for elderly forensic psychiatry services? *Medicine, Science and Law, 45*(2).

Ogden, J. (2016) Celebrating variability and a call to limit systematisation: the example of the Behaviour Change Technique Taxonomy and the Behaviour Change Wheel. *Health Psychology Review, 10* (3), 245-250.

Osborn, D. P., & Warner, J. P. (1998). Assessing the physical health of psychiatric patients. *Psychiatric Bulletin*, *22*(11), 695-697.

Parsonage, M. (2016). Traumatic brain injury and offending. *Centre for Mental health*.

Patenaude, A. L. (2004). No promises, but I'm willing to listen and tell what I hear: Conducting qualitative research among prison inmates and staff. *The Prison Journal*, *84*, 69-91.

Perlin, M. L. (2016). International human rights and institutional forensic psychiatry: The core issues. In *The Use of Coercive Measures in Forensic Psychiatric Care* (pp. 9-29). Springer.

Price-Robertson, R., Obradovic, A., & Morgan, B. (2016). Relational recovery: beyond individualism in the recovery approach. *Advances in Mental Health, 15*(2), 108-120.

Phelan, M., Stradins, L., & Morrison, S. (2001). Physical Health of People with Severe Mental Illness. *British Medical Journal*, *322*(7284), 443.

Post, M. (2014). Definitions of quality of life: what has happened and how to move on. *Topics in spinal cord injury rehabilitation*, *20*(3), 167-180.

Read, J. (2005). The bio-bio-bio model of madness'. *Psychologist*, *18*(10), 596.

Reynolds-Tylus, T. (2019). Psychological reactance and persuasive health communication: a review of the literature. *Frontiers in Communication*, *4*, 56.

Ricciardelli, R., Clow, K. A., & White, P. (2010). Investigating hegemonic masculinity: Portrayals of masculinity in men's lifestyle magazines. *Sex Roles*, *63*(1-2), 64-78.

Ridley, J., McKeown, M., Machin, K., Rosengard, A., Little, S., Briggs, S., Jones, F., Deypurkaystha, M. (2014). *Exploring family carer involvement in forensic mental health services*. Support in Mind Scotland.

Riggs Romaine, C. L., & Kavanaugh, A. (2019). Risks, benefits, and complexities: Reporting race & ethnicity in forensic mental health reports. *International Journal of Forensic Mental Health*, *18*(2), 138-152.

Robertson, J., Emerson, E., Gregory, N., Hatton, C., Turner, S., Kessissoglou, S., & Hallam, A. (2000). Lifestyle related risk factors for poor health in residential settings for people with intellectual disabilities. *Research in developmental disabilities*, *21*(6), 469-486.

Robson, D., & Gray, R. (2007). Serious mental illness and physical health problems: a discussion paper. *International journal of nursing studies*, *44*(3), 457-466.

Robson, D., Haddad, M., Gray, R., & Gournay, K. (2013). Mental health nursing and physical health care: A cross-sectional study of nurses' attitudes, practice, and perceived training needs for the physical health care of people with severe mental illness. *International Journal of Mental Health Nursing*, *22*(5), 409-417.

Rosenberg, B. D., & Siegel, J. T. (2018). A 50-year review of psychological reactance theory: Do not read this article. *Motivation Science*, *4*(4), 281.

Rosenstock, I. M., Strecher, V. J., Becker, M. H. (1988). Social learning theory and the health belief model. *Health Education & Behavior, 15 (2), 175–183.*

Ryan, R. M., & Deci, E. L. (2011). A self-determination theory perspective on social, institutional, cultural, and economic supports for autonomy and their importance for well-being. In *Human autonomy in cross-cultural context* (pp. 45-64). Springer.

Sangelaji, B., Smith, C., Paul, L., Treharne, G., & Hale, L. (2017). Promoting physical activity engagement for people with multiple sclerosis living in rural settings: A proof-of-concept case study. *European Journal of Physiotherapy*, *19*(1), 17-21.

Seligman, M. E. (2011). Flourish: a visionary new understanding of happiness and well-being. *Policy, 27*(3), 60-1.

Sequeira, H., & Halstead, S. (2002). Control and restraint in the UK: service user perspectives. *The British journal of forensic practice*, *4*(1), 9-11.

Sesso, H. D., Paffenbarger Jr, R. S., & Lee, I. M. (2000). Physical activity and coronary heart disease in men: The Harvard Alumni Health Study. *Circulation*, *102*(9), 975-980.

Singleton, N., Farrell, M., & Meltzer, H. (2003). Substance misuse among prisoners in England and Wales. *International review of psychiatry*, *15*(1-2), 150-152.

Shah, A., Waldron, G., Boast, N., Coid, J. W., & Ullrich, S. (2011). Factors Associated with Length of Admission at a Medium Secure Forensic Psychiatric Unit. *The Journal of Forensic Psychiatry & Psychology, 22*, 496–512.

