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Finding Meaning in Secure Care: An Interpretative Phenomenological Analysis

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Abstract

Introduction: Long stay care in forensic mental health settings is planned for under the Care Programme Approach. Originally designed for community patients, forensic patients in custodial secure hospitals are treated with the same care planning framework. This is despite the very specific treatment conditions and legal status of forensic mental health patients. This leads to non-specific care, often void of efficacy, and ineffective care planning frameworks leads to the phenomena of the long stay patient. This study aimed to explore phenomenologically, the lived experience of long stay patients, and the staff that treat them, to better understand the forensic secure setting and related care planning in the UK.

Method: 15 patients were recruited from a medium secure unit, and 11 staff who delivered care and who knew those patients, often for many years, were interviewed with an insider researcher framework where the researcher also worked with both the patients and staff. Data was analysed using Interpretative Phenomenological Analysis.

Findings: Results explore the lived experience of both staff and the long stay forensic patients they treat. Patient Superordinate themes include: "Control as a mechanism of self-preservation", "The Outside World as the Feared Place," "The Need for Leverage in Relationships" and "Hiding the Internal Reality from Others." Staff Superordinate themes include: "Acceptance of Futility," "Becoming More than a Therapeutic Relationship," "Firefighting rather than Treating," "Realisation of the Challenge" and "Acting as means of Self Preservation."

Discussion*:* An exploration of the findings is discussed, in reference to extant literature and theory. Practical implications rooted in phenomenology offer phenotypes for advancing clinical practice, care provision, education and training, when working with this highly specialised, and growing subsection of forensic patients.

Conclusions: With little in the way of specialised forensic care, apart from the physical forensic secure hospital and adjunct legal mechanisms, long stay patients are a growing portion of the overall forensic patient population. This phenomenological exploration of lived experiences, sheds light on why and how this may be the case and offers a phenomenological reframing of what forensic care may offer patients, and how staff can adapt to these challenges.

Declaration of Authenticity

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged.

In addition, I certify that all information sources and literature used are indicated in the thesis.

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Luke QUANE

PhD Candidate

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Glossary of Terms & Definitions

Section 2
Under a section 2, you are detained in hospital for **assessment** of your mental health and to get any treatment you might need, up to 28 days.

Section 3
Under a section 3 (s3) you are detained in hospital for **treatment**. Treatment might be necessary your health, your safety or for the protection of other people, up to 6 months, extendable for 6 further months, and then extendable for periods of 12 months.

Section 5
You can be held under a section 5 by a doctor or nurse to **stop you from leaving hospital** as a voluntary or informal patient.

A section 5(2) is known as the **doctor's holding power**. The doctor in charge of your care at the time (or a doctor nominated by the doctor in charge of your care) must complete a form explaining why you need to be detained and why informal treatment is inappropriate. A s5(2) can be used both in a mental health hospital and a general hospital, up to 72 hours.

A section 5(4) is known as the **nurse's holding power.** Nurses must be of a 'prescribed class', which means that they should be registered in the area of mental health or learning disabilities nursing. This power can only be used when: You must be immediately stopped from leaving hospital for your own health or safety or for the protection of others, for up to 6 hours if it is not possible to get a doctor to attend who can section you under s5(2)

Section 37
The criminal courts can use section 37 if they think you should be in hospital instead of prison.

Section 38
The court has convicted you, but you have not been sentenced.

Section 41
Section 41 is a restriction order. The Crown Court can add this order to a section 37 if they feel you are a risk to the public
You can also be on a section 41, if you are living into the community, and still have the Ministry of Justice restrictions.

Section 47
An order to remove a sentenced prisoner to hospital for treatment.

Section 48
An order to remove non sentenced, or remand prisoners, to hospital.

Section 49
This means that the Ministry of Justice is responsible for granting leave and allowing discharge from hospital.

Accident and Emergency (A&E)
A walk-in centre at hospitals for when urgent or immediate treatment is necessary.

Acute

An acute illness is one that develops suddenly. Acute conditions may or may not be severe and they usually last for a short amount of time.

Admission beds
NHS beds that are available for people in a crisis, when care cannot be provided in their own home.

Advocate
An advocate is someone who helps to support a service user or carer through their contact with health services.

Allied Health Professionals (AHPs)
A range of health professionals that includes physiotherapists, occupational therapists, dieticians, art therapists, and speech and language therapists.

Anti-psychotic medication
Medication used to treat psychosis. There are several different types of anti-psychotic medication.

Assertive outreach
Assertive outreach refers to a way of delivering treatment. An Assertive Outreach Team actively take their service to people instead of people coming to the team. Care and support may be offered in the service user's home or in some other community setting. Care and support is offered at times suited to the service user rather than times suited to the team's convenience.

Assessment
When someone is unwell, health care professionals meet with the person to talk to them and find out more about their symptoms so they can make a diagnosis and plan treatments. This is called an assessment. Family members should be involved in assessments, unless the person who is unwell says they do not want that.

Caldicott guardian
The person within a Trust who has responsibility for policies on safeguarding the confidentiality of patient information.

Care pathways
This is the route someone who is unwell follows through health services. The path starts when someone first contacts health services – through their GP or an accident and emergency department, for example. The path continues through diagnosis, treatment, and care.

Care plan
Mental health professionals draw up a care plan with someone when they first start offering them support, after they have assessed what someone's needs are and what is the best package of help they can offer. People should be given a copy of their care plan and it should be reviewed regularly. Service users, and their families and carers, can be involved in the discussion of what the right care plan is.

Care Programme Approach (CPA)
A way of assessing the health and social care needs of people with mental health problems, and coming up with a care plan that ensures people get the full help and support they need.

Carer
A friend or relative who voluntarily looks after someone who is ill, disabled, vulnerable, or frail. Carers can provide care part-time or full-time.

Challenging behaviour
Behaviour that puts the safety of the person or other people at risk, or that has a significant impact on the person's or other people's quality of life.

Child and Adolescent Mental Health Services (CAMHS)
CAMHS provide individual and family work helping children and young people under the age of 18 who experience emotional difficulties or mental health problems

Chronic condition
A condition that develops slowly and/or lasts a long time.

Client
Someone who uses health services. Some people use the terms patient or service user instead.

Clinical governance
A system of steps and procedures through which NHS organisations are accountable for improving quality and safeguarding high standards to ensure that patients receive the highest possible quality of care

Clinician
A health professional who is directly involved in the care and treatment of people. Examples include nurses, doctors, and therapists.

Cognitive behavioural therapy (CBT)
This is a way of helping people to cope with stress and emotional difficulties by encouraging them to make the connections between how we think, how we feel, and how we behave.

Commissioning
The process by which commissioners decide which services to purchase for the local community and which provider to purchase them from. Most mental health services are commissioned by Primary Care Trusts.

Community care
Care and support provided outside of a hospital.

Crisis
A mental health crisis is a sudden and intense period of severe mental distress.

Day care
Communal care that is usually provided away from a service user's place of residence with carers present.

Depot injections
Long acting medication often used where people are unable or unwilling to take tablets regularly.

Dual diagnosis
When two or more problems or disorders affect a person at the same time.

Early intervention service
A service for people experiencing their first episode of psychosis. Research suggests that early detection and treatment will significantly increase recovery.

Forensic services
Services that provide support to offenders with mental health problems.

Formal patient
A formal patient is a person who has been detained in hospital under a section of the Mental Health Act (1983).

Foundation Trusts
NHS Foundation Trusts have been created to shift a certain amount of decision-making from central Government control to local organisations and communities. This should make Foundation Trusts more responsive to the needs and wishes of their local people.

Functional mental health problems
A term for any mental illness in which there is no evidence of organic disturbance (as there is with dementia) even though physical performance is impaired.

General practitioner (GP)
GPs are family doctors who provide general health services to a local community. They are usually based in a GP surgery or practice and are often the first place people go with a health concern.

Holistic
Taking into consideration as much about a person as possible in the treatment of an illness – this includes their physical, emotional, psychological, spiritual, and social needs.

Independent sector
Voluntary, charitable, and private care providers.

Inpatient services
Services where the service user is accommodated on a ward and receives treatment there from specialist health professionals.

Integrated Services
Health and social care professionals (such as social workers) working together in one team to provide a comprehensive range of support.

Intervention
An 'intervention' describes any treatment or support that is given to someone who is unwell. An intervention could be medication, a talking therapy, or an hour spent with a volunteer.

Long Stay Patient
A long stay forensic patient in NHS care, has neither a specific nor standardised timeframe nor criteria. This had led to researches self-defining this term, but broadly matches the criteria proposed by Hare-Duke (2018). They defined a high secure patient as having spent 10 years in high secure, 5 years in medium secure, or 15 years when there is a mix of medium and high secure admissions.

Low secure mental health services
Intensive rehabilitation services for offenders who have mental health problems.

Mental health
Someone's ability to manage and cope with the stress and challenges of life, and to manage any diagnosed mental health problems as part of leading their normal everyday life.

Mental Health Act (England & Wales) 1983, as amended 2007
The Mental Health Act is a law that allows for the compulsory detention of people in hospital for assessment and treatment of a mental illness.

Mental health trust
A mental health trust provides treatment, care and advice to people who have mental health problems. The services may be provided from a hospital or in the community.

Multi-disciplinary team
A team made up of a range of both health and social care workers combining their skills to help people.

National institute for clinical excellence (NICE)
An organisation responsible for providing guidance on best practice and the prevention and treatment of ill health.

National Service Frameworks (NSF)
A set of quality standards for services issued by the Department of Health.

Non-executive director (Ned)
A member of the Trust's board who represents community interest and uses their knowledge and expertise to help improve trust services.

Non-executive directors have a responsibility to ensure the trust is fully accountable to the public for the services it provides and the public funds it uses.

Older Adults
Adults aged over sixty-five.

Organic illness
Illness affecting memory and other functions that is often associated with old age. Dementia, including Alzheimer's Disease, is an organic mental illness.

Out-patient Services
Services provided to someone who comes to a hospital for treatment, consultation, and advice but who does not require a stay in the hospital.

Overview and scrutiny committee
A County Council committee that is responsible for looking at the details and implications of decisions about changes to health services, and the processes used to reach these decisions.

Patient
Someone who uses health services. Some people use the terms service user or client instead.

Patient Advice and Liaison Service (PALS)
All NHS Trusts have a Patient Advice and Liaison Service. They provide support, advice, and information to service users and their families. They can also tell you how to complain about a service, and can explain the Trust's complaints procedures.

Pharmacist
Specialist health professionals who make, dispense, and sell medicines.

Primary care

Health services that are the first point of contact for people with health concerns. Examples include GP surgeries, pharmacies, the local dentists, and opticians.

Primary Care Trust (PCT)
Primary Care Trusts are responsible for planning and securing health services in their local area.

Psychiatric intensive care unit (PICU)
A locked ward in a hospital where some people detained under the Mental Health Act may stay. They stay in the unit because they have been assessed as being at risk to themselves or others on an open acute inpatient care ward.

Psycho-educational groups
Group work, using psychological therapy techniques, that address mental and emotional problems such as anxiety, depression, trauma, and severe stress.

Psychosis
A mental state in which someone may show confused thinking, think that people are watching them, and see, feel, or hear things that other people cannot.

PRN – Pro Re Nata
Latin abbreviation for as required, usually used when speaking about medication, which is used as required, i.e. pain killers,

Rehabilitation
A programme of therapy that aims to restore someone's independence and confidence and reduce disability.

Residential and nursing homes
Residential and nursing homes provide round the clock care for vulnerable adults and older adults who can no longer be supported in their own homes. Homes may be run by local councils or independent organisations.

Respite care
An opportunity for a carer to have a break.

Secondary Mental Health Services
Specialist mental health services usually provided by a Mental Health Trust. Services include support and treatment in the community as well as in hospitals.

Sectioning
When someone is sectioned it means they are compulsorily admitted to hospital.

Service level agreements (SLAs)
Internal NHS agreements between Primary Care Trusts and other NHS Trusts on the services to be provided to the local population, what their standards will be, and how monitoring will take place.

Service user
This is someone who uses health services. Some people use the terms patient or client instead.

Social care
Social care describes services and support that help people live their lives as fully as possible, whereas health care focuses on treating an illness. Both types of care are offered as a combined package of support to people with mental health problems.

Social inclusion
Ensuring that vulnerable or disadvantaged groups are able to access all of the activities and benefits available to anyone living in the community.

Stakeholder
Anybody who has an interest in an organisation, its activities, and its achievements.

Stigma
Society's negative attitude to people, often caused by lack of understanding. Stigma can be a problem for people who experience mental ill health.

Supervised Community Treatment
When someone detained under the Mental Health Act for treatment is discharged from hospital, they can be placed on 'Supervised Community Treatment.' This means they can return home but continue to be treated without their consent.

Supplementary prescribing
A partnership between a doctor, a service user, and a nurse or Allied Health Professional (AHP). Under the partnership the nurse or AHP can make adjustments to someone's medication based on an agreed care plan.

Bibliography of terms adapted from BCPFT

http://www.bcpft.nhs.uk/help-advice/understanding-mental-health/66-understanding-

mental-health-jargon

Abbreviations

A&E – Accident and Emergency

ACF – Acute Care Forum

AHP – Allied Healthcare Professional

AMHP – Approved Mental Health Practitioner

AOA – Adult and Older Adult (Services)

AoG – Assembly of Governors

AOT – Assertive Outreach Team

AP – Assistant Practitioner

ASD – Autistic Spectrum Disorder

ASW – Approved Social Worker

BME – Black and Minority Ethnic

BoD – Board of Directors

CAMHS – Child and Adolescent Mental Health Services

CAT – Change Agent Team

CBT – Cognitive Behavioural Therapy

CDW – Community Development Worker

CEO – Chief Executive Officer

CHAI – Commission for Healthcare Audit Inspection

CMHT – Community Mental Health Team

CNST – Clinical Negligence Scheme for Trust

CPA – Care Programme Approach

CPN – Community Psychiatric Nurse

CRHT – Crisis Resolution and Home Treatment

CSCI – Commission for Social Care Inspection

CQC – Care Quality Commission

CQUIN – Commissioning for Quality and Innovation

DAAT – Drug and Alcohol Action Team

DDA – Disability Discrimination Act

DNA – Did Not Attend

DoH – Department of Health

DSPD – Dangerous and Severe Personality Disorder

DTC – Day Treatment Centre

ECT – Electro Convulsive Therapy

ED – Executive Directors

EDS – Eating Disorder Service

EIS – Early Intervention Service

FT – Foundation Trust

FTN – Foundation Trust Network

GP – General Practitioner

HAZ – Health Action Zone

HCA – Healthcare Assistant

HCJ – Health and Criminal Justice

HDRU – High Dependency Rehabilitation Unit

HNA – Health Needs Assessment

HR – Human Resources

IAPT – Improving Access to Psychological Therapies

IC – Infection Control

ICN – Integrated Care Network

ICP – Integrated Care Pathway

IP – In-patient

LA – Local Authority

LD – Learning Disabilities

LINks – Local Involvement Networks

MCA – Mental Capacity Act

MDT – Multi-Disciplinary Team

MHA – Mental Health Act

MM – Modern Matron

NED – Non-Executive Director

NHS – National Health Service

NICE – National Institute for Clinical Excellence in Health

NPSA – National Patient Safety Agency

OBD – Occupied Bed Days

OP – Out-patient

OPMH – Old People's Mental Health

OT – Occupational Therapist/Therapy

OTA – Occupational Therapy Assistant

PALS – Patient Advice and Liaison Service

PCT – Primary Care Trust

PCLT - Primary Care Liaison Team

PCS – Professional Clinical Services

PD – Personality Disorder

PICU – Psychiatric Intensive Care Unit

PPI – Patient and Public Involvement

PRN – Pro Re Nata – As required

PSW – Professional Social Worker

PTG – Post Traumatic Growth

RMN – Registered Mental Nurse

RNMH – Registered Nurse in Mental Handicap

RSU – Regional Secure Unit

SaLT – Speech and Language Therapy

SAP – Single Assessment Process

SHA – Strategic Health Authority

SMS – Substance Misuse Services

TLE – Traumatic Life Event

Glossary of Terms adapted from BCPFT - http://www.bcpft.nhs.uk/help-advice/understanding-mental-health/66-understanding-mental-health-jargon

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This project started well before mask wearing and lockdowns, and was conducted in the midst of the Covid-19 pandemic. Whilst studying part time, I was working fulltime as front line keyworker staff in the same medium secure hospital during the entire Covid-19 pandemic. The days, weeks and months were very long, the shifts were dangerous, patients and colleagues were ill, and some even died. I would like to pay particular thanks to the staff and patients I worked with during this time. We pulled together, and got through each day. I would also like to thank each one for finding the time to interview, and being so open, honest and candid.

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1 Introduction & Literature Review

1.1 Introduction & Context Setting

Forensic mental health inpatient settings in the United Kingdom (UK) serve to provide a secure location in which to treat mentally disordered offenders. All of these patients have been sectioned under the UK's Mental Health Act (1983), and many of these patients are often serving judicial custodial sentences concurrently. Some patients have received sectioning from the Courts system, where they are removed indefinitely to a secure hospital until they are deemed fit by the treating team and the Home Office for release, and some have been temporarily transferred from a prison, in order to receive treatment.

These patients are treated under a framework known as the Care Programme Approach (CPA) (Department of Health, 2008; National Health Service, 2018; NHS England, 2022). Multidisciplinary teams of mental health professionals; psychiatrists, occupational therapists, psychologists and mental health nurses, all plan for care. There is a focus on medicine, psychological intervention and general rehabilitation. When planning for care of forensic patients under the CPA, there is focus on one's personal and professional life with planning pertain to employment status and educational level. Whether one in any training course, university, or in education. Whether one is happy with one's finances, accommodation, leisure activities and family interactions. There is a focus on these tenets, because the CPA was originally envisioned for use within community services, with patients who are receiving care in the general population and often at home. But the CPA has also found itself directing care of those in need of enhanced care-planning and that includes forensic mental health patients. This is in spite of the many patients that return to prison, and the many ageing long stay patients that find themselves in secure services for decades. This has prompted the need for specialised

research and planning in what is becoming a new phenomenon, geriatric forensic care (Di Lorito, Völlm, et al., 2018; Hare Duke et al., 2018; Seaward et al., 2023; K. Walker et al., 2023).

This nonspecific care planning method was not designed for, nor is of particular subtility, for inpatient forensic secure settings. There is also a widely agreed need to move away from this method of care planning, for its reform, refocus and replacement (Department of Health, 2008; Georgiou & Jethwa, 2021; Kingdon, 2019a; Kingdon & Amanullah, 2005; A. Simpson et al., 2003; Tyrer, 2019a). The CPA was introduced in 1991, and only very minor changes have been made since. It is still used in forensic secure settings today, 35 years after its introduction to treat those in community settings. Whilst there are current movements within the NHS to have this planning system changed, there are currently no changes planned for forensic mental health patients. NHS England (2022) has recognised this need, and has released position papers on community care changes, noting that "[this change] enables a shift away from an inequitable, rigid and arbitrary CPA classification, and bring up the standard of care towards a minimum universal standard of high quality of care for everyone in need," albeit, those patients under the care of forensic settings, will still be subject to those inequitable, rigid and arbitrary CPA classifications, which deliver less than high quality care.

To understand further the implementation of the Care Plan Approach with forensic sample populations, it is prudent to explore the short history of modern institutional psychiatric care, and the traditional liberalist and neoliberalist approaches that have directed policy, and fundamentally the treatment of forensic patients in the 21st century.

History of Institutional Psychiatric Care in the U.K.

Modern institutional psychiatric care is a relatively new phenomenon. Shorter (1997) explores how even since the Middle Ages across Europe, there were custodial type asylums, but by the

late 1700s, these asylums became therapeutic, and sought to treat people with mental ill-health. Innovators like Chiarugi in Italy, and Pinel in France; were soon overrun by patients. Knapp et al., (2007) summarises how laws tried to control for this demand, with the introduction of catchment areas for patients, and therein started asylum legislation in England with The County Asylums Act 1808, and in France, The Law of 1838. By 1869, the Mental Aftercare Association was established in London, which aimed to help in post discharge care, but it was not until after World War II, does Shorter note of the shift from asylum to general hospital, and the start of "de-asylumisation" (Shorter, 1997, p. 18). With the arrival of the National Health Service in the UK in 1948, came the transformation of mental health services into a public health provision, and it was this integration, "that was seen as the key to modernisation and to the development of services freed from the taint of the Poor Laws and lunacy code" (Webster, 1991, p. 104). The Mental Health Act of 1959 called for deinstitutionalisation of patients in the United Kingdom, where the decrease in asylum beds corresponded with an increase in beds in general hospitals, day hospitals and community services (Knapp et al., 2007). This was all in the context of the growing fields of psychopharmacology and psychiatry.

Foucault writes The Birth of Social Medicine (1954) and examines the history of mental illness in Europe through the lens of classical liberalism and neoliberalist ideologies. Exploring how the modern mental health system has come into being, through the progression and eventual change in the way in which the poorest in society were treated and looked after by society.

Foucault's (2001) writings explore how modern medicine was being linked to the capitalist economy, medicine for every ill. He explores the ideas of British Medical Officer for Health, John Simon, who he credits as being the founder of English social medicine, that being a system not of medical intervention, but one of medical control, "Unlike urban medicine and especially state medicine, this English approach to medicine was to have a future. The English system of John Simon and his successors enabled three things to be established: medical assistance of the poor,

control of the health of the labour force, and general surveying of public health, whereby the wealthy classes would be protected from the greatest dangers" (Foucault, 2001, p. 155). Three medical systems were co-existent; a welfare system for the poorest people, an administration responsible for the vaccination of the poor and control of epidemics, and a private medicine for those who could afford it. Lay and religious organisations had control over the distribution of food, and often cared for the poor and abandoned children. They provided a provision of workshops and work rooms which were used as a type of surveillance to keep an eye over vagabonds and troublesome elements of society.

There were then new needs that required hospitalisation, not only those who were unwell, but those who were infirm, old, unable, destitute and the needy pauper. The idea of the poor being funded by the wealthy was not one supported by the bourgeoisie, and that support was only offered to the poor so that they may get back into work, go they can look after and support themselves, no longer a burden on society. With industrialised society, there is not a need for people who are infirm. "within the body of individuals and of populations, appears as the bearer of new variables, not merely between the scarce and the numerous, the submissive and the restive, rich and poor, healthy and sick, strong and weak, but also between the more and less utilisable, more or less amenable to profitable investment, those with greater or lesser prospects of survival, death and illness, and more of less of ab ability to be trained usefully" (Foucault, 1954, p342).

When European society was to become industrialised there was no time for the unfit, of which madmen were classed. The unfit also included old people, the sick, the unemployed. Hospitals became workhouses for these people, so that they may support themselves, and not be a burden on society. As above, in the late 1700s, Pinel in France was said to have released those who were locked away in French asylums, but he released not only those who could work, but

also those who would not work, the old and sick, as there was a need for a second wave of labour for society to progress.

Pinel did not release those classed as madman, as they were considered unable to work. These madmen were to remain in the workhouses. These workhouses then became mental health institutions, once filled with all of societies undesirables, only the mad remained. O'Neill (2007) explores how Pinel saw manual work in a moralistic light and purported it having a special place in the treatment of illness. By now, it was the late 1800s, and this moralistic and classical liberalist approach taken by Pinel, even advocated for patients working alongside, and collaborating with staff in these hospitals.

With the advent of the NHS, the workhouse becomes the psychiatric hospital, confining those who were unable to work for physical reasons and confine those who could not work for non-physical reasons. The de-asylumisation movement aforementioned, seems to have overstepped those who were mentally ill, and those who were still in the asylum system, are now found in the new mental health system of the National Health Service.

From that point onward, mental health becomes an object of medicine, and coincides with the advent of psychopharmacological intervention, the birth of modern psychiatry, and the birth of modern institutional psychiatric care in the UK.

Modern Forensic Psychiatry

Forensic psychiatric patients in the United Kingdom are very often, subject to the most restrictive sections of the Mental Health Act, (1983). Patients are transferred to forensic hospitals when they become mentally unwell whilst serving a custodial sentence in a prison (section 47/49), or whilst on remand (section 48/49). People also find themselves in forensic hospitals when they are found not guilty of a crime, and rather than being subject to a custodial

sentence, are given a hospital order with restrictions (section 37/41). This is when the court sends a patient to a secure forensic hospital indefinitely, to receive inpatient psychiatric care. This leads to a situation where the care staff directing, delivering and planning care for these patients are their caregivers primarily, but they also serve as custodians, protecting the public. This dual carer/custodian role brings about particular and strange dynamics (Aiyegbusi & Kelly, 2012; Kelly & Wadey, 2017; Short et al., 2009; Wilstrand et al., 2007) and peculiarities found in the field. It can mean that staff and patients are potentially at risk of being harmed by the patients. This is compounded by the fact that on long term wards, former prisoners who have served their sentence, are still incarcerated as they are not yet mentally well enough to be discharged from care. Restricted patients, like those on the aforementioned sections of the Mental Health Act, not only require the recommendation of their responsible clinician, often a forensic psychiatrist, for discharge, but also permission from the UK's Home Office. In contrast, discharge from general mental health hospitals is at the sole discretion of the responsible clinician.

Forensic Hospitals are further divided into three categories by NHS England. High Secure hospitals, namely Broadmoor, Ashworth and Rampton. These hospitals are very highly regulated and controlled places and have specific laws and guidance that dictate their construction and running (HM Government, 2019). Located in remote areas in the English countryside, they are places reminiscent of past Victorian asylum, and are often housed in old Victorian asylum and workhouse properties (see Figures 1-8).

As patients progress through their care, often after many years and if their level of risk is deemed safe enough by the care team, patients, are then transferred to a medium secure service, a similar setup with less security measures. These hospitals are usually closer to where the patient is from, and this allows for easier family visitation and slow community integration. It is envisioned that patients spend 18 months to 2 years there (Kasmi et al., 2020), before being

transferred to a low secure service, but this length of stay is often protracted due to treatment resistance, legalities pertaining to patients' restriction orders and or violence (Shah et al., 2011).

The patient's eventual discharge from hospital will be subject to many restrictions and will be subject to supervision by community mental health teams. These patients often live in approved hostel accommodation and have curfews and restrictions on their liberty. If after a time of treatment compliance in the community, and good progress, they can be discharged totally from services.

The whole process is very protracted, and staff and patients know that. Patients and staff have to deal with the multiple challenges, from everyday violence to lack of treatment provision. It is a system of frustration, danger, angst and one that seems never-ending and meaningless.

Forensic mental health is the complex confluence of the criminal justice system and the assessment and treatment of mental health conditions. The focus of forensic mental health professionals and the institutions in which they work is the "reduction of offending in those with mental health problems or mental health problems in those who have offended" (Soothill et al., 2008). The professionals involved in treatment range from forensic psychiatrists, psychologists and psychotherapists, mental health nurses, occupational therapists, and social workers. They work independently in exercising their speciality, and interdependently in a multidisciplinary team delivering treatment.

Due to the nature of risk involved with those who need treatment in this context, treatment is provided within the confines of high, medium, and low secure services, with gradating levels of physical, relational and procedural security. Risk is commonly understood in the field of mental health to mean the risk of harm to the self and to others. "Those suitable for transfer from prisons will generally be charged with, or have been convicted of, a specified violent or sexual

offence as defined in Schedule 15 of the Criminal Justice Act 2003 or another serious offence, such as arson" (NHS England, 2013, p. 24). One may also be admitted with without any criminal conviction or pending charges. If a person is presenting with a pattern of clear escalating risk to others or to the self within the context of mental illness, criteria may be met for treatment in secure services.

"Many, but not all of those admitted to secure services, will have been in contact with the criminal justice system and will have either been charged with or convicted of a violent criminal offence" (NHS England, 2013, p. 2). Assessment of capacity and of mental state can be conducted within the safety of the secure setting, and treatment can be provided when the service user is awaiting disposal by the courts, on remand, or indeed sentenced. Treatment can and does continue when any sentence tariffs have been completed, and if service users become well, they can be returned or transferred to prison to continue serving their sentence.

A person necessitating treatment under high secure conditions and parameters, pose a grave and serious danger to the public, need above "category B" style prison security, they are at severe risk of escaping or absconding from hospital, and require an enhanced level of physical, relational and procedural security in a high security environment (NHS England, 2014). When a person's level of risk has lowered, as so they may be treated in a lower secure environment, they may be transferred to medium or low secure services, each with gradating levels of security.

Physical and procedural standards are strictly controlled for these secure units. Some example recommendations by the Royal College of Psychiatrists, (Quality Network for Forensic Mental Health, 2016) include a perimeter fence with a specific height stipulation, a personal alarm system for staff and other physical and practical recommendations. Relational security with secure services is advised by a set of guidelines known as See Think Act (Department of Health,

2010a). “Relational security is the knowledge and understanding we have of a patient and of the environment, and the translation of that information into appropriate responses and care (Department of Health, 2010a, p. 5). A sound understanding of service users, the professional team, of the environment, and how these all interact is imperative to ensuring safety in secure environments. Inter-patient dynamics, boundary setting with service users and on ward dynamics are all explored at length. These guidelines inform staff behaviour, and aids in the creation of a team that is well informed of current ward dynamics, though the acute understanding and constant referral to relational security.

Working with these high-risk patients in secure settings, controlling the environment and ward dynamics to ensure a safe workspace and place to recover is a rather specific and specialised workplace. It is place where there is a focus on recovery, but also has a pertinent emphasis on risk and risk reduction, assessment, and management. This safety is maintained with acute understanding of relational security (Department of Health, 2010b) which can be compared to the equally obscure concept of “jail craft” (Peacock et al., 2017). Concepts pertaining to relational security and “jail craft” were systematically explored by sociologist Goffman (1961) explore the concept of institutions like a medium secure hospital; and in defining the term, “total institution”, to denote a place that is symbolised by “…the barrier to social intercourse with the outside world.” He describes these as places that have all encompassing tendencies, controlling many aspects of the inpatients’ lives. Goffman describes five types of total institution, prisons, convents etc. of which, of which the forensic hospital if a hybrid. It is there to protect the community, and to help those who are an unintended threat to others, unintended due to their illness. Within the forensic hospital institution, life is controlled, through tightly controlled procedural frameworks imposed by staff, nursing staff primarily, and patients find themselves undergoing the processes of self-mortification (aligning the self to the rules and regulations of the institution), looping (the desensitising to assaults on the self), desegregation and being

subject to privilege systems (being rewarded for behaving within the defined rules of the institution).

Goffman notes how behaviours change to comply or rebel against this system of applied rules and regulation. How there are adaptation processes of forming cliques, withdrawing from engagement, colonisation, conversion, and release anxiety. The institution fundamentally changes how the staff and patient act, and it is from within this changed context, that the person is treated and rehabilitated. It is within this environment, where modern forensic mental health treatment is carried out, and recovery sought.

Risk, Recovery and Care Planning

In psychiatry and in mental health broadly, recovery is assumed to be the goal of treatment but there is also a credence given to risk management, and that is a primary focus for the staff delivering that treatment. Whilst these places are hospitals primarily, it is also a “secure unit,” and with an understanding of the historical basis of these hospitals, one can see the peculiar paradox of these “units.”