Shaw, C. (2014). Peer support in secure services. *Together: for mental wellbeing.* http://www.together-uk.org/wp-content/uploads/downloads/2014/11/Peer-Support-in-Secure-Settings-Final-Report-4-Nov-14.pdf

Shaw, J., Davies, J., & Morey, H. (2001). An assessment of the security, dependency and treatment needs of all patients in secure services in a UK health region. *The Journal of Forensic Psychiatry*, *12*(3), 610-637.

Slade, M. (2009). The contribution of mental health services to recovery. *Journal of Mental Health, 18*(5), 367-371.

Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., Perkins, R., Shepherd, G., Tse, S., & Whitley, R. (2014). Uses and abuses of recovery: Implementing recovery-oriented practices in mental health systems. *World Psychiatry, 13*(1), 12–20.

Smith, J.A. (1996). Beyond the divide between cognition and discourse: using interpretative phenomenological analysis in health psychology. *Psychology and Health, 11,* 261-271.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* Sage.

Smith, S., Yeomans, D., Bushe, C. J., Eriksson, C., Harrison, T., Holmes, R., Mynors-Wallis, L., Oatway, H., & Sullivan, G. (2007). A well-being

programme in severe mental illness. Baseline findings in a UK cohort. *International journal of clinical practice*, *61*(12), 1971–1978.

Snyder, C., van Wormer, K., Chadha, J., & Jaggers, J. W. (2009). Older adult inmates: The challenge for social work. *Social work*, *54*(2), 117-124.

Spandler, H., & Calton, T. (2009). Psychosis and human rights: conflicts in mental health policy and practice. *Social Policy and Society*, *8*(2), 245-256.

Stein, P., & Kendall, J. (2006). *Psychological Trauma and the Developing Brain.* Hawthorne Press.

Stroup, T. S., & Gray, N. (2018). Management of common adverse effects of antipsychotic medications. *World Psychiatry*, *17*(3), 341-356.

Sturge, G., (2020) UK Prison Population Statistics. *UK House of Commons Briefing Paper*. https://researchbriefings.files.parliament.uk/documents/SN04334/SN04334.pdf.

Suls, J., & Rothman, A. (2004). Evolution of the biopsychosocial model: prospects and challenges for health psychology. *Health psychology*, *23*(2), 119.

Tapp, J., Warren, F., Fife-Schaw, C., Perkins, D., & Moore, E. (2013). What do the experts by experience tell us about 'what works' in high secure forensic inpatient hospital services?. *The Journal of Forensic Psychiatry & Psychology*, *24*(2), 160-178.

Tessier, A., Boyer, L., Husky, M., Baylé, F., Llorca, P. M., & Misdrahi, D. (2017). Medication adherence in schizophrenia: The role of insight, therapeutic alliance and perceived trauma associated with psychiatric care. *Psychiatry research*, *257*, 315-321.

Tetlie, T., Eik-Nes, N., & Tom Palmstierna, M. D. (2008). The effect of exercise on psychological & physical health outcomes: preliminary results from a Norwegian forensic hospital. *Journal of Psychosocial Nursing & Mental Health Services*, *46*(7), 38.

Thomas, J. (2009). Current measures and the challenges of measuring children's wellbeing. *Office for National Statistics*.

Thornicroft, G,. Rose, D,. & Kassam, A. (2007) Discrimination in Health Care Against People with Mental Illness. *International Review of Psychiatry, 19(*2), 113-122.

Walker, E., Kestler, L., Bollini, A., & Hochman, K. M. (2004). Schizophrenia: etiology and course. *Annual Review of Psychology*, *55*, 401-430.

Walsh, E., & Freshwater, D. (2009). Developing the mental health awareness of prison staff in England and Wales. *Journal of Correctional Health Care*, *15*(4), 302-309.

Walsh, C. A., Cahir, C., Tecklenborg, S., Byrne, C., Culbertson, M. A., & Bennett, K. E. (2019). The association between medication non-adherence and adverse health outcomes in ageing populations: A systematic review and meta-analysis. *British Journal of Clinical Pharmacology, 85*(11), 2464-2478.

Whitley, R., & Drake, R. E. (2010). Recovery: a dimensional approach. *Psychiatric services*, *61*(12), 1248-1250.

Whoqol Group. (1995). The World Health Organization Quality of Life Assessment (WHOQOL): Position Paper from the World Health Organization. *Social Science & Medicine*, *41*(10), 1403-1409.

Willig, C. (2001). *Introducing qualitative research in psychology*. Sage.

Willig, C. (2012). Perspectives on the epistemological bases for qualitative research. In H. Cooper (Ed.), *The handbook of research methods in psychology* (pp.1-17). American Psychological Association.

Willig, C. (2013). *Introducing qualitative research in psychology*. McGraw-Hill Education.

Wirshing, D. A. (2004). Schizophrenia and obesity: impact of antipsychotic medications. *Journal of Clinical Psychiatry*, *65*(18), 13-26.