Rethink, a mental health charity, note that ‘personal recovery means that you are able to live a meaningful life’ (Rethink Mental Illness, 2016). Mental Health Foundation (2017) note that it is, ‘the concept of recovery is about staying in control of your life’. Centre for Mental Health (2017) say that ‘recovery is about building a meaningful and satisfying life’. Mind (2016) contribute, in noting that ‘recovery, for many people, getting better doesn't necessarily mean going back to how your life was before, but learning new ways to live your life the way you want to, and gaining control over areas of your life that might have felt out of your control before’.

Whether such ideas on about recovery can be possible to implement in the context of the forensic hospital is debatable at least.

Chandley & Rouski (2014) imply that forensic recovery is more problematic than mainstream recovery. Mann et al., (2014, p. 125) note that there is 'increasing focus on recovery within mental health services, and how there has been limited exploration of the applicability of these principles within forensic services.' They also note that "there is less evidence on the applicability of personal recovery within specialist mental health settings such as forensic rehabilitation" (Mann et al., 2014, p. 125). They continue to note that recovery is often closely associated with social inclusion and being able to take on satisfying and meaningful social roles, which is nigh on impossible given the nature of secure care, within the framework of a closed institution.

"Forensic mental health care is resource-intensive, transition to community is difficult and potentially risky, stigmatisation of forensic cases remains an issue and lack of community psychiatric resources can delay discharge" (Quality Network for Forensic Mental Health, 2013, p. 39). In the forensic patients' road to recovery, there is a particular need to manage risk (risk of physical violence or recidivism/re-offending), with equal emphasis being placed on both recovery and risk management (Quality Network for Forensic Mental Health, 2013, p. 13) . "Forensic psychiatry in the UK has recently been castigated as a rigid, counter-therapeutic, self-perpetuating institution which inhibits the development of wider systems of support for mentally disordered offenders" (Sugarman & Oakley, 2012).

With non-forensic mental health patients, often after a short stay in an acute inpatient ward, patients are discharged and treated in the community, often in their homes by a community team of health professionals. With community-based recovery, there is an important difference between non-forensic care and forensic patients: risk potential and recidivism, or reoffending. Often, forensic patients have a criminal record and have usually committed a crime or offence (when mentally unwell) that has warranted their detention in secure care for treatment. There

is then a perceived level of risk upon discharge, that this offence may happen again, but this is consistently reported to be a political issue rather than one of fact (Natarajan et al., 2012).

Tidmarsh (2002) notes that there is no appetite for risk in mental health cases; risk is no longer acceptable, all professional bodies try to ameliorate risk, and reduce harm. The primary risk is of relapse with which the risk of harm: harm to the self and harm to others, increases. With forensic mental health patients, there is a sense of stigma that assumes that all patients who are ex-forensic are dangerous when they relapse in mental state. Chow et al, (2013), notes of the peculiar culture in Britain, one which is dominated by a preoccupation with the risk that people with mental illness present to themselves and to others, and a culture of blame.

Skeem & Mulvey (2002) open their book chapter by noting that there is a rise of the 'psychiatricisation of criminal behaviour', which is giving rise to the number of people with both legal and mental health issues and reinforces stigma and criminalisation of the mentally unwell. Discharged forensic patients are often placed on a community supervision order, and are still subject to restrictions by the Home Office, meaning that they can be recalled to secure care if they break certain conditions of the "conditional discharge" (Chiringa et al., 2014). Chringa et al. explores with recalled patients the reasons for the returning to care. The patients interviewed noted that they perceived the recall system as unfair that it inappropriately criminalized their behaviour and was based on an assessment of risk that they did not understand or accept. The researchers continue to note that patients were not fully aware of the conditions of their discharge, and most did not accept responsibility for their role in being recalled and blamed the system. They note that care following discharge was rarely seen as positive, and supervision was often seen as disruptive and controlling, and focused more on surveillance rather than support. It is also understood, that longer stay patients, can find a sense of dependency on the hospital and the support that it provides (Jacques et al., 2010).

Can such restrictions and level of surveillance work in harmony with the core concepts of recovery, personal autonomy, and responsibility for the self. Responsibility for one's own care, is a peculiar concept, as patients on forensic Mental Health Act sections can be treated against their will. Taking responsibility for one's own therapeutic process was noted as key in recovery (Willemsen et al., 2016a). With a forensic population sample, Willemsen et al. note that it is not self-determination that is a fundamental existential factor in recovery, but rather it is the acceptance of responsibility for one's own process and quality of life, the author continues in noting that it is not a therapist's, or caregivers' responsibility to changing patients' lives, it was the patients.

Askola et al., (2015) seconds this notion of responsibility in recovery. A patient notes that 'being within the confines of the institution, even though they feel like a prisoner, they feel free; free of drinking, and partying, and destroying their life 'out there.'' Patients also note how they eventually learn to see the hospital as a way of protecting themselves from re offending. In this context, patients , it can be said, have found some form of an institutional sense of meaning and responsibility within the confines of the total institution, they have been rehabilitated to the status quo of the institution from which they reside and is also often reinforced once these patients have realised they have been abandoned by their families/friends and others in the community thus leaving them feeling truly vulnerable, alone and submissive to the control of the hospital now perceived as a secluded yet protective and disciplined environment somehow.

The discharged patient, in order to return to hospital, may now try to 'sabotage' their recovery in doing so often causing harm to themselves or others, in order to get re-sectioned, or recalled under the Mental Health Act, and returned to hospital. In aforementioned research by Chiringa et al., (2014), they continue to explore with service users, reasons why these ex-patients were recalled back to inpatient care, and they note some strange behaviours. Blaming the system, how care was of a poor standard following their discharge. Patients were to complain of lack of

food in their supported accommodation, where the service users are in receipt of state benefits or working and can provide for themselves. Service users were also to complain about a lack of activities in their hostels, even though they could come and go as they pleased. What these researchers fail to note however, that these are not the reasons why the patients were recalled, but rather why the former patients wanted to be recalled and committed acts of self-sabotage in order to get recalled. O'Sullivan et al., (2013), explore the lived experience of recalled patients, when patients have been discharged conditionally, but have broken a condition of their discharge, and thus are recalled into care. They suggest increasing service users' awareness of available post-diagnosis identities, which meet the needs of individuals' lived contexts and promotion of recovery-oriented care in forensic settings.

Common amongst those complains, is a lack of responsibility for the self of the re-admitted patient. The participants (Chiringa et al., 2014) study, speak in a way, whereby they tried to get recalled, purposefully sabotaging their care and mental state, in order to return to hospital. This phenomenon is not researched well but is not a new phenomenon; Goffman was to write about how patients may 'mess things up as a way of postponing release, without having to admit to one's inmates that they just don't want to go' (Goffman, 1961, p. 55). Patients find themselves returning, and not leaving the hospital that they once hated.

Shepard et al., (2016) through their systematic review of recovery in forensic settings, find that the environment for recovery should be one that is safe and secure in supporting the changing sense of self. An environment that is hopeful, supportive and empowering, and overall, one that supports the changing self. Within the forensic setting, Skinner et al., (2014) suggest that their recovery programme focused on confidence, hope, taking control and responsibility, identifying strengths and improving access to social support was what had the most positive impact on recovery. Piat et al., (2009) also find that responsibility for life and self-determination were a key aspect linked to recovery. However, the theoretical descriptions outlined above with regards

to what “forensic recovery” should be, are still not researched empirically from within an existential perspective in specific work settings, e.g., what happens to seriously mentally ill patients’ existential sense of themselves as persons and as chronically mentally ill patients, when living in a medium secure forensic hospital which operates as an example of a total institution as explored above, where staff often take full control of many aspects of patients’ lives, is it possible for service users to take control of their recovery? There is an attempt at involving them in the planning of that care, through the coproduction of a care plan under the Care Programme Approach.

The Care Programme Approach

Care planning in forensic mental health in England, is done under the framework of The Care Programme Approach, the gold standard and mandated framework. Patients and staff world collaboratively in assessing treatment needs, goals, and risk. It is mandated for particular mental health patients, needing advanced care. This includes civil, non-forensic patients, who have complex mental health needs, who have undergone many hospitalisations, have complex treatment plans, have input from multiple public agencies like social work, and more. In spite of the particular set of circumstances that forensic patients find themselves in, they are treated under the same framework.

The CPA was itself, introduced in response to scandal in mental health care, not in an advancement in knowledge. It was introduced after systemic failings in follow up care (A. Simpson et al., 2003; Tyrer, 2019b). Scott & Aboud (2021a) performed a meta-analysis and highlight the barriers in patient engagement and staff commitment in care planning. From simple concerns in confidentiality, to paternalistic, formulaic care planning styles, their very robust meta-analysis with close to 50 identified barriers is very damning of modern methods of care planning. They conclude that there is no research that has had any measurable benefits or positive outcomes linked to mental health care planning and that findings of the very few

empirical studies of care planning from the perspective of mental health service users and carers are disquieting. Simpson et al., (2003) note of the service users receiving care under the CPA experience it as consistently disappointing, and how patients' carers have little if any knowledge of what the CPA even is.

Simpson et al., (2016a), notes that care planning and care coordination is administratively burdensome, and that they were rarely consulted. When it came to risk assessment, and important aspect in forensic care, they note that whilst these were central to clinical concerns, they were rarely discussed with service users. It is also noted that these risk assessments are even illusive to the staff that use them, with work needed in trying to improve the awareness of the HCR-20 risk assessment, central to forensic patient care planning and risk assessment (Turton et al., 2022a). It could be also said that there is a fundamental issue in bringing these risk assessments to life, from risk assessment to risk management (Hutten et al., 2022).

"Almost no literature addresses treatment planning for forensic psychiatric patients" (Schaufenbil et al., 2015). Schaufenbil and their team note that recovery orientated multifocal treatment has been important into forensic mental health systems, despite this client group having very specific and particular needs. Care planning is poorly defined and lacks effective implementation (Bee et al., 2015a). This particular problem is further compounded, as longer stay forensic patients are often older in age, and this itself brings about the need for even more specialised care (Walker et al., 2022a).

Socioeconomics & Neoliberalism

Esposito & Perez, (2014), explore the neoliberal obsession of medicalisation of mental ill health. They write about the need for the pathologisation of behaviours that deviate from what the markets define as functional, productive and desirable. In order to produce market ready discharges from hospital, the CPA has a peculiar focus. There is a particular focus on money and

financial issues. With employment and training. With education and housing. Surely the aim of care planning, is to ensure the bettering mental health of the individual, through psychosocial intervention, and psychiatry. To suggest that to improve mental health, requires one too have a focus on the patient's employment, professional training, education, financial situation and housing, would suggest a very thinly veiled ulterior motive to the plan, rooted in a liberalist mindset, reminiscent of the ideas of Pinel, and highlighted by Foucault and others.

Those with mental health illness and those with problems pertaining to their mental health, were treated within the context of the time, whether this be with contempt, or with care. From institutionalisation to asylums in the age of moralism, to workhouses in the Victorian age, the aim was to keep these people out of society. As discussed above, Pinel was famous for his releasing of people from the asylums, as Foucault wrote, but he only released those who were able to work, as there was a workforce shortage in the new industrialised world. Those who remained in the workhouse, those who were considered too ill to work, were then classed as psychiatric patients, and the new field of psychiatry was born.

This attitude today, it could be said, prevails. The forensic patient, under the Care Programme Approach, working collaboratively with staff, develop a "plan" for care. There is the usual medical and often psychological support planning, but there is also planning, that is truly rooted in the neoliberal philosophy that permeates today. Planning for care, and for discharge, in order to contribute to society seems to be the aim of the care planning system. McWade (2016) critiques the implementation of the CPA concluding with "… the paradox faced by people experiencing madness or distress who are promised individual freedoms within a system that increasingly threatens those freedoms through the unrealisable ideals of free and rational choice." With the care plan focusing on neoliberal tenets, one would wonder if planning for unattainable aims and goals is causing harm for these forensic patients, and inadvertently is a source of institutional and bureaucratic iatrogenesis. Many of the goals that staff and patients

plan for, will not come to fruition by virtue of their institutionalised behaviours, criminal history, or simply having to explain to employers the gaps in ones CV. The stigma of the forensic history, the overemphasis on risk, the lack of education, employability and skills. The original liberal movement of the late 1800s, and the current neo-liberal movement of the late 20th century, lends itself to the same aim, to force economic participation, and economic self-sufficiency, at all means.

Iatrogenesis in Recovery

The iatrogenic effects of psychiatric medication have been well documented (Hartman, 2015; Heitzmann et al., 2016; S. Jordan, 2011; Lam, 2010; Lopes & Fernandes, 2012; Nalbant et al., 2013; Tsai et al., 2011). From tardive dyskinesia affecting up to 50% of patients treated with neuroleptics (Can et al., 2013). Akathisia, dystonia, exertional dyspnoea, osteoporosis and medication dependence. The side effects of neuroleptic medication are well researched and well understood, yet they continue to be front line treatments for mental disorders and behavioural disturbances. Many are classed as essential medicines by the World Health Organisation (World Health Organization, 2015). Another intervention, that of physical restraint and forced chemical restraint is of particular concern in recent years, and the need for reduction in these harmful iatrogenic interventions is obvious and is currently a priority in these settings (CQC, 2017; HM Gov, 2014).

Non-medical interventions like psychotherapies and psychology are often used to treat a variety of conditions. Law et al., (2015) note of the iatrogenic effects of triage and assessment, whilst many have explored the mal effect of psychosocial interventions on patients (Berry et al., 2015; Gewirtz, 2008; Moos, 2012; Treasure et al., 2011). Staff focus and approaches in care provision is often focused on targets, as missing targets within the NHS entails financial penalties. Therefore, nurses, rather than nursing, often find themselves, completing audits, care plans and

other non-therapeutic tasks, rather than engaging patients in therapeutic interactions and activities.

It is also worth noting that often mental health nurses working in these medium secure hospitals are not trained in simple psychotherapeutic interventions and are only formally trained in basic physical health interventions, in order to fully understand and address the physical side effects of many anti-psychotic medications on their patients (Hemingway et al., 2014; Warrender, 2015).

Oftentimes staff are unable to pick up on 'moments of high receptiveness' (De Gauna et al., 2015), when patients engage in their care on a higher level, but this is not noticed by staff, eradicating any therapeutic relationship. Rather than providing safe and productive therapeutic engagement for patients, staff are instead often simply trying to complete administrative tasks relating to the CPA (A. Simpson & Bowers, 2003; Tyrer, 2019b). Even when staff think they are being less restrictive and more humane by treating in the community, there is still an intrusive system of nurses, social workers and doctors supervising patients (Coffey, 2012).

"Services and wider systems should consider iatrogenic processes, which may contribute to and maintain the distress experienced by those with early psychosis" (Tan et al., 2014, p. 80). Ninety-eight per cent of patients in a report by Reddy and Spaulding (2010) report feeling at least one negative event during their stay in psychiatric hospital. In designing and delivering mental health services, managers and practitioners should be proactive in minimizing experiences that are commonly identified as traumatic, including coercive treatments and assaults (Berry et al., 2015). There is a scarcity of research specifically concerned with the identification of the ill effects of compulsory detention and detection of a subset of highly vulnerable patients who are likely to respond negatively to compulsory care (Pandarakalam, 2015).

"The mere application of formal protocols (such as formal careplanning), which inevitably transform personal requests into general responses, can become the problem rather than the solution, adding other compulsions and addictions to the rich agenda of clients' problems" (Allamani, 2012). These protocols are followed in treating psychiatric illnesses although for many psychiatric conditions there are no established evidence-based treatment guidelines. Even when such guidelines are available, following them may not result in complete resolution of the symptoms in many patients. One will inadvertently rely upon anecdotal experience and less well- established information while managing these patients (Hasnain, 2010).

Summary

The aim of this introduction was to set context and to give a history of the current secure mental health system in the UK. A history from old asylum to workhouse to prison and finally to secure care was explored. A history of the introduction of the care plan approach is also explored and how this method of care planning can be seen in the light of the libertarian movement of the Age of Enlightenment of the 1800s, and the later neoliberal movement of the 1980s. Attempting at standardising care-planning under the CPA is another move in this neo libertarian approach to recovery, but an approach with dubious relevance to forensic patients, with a specific emphasis being placed on risk, rather than on recovery. Patients' criminal histories, often severe symptomology, socio-economic barriers of long-term internment along with wider socio-political issues, may hinder their recovery and wider societal reintegration upon discharge. With the advent of medical treatments and psychiatric pharmaceutical interventions, came a wave of treatments that lessened symptoms for patients, but that does little to negate society's socio-political prejudices and the great socio-economic challenges that these forensic patients will face if discharged. These psychiatric and pharmacological treatments have known iatrogenic effects, but what is less explored are the iatrogenic effects of the psychosocial interventions, and the wider CPA process as applied in forensic care.

Below are graphics of those workhouses and asylums, now forensic hospitals, and examples of occupational interventions, from the traditional liberal, and neoliberalist ideologies.

Supplementary patient and staff conceptualisations to further aid context setting, can be found in the appendix E.

1.2 Empirical Literature Research

Care Planning in Forensic Mental Health

A review of literature was conducted, to explore how care is planned for in forensic settings in the United Kingdom. Papers identified explored care planning broadly but also more specifically, the Care Programme Approach (herein CPA). Studies explore the CPA specifically, and others in a more applied context in how it directs care. Literature highlight processes in conducting care directed by the Care Programme Approach, and provide evaluative commentary broadly, and others take a more critical approach on highlighting failures of the care planning system, and others explore recent developments and advancements.

Planning for Care: The Care Programme Approach

The Care Programme Approach was developed to help manage the personal risks posed by patients with complex clinical features (Department of Health, 2008; National Health Service, 2018; n.d.). It was introduced as a mandatory framework for care planning in England in 1992 and was recommended for use in Scotland in 1996 but has been mandatory for restricted, forensic patients since 2002 (Quinn & Crichton, 2011). There have been attempts to refocus staffs' priorities when planning for care toward those rooted by patient participation, (Baguley et al., 2009), but the framework for care has changed little since its inception.

Scott & Aboud's (2021b) meta-analysis of literature finds that there are neither measurable benefits nor positive outcomes linked to mental health care planning. They conclude, "a review of the meta-analyses and systematic reviews of service users and carers identified many barriers to their meaningful engagement in care planning. No research has demonstrated any measurable benefits or positive outcomes linked to mental health care planning." They also note of the very few empirical studies of care planning from the

perspectives of mental health service users, and this may give some insight into systematic failings in how care is planned for, and that is without true patient input.

Given the inherent risk element that comes with forensic population samples, the CPA review meetings are often accompanied by risk assessment formulation meetings and structured professional judgement meetings, which have varying amount of patient input, sometimes none. This is because the CPA was not originally designed for use in forensic settings, and is missing the inherent and specific risk assessments needed when working with forensic patients. From "Historical-Clinical-Risk Management-20 V3", (herein HCR-20) (Webster et al., 1997) and "The Risk for Sexual Violence Protocol V2" (Hart & Boer, 2010), many tools are used to predict, plan and formulate about patients' risk.

The use of the CPA is currently under review, and there are plans to move away from this framework of care when working with community patients (NHS England, 2022). NHS England's Position Statement highlight the move toward more personalised care, with care packages and meaningful coproduced interventions – which is something that the CPA framework itself, tried to plan for. The statement also notes, that, "the CPA will continue to be used in adult secure services and is included in published service specifications." After 30 years, there is explicit acknowledgement of how this framework of care has led to "a large variation in the proportion of people on the CPA between trusts, which suggests that there are different systematic differences in how trusts individually interpret and apply CPA policy" (NCCMH, 2019).

After 15 years, there is a glimpse of acknowledgement that the CPA is applied ah-hoc, is implementing individualised coproduced and planned care with no explicit standards, and is finally undergoing a review, but not for forensic patients. The planning framework is changing, but what is delivered seems to essentially remain the same. Bee et al., (2015b), note that user-involved care-planning is poorly defined and lacks effective implementation support. It is also

noted that care planning does not respond to the needs of those for whom the plans are made, and lack the complexity needed for the people they intend to help (Brooks et al., 2018). In highlighting the superficial nature of the planning method, they highlight the focus on "planning" for risk, which is not planning for care.

Rio et al., (2020), find that there is a limitation in care provision literature amongst academic circles and highlight the focus on risk. Jones et al., (2018), also highlight this lack of strong academic papers nor research that direct care planning. They note that changes in care planning Is usually in response to policy change, and note that these changing policies, "…may explain the absence of seminal literature within the field." Chakraborty et al., (2015), note that patients don't even notice differences of quality in care provision, when they are taken off the CPA. Tyrer surmises, that the CPA was introduced as a quick response to a scandal, rather than through rigorous planning, testing and research. This could explain the inconsistencies found in its implementation, differences in care quality, inconsistencies in planned interventions and overall, the lack of research backed careplanning of true integrity and quality (Tyrer, 2019a).

One example of this "standardised" CPA is an example of how it is a mandated framework for inpatient forensic care in the UK, Swinson et al., (2010). They find that in their study of 380 homicide perpetrators, 69% were not receiving care under enhanced CPA, including 26 with severe mental illness and a history of previous violence. Of 107 patients under enhanced CPA, 35 were non-compliant and 40 had disengaged from services at the time of the offence.

Following each patient's CPA review meeting Longdon et al., (2018) find reductions in the 11-item Health of the Nation Scale scores between baseline and 6 months and between 6 and 12 months, but no change on its additional 7-item secure subscale. While they find some improvement in sociability with patients, there was little to no change in the forensic patient specific HCR-20 risk assessment scores after 12 months of inpatient care, i.e. risk of violence had

not reduced in 12 months. If working with stalking risk, the Stalking Assessment and Management (SAM), a structured professional judgment measure for assessing stalking risks Shea et al., (2018), find that the tool is used despite its poor interrater reliability score.

In planning care, eight domains were identified as being crucial in treatment planning, in a study by Hillege et al., (2018) focusing on mental health problems, personal characteristics, family, offense, motivation, treatment, school/work/housing, and peers/spare time. They also suggest that protective factors and comorbid problems on multiple domains should be considered. Schaufenbil et al., (2015) in their study found only few articles that explicitly and directly address the unique aspects of treatment planning for the forensic patient, but rather the pertinent focus was on risk management.

Forensic case formulation, of increasing interest to practitioners and researchers raises many ethical, theoretical, and practical issues. Davies et al., (2013) note of the systemic, contextual and individual factors which need to be considered include the multitude of staff often involved with any one individual. They highlight the pressure to 'get it right' because of the range of risk implications that are associated with individuals within forensic mental health settings.

In the modern approach to careplanning, one of co-production, where plans are co-made with a patient. Coffey et al., (2019), explored the care planning experience with staff and patients. They note of the opposing views of staff and patients, with patients pointing out the lack of involvement, being unaware of the careplan content and having no sense of ownership over their own care plans. Staff say that service users are actively involved in the planning of care, holding the converse view. They say that patients have an unwillingness and inability to work collaboratively. They conclude by noting that guidance issued by the Healthcare Commission (2008), has done little to advance the care planning system of care.

Whilst patients are excluded from some aspects of care planning, particularly those pertaining to risk, Turton et al., (2022b), also note that these risk assessments are not easily accessed by the very staff that they aim to advise. They completed a quality improvement project, in trying to raise awareness of the HCR-20 risk assessment, which is specific to forensic patients and a fundamental and risk assessment that directs care.

Simpson et al., (2016b), conclude in their similar review of the care planning field, that "research [is needed] to investigate innovative approaches to maximise staff contact time with service users and carers, shared decision-making in risk assessments, and training designed to enable personalised, recovery-focused care coordination is indicated." From this, Hauso et al., (2021), implemented a recovery oriented practice toward improving service user involvement, and whilst their intervention did wield a higher degree of involvement, they conclude by noting that involvement is needed in all areas of care, not simply writing the care plan, but in risk assessments and the care plan's implementation. This is particularly poignant, considering that longer stay forensic patients, tend to be older and they themselves, have specific and particular care needs (Visser et al., 2021).

In a qualitative study, of patients and staff, engagement is best when a "limit-setting style characterized by empathic responding and an authoritative, rather than authoritarian interpersonal style," is employed by staff. Elucidating the components of this style is critical for effective training and best practice of mental health nurses, and to reduce aggressive responses from limit setting (Maguire et al., 2014). Barnao provides clinicians with some structure in applying the Good Lives Model (GLM, Ward & Gannon, 2006) within a forensic mental health team context. Typically used with non-mentally disordered offender populations, this paper presents a set of tools that have been designed specifically with mentally disordered offenders in mind (Barnao, 2013). Of note, the CPA care plans and accompanying risk assessments do not specifically address offending behaviours in a way which tries to rehabilitate the

offender/prisoner. They are tools of planning mental health care and psychiatric risk, and not mechanisms of offending rehabilitation.

O'Dowd et al., (2022), through framework synthesis, further explore the experience of professionals' use of risk assessment. They are described as both barriers and facilitators of care; staff found it difficult to perform these assessments and also deliver care. There was also a reluctance to involve patients in risk assessments, which is contrary to the spirit of co-production. Given the scant research on service user involvement in risk assessment, they recommend further research in this area. Forensic nursing risk assessment tool the Behavioural Status Index (BEST-Index). Walker et al., 2019 highlight the shortage of proper instruments with which to carry out valid and reliable therapeutic assessments which are behaviourally based. They note that the wider MDT acknowledge the value of nursing risk assessment but require adequate information to enable them to interpret findings (H. Walker et al., 2019).

The role conflict experienced by forensic psychiatric nurses between their therapeutic responsibilities and their responsibility to operationalize security procedures is well established in the literature. There has been less investigation into how this role conflict is played out specifically in the management of inpatient substance misuse in forensic units. The impact of the procedures on nurse-patient relationships was reported as largely negative by the participants. They reported that the intrusion of the procedures had a detrimental effect on their relationships with patients. The relative degree of intrusion posed by each of the procedures was an important factor in determining the extent and duration of damage to nurse-patient relationships, as was the communication skills of the nurse conducting the procedure (Price & Wibberley, 2012). Chizh focuses on the safety practices of nursing staff and patients in the U.S. and highlights the need for nurses to have knowledge on their surroundings literacy, knowledge about their patients, their assessment and observation of the patients for medication, and their use of chemical restraint (Chizh, 2015).

The Care Quality Commission recently acknowledged the use of mechanical restraint as an intervention for the management of self-harm. Their work involved an exploration of the defining characteristics as well as the history and ethics of mechanical restraint. Informed consent and examining the legal, ethical and organizational frameworks supporting the use of this intervention in the clinical setting were critical to implementation. Ultimately their use could their use be life saving, but also a 'catalyst for change' (Carr, 2012). In the use of prolonged anti-libidinal medication Khan notes of the further research required before it is demonstrated that the administration of reduces sexual recidivism, and that tolerability is maintained. It is a concern that, despite treatment being mandated in many jurisdictions, evidence for the effectiveness of pharmacological interventions is so sparse and that no RCTs appear to have been published in two decades (Khan et al., 2015). The moralistic and ethical arguments of mechanical restraint, forced medications and little evidential research backing up their effectivity, leaves professionals with precarious ethical authority providing therapeutic relationships and recovery pathways for their patients.

One study included a survey of views on recovery, empowerment and therapeutic relationships in service users and recovery in care coordinators case studies. Significant differences were found across sites for scores on therapeutic relationships. Variation within sites and participant groups was reported in experiences of care planning and understandings of recovery and personalisation. Care plans were described as administratively burdensome and were rarely consulted. Carers reported varying levels of involvement. Risk assessments were central to clinical concerns but were rarely discussed with service users. Service users valued therapeutic relationships with care coordinators and others, and saw these as central to recovery. Simpson et al., 2016. Administrative elements of care coordination reduce opportunities for recovery-focused and personalised work. There were few common understandings of recovery which may

limit shared goals. Conversations on risk appeared to be neglected and assessments kept from service users. Coffey et al further researchers this topic with a mixed methods study by Coffey et al., (2019), exploring the care planning experience with staff and patients. They note of the opposing views of staff and patients, with patients pointing out the lack of involvement, being unaware of their content and having no sense of ownership over their own care plans. Staff say that service users are actively involved in the planning of care, but hold the converse view, that the patients have an unwillingness and inability to work collaboratively. They conclude by noting that guidance issued by the Healthcare Commission (2008), has done little to advance the care planning system of care. Whilst patients are excluded from some care planning, particularly that pertaining to risk, Turton et al., (2022b), also note that these risk assessments are not easily accessed by the very staff that they aim to advise. They completed a quality improvement project, in trying to raise awareness of the HCR-20 risk assessment, which is specific to forensic patients and a fundamental and risk assessment that directs care. Simpson et al., (2016b), conclude in their similar review of the care planning field, that "research [is needed] to investigate innovative approaches to maximise staff contact time with service users and carers, shared decision-making in risk assessments, and training designed to enable personalised, recovery-focused care coordination is indicated." From this, Hauso et al., (2021), implemented a recovery oriented practice toward improving service user involvement, and whilst their intervention did wield a higher degree of involvement, they conclude by noting that involvement is needed in all areas of care.

Failures in Care Planning

Even simple psychiatric tasks, like enhanced observations faces critique. Needing closer support from staff, through being checked on every 15 minutes, to constant eyesight observations. Collins et al., (2022), focus on this ritualistic task, and advocate for staff training and development, to improve the most simple and fundamental task of providing care in this setting.

In exploring the use of as required PRN (as required / pro re nata) medications for short term sedation, Barr et al., (2018) highlighted the need for increased accountability for the prescribing and administration of PRN medications along with more nursing education/training to use alternative first line interventions (Barr et al., 2018). Abbasi et al., (Abbasi et al., 2011) explore the almost negligent dietary and nutritional set up in these settings, admission body mass index increase from admission to discharge with the average BMI of each sample exceeds the general population such that a majority of patients in this study are clinically obese, something which is still of concern almost 15 years later Russell et al. 2018.

Martin & Ricciardelli, (2022) also note that patient documentation, those notes that help direct care, and advance the patient care plan, focus on concepts that are not recommendations from nursing bodies. Rather than focusing on assessment, planning, implementation, and evaluation, they find that nursing documentation focus on interactions, food intake, activities, sleep, mental and physical health and hygiene. Forsyth et al., (2019), found that the social care assessments and plans were not implemented in an older person forensic setting. Identified needs were not consistently translated into care plans and there was little evidence to suggest patient involvement in the care planning process. Georgiou & Jethwa find that there is a substantial need for improvement in standardisation and consistency in the application of the CPA process, for the purposes of enhanced care delivery, greater continuity of care, and improved patient outcome (Georgiou & Jethwa, 2021). Taborda essentially concludes that work is needed in education and training to ensure an appropriately qualified workforce for this challenging population (Taborda et al., 2013).

In exploring risk care planning and management, Hutten et al., (2022), found 21 methods of integrating the results of risk assessments into management plans and care plans. They find that only two studies provided concrete guidelines on how to do this and highlight the importance

of providing clinicians with structured methods on how to best plan for care. Klingemann et al., (2021), explores and unveils the level of coercion that is still in the hospital in ensuring care plan compliance, focusing on the language used and the thin veil that threatening language and coercion is used today. The objective of the Pelto-Pir, (2019) study was to investigate how mental health professionals describe and reflect upon different forms of informal coercion. Results indicated that informal coercion includes forms that are not obviously arranged in a hierarchy, and that its use is complex with a variety of pathways between different forms before treatment is accepted by the patient or compulsion is imposed.