Wong, M. T., Lumsden, J., Fenton, G. W., & Fenwick, P. B. (1995). Elderly offenders in a maximum security mental hospital. *Aggressive behavior*, *21*(5), 321-324.

World Health Organisation. (1998). The World Health Organization Quality of Life Assessment (WHOQOL): development and general psychometric properties. *Social Science & Medicine, 46*(12), 1569-1585.

World Health Organization. (2014). *Basic documents, 48th ed*. *(World Health Organization).* https://apps.who.int/iris/handle/10665/151605

World Health Organisation. (2015) *Health and Human Rights Factsheet (WHO Publication No 323).* http://www.who.int/mediacentre/factsheets/fs323/en/.

World Health Organization Maximizing Positive Synergies Collaborative Group. (2009). An assessment of interactions between global health initiatives and country health systems. *The Lancet, 373*(9681), 2137-2169.

Zumstein, N., & Riese, F. (2020). Defining Severe and Persistent Mental Illness-A Pragmatic Utility Concept Analysis. *Frontiers in psychiatry*, *11*, 648.

Veenhoven, R. (2007). Subjective measures of well-being. In *Human well-being* (pp. 214-239). Palgrave Macmillan.

Verdonk, P., Seesing, H., de Rijk, A. (2010) Doing masculinity, not doing health? A qualitative study among Dutch male employees about health beliefs and workplace physical activity. *BMC Public Health, 19,* 10-712.

Völlm, B., Edworthy, R., Holley, J., Talbot, E., Majid, S., Duggan, C., Weaver, T., & McDonald, R. (2017). A mixed-methods study exploring the characteristics and needs of long-stay patients in high and medium secure settings in England: implications for service organisation. *Health Service and Delivery Research, 5*(11).

Völlm, B., Foster, S., Bates, P., & Huband, N. (2017) How Best to Engage Users of Forensic Services in Research: Literature Review and Recommendations. *International Journal of Forensic Mental Health,* 16, 183-195.

Völlm, B., & Nedopil, N. (2016). The use of coercive measures in forensic psychiatric care. *Legal, Ethical and Practical Challenges.* Springer.

APPENDICES

Appendix A: Legislative Acts within FMHS

Appendix B: Information Sheet

Appendix C: Consent Form

Appendix D: Demographics Questionnaire

Appendix E: Debrief Sheet

Appendix F: Interview Schedule

Appendix G: Coding Transcript

Appendix H: Coding Table

Appendix I: Thematic Maps

Appendix J: NHS Ethics Letter

APPENDICES

Appendix A: Legislative Acts within FMHS

Appendix A: Legislative Acts Within FMHS

Human Rights Act	UK law has enshrined most of the international human rights treaties, with the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment 1987 and the UN Convention on the Rights of Persons with Disabilities 2006 being most relevant to FMHS. The UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment 1987 criminalises acts of torture within public authority services to prevent abuse at the arrest, interrogation, detention, and imprisonment of individuals. The UN Convention on the Rights of Persons with Disabilities 2006 aims to protect the rights of people with disabilities, including mental health diagnoses. A key part of this is informed consent and decision making. Article 25 within the UN Convention on the Rights of Persons with Disabilities 2006 – the right to health – which protects access to treatment and accessible information on healthcare services to ensure good quality physical and mental healthcare prevails.
Equalities Act	The Equality Act (2005) ratified most of the UN Convention on the Rights of Persons with Disabilities with existig discrimination legislation. There are nine protected characteristics within the act: disability, age, race, religion or belief, sex, sexual orientation, gender reassignment, and pregnancy and maternity; with mental health diagnoses being included within the protected characteristic of disability. Many patients in FMHS will also have other protected characteristics aside from disability. By identifying

	protected characteristics the aim is to prevent discrimination and stigma.
Mental Health Act	The Mental Health Act (1983) (MHA) sets out the legal framework for the reception, detention, care & treatment of someone with a suspected or diagnosed mental health condition. To recommend detention under the MHA an assessment with an approved mental health professional (AMHP), a registered medical practitioner (e.g., individual's GP), and a doctor trained in the MHA must take place. An individual can be detained even if they have capacity or are unwilling, and the MHA act outlines powers for physical restraint and forcible medical treatment if this is refused. There are different sections of the MHA that individuals can be detained under, and the length and nature of the detention will affect which section is used, however there is no limit to how often sections relating to treatment can be renewed and with some hospital orders the Length of Stay (LoS) will relate to treatment 'success'.
Mental Capacity Act	The Mental Capacity Act (MCA) 2006 refers to the assessment of capacity to make treatment decisions whilst under the care of or detained by public services. It is separate from the MHA; however, a capacity assessment should be made in all cases regarding an individuals' treatment. If they are deemed to 'lack capacity' a 'best interest' decision will be made often by their care team or family member.

Appendix B: Information Sheet

Information for Participants

Before you decide whether to take part X would like you to understand why this research is being done and what it would involve for you.

Why are we doing this study?