In an a somewhat accepted form of coercion, the use of the behaviour modification programmes (BMPs) have been subjected to scrutiny and harsh criticism on the part of researchers, clinicians, and professional organizations. Their use persists in forensic settings, and Homes & Murray (2011) highlight that this approach to care is unethical and violating guidelines of Royal College of Nursing and others. Moving from behaviour modification to positive behaviour support plans PBS, two ends of the same book, Griffiths & Wilcox (2013) demonstrates that when staff are trained in the (PBS) model of care it can help them to manage challenging behaviour in patients and provide a safer environment for everyone. PBS care plans draw firm boundaries for conduct, appreciating positive behaviour and aid the nurse and patient to minimise what is unacceptable. However, putting a plan in place is not enough, staff need to understand how this intervention works, and patients need to agree to engage with it.

Klinglemann et al, 2021 present research that was to explore forms of treatment pressure put on patients, not only by clinicians, but also by patients' relatives, during admission to psychiatric hospitals across Europe. Findings show that the level of perceived coercion in voluntary patients ranges from 'persuasion' and 'interpersonal leverage' to 'threat', 'someone else's decisions' and 'violence.' They then propose to reserve the term 'informal coercion' to describe practices for pressuring patients into treatment by threatening them, by making them believe that they have

no choice, and by taking away their power to make autonomous decisions (Klingemann et al., 2021).

A joint crisis plan, and crisis planning were seen as important tools in early intervention psychosis, but Lonsdale and Webber, (2021), find that this type of planning is not consistently applied in practice either, and that this collaborative style of planning needs policy, practice and local system changes in order to be fully implemented. Part of this crises planning, is often methods of interventions that may be used when one becomes ill.

In exploring factors predicting a desire to discontinue medication Crellin et al., 2022 interviewed those content with taking long-term antipsychotic medication. Some reported they took it reluctantly (19%), accepted it on a temporary basis (24%) or actively disliked it (18%). 31% (95% CI, 25 to 37%) said they would like to try to stop medication with professional support, and 45% (95% CI, 39 to 51%) wanted the opportunity to reduce medication. This large study reveals that patients are commonly unhappy about the idea of taking antipsychotics on a continuing or life-long basis. Professional support for people who want to try to reduce or stop medication is valued, but perhaps, should be an integral part of planning for care, the education and importance of medications needs to be understood, but also how they do not have to be a life long medication (Crellin et al., 2022).

The Nagata et. al. (2019) study aimed to quantify reoffending and readmission following patients' discharge from forensic psychiatric hospital units across Japan and explore related risk factors. They reported low reoffending rates could be attributed to the intensive treatment and care plans required by Japanese law, but the higher rate of readmission to psychiatric hospitals may indicate shortcomings in community mental health services in (Nagata et al., 2019). In a contrasting approach, research from the UK on peer support for discharged patients has been suggested as an approach to reducing readmission post-discharge. Implementation has been

called for in policy, however, there is a lack of evidence on effectivity. Gillard et al. 2022 aimed to show whether peer support for discharged patients reduces readmissions and found that close to 50% of patients were readmitted at least once within 12 months of discharge. This addresses uncertainty in the evidence base and suggests that peer support should not be implemented to reduce readmission, contrary to policy (Gillard, Bremner, et al., 2022) (Gillard, Barlow, et al., 2022).

Advancements in Care Planning

There is a call to move beyond the CPA care planning model, in movement toward a real individualised system of care planning (Kingdon, 2019b). Moernaut & Vanheule, (2020), insist that a reframing of understanding mental illness is needed, and they insist on further understanding the underlying negative symptoms of illness, from a framework of phenomenology or psychoanalysis. Perhaps, the same conceptual framework can be applied to how care is planned for those patients. They highlight five clusters in their systematic qualitative review, failing social interactions; experiences of disconnection; overwhelming psychotic experiences; an eroded self-image; and detrimental side effects of psychotropic medication.

The importance of joint working is discussed above and again highlighted by Walker et al., (2022b), particularly with older forensic populations, who are usually longer stay patients. They also note of the exclusion of patient involvement in care planning and note the gap of expertise in working with long stay older patients. However, the constant move to reinvent and make records electronic prove to be a barrier. Farr et al., (2019), focuses on the new age computer-based care planning, and highlights familiar barriers. They speak of how the patients' mental health needs and practitioners' relationships with their patients, helped in enabling reflective thinking, and that the new system could enable co production of care planning, speaking of patients in a very passive tone. The quantification of careplanning with the CPA may serve an

audit and bureaucratic purpose but is of little use for the patient it intends to help. There is a need for a new framework, which is not simply a quantification of the same CPA approach, for purposes of spurious evidencing of efficacy as with new incarnations like Dialog+ (Mosler et al., 2020). In examining furthering personal recovery in secure services with the aim of improving personalised care, Senneseth et al., (2022), advocates for the inclusion of a new tenet on recovery framework. They focus on the inclusion of "safe and secure" as a new tenet; this fundamental is something that is presumed and assumed, particularly when it comes to forensic populations.

After leaving custodial forensic are, patients often spend some time in supervised supported accommodation. Around 100,000 people live in mental health supported accommodation in England, at considerable cost, but there is little evidence to guide investment in the most effective models of supported accommodation, or hostel accommodation for discharged patients (Killaspy & Priebe, 2020). Killaspy et al. (2020) investigate the proportion of service users who successfully moved on to more independent accommodation. Overall, only 40% of participants successfully moved to independent accommodation, and this was associated with reduced costs of, and promotion of,3 human rights and recovery-based practice. Greater focus on human rights and recovery-based practice may increase service effectiveness. This low number may be explained by Smith et al., (2020) who find that a longer hospital stay length is more strongly associated with a decrease in patients' social integration than repeated admissions. They recommend that special attention should be paid to helping patients to find and keep housing and employment while hospitalised for long periods. Giacco et al., (2021), assessed whether and how neighbourhood factors are associated with social contacts and satisfaction with friendships for people with psychosis. Higher population density was associated with fewer social contacts but not with satisfaction with friendships. No associations were found for social contacts or satisfaction with friendships with social deprivation or fragmentation indexes. Clinicians in urban areas should be aware that their patients with

psychosis are more socially isolated when more people live around them, and this could impact their clinical outcomes. These findings may inform housing programmes, and perhaps a move away from the hotel, multi-occupancy model.

Interestingly, in exploring this, over the past few years the term ‘service users’ has been increasingly used to describe patients in mental healthcare. Priebe’s 2021 paper argues that the term ‘service user’ in this context should be avoided; the term is discriminating, cynical, patronising, and detrimental. While not intentional, the term ‘patient’ however describes appropriately a temporary role in healthcare, provides parity of esteem with patients in physical healthcare and reflects the reasons why large parts of society are willing to fund healthcare, in solidarity with those who are sick (Priebe, 2021).

Experiences of Forensic Mental Health Careplanning Provision

A literature review was conducted to identify research conducted that aimed to explore experiences specifically, with the relevant population samples, mental health patients and mental health staffing professionals in a forensic care setting in the United Kingdom. Wide ranging population samples were identified, ranging from forensic psychiatric inpatient, learning difficulties inpatient, prisoners, peer facilitators, carers, and staff from ranging disciplines. Studies were conducted in a range of settings, from community settings to prisons and forensic mental health hospitals specifically.

Experiences of Patients

Findings pertaining to patient experiences of care, can be broadly characterised by studies exploring experiences of interventions; the treatments that patients undergo, Recovery and risk;

the process of becoming well, and controlling for dangerous behaviours, Diagnoses; having an illness named and living with a diagnosis, and criminality; having a criminal history.

A recent systematic review and thematic synthesis by Humphries et al., (2023) (see: Table 1) aimed to understand and explore the experiences of secure care from the perspective of patients. They tout this as being the first that systematic review that aims to explore care in a broad sense, without the confines of a particular aspect of care. Their study identified just 17 papers, of which three adopted a phenomenological research approach. They note that their study is the first published systematic review that explores the broad topic of patient experience. Humphries et al acknowledge that research with this sample often focus on either positive or negative aspects of care. This review finds more suitable studies, albeit from this positive or negative aspect of care, but does add to the exploration of experience. This is however, from within the more confined aim, and viewpoint of specific interventions, experience of risk, having diagnoses and criminality.

A review of literature was conducted to explore phenomenologically with patients in forensic mental health, their experiences of receiving care. These identified research dissemination papers presented below, had a focus on interventions, recovery and risk, diagnoses, and criminality from within the forensic system, few focusing on the overall experience of care in a broad sense. As with recent systematic review research by Humphries et al, many of these identified papers, explore specific positive or negative aspects of care, rather than the overall experience of receiving care within the forensic setting itself.

Patients on Interventions

During the literature review search, there were a number of papers that paid specific attention to interventions in forensic care. In exploring a three-day dramatherapy workshop run as part

of an 18-week treatment group for mentally disordered sexual offenders Colquhoun et al., (2018) using IPA, revealed four superordinate themes, Not Being the Person I Was, Gaining New Perspectives, Social Relationships, and Barriers. They note that peer comparison and impression management were of particular importance when delivering such programmes. Similarly, Waltson et al., (2016) also conduct an IPA analysis on a similar population sample and themes associated with identity, feeling safe in the group, working on a hypothetical basis, and generalized benefits were found, with finds suggesting the incorporation of these people into more generalised groups for treatment. Further research with this client group, explored the criminogenic needs of a group of men attending a community-based introductory sex offender programme, through their victim apology letters. Duff (2010) suggest that these men do not understand themselves or their behaviour in terms of criminogenic need, for the most part, and the implications for this are considered.

Interviews with female patients with learning difficulties receiving DBT (Thomson & Johnson, 2017) find 3 themes, How you do DBT, What we think about DBT, Using DBT. The qualitative approach adds a valuable contribution to the wider literature, highlighting the importance of capturing the women's voices. As most published literature regarding the effectiveness of DBT is not written from first hand service user experiences. An article Pearson et al., (2019) also aimed to explore experiences of DBT in a community setting for people also with intellectual disability. Four superordinate themes ‘experience of power’ ‘differences in therapy contexts’ ‘the experience of a positive therapeutic relationship’ and ‘a new way of being’ described the impact DBT had on participants’ everyday lives and the shift in their sense of self. This study provides insight into the lived experiences of people with intellectual disabilities receiving DBT. Both papers explore the use of DBT and its efficacy with those with diagnosed learning disabilities, offering unique insights into their lived experience, through the IPA methodology.

In exploring fire setting with mild intellectual disabilities residing in a forensic intellectual disability hospital, Rose et al., (2016) find five super-ordinate themes emerged from the analysis:

"the importance of the first fire," "fire setting to escape distress," "fire setting to enable positive emotional experiences," "fire setting to communicate with services," "Fire Setters Treatment Programme." The analysis provides an understanding of why some fire setting behaviours emerge and highlights factors that contribute to the maintenance and desistence of repeat fire setting acts. In exploring further research with those with learning difficulties, Davies et al., (2016a) conducted a project exploring service users' experiences of positive behavioural support (PBS) within a medium secure mental health service, with four themes exploring, My plan; How I understand PBS; How PBS has helped me, the benefits; Making the plan work. Service users valued the experience of being involved in the process, offering important insights into their experiences, and unique nuanced expressions. They also shared with their research teams, how they felt frustrated by staff not following the plan and not understanding why they had a plan whilst others did not.

Awenat's work also explores the importance of service user involvement in research. They find two superordinate themes of: 'Working Together' depicting participants' feelings of the pivotal role of good relationships with researchers, and 'Journey of Change' outlined how participants' involvement in the research impacted on their personal lives. They also conclude in noting the importance of Involving forensic service users in research, not only is feasible but that should be encouraged, despite certain challenges, they note that is not only beneficial for the research itself, but also an important process for service users (Awenat et al., 2018).

Falcus & Johnson (2018) worked with patients with personality-disorders exploring experiences of treatment with the IPA and themes "A victim of a hostile and rejecting world," "Self as unacceptable to others," "Unwanted emotions that cannot be tolerated or controlled," and "Violent revenge as catharsis" emerged from the data. They make an argument for more specific forensic evidence-based treatment, as working with the concepts of shame and others, may require staff to garner more specific skills and abilities when working with people with diagnoses

of borderline personality disorder and anti-social personality disorder, diagnoses commonplace in the forensic setting.

In exploring the patient experience of seclusion rooms, Askew et al., (2019a) interviewed forensic inpatients to learn of their experience of the seclusion rooms, an under researched and often stigmatized population. Seven inpatients in a medium secure hospital were interviewed, with results: 'intense fear,' 'not getting the care I needed,' 'I am being abused' and 'power struggle.' They highlight that while participants were in the seclusion room, they experienced extreme fear. Staff interaction played a considerable role in shaping the participants' experience, but staff actions were interpreted as neglectful and abusive. Participants experienced struggling for power with staff, seeking out power when left in a powerless position. Much like Falcus & Johnson (2018), Askew et al., (2019a) also suggest that tailored forensic interventions be sought when working with these patient groups.

In contrast, those subject to a community order were explored themes of taste of freedom, not being in control, getting control back, loneliness, and feeling like a service user. Davies et al., (2015) explore how achieving clarity over the role of support staff and pathways out of the system; increasing opportunities for service users to voice concerns; empowering staff teams via extensive training and supervision; and directly addressing internalised stigma to promote community integration. In this case, the patients explored a lack of control and agency, in contrast to the lack of clarity and support and training with staff.

The role of religion in forensic care is represented in the research, and in exploring the role of religion in high secure settings, Glorney's (2019) paper finds themes: "religion and spirituality as providing a framework for recovery"; "religion and spirituality as offering key ingredients in the recovery process"; and "barriers to recovery through religion/spirituality". They suggest that religion might act as a catalyst in therapeutic engagement for some service users and staff could be more active in their enquiry of the value that patients place on the personal meaning of life.

This could be seen as somewhat different from their identities of illness and offender, in promoting hope, agency and personal meaning.

Also working with a sample of high secure patients, Mason & Adler (2012) explore group work in this context, and found that an important theme was culture of the environment, which was closely linked to the concepts of choice, which stem from and are greatly influenced by culture. Patients also explore relationships, trust, motivation, group-work content and expected outcomes, as important aspects of group work, and their engagement in it. Given the complexities of need presented by service users within high secure settings, professionals need to recognise the range of approaches needed with these forensic patients.

In exploring experiences of psychotherapy more broadly, Hussain, 2020 worked with medium secure patients and found three superordinate themes: ‘shifting self’, ‘relationship with other’ and ‘therapeutic journey’. A gradual, non-linear process of change was evident in the men’s narratives, who at the various phases of psychological therapy were faced with the challenge of questioning and redefining their identity. This involved lowering their guard, learning to become comfortable with vulnerability and face their past in the presence of a supportive ‘other’, in order to move towards building anew or better future for themselves.

Stewart et al’s (2012) examines service user feedback on violence risk as this had not been conducted. and explored service users' experiences of the violent offender treatment programme. Four broad themes were found: consistency, learning and application, the group experience, and programme structure. Ritchie et al (2010) study notes that few qualitative studies have been conducted to explore the views and lived experience of dual-diagnosis patients undergoing a relapse prevention programme. Four themes,: ‘former self’, ‘increasing self-knowledge/awareness’, ‘group as a mediator’ and ‘future self’ show that the subjective experience of group members emphasises the importance of interpersonal relationships, developing a supportive therapeutic alliance, and the learning and development of social and coping skills.

Patients on Recovery & Risk

In exploring the concept of recovery with low secure patients, Clarke et al. (2017) finds the themes: It’s a journey; We’re vulnerable in here; Relationships with staff; Loss; and Hope. Whilst findings are generally in keeping with current literature, the idea that patients are vulnerable in their secure setting is an interesting a pertinent theme that warrants further exploration; it appears as if it is a deeper level of self-reflection, and also an admission of vulnerability. Ferriot et al., (2012) also explores recovery with a high secure cohort of patients. Themes emerge: the role of previous experience and its impact on their personal development; periods of loss of grip on reality; the reframing of events in their life via therapeutic interventions and internal integration, and roadblocks to the process of recovery. The findings highlight the importance of attending to patient narratives about their offending and the context in which it took place as an inevitable aspect of their search for meaning in the aftermath of the death they perpetrated.

McQueen & Turner’s (2012) paper aimed to capture the views of forensic mental health service users on how services promote the aspiration to work, the development of skills for work, and the vocational rehabilitation process. They take a neoliberal approach and note that forensic services should focus on employment and the aspiration to work early, demonstrating awareness that attitude and the aspiration to work are a much more reliable indicator of success than diagnosis and mental health symptoms. Themes included: "Normalising my life": the positive impact of work; "Gradual steps": facing barriers; and "Practical help and encouragement": feeling supported. In contrast, exploring rehabilitation void of the concept of employment and vocation, medium-secure patients explored what encourages engagement in treatment. Four superordinate themes emerged: different worlds; what the individual brings; what the therapy entails; and control (Lord et al., 2016a).

In exploring collaborative risk assessment and management within a low secure service. Grey et al.'s (2020) study found 2 superordinate themes: 'Snakes and Ladders' and 'Knowledge is Power'. These findings are consistent with the forensic literature and Grey et al. recommends that work be done to develop collaborative working throughout the risk process. O'Dowd et. al., (2022) interviewed seven forensic mental health service users in low secure mental health inpatient settings about their experiences of violence risk assessment and management. Results identified four superordinate themes; Who is this for? Power, Misunderstood, and Moving Forward. The collaborative working that O'Dowd proposes, seems to be at odds with this work with patients not being able to see who these risk assessments are for and that they felt misunderstood. Likewise, Dixon (2012) examines mentally disordered offenders' awareness and attitude to formal risk assessments in relation to theories of governmentality. These were seen by participants as a means through which professionals measured and monitored behaviour. Patients generally identified fewer risks in relation to the dangers they posed to others than professional staff and did not view risk screening schedules as objective, but rather emphasised the need to persuade staff that their risk had reduced (Dixon, 2012).

Patients on Diagnoses

Jade-Lovell & Hardy, (2014), explore with those with borderline personality disorder and their experience of this diagnosis in a forensic setting; find themes pertaining to identity, power, protection and containment, and confusion. The themes of identity, power and protection and containment represented polarised positions which in turn contributed to the theme of confusion. Black et al.'s study (2013a) explored the experience of having a personality disorder diagnosis within the context of forensic secure and community services. Participants described two facets of their lived experience: the way they see themselves now, in light of their offending and social background and the pejorative nature of the personality disorder label, its relationship to mental illness and their need to distance themselves from it. Importantly, having

a forensic identity affects participants' perceptions of their diagnosis and its treatment as well as their views about themselves. Larissa-Bennett & Moss's (2013) paper explored client-reported functions of deliberate self-injury for prisoners located within a dangerous and severe personality disorder unit with themes emerging, 'status-seeking' function of deliberate self-injury was also observed, which is not explicitly nor fully discussed within the current literature base. The self-concept or self-image of these patients and prisoners appears misunderstood and unresearched.

The lived experience of mentally disordered offenders with dual diagnosis was the focus O'Sullivan et al. (2013) paper. Interviews with five recalled service users, i.e. those returned to hospital, from a medium secure unit in England were conducted. Five themes were identified relating to identity, control, autonomy, and recovery. Clinical implications include increasing service users' awareness of available post-diagnosis identities, which meet the needs of individuals' lived contexts and promotion of recovery-oriented care in forensic settings. Clarkson et al's (2009) semi-structured interviews exploring to experiences of direct support staff were developed from two focus groups with 11 adults with intellectual disability residing within a forensic inpatient service. They revealed two themes: staff relationship factors and positive and negative attributes of staff. The participants valued relationships with staff based on qualities such as honesty, trust, and a caring, nurturing manner that enabled individuals to feel safe. Staff characteristics such as immaturity, inexperience, and a short temper appeared to lead to feelings of discontentment amongst the participants. The implications of the findings are discussed in relation to clinical practice, staff recruitment, and training (Clarkson et al., 2009).

Patients on Criminality

In exploring the lived experiences of four males convicted of manufacturing indecent images of children to determine whether there were similarities or differences in their experiences, perspectives and behaviours which might lead to a better understanding of this offence type. find links between formative life experiences and subsequent offending. Their findings indicate

that the majority of the producers had an awareness of their sexual interest in children prior to engagement with the internet and that producers of indecent images of children may not be a homogeneous group, and that some are meeting quite different needs than others by engaging in the behaviour (Sheehan & Sullivan, 2010). In investigating stalking, Wheatley et al and Flowers et al., (2020) using IPA specifically, found five superordinate themes: "The quest for attention and affection creating connection," "Conflicted identity and extremes of self," "My life, a film set," "Gameplaying: One step ahead," and "Severed connections, changing the Gameplay." Wheatley (2020) find themes of “Neediness”, "Nothing could stop me", and “Labelling”. The findings of both studies contribute to both knowledge and practice gaps by supporting the relational goal pursuit theory for stalking and providing an evidence base to support therapeutic interventions for people who stalk. The effectiveness of deterrence and a need to improve social awareness for stalking are discussed. The specificity of these papers, focusing on specific and very particular tenets of criminality, whilst contributing to the literature, are absent of the overall view of the lived experience of patients and the meaning of having a criminal past from within forensic or prison setting.

Semi-structured with young offenders exploring identifying themes within the participant’s narratives; ‘dissociating from an offender identity and “authoring a new non-offender identity' as well as 'masculinity as multifaceted'. This study identifies that the principles of autonomy, relatedness and competence, as outlined in self-determination theory, potentially offer fruitful areas to be implemented in community treatment orders (Millward & Senker, 2012). In exploring gang membership. Superordinate themes of 'Positioning self in a social world,' 'Solutions to identity, meaning and belonging,' and 'Catalysts for change' shed light on the similarities and divergence across their experience and are discussed in respect of existing literature. Implications for policy, practice and future research are discussed (Bolger & Needs, 2021). Exploring the meaning of these narratives, from this less contextual and specific viewpoint, offers insightful perspectives into the lived experience of these criminals.

Further Research with Patients

A review of literature was conducted to explore the use of other qualitative approaches and methodologies when exploring with patients in forensic mental health, their experience of care. These identified research dissemination papers presented below, seemed to have a focus on treatment & recovery, diagnoses, and interventions within the forensic system.

Treatment & Recovery

Shepard et al., (2016) in their systematic review of qualitative research, identify only five papers that have explored the phenomena of personal recovery within forensic settings. One paper, O'Sullivan et al., (2013), aimed to explore the experiences of individuals in Medium secure units with dual diagnosis who have been recalled, and IPA was used in this study. Another, Ferrito et al., (2012), aimed to explore the processes of recovery and redemption in the narratives of homicide perpetrators who were admitted to a secure hospital for treatment, these researchers also used IPA as their chosen method for data analysis. The primary aim of Mezey et al., (2010a), was to explore forensic psychiatric patients' perceptions and experiences of recovery and to identify whether they had different narratives and emphases from non-offender patients, that could inform service planning and interventions.' They use a hybrid method of data analysis involving service users. The authors explore this further (Shepherd, Doyle, et al., 2016) in developing a model of the personal recovery processes for people needing forensic mental health services. Five studies were identified through the search process and combined through meta-synthesis. Three key overarching themes were synthesised: safety and security as a necessary base for the recovery process, the dynamics of hope and social networks in supporting the recovery process and work on identity as a changing feature in the recovery process.

Laithwaite & Gumley, (2007), use grounded theory in exploring users' perspectives on being a patient in a high-security setting and the factors they consider important in their recovery. Stanton et al., (2006), explore filicide examining themes elicited through interview. Clarke et al's (2016a) systematic review and narrative synthesis of qualitative literature for forensic mental health patients' perceptions of recovery as to find six superordinate themes: connectedness, sense of self, coming to terms with the past, freedom, hope and health and intervention. They make recommendations to expand on these findings include using grounded theory methods to develop theoretical understanding of the data. To further synthesise published descriptions and models of personal recovery into an empirically based conceptual framework Leamy et al., (2011) found emergent conceptual framework consisting of 13 characteristics of the recovery journey; five recovery processes comprising: connectedness; hope and optimism about the future; identity; meaning in life; and empowerment and recovery stage descriptions which mapped onto the transtheoretical model of change. Studies that focused on recovery for individuals of Black and minority ethnic (BME) origin showed a greater emphasis on spirituality and stigma and also identified two additional themes: culturally specific facilitating factors and collectivist notions of recovery.

Long stay patients from two high and six medium secure hospitals partook in research by Holley et al., (2020) Four themes emerged illustrating participants' attribution, outlook, approach, and readiness for change. They suggest that planning care for long stay patients in secure psychiatric settings should take account of the differing stances patients adopt towards engagement and progression, individualised opportunities, avoiding treatment repetition and maintaining continuity in key professional relationships. Refocusing on quality of life may be appropriate for some long-term patients who are unwilling or unable to move on. For some long-term patients, purpose designed long stay setting may be appropriate, and this view is not one which is evident amongst the research.

Clarke et al., (2016b) also explore what recovery means with forensic mental health patients. They also conducted a systematic review, exploring through thematic synthesis themes that contributed to recovery, highlighting the concepts of connectedness, sense of self, coming to terms with the past, freedom, hope and health and intervention. Turton et al., (2011) also explore with patients, meaning in recovery. They note of the usual tenets that construct the well understood concept of recovery, but also note of, "Clinical' recovery themes were also seen as important, as were aspects of care that reflect core human values, such as kindness".

In exploring clinical recovery with an older population sample, and contrasting against those who were deemed not recovered, O'Keeffe et al., (2022) conducted a thematic analysis to investigate contrasting themes. Five shared themes were produced: pursuing balance in conflict, generating meaning in life, experiencing a dynamic personal relationship with time, redressing inequality while managing added challenges/vulnerability, and directing life from resilience to flourishing. The five group-specific sub-themes developed illuminate differences in the meaning ascribed to personal recovery by each group. They highlight the importance of how personal recovery is conceptualised by service users and identify ways clinical recovery may influence personal recovery. Di Lorito (2018) further, explores the phenomena of the ageing patient within secure forensic secure care. In their review of seven studies, they note the need the "unique needs in relation to treatment, activities, mental, physical, and support. Further research looking at individual patients' needs is paramount to inform policy development and good practice in this area. Yorston & Taylor (2009) explores this even further with patients aged 60 and over who are resident in a high-security hospital, and their care staff. Four themes were identified: quality of life, vulnerability, risk to others, and resources. An overarching theme emerged to do with the uniqueness of these older patients, in their difference both from younger high security peers and from people of similar age elsewhere. They note that many older serious offenders with mental disorder have extensive experience of relevant services, can be used to develop treatments and interventions for this specific population sample.

In contrast, Jordan (2012), explores with prisoners in prison receiving treatment for mental health, which is quite different from forensic secure care, and their perspectives of healthcare delivered in prisons. From the viewpoint of patients (in prison) only, they find key themes in their care as understanding, care, trust, flexibility, cooperation, conversation, relaxation, enjoyment, and patient power. Podder et al., (2015), using grounded theory, explore the lives of 10 life sentenced prisoners. They find that, predominant helplessness, loss of dignity, suicidal ideation, feelings of shame and dejection on the one hand, while on the other maintaining faith in the Supreme power and hope, an urge to revenge, aggression towards others, high self-esteem and a will to fight back. In interviewing prisoners who have attempted suicide, (Rivlin et al., 2013) they highlight five risks, being unable to cope in prison, being motivated by psychosis, instrumental motives, being unexpected by the prisoner themselves, and being associated with the withdrawal from drugs. They recommend that risk assessments take into account these identified risks.

In order to contribute the tailoring of forensic mental health services for women, (Long et al., 2012) found that the following themes were to be highlighted from their study. interpersonal relationships; treatment programming; service user empowerment; the ward as a place of safety; and hope for the future. They do note that the specific-gender factors may affect therapeutic milieu, and the researchers note of the scant research on this population sample;
In exploring forensic assertive community treatment teams, (Cuddeback et al., 2011) conducted interviews with 14 patients and find the profound needs of these patients, it is suggested that most patients have no complaints or dislikes about the teams, and found housing assistance, access to mental health services, and access to medication and psychiatrists particularly helpful".

Diagnoses

A systematic review of qualitative and quantitative research exploring of first episode of psychosis, the meta-synthesis identified six themes in relation to stigma on pathways to care among the target population: ‘sense of difference’, ‘characterizing difference negatively’, ‘negative reactions (anticipated and experienced)’, ‘strategies’, ‘lack of knowledge and understanding’, and ‘service-related factors’ (Gronholm et al., 2017). In exploring anger and psychosis with forensic mental health patients, and the interplay between the two, (Joyce et al., 2013) conduct a grounded theory study and find that anger, mental illness, substance misuse and social issues were recognised as contributing factors to offending behaviour.

Yamahuchi et al., (2015) through semi-structured interviews explored with seven near-fatal suicide attempters with untreated schizophrenia subjective experiences at the time of the suicide attempt. Black et al., in their (2013b) paper, explore the lived experience of having a personality disorder with service users. They interviewed those with diagnoses of personality in a forensic setting, and used the IPA method to analyse, and find that the stigma of having a label of a forensic patient, and how this effects their treatment and views of themselves, similar to aforementioned research by Shepard et al., (2017), explore the lived experience of personality disorder and recovery within community and forensic settings.

Oddie & Davies (2009) evaluates a substance misuse programme in a medium secure forensic mental health hospital. They note of forced incarceration as being the most protective factor, followed by the support of staff. With lack of available help and upcoming decisions on detention as being most detrimental to their abstinence. As this study was cross relational note of the value in longitudinal evaluation for such programmes. Wilkie et al., (2014) In exploring events where patients abscond from care, they find that patients who absconded from hospital were more likely to have a history of absconding attempts, a diagnosed substance use disorder. They suggest that MDT teams explore with their patients, their motivations for absconding from

care in order to further understand this phenomenon. Pagano et al., (2018) Explore through ethnographic studies, drug abuse recovery houses, and highlight the importance in value of this type of ethnographic research when exploring phenomena with particular marginalised population samples. In conducting interviews to exploring opiate dependency with an incarcerated population sample, Larney et al., (2017) find the need for research on how best to attract and retain opioid-dependent prisoners in treatment and the need to provide other interventions for prisoners uninterested in post-release OST, such as take-home naloxone.

In exploring adaptation skills and abilities in inpatients with a diagnosis of ADHD, Canela et al., (2017), explore and classify these abilities as falling under, organizational, motoric, attentional, social or psychopharmacological, and report that these learned abilities are useful in their everyday life. They suggest that if professionals had a greater understanding of patients' symptoms, they would be more amenable to treatment and engagement.