We want to gather information about patients' experiences of their physical healthcare whilst in a forensic mental health hospital, like [insert name of hospital]. We think patients' knowledge can help us understand how to make physical healthcare more available and improve the quality. The first step is to understand what you currently have access to, if this is good or not and what changes you would want to see.

What we will talk about?

We want to hear your opinion about the physical healthcare available in forensic mental health hospitals, if there have been any difficulties accessing physical healthcare in forensic mental health hospitals and if this care has helped you feel healthy/well. We also want to hear any ideas you might have to improve physical health care in a forensic mental health hospital and if the quality of physical healthcare has changed over time.

What will happen if I take part?

If you decide to take part, X will contact you via your clinical team, in person or by post to arrange a time and place for the interview. The interviews will usually be held on the ward.

You will be asked to sign a consent form. Even after signing this form you do not have to answer any questions you do not wish to answer. X will ask you some questions about the physical healthcare whilst you have been in a forensic mental health hospital. X will <u>not</u> ask about the details of your offences. If you feel uncomfortable in the interview you may pause or leave the interview at any time without having to give a reason.

The interview will take approximately 1 hour, and our meeting will last about 1 hour and 30 minutes. The interview can be over two sessions, if you prefer. You can have breaks during the interview. The interview will be audio recorded and then written up by X.

You can ask for your information to be withdrawn from this project up to two weeks after the interview. X will not ask why you want your information to be withdrawn and she will destroy it immediately.

Do I have to take part?

No, you don't have to take part. It's up to you to decide whether or not to participate in this research. Your care and treatment by the hospital will not be affected by whether you choose to take part.

Will I benefit from taking part?

Research participants often find that speaking about their experiences can be helpful. X wants to understand the patient's perspective of physical healthcare and hopes this will benefit you and other people who are in the care of forensic mental health hospitals. X is also offering £5 vouchers to reimburse you for your time.

Are there any risks involved?

Hopefully you will find talking about your experiences a helpful process, but it can also be difficult or upsetting. If you think talking about physical healthcare will be distressing, you do not have to take part. If the interview is upsetting, we will pause and only carry on if you are ready. We can also stop the interview and you do not have to carry on. You can also leave the interview. It will not affect your care.

After the interview you will be asked how you feel, and a member of your clinical team can be informed to offer support. We will also give you a 'debrief sheet' with ways to seek support if you want to access these afterwards.

Will my information be confidential?

No one will know you are taking part other than X and your clinical team. It is your decision whether you choose to tell anybody else.

X will only tell your clinical team that you are taking part in the study; she will not share the information you give her. However, if X is significantly concerned about a risk or danger to yourself or others, the clinical team will be asked to follow-up these concerns

with yourself. X will always attempt to discuss this with you before she speaks to someone.

Your name and any identifiable information will be removed before writing up the findings. Only X will have access to your personal information (e.g. name and ward). Any names you say, including yours, will be given an alternative.

Where will my information be kept? Will it be safe?

All data will be kept on a password-protected file and computer, which will be kept in a secured place. X will keep your personal information (your name and contact details) separate from your interview. Only X will have access to your personal information. What you say in the interview will be given an identification number. Once the research has been completed all data will be destroyed.

What will happen to the results of this study?

The results of this study will be written up as part of X's qualification. The results may be submitted for publication in academic journals and presented at conferences. None of your personal information will be included. The identification number or alternative name will be used.

Will I be contacted after the study has ended?

If you do not want a summary of the study, you will not be contacted once the study has ended. If you would like a summary of the findings be sent to you once the project has ended X will send these to you with a letter. To request a summary please tick the box on the consent form. You are welcome to contact X after the interview if you have any queries about this study whilst the project is running.

What if there is a problem?

If you have any concerns about how X has approached or treated you during this research project, you can speak to the Patient Advice and Liaison Service (PALS number: XXX) run by the National Health Service (NHS) or a member of staff at University of East London. Please ask X or (named person of contact at the hospital) if you need more information.

Who has approved this study?

This study is part of a Clinical Psychology Doctorate thesis being undertaken by X X (Trainee Clinical Psychologist and Researcher) who attends The University of East London. She is supervised by Dr XX (Clinical Psychologist and Researcher). This study has received ethical approval from the NHS Research Ethics Committee.

Is my data affected by the General Data Protection Regulation (GDPR)?
All your data will be handled to follow GDPR guidelines and maintain your privacy. The University of East London is the sponsor of this study. The University of East London and their staff will not have access to any of your personal information.

[NHS Hospital] will use your name and contact details to tell you about the research study. The [NHS Hospital] will not breach NHS Confidentiality when identifying patients for research.

X is working with your hospital and organising the research. She will not have access to your medical records. To protect your rights X will not use any identifiable information in the final written work or on anything the University of East London may see. X will act as the data controller for this study, this means that she is responsible for looking after your information. She will not keep any identifying information after the research is completed.

More information is available at https://www.hra.nhs.uk/information-about-patients/.

What should I do if I want more information or want to take part?
If you want more information or you are interested in taking part please contact X through your care team, (named person of contact at the hospital), or using the contact email below.

Email: uXXXXXXX@uel.ac.uk

Appendix C: Consent Form

CONSENT TO PARTICIPATE

Service Users experiences of physical healthcare in a forensic mental health hospital

Please tick the appropriate box

	Yes	No
I have read the information sheet and have been given a copy.		
The nature and purpose of the research has been explained to me and I have had the opportunity to talk about it in detail.		
I understand the reason for the research and the procedures I will be involved in.		
I understand the data will remain anonymous unless the interviewer is concerned about the immediate risk of harm to others or myself, in which case they will inform (named of contact at the hospital)		
I understand that only the interviewer, supervisor and reviewer of academic research would have access to what was said in the interview and other questionnaire data. I also understand that only the interviewer will know my personal information.		
It has been explained to me what will happen to my data once the study has been completed.		
I have been given a sheet with information about support I can access.		
I have been given an explanation as to why the interview will be audio recorded.		
I would like a summary of the study results sent to me.		
I freely and fully consent to participate in the study, which has been fully explained to me.		
Once I give this consent I understand that I have the right to withdraw from the study within two weeks from the interview date, without disadvantage to myself and without being obliged to give any reason, and that the data collected will be destroyed.		

Participant's Name (BLOCK CAPITAL)…………………………………………

Participant's Signature ……………………………………………………………

Researcher's Name (BLOCK CAPITALS)…………………………………………

126

Researcher's Signature……………………………

Date: ……………………..………

Appendix D: Demographics Questionnaire

DEMOGRAPHIC QUESTIONNAIRE

How old are you?

_____

How do you describe your ethnicity?

_____

What (if any) religion do you practice or have an association with?

_____

How long have you been in forensic mental health services?

_____

How long have you been in your current forensic mental health hospital?

_____

How often do you exercise? (times per month)

_____

How often do you cook for yourself? (times per month)

_____

Appendix E: Debrief Sheet

DEBRIEF (High Secure)

Information to support your wellbeing

Resources to support your own wellbeing & safety

If you feel that you want to take your own life or hurt yourself or others tell a member of the ward team as soon as you can who will offer support and help you stay safe.

If you need help and support with your mental health please speak to your named nurse on the ward. You can also ask to speak to your consultant or duty doctor.

If you would like someone to check your wellbeing later today, ask [redacted] to organise this.

You can ask to speak to the local collaborator of the research, [redacted], who will ensure support is offered.

You can also ask ward staff to make an appointment with your GP.

If you want non-judgmental support and someone to talk to please call the Samaritans on **116 123**. This is a free number and Samaritans are available 24 hours a day, every day. You can ask ward staff if you want to speak to them.

You do not need to be suicidal to talk to the Samaritans; you can talk to them about anything that you find challenging and want to discuss it.

Resources to support your mental health and physical health

If you want more information about mental health difficulties and ways of coping you can ask for information leaflets available from the psychiatry team.

SANE also offers emotional support and information to anyone affected by mental health problems via their helpline. The helpline is open everyday from 6pm-11pm. **Tel: 0300 304 7000.** This is a freephone number.

If you're not happy with your physical and mental healthcare

If you want advice or support with the care you receive from the hospital you can talk to the Patient Advice and Liaison Service (PALS). They will listen and try to resolve concerns, provide information and give support. This can be for mental and physical healthcare. Call the [redacted] PALS service on [redacted]**.** All contact is confidential.

You can also speak to an Independent Mental Health Advocate (IMHA) who can meet you on the ward. They can offer advice and support about your rights under the mental health act and any treatment you are receiving or might be given.

129

[redacted] provide Independent Mental Health Advocacy for patients at [redacted]. The advocacy team is based in the hospital and available Monday to Friday from 9am until 5pm. If you would like the support of an advocate you can call their confidential helpline on **[redacted]**.

Appendix F: Interview Schedule

PRELIMINARY INTERVIEW SCHEDULE

What is your understanding of wellbeing? [Changed to 'What does wellbeing mean to you?]
> *How would you describe mental wellbeing?*
> *How would you describe physical wellbeing?*

Do you feel your physical health impacts on your mental or general wellbeing? [Changed to 'Does your physical health impact your mental and emotional wellbeing?]
> *In what way?*

How do you support your physical wellbeing? [Changed to 'What do you do to support your physical health?]
> *How often?*
> *What do you do?*

How do staff support your physical wellbeing?
> *How often?*
> *What do you do?*

Have you ever worried about your health?

What services are available to you for your physical health?

Do you feel you need to have ongoing physical healthcare support? [Changed to 'Do you feel you have any long term physical healthcare needs?]
> *How would this be met?*
> *What would happen?*

What do you think contributes to poor health in a forensic mental health hospital?

What do you think contributes to good health in a forensic mental health hospital?

Have you had any difficulties accessing services for your physical health?