Interventions

To explore and evaluate involvement initiatives in secure mental health settings McKeown et al., (2016) offers four broad themes: safety and security first; bringing it all back home; it picks you up; it's the talk. Involvement initiatives with service users resident in secure hospitals can be organized to good effect and the active role of commissioners is crucial. Positive outcomes are optimized when care is taken over the social space where involvement takes place and the process of involvement is appreciated by participants. Enquan et al., (2020) focused on inmates who were absent from classes without valid reasons and sought to persuade them to attend using motivational interviewing within the structure of individualised care plans. Following the implementation of our strategies, the attendance rate rose to 85%. However, without continued efforts to incorporate the strategies into standard operations, attendance rates were unsustainable. Using a mindfulness scale as their barometer, Sistig et al. (2015) explored with forensic patients the acceptability and effectiveness of an eight-week mindful yoga programme

in improving psychological outcomes in 26 forensic inpatients. 92% of patients were accepting of the programme, with positive results and engagement having an overall effect on their symptoms, with the sample showing a reduction in symptomology and anxiety. In further exploration of engaging with interventions, (Roberts et al., 2015) research with low secure forensic mental health patient, the efficacy of an interagency community-based activity. Patients found that participation had led to some individuals engaging in new opportunities for vocational and leisure activities.

Interviews with patients, showed a complex picture of their experiences of daily life. This study demonstrated the impact of the environment on the patients and the ongoing challenge of the need to balance treatment/therapy with security demands and opportunities. Three interrelated themes were identified: Power and Occupation; Therapy or Punishment; Occupational Opportunities within Restrictions. These findings serve as a reminder to clinical teams to reassess the value of occupations attributed by their patients and the impact of the secure environment, whilst also acknowledging the potential for occupations to have a negative impact on well-being (Morris et al., 2016). In contrast, Haw et al, 2011, explore rehabilitation inpatients' experiences and preferences for physical restraint, seclusion and emergency intra-muscular medication using mixed qualitative and quantitative methods. 16% of participants reported the last episode of seclusion or restraint had been a positive experience for them. The figure for emergency intra-muscular medication was 36%. They recommend that patients' views on coercive treatments should be incorporated into their care plans and they should be encouraged to make advance statements (Haw et al., 2011).

In exploring engagement with therapies, semi-structured interviews were conducted with 17 participants in a trial of group music therapy, art therapy and dance-movement therapy. Three overarching themes were found relating to the experience of choosing an arts therapies group

and subsequently attending it: past experiences of the art forms, social interactions in the groups and expectations of helpfulness (Millard, Cardona, et al., 2021). The same authors also sought to obtain service user opinions on three decision aids designed for the arts therapies with four themes: Previous experiences of the arts shaped discussions; Aims of treatment are essential information; There were different expectations of each decision aid; The decision aids offered an evolving understanding of the art form in the workshops. All decision aids were useful in different ways, therefore timing in the decision making process and physical location of the aids are worth considering (Millard, Hounsell, et al., 2021).

To examine the evidence for the use of psychological and psychosocial interventions offered to forensic mental health inpatients, the authors note that current practice is based on limited evidence with no consistent significant findings. This review suggests psychoeducational and psychosocial interventions did not reduce violence/risk, but there is tentative support they may improve symptoms Only seven out of 91 comparisons revealed statistically significant results with no consistent significant findings. The most frequently reported outcomes were violence/risk and symptoms. 61% of the violence/risk comparisons and 79% of the symptom comparisons reported improvements in the intervention groups compared with the control groups (MacInnes & Masino, 2019). In exploring DBT specifically, a qualitative systematic literature review of all DBT programs within forensic psychiatric and correctional populations using the PRISMA statement guidelines is presented, along with a detailed exploration of how these programs align with best practices in offender rehabilitation, and whether they are effective in reducing recidivism risk. Results offer very preliminary evidence that DBT has the potential to reduce recidivism risk in criminal justice systems if applied within a Risk-Need-Responsivity framework (Tomlinson, 2018). Willemsen et al., (2016b) explore through interview and thematic analysis, what participants of a psychotherapeutic group for sex offenders. They find that when “when clients trust their peers and feel respected by therapists, emotional

engagement in treatment is achieved." They are then able to better control emotions and see improved interactions with their peers.

In a more practical and applied intervention, Botero-Rodriguez 2021, explored the feasibility, experiences, and outcomes of a group volunteer befriending intervention for patients with severe mental illness. Whilst their objective social situation had significantly improved at the end of the intervention, symptomology and internalised stigma did not show statistically significant differences. The interviews with participants revealed positive experiences overall which fell into five categories: stigma reduction; personal growth; formation of relationships; continuity and sustainability of befriending; 5) acceptability and feasibility of befriending. (Botero-Rodríguez et al., 2021) In a truly coproduced intervention Olso et al., 2016 explore service users' experiences of having the opportunity to refer themselves for a short inpatient stay. Reported than being more than just a bed, it was perceived as a new, unconventional health service, which differed substantially from earlier experiences of inpatient care and was characterised by different values and treatment principles and was of particular success at trial.

Experiences of Professionals

Findings pertaining to professionals' experiences of delivering care and can be broadly characterised by studies exploring experiences of assessments and interventions; adverse incidents when delivering care and working with forensic patients more generally. A presentation of systematic reviews on the topic of staff experiences of discharging care can be found on (see Table 2). This summarises the few systematic reviews that explore professionals' experiences of delivering and working in forensic mental health hospitals and also where applicable shows the broader themes that were found through thematic synthesis. This follows the pattern as highlighted in work by Humphries et al., (2023); there is scant research exploring

the experiences in a broad sense, with many studies focusing on positive or negative aspects of care. This review will highlighted these aspects of are planning that are often focused on the positive and negative aspects of delivering care, with a specific focus on the aforementioned themes of assessments, delivering interventions, adverse events that one is witness to, and risk.

Professionals on Assessments/Interventions

In exploring the assessments of contributary factors for men who have sexually offended Chawke et al., 2020 using Interpretative Phenomenological Analysis, highlighted the relational/social nature of the interaction and the clinicians' experience of a somewhat blurred line in practice between forensic assessments and therapeutic endeavours (Chawke et al., 2020).

Interpretative Phenomenological Analysis was conducted following semi-structured interviews with six Mentalisation Based Therapy (MBT) clinicians. Findings highlight how the challenges of working with clients with ASPD presented a significant threat to clinicians' professional identity. These challenges were compounded by confusion surrounding the MBT model, lack of support from multidisciplinary staff and insufficient service infrastructure. MBT clinicians' attempts to overcome these barriers led to them striving and breaching time boundaries, leaving them at risk of burnout. These findings contribute to existing literature surrounding clients with ASPD and provide new insight into implementation barriers when delivering a community based MBT service with this client group (Warner & Keenan, 2021).

Professionals on Adverse Events

Given the approach that IPA takes, in understanding the lived experience of staff in these settings, there are studies that explicitly explore the adverse events that occur in these hospitals, and many have concluding commentary on how professional can improve in their practice.

Back et al., 2021, explore survivors' experiences of sexual assault. After exploring any themes, they suggest that survivors' needs cannot be met if vulnerabilities are overlooked or ignored. At the same time, the concept of vulnerability warrants caution since vulnerabilities are often placed within individual survivors, but the formal support system also appears vulnerable in its ability to meet the diverse needs and priorities of those served. They suggest that there is a need for more individually tailored and trauma-informed responses to sexual assaults that simultaneously address co-occurring difficulties and inequalities in survivors (Bach et al., 2021). When exploring this from the other angle, Sandhu et al., (2016b) explores the emotional challenges faced by staff working on a sex offender treatment programme for people with an intellectual disability. Staff experienced a range of negative emotions that they dealt with in a variety of ways including through the use of humour and various emotional defences. Empathy was a challenging and complex issue with individuals taking a variety of positions. Staff awareness and understanding of the role of emotions in relation to their own well-being and in relation to therapeutic processes varied. The importance of emotional intelligence is disused in relation to working with this client group (Sandhu et al., 2012).

In exploring violence more generally, Jussab & Murphy, (2015), explored therapists' experiences of client violence, with emerging themes including: processing the moment-to-moment experience of client violence; professional vulnerabilities and needs as a result of client violence; and the ruptured therapeutic relationship. They propose strategies for supporting practicing psychologists; addressing self-doubt, reenergizing professional competencies as well as repairing and repairing the therapeutic relationship. With a focus on self harm, Shaw & Sandy (2016b) explore nurses' attitudes toward self-harm. Opinions were varied but were mainly negative, and this was usually related to limited knowledge and skills. They use their findings to create a training programme for nurses to help them work with this client group in a way which is holistic and changes attitudes (Shaw & Sandy, 2016a).

McManus finds that hearing distressing material can have a lasting impact on therapists, including experiencing intrusive images, changing perceptions of risk and mood and health changes, as predicted by theories of vicarious traumatisation and secondary traumatic stress The study has provided further evidence that hearing distressing material can have a lasting impact on therapists, including experiencing intrusive images, changing perceptions of risk and mood and health changes, as predicted by theories of vicarious traumatisation and secondary traumatic stress (McManus, 2010).

Professionals on Working with Forensic Patients

Gillespie & Flowers, (2009), explore with forensic mental health nurses working in Scotland, their experiences are explored, and a shift appears to be emerging toward a culture of humanism, but there appears as if much work still needs to be done in terms of training and development of staff.

In exploring nurses' experiences of working with individuals diagnosed with both intellectual disability and personality disorder (PD) in a medium-secure forensic intellectual disability setting, Lee & Kiemle (2015) four master themes emerged from (i) disorder overriding disability; (ii) resilience; (iii) ambivalence towards label and (iv) knowledge. The findings highlight that for these participants, the clients' intellectual disability appeared to be lost under the complexity of the PD diagnosis. The clinical implications are discussed in terms of developing training, supervision and support (Lee & Kiemle, 2015). Muiruri et al (2019) find, four superordinate themes were identified: fear of patient-prisoner, time constraint, labelling, and optimism on recidivism. They note that future research should investigate the extent to which these impact on the patient-prisoner experience. Shaw & Sandy find that nurses' attitudes toward self-harm varied but were mainly negative, and this was usually related to limited knowledge and skills. They suggest improvements to curriculum development (Shaw & Sandy, 2016a).

Four psychologists were interviewed for their experiences of working with inmates. Thiry & Thiriez 2014 find three main themes, 1) the atypical nature of the request for psychological help in prison, 2) the difficult balance between security and therapeutic stakes, and 3) the sociological as well as the psychological characteristics of the inmates. They propose a reflection on the status of psychotherapy in a forensic environment, and note that all therapy is treatment, but that not all treatment is therapeutic, noting that psychotherapeutic rigour cannot be maintained in a prison setting (Thiry & Thiriez, 2014).

Bond & Gemmell (2014) explore with prison officers working on a psychologically informed planned environment in a life sentence prisoners and find their main themes identified were labelled 'Role Conflict', 'Growth', 'Relationships' and 'Impact'. A rich and detailed account of the experience of the 'voyage of discovery' and the personal challenges, costs and rewards of the PIPE work was achieved. The experiences shared reveal the personal challenge, costs, and rewards, but recommend training and support for those working in these settings (Bond & Gemmell, 2014). Evans et al., (2012) aim to explore the experiences of support staff within secure mental health services with regards to the formation and development of therapeutic relationships with patients exploring this with unqualified support staff based within secure establishments and working directly with patients. Themes included: 'Building bridges': developing relationships with patients; ''You do forget what they've done': seeing the person and managing risk, and 'Playing your cards close to our chest': maintaining boundaries. They report addressing a gap in the literature, which regarding the need to study the formation of relationships between patients and unqualified support staff in secure mental health services, but they still note of the scope for further research to focus in aiding an understanding of the role and benefits of such relationships.

Further Research with Professionals

A review of literature was conducted to explore the use of other qualitative approaches and methodologies when exploring with professionals in forensic mental health, their experience of delivering care. These identified research dissemination papers presented below, pertained primarily to the interventions that they perform and therapies they carry out, along with a corpus of work on risk.

Interventions

Much research highlights institutional issues and personnel issues in forensic mental health, which hinders the quality of care delivered to this vulnerable client group. Christofides et al., (2012), explore with clinical psychologists, their use of case formulation with MDT teams, noting that the practice is often delivered through casual conversation with staff rather than through structured training presentations or seminars and suggest this understudied technique is further studied. In further highlighting the lack of vigour in interventions, restorative justice interventions were found to be congruent with models of mental health and offender recovery. Processing emotions, developing thinking and coherent narrative, and immediacy are found to be key components of the intervention. Cook et al., (2015) calls for high levels of skill needed when facilitating this process with this complex, vulnerable and potentially unstable client group. Neal and Brodsky (2016) through a mixed methods study, explore qualitatively, forensic psychologists' de-biasing strategies. They highlight issues of concern, namely, disliking or having sympathy for defendants. Disgust or anger toward an offense, limited cultural competency and pre-existing values, along with colleagues influences and protecting referral streams. They suggest biasing strategies to improve professional bias.

Four themes were identified by Oates et al., in their integrative review, engagement with the patient group, the ward social environment, impact on the nurse, and implications for practice.

They plead that when policymakers address workforce shortages in high secure forensic nursing, they must take account of the unique features of the setting and patient group, highlighting that nurses must be adequately prepared and supported to function in an ethically and emotionally challenging environment (Oates et al., 2020a).

Møllerhøj, Stølan and Brandt-Christensen (2016) explore with general psychiatry staff, treating forensic patients in a non-forensic setting exploring this using content and contextual analysis. They conclude, "the interplay between physical environment, bottlenecks, poor information exchange, lack of knowledge and competences, complex psychopathology, and a vague and therefore uncomfortable task of nursing leads to a focus on criminal offenses rather than mental disorders and an increased risk of brutalization and stigmatization in nursing practices".

McRae, (2013a) explore the admission process of service users with a diagnoses of antisocial personal disorder to secure hospital, an note of team disagreements and decisional issues that are mediated by a leader, usually the clinician responsible for patient care. They note that resource pressures may lead to cajoled decisions which could undermine the institutional purpose of the hospital. They further explore (McRae, 2013b) MDT admission decision making upon admission and explored interprofessional dynamics. With a sample of ASPD patients, they note that they change according to legal coercive pressures, and often give a false impression of improvement. They conclude in noting that there may be change in the offenders self-understanding, but the completion of treatment can often result in re-admission to prison. Grounds et al., (2004) also use thematic analysis while interviewing staff and hospital management on the decision making processes involved in decision making around admission to forensic hospitals. they conclude that admission decisions entail complex professional judgements under the backdrop of the ethos of the admitting unit and the wider context peppered by the need to maintain a collaborative, shared vision amongst staff, responsibility for

gate-keeping and managing expectations of referrers and managers, the need to ensure turnover of places, are seen as dominant considerations.

A review explores how mental health professionals working in forensic mental health settings experience the violence risk assessment and management process. The themes which emerged were: The Patient as a Person; The Caring Relationship; Multidisciplinary Working and Reliance on Clinical Intuition (O'Dowd, Cohen, et al., 2022). Two focus groups with registered nurses exploring attitudes and factors used in decision-making about seclusion finding that there are complexities and competing variables involved in the decision-making process. There is increasing focus on staff and organisational factors on the use of seclusion. And ethical considerations tend to lead to tension between keeping safety and promoting a therapeutic and patient centred approach (Green et al., 2018).

This study by (Hancock et al., 2018) explored staff experiences and perspectives of what helped and hindered them in their work to support that prisoners with mental health conditions to the community, themes including: housing secured before release; clearly defined and effective communication pathways; shared understanding of systems and roles; in-reach and continuity of contact, and consumers' pre-release preparation and knowledge, but they highlight the current fragmented and disparate systems and practices need to align and clear expectations and understandings need to be shared across the whole. Further exploring transition to the community, (Callister et al., 2020) explore from the perspective of caregivers the care coordination for patients discharged from the hospital, with five themes emerging, suboptimal access to clinicians after discharge, feeling disregarded by clinicians, need for information and training at discharge, overwhelming responsibilities to manage appointments and medications, and need for emotional support. They simply suggest the need for clinicians to provide caregivers with support, training, and communication after hospital discharge.