Has anything been challenging about physical healthcare?
> *What has been challenging? Or how?*
> *What would have made this better?*

If you were in the community do you think your physical health would be different?

> *How might it be different?*
>
> *How do you feel about that?*
>
> *Why do you think it would be different?*

If you wanted or could, would you access physical health services more or less?

Have you been able to access physical healthcare services more or less in the last 5 years within forensic mental health services?

> *Why do you think that is?*
>
> *What has changed or not changed?*
>
> *When did it change?*

Do you think the quality of physical healthcare is good enough?

> *Would it be better or worse in the community? Or lesser secure services?*
>
> *Why would that be?*

Has the quality changed in the last 5 years? Or services available?

> *What have you noticed about the services/quality?*
>
> *How do you feel about what is available to you?*
>
> *Why do you think it has changed?*

Do you think physical healthcare impacts your quality of life?

> *How does it impact? Or why does it not impact?*
>
> *Would you change that? How?*

What changes might be made to physical healthcare to improve quality of life?

What is being provided or useful for your physical health?

What would you like more of to support your physical health?

Appendix G: Coding Transcript Excerpt

Line	Transcript	Code	Comment
010	CI: So what do you do at the moment to improve your		
011	physical wellbeing?		
012			
013	P006: I go out for walks on the terrace down there, you can	Walking and Physical	Is there a mental
014	see it, you see that fence there, that's actually the perimeter	exercise	health benefit to this?
015	of where I'm allowed to go out walking (looking out window,		
016	IE points out fence that is the perimeter of where he is		Does this change how
017	allowed to go out walking) on my own as well no staff, cos	Not needing staff	exercise feels, less
018	this is a rehab ward so we are allowed to do that. So I do	facilitation	regimented?
019	that and I also go to work twice a week in the main		Restrictive?
020	workshops, and then I go shopping once a week as well,	Recovery focus activities	
021	which as you have seen there are a lot of stairs to get to this		Focus on broader
022	ward, so that is a good bit of exercise as well. But that is		range of activities in
023	about all I do really.		mental health
024			services.
025	CI: And do staff do anything to help support your physical		
026	health?		Improve question
027			clarity
028	P006: Staff are always offering terrace walks, now the	Offering activities	Repetitive nature of
029	terrace walks is the other side of the picket fence, and I don't		the activities offered.
030	know if you know but it goes way way way way down there,		
031	staff will come to you and say do you want to go for a terrace	Feeling far away, barrier to	
032	walk and stuff like that so we do get offered things by the	motivation	
033	staff like that.		
034			
035	CI: Is that something you are interested in doing more-		
036			
037	P006: Sometimes I do and sometimes I don't, it just all	Motivation for consistent	Key quote: apathetic
038	depends, what, how I am feeling in terms of energy and stuff	engagement	nature of
039	you know, I do take medications which affect my, not so		engagement and
040	much my mental wellbeing but my physical, medication does	Impact of medication and	barriers of mental
041	have an effect on that.	mental health	health service
042			
043	CI: I can understand that, have you ever worried about your		
044	health when you have been in a hospital like this?		
045			Trust in staff and
046	P006: Not particularly no.		service
047			
048	CI: Why do you think that is?		
049			

| References | Mailings | Review | View | Help | Grammarly | Table Design |

Line	Transcript	Code	Note
050	P006: Not sure.		
051			
052	CI: Do you feel that the staff are very responsive to your		
053	physical health needs as well as your mental health needs?		
054			
055	P006: Yeah, I asked to discuss it once a month, with my, you	Proactive engagement	
056	know about primary nurses and all that, yeah so I have a	Concern about physical health	
057	primary nurse, and we discuss that once a month, my mental		Recovery approach
058	wellbeing, my physical wellbeing, we do discuss it monthly,		and holistic care
059	and I have an extensive medical examination once every 6		planning
060	months for my CPA's.		
061			
062	CI: And do you find that, that's helpful or not helpful?		
063			
064	P006: I think it is helpful, you know, just a little nod that you	Reassurance of physical	How do staff promote
065	are alright like, that you are not ill in any way.	wellbeing	physical health at
066			these times?
067	CI: Do you trust them when they go through your physical		
068	health and make sure everything is OK?		
069			
070	P006: Yeah course yeah	Trust in staff	Importance of
071			relational approach to
072	CI: Do you know what services are available for physical		care in forensic
073	health here?		services
074			
075	P006: Dietician is here, and we can see the Dietician, and we	Accessible services	Strong awareness of
076	have got a healthcare centre, just across the way from the		the healthcare
077	building, erm which has got like dentists and physiotherapy	Primary care facilitation	services on offer –
078	and a GP doctor, and optician, so yeah we got all that at our		link to engagement?
079	disposal as well.		
080			
081	CI: And is that something you can access if you need to or is it		
082	hard?		
083			
084	P006: Yeah, no no it is very easy you can usually get an	Quick access to care	Favourable
085	appointment like for the GP you can get an appointment		perception of what is
086	probably within a couple of days, but like the dentist only		on offer and
087	comes in once a month and the optician comes in once a		responsiveness – how
088	month as well, so if you want to see them 2 you will have to		does this effect
089	wait a little while, but the physiotherapy is by referral only as		impact on health?
090	well, but to see the GP is usually quite instant.		
091			

Appendix H: Coding Table Example

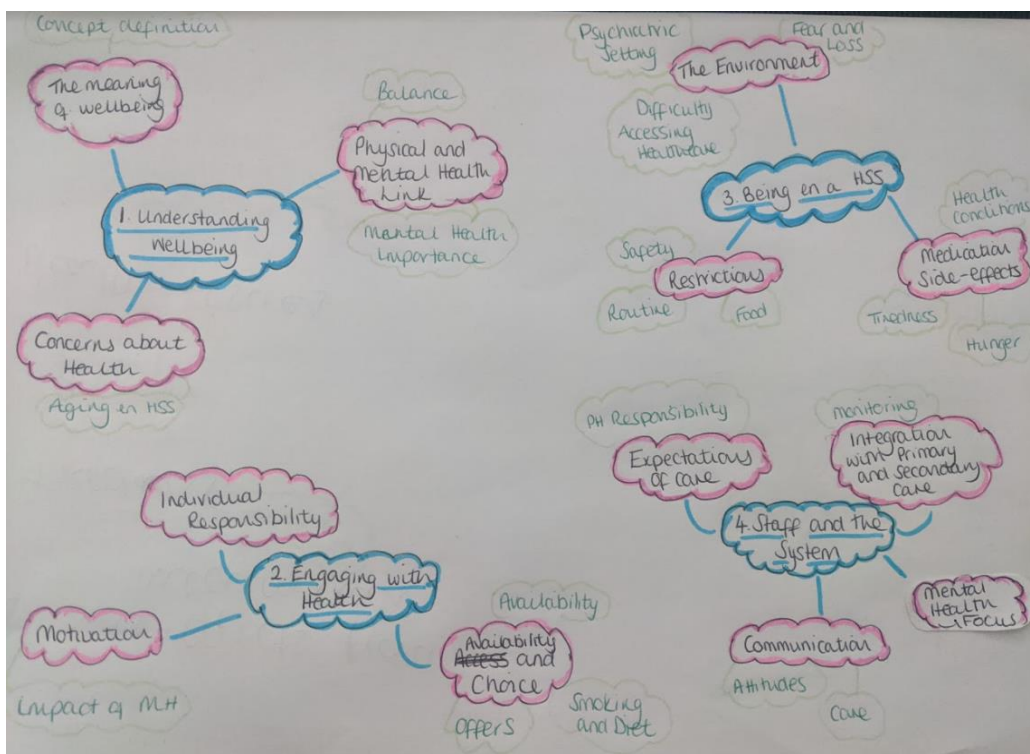|	A	B	C	D	E	F
	PN	Line	Quote	Code	Theme	Global Theme
	OO2	2	Well, it comes in 2 forms physical and mental. Mental being emotional and um essentially	Meaning of Wellbeing	Understanding Wellbeing	Meaning of Wellbeing
	OO2	5	you could be ill and it can make you depressed or concern for you physical wellbeing in terms of life and death for example.	Physical health as part of wellbeing	Physicalhealth and mental health link	Meaning of Wellbeing
	OO2	9	I try and eat healthy. I am on a weight reduction diet at the moment, so seem to be going about a week and lost about 3kg's. I use to eat a lot of rubbish, but I stopped doing that now, and yeah just being positive and healthy.	Engaging in healthy behaviours	Individual Responsibility	Engaging with health
	OO2	13	To me, um, being able to do the things I like to do without any physical repercussions. Like, for example, if I had emphysema I obviously wouldn't be able to walk to far without getting out of breath, but being healthy is doing normal things without and physical repercussions.	Meaning of Health	Understanding Wellbeing	Meaning of Wellbeing
	OO2	18	it is actually difficult. I mean cos you got a canteen here, so I would go over and buy stuff I shouldn't really buy if I want to live healthily, and my weight did balloon quite a bit, but I have made changes now I have stopped taking this doing this, eating more of this like fruit and vegetables and dropping out the biscuits and chocolate and stuff and so on.	Healthy eating motivation	Motivation	Engaging with health
	OO2	23	Making Changes is difficult [laughs], very very difficult, I get so hungry sometimes I can't get to sleep at night, but I am getting used to it.	Hunger/healthy eating	Motivation	Engaging with health
			I can't eat the food I like to eat on the outside when I like to eat it, erm although I think the			

Appendix I: Thematic Map Development

Version 1
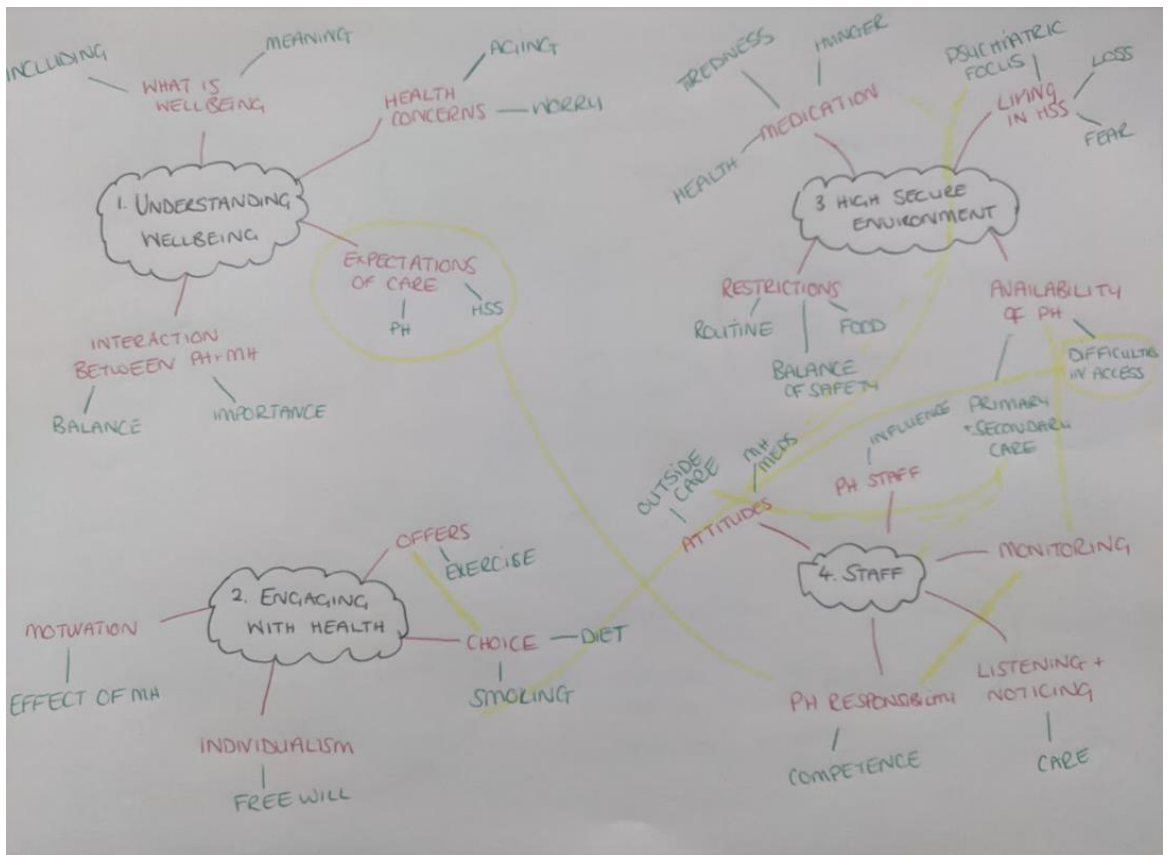
Version 2

Version 3

Version 4

Meaning of Wellbeing

Physical and Mental Health Link

Mental Health Facilitating Physical Health

"As the saying goes, a healthy body is a healthy mind": Understanding Wellbeing and the Individual

Aging, Health Concerns and Institutionalisations

Individual Aspects of Wellbeing

Individual Responsibility

Motivation and Barriers

Weight Gain and Hunger

Diabetes

Tiredness

Medication and Side Effects

Accessing Healthcare

Fear and Loss

Living in High Security

Lifestyle

"It has its own rules": Being in a High Secure Forensic Mental Health Hospital

Availability and Choice

Restrictions

Diet

Routine

Expectations of care

Monitoring

Mental Health Focus

Staff Approach

"It is pretty poor if you're in a psychiatric hospital and you went down with a physical illness": The Role of the System and Staff

Value of Integration with Primary and Secondary Care

Communication

Attitudes

Facilities

138

Appendix J: NHS REC and HRA Ethics Approval Letter

NHS
Health Research Authority

22 November 2018

Miss Samantha McCullough
Trainee Clinical Psychologist

Dear Miss McCullough

Study title:	**Exploring 'Long-Stay' Male Service Users' Perception of their Physical Healthcare in Forensic Mental Health Services**
REC reference:	**18/LO/1752**
Protocol number:	**N/A**
IRAS project ID:	**249359**

Thank you for your letter of response to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Vice Chair and the Lead Reviewer.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Confirmation of ethical opinion

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

Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

Miss Samantha McCullough
Trainee Clinical Psychologist

NHS
Health Research
Authority

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

22 November 2018

Dear Miss McCullough

HRA and Health and Care
Research Wales (HCRW)
Approval Letter

Study title:	Exploring 'Long-Stay' Male Service Users' Perception of their Physical Healthcare in Forensic Mental Health Services
IRAS project ID:	249359
REC reference:	18/LO/1752
Sponsor	University of East London

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?
You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the "*summary of assessment*" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).