Kriegel et al., (2016) also explore community housing initiatives with discharged forensic patients. They find that those people from forensic mental health backgrounds, oftentimes live in congregate settings, and their teams often take a risk reduction approach to recovery and substance use, rather than a harm reduction approach.

Risk

The Ward Atmosphere Scale (WAS) is the most frequently used scale in appraising the safety and effectivity of a psychiatric ward, and its psychometric properties have been reported as good. Given the changes in the practice of inpatient care over the last 50 years, there are no briefer nor more recent psychometrically robust scales to measure ward atmosphere, and (Banks & Priebe, 2020) suggest that these should be developed. These risk assessment tools are still being used, in spite of the many recovery based changes in recent decades.

Burnout can be seen as risk in forensic setting, for staff would be unable to perform to their best ability, and to the astute standard needed. Ireland et al.'s 2022 systematic review indicated three superordinate themes: outcomes adversely impacting staff and patients; personal characteristics moderating the impact of events; and organisational and interpersonal support moderating the impact of events. Those who experienced less burnout reported lower trauma symptoms, while staff who experienced higher levels of secondary trauma at work reported higher levels of trauma symptoms. A higher level of resilience was related to lower levels of trauma symptomology. (Ireland et al., 2022) Using thematic analysis, Chandler et al., (2017) explore occupational burnout with staff working within a forensic personality disorder unit. They find that with this population sample, higher levels of burnout were found, compared to those staff working in non-forensic services. They attribute this to the wide range of complex and additional challenges posed to staff working with this sample of patients.

Cashmore et al., (2016), explore with correctional healthcare workers, workplace violence and in proposing how to improve safety. In highlighting specific issues, they felt as if risk increased with low staff to patient ratio, high staff workload, underperforming security staff and poor management of violence and aggression and horizontal violence; aggression between nursing staff and another member of the nursing team. They note the importance of appropriate workplace health and safety policies and procedures, professionalism among health staff, the presence of prison guards and the quality of security provided, and physical barriers within clinics. Kurtz & Jeffcote, (2011), look at the experiences of work with two cohorts of forensic mental health staff from two differing units, medium secure unit treatment predominately those with psychosis, and another there the treatment audience was those with personality disorder. Analysis of their two samples of staff were to culminate in the expression “everything contradicts in your mind.” They note that “staff support came in the form of close relationships with staff, as they found themselves isolated from the wider environment.” Suggesting, that in order to prevent burnout, you need to form close relationships with your more resilient colleagues and leverage on that interpersonal support. Those with burnout, now support each other.

Short et al. (2009) explore with prison officers and mental health staff in a prison, self-harm, their views of self-harm. Staff were to report self-harming behaviours genuine, or as non-genuine and manipulate using self-harm for their rational means. This led to staff feeling unable to work confidently with people who present with self-harming behaviours. To explore understanding of self-harm among women prisoners, prison officers and health-care staff and how their feelings might influence service provision and development. Prison officers often attributed motives to self-harm such as 'manipulation' and 'attention-seeking', whereas descriptions by women prisoners, prison governors and health-care staff suggested explanations in affect regulation or self-punishment. Understanding of self-harm rom this viewpoint, may be a mechanism of as self-protection/coping strategies (Kenning et al., 2010).

Limitations of Previous Research

Many research papers explore the patients' own experience of inpatient care, (Lilja & Hellzén, 2008; A. I. F. Simpson & Penney, 2011; J. A. Smith, 1996), many focusing their research on acute inpatient care, (Atwal & Caldwell, 2006; Baker et al., 2014; Cleary et al., 1999, 2012; Cleary & Cleary, 1999; Hummelvoll & Severinsson, 2001; Quirk & Lelliott, 2001). Some papers explore experience from the viewpoint of staff, (Boardman et al., 2018; Kurtz & Jeffcote, 2011; Wimpenny et al., 2014; Wright et al., 2014) and other research teams explored the views of current inpatient service users, (Coffey, 2006; B. Davies et al., 2016b; Gilburt et al., 2008; Mezey et al., 2010a; Repper, 2000; Shattell et al., 2007).

Papers often explore a specific phenomenon, including, working with families in mental health, (Bownas, 2012), stress and satisfaction with staff, (Reid et al., 1999), barriers to research with nursing staff, (Carrion et al., 2004), self-harm from a nursing perspective, (Wilstrand et al., 2007), values of what goes into making a good mental health nurse, (Dziopa & Ahern, 2009), and receiving occupational therapy, (Craik et al., 2010a).

Few identified papers explore both the views of service users and staff from a dual perspective (from that of both the service user and staff). Doyle et. al.'s (2017a) systematic review identifies two papers that examine a related phenomenon, one explores attitudes to the management of violence and aggression. Another qualitative paper exploring the view of both staff and service users, explores ward atmosphere (Brunt & Rask, 2007).

There are good quality studies on the use of service users' views in research. Through inclusive data collection methodology, researchers have been able to explore service users' views on interventions in mental health, from psychiatric to spiritual (Coffey, 2006; Lester et al., 2012; Mérineau-Côté & Morin, 2014; Papoulias et al., 2014; Raffay et al., 2016). To exploring nursing attitudes and in evaluating the effectiveness of nursing training (Escobar-Koch et al., 2010;

Richards et al., 2005). Other examples include more complex issues on supporting recovery, (Keith et al., 2011), service users' views on labelling, (Dickens et al., 2011) ethnic diversity and black mental health, (Bowl, 2007), and being recalled under the Mental Health Act (Chiringa et al., 2014).

These projects have employed single and mixed methods, qualitative and quantitative approaches to data collection. While a majority employ a thematic analysis to recorded interview transcriptions, Moltu et al (2012) used a hermeneutic-phenomenological approach when conducting collaborative research with service users. Merineau-Cote & Morin, (2014) explored service user experience of mechanical restraint and use of seclusion rooms.

Research is wide ranging and inclusive, however the lack of research-supported and research-based care planning literature is obvious, as highlighted by Scott and Aboud's systematic review and meta analysis of the field (Scott & Aboud, 2021a). Another recent systematic review by Humphries et al., (2023), highlight the wide ranging research phenomena explored with patients, but also highlight the scarcity of exploration of general experiences of patients undergoing care within forensic secure populations, highlighting 17 suitable papers, of which only three explore experiences specifically, they highlight the emphasis in the extant literature, of a focus on positives and negatives aspects in care delivery, rather than an exploration that is homogenous and exploring general experiences of care. Broadening the horizons of understanding may benefit in the ability to be fully sympathetic to the patient and staff experience.

In spite of this extensive literature review, focusing on multiple approaches to exploring the forensic mental health field, and careplanning specifically, extraordinarily little research was found that focuses on how careplanning methodology is created, or indeed justifies any models use. Many papers are critical of careplanning, and the interventions that it plans for. The

importance of patient involvement in research is well documented, but Marklund et. al., (2020), not that whilst this importance is recognised, the perceived needs of patients were "largely ignored or opposed by staff, due to the content and structure of care." They highlight how patients in this study, simply felt as if patient involvement was not taken into true account. Marklund et al., call for fundamental change in this respect. There is also obvious scant research conducted on the Care Programme Approach itself, as most care plan literature, appears to focus on specific interventions, rather than the framework of care under which the patient is under.

In the face of the earlier introduction and context setting, it brings to light how this may be the case. Those interventions and planning for care, have been borrowed from non specific fields of psychiatry and applied to forensic populations. Reavey et. al., 2019, note of the specific and unique environment that the forensic psychiatric hospital is, within the context of the wider post asylum world. However, thirty year old care planning method, introduced into forensic secure care and still used in spite of any research proving effectivity with forensic populations, and designed for community settings. The CPA has been applied to medium secure forensic mental health settings, in spite of its proven reliability, applicability or effectivity. Reavey et al., (2019) explores the poor implementation of planning frameworks, considers the difficulties in implementing recovery orientated careplanning in forensic settings. Furthermore, Penney et al., (2019), explore how this the forensic psychiatric population has changing needs over time, and how patients have very specific attributes that necessitate changes in care plan design. They note how in recent times, patients tend to have less serious violence histories than in the past, and today, patients tend to present as younger, with drug addictions neurological issue and have less severe violent histories. In light of the changing needs of patients within these contexts, they recommend that treatment, and careplanning is optimised to best serve their needs. An exploration of what these new patients experience is needed.

Rio et. al., (2020), find that there is a limitation in care provision literature amongst academic circles and highlight the focus on risk within literature. This review found that studies with patients, focus on patient interventions, recovery, diagnoses, and criminality, in exploring their lived experiences further. Studies with professionals, explored their experience of assessments, interventions, adverse events and working with forensic patients more generally. Multi-perspectival studies explore recovery and risk, interventions and diagnoses more generally, but there is an obvious lack in research exploring experiences of careplanning and planning for care more broadly. (Russo & Rose, 2013) note that during institutional monitoring visits, that there is an unspoken voice, and that patients are not represented which leads to underreported human rights issues, warranting further exploration of patient experience which also considers these power positionings of researcher and participant.

Advancements & Originality of this Research

Scott & Aboud's (2021b) review of research shows that there are neither measurable benefits nor positive outcomes linked to mental health care planning, they summarise their work by noting that current literature does not demonstrate any measurable benefits nor positive outcomes linked to mental health care planning. This may be explained by Tyrer (2019b) who surmises, that the CPA was introduced as a quick response to a scandal, rather than through rigorous planning, testing and research. Not only can this explain the inconsistencies found in the implementation of the CPA, but also differences in care quality, inconsistencies in planning interventions and overall and the lack of research driven careplanning. Besides this, Schaufenbil (2015) also says that there is no specific careplanning for forensic mental health patients, and that other models of planning are imported into the forensic field, in spite of the forensic mental health field having a fundamentally different roles and responsibilities in treating those it serves and to society. It has been found that longer stay patients are articulate and have good knowledge of the system in which they have lived and are articulate enough to contribute to the

careplanning research (Yorston & Taylor, 2009), the present study is one of very few projects that has enacted on this recommendation. There is also an acknowledged need for further work in exploring patients experiences of secure care (Humphries et al., 2023; Ratcliffe & Stenfert Kroese, 2020) and work with them on understanding their nuanced understanding experiences.

Few opinion pieces can be found that advocate a move away from the Care Programme Approach, Tyrer (2019b) notes of the monstrosity of paperwork it has created with intangible benefits and Kingdon (2019b) notes that there is a need for "a system based on evidence-based clinical pathways and reliable measures of severity and need should replace the current approach." There is a need for a new framework, which is not simply a quantification of the same CPA approach, for purposes of spurious evidencing of efficacy as with new incarnations like Dialog+ (Mosler et al., 2020). This research aims to explore how care is experienced, both in its deliverance and receipt, in the forensic hospital in order to better direct that care provision.

Additionally, this research explores those papers with a narrower and with the more specific scope paying attention to those papers which explore positive and negative aspects of care, alongside those papers with the broader sense of experience of inpatient stay (Humphries et al., 2023). Of the 17 papers Humphries found, they note that 8 of those identified failed to pay attention to the researcher-participant relationship, the phenomenological and insider researcher approach of this research makes this position clear, and adds to this niche and hard to reach research population.

Rationale & Aims of this Research

This study aims to explore through investigation with staff and patients, their experiences of living and working in secure care, understanding their experiences of receiving and delivering care, in the creation of a foundation for careplanning that is rooted in research. Rather than

coproduction or tokenistic involvement from patients as seen elsewhere, this research sees the patients as active participants on an equal footing with their staff counterparts.

The research will explore from a phenomenological perspective, in order to understand the lived experience of participants, to then inform this new foundation for care planning. Given the insider researcher role of the interviewer and researcher, these interviews will explore in depth, these experiences whilst paying reference to and being cogitate of, the specific ecosystem that the patients and staff find themselves. The existentialist lens from which the lives will be explored is not done in negligence of the specific socio-political, nor socio-cultural peculiarities that these participants are aware, this broad view will further enhance the interpretative element of the work.

Findings will inform and aid in the creation of an alternative care plan framework for long stay patients and staff, routed in phenomenology and existentialism, informed by their experiences.

Research Questions

1. How do long stay forensic mental health patients find meaning in their lives?
2. How do staff that work in long stay forensic mental health find meaning in their roles?
3. What does an alternative careplan look like, informed by those experiences?

Insider Researcher Position

Insider researching has unique, strange, and peculiar ethical considerations that must be addressed. While the researcher will know professionally, and sometimes personally, their research subjects, there are important ethical considerations that must be taken into account. Costly (2010), writes about this researching role in depth.

“There is the possibility that colleagues may feel obliged to cooperate with your research.” “It is therefore important to articulate your own perspectives or premises clearly, that is to state your personal model of understanding of a situation” … “but you should also demonstrate that you understand alternative perspectives.” “You have to decide how you would deal with a situation if a participant tried to use an interview in this way.”

Bonner and Tolhurst (2002), explore some of the advantages of researching in this role. They note that the researcher will have a greater understanding of the culture being studied, and to that end, will not spend time unnecessarily exploring nuances and vocabulary and meaning behind insider terminology. As the researcher and the participant know each other, there is no altering to the natural flow of social interaction. This leads to more natural and rich conversation and having an already established intimacy also promotes both the telling and the judging of truths.

But indeed, there are disadvantages to interviewing as an insider researcher and some of these are highlighted by Herman (1989). As an insider one may tend to overlook certain behaviours that one might consider as normal or unimportant. While those without such an acute understanding of context may highlight these. With greater familiarity may come a loss of objectivity. One may be making assumptions about meanings and not seeking clarification, given the collective understanding of language and vocabulary. One may be guilty of assuming one knows the participants views and not conduct interviews in an objective way. To the same end participants may assume what you already know and may miss out on explaining important particulars that they may assume one already understands.

Costely, 2010 also notes on how closeness to the situation may hinder the researcher from seeing all dimensions of the bigger picture. Having certain positions of power in the interview setup may hinder frankness and openness with the interviewee. There may be anxiety in opening up with staff in superordinate roles, and likewise with staff in subordinate roles, unwilling or unable to open up.

There are other ethical considerations that the author notes on peer pressure in this line of research enquiry. "There is the possibility that colleagues may feel obliged to cooperate with your research" (Costley et al., 2010, p. 31). "To the extent that researchers are insiders, you are drawing on the normal ground rules of reciprocity and trust, that pertain for social interactions in the community. The extent that being a researcher means using these ground rules for research purposes, there is a risk of exploitation and betrayal" (Costley et al., 2010, p. 31) original quote (M. Griffiths, 1998, p. 40).
"All serious researchers recognise the difference between opinion and knowledge, even if they disagree about how to identify each one of them" (M. Griffiths, 1998, p. 47).
"Thus… the removal of bias requires researchers to address their value positions, which therefore need to be explicitly stated as far as possible" (M. Griffiths, 1998, p. 47).

There is great importance of identifying and exploring the political nature and the power of the researcher, the environment, and the socio-normative of the environment of the research (M. Griffiths, 1998, p. 53). Some more ramifications below by (Costley et al., 2010, p. 32). Any possible criticism that the researcher makes in evaluation of the research will be instantly perceived by the organisation and could cause tension.
It may be difficult to ensure anonymity of the company is big and well known.
Offering confidentiality to a colleague rather than a participant of research is a more longstanding promise. You have knowledge of things that you might not have ethical clearance to access or use as research.

"It is possible that you may see the participant as someone who needs help and support of some kind. In this way, interviews with colleagues can act as a form of therapy, an opportunity for them to air a grievance… how to deal with this?" (Costley et al., 2010, p. 34). Is it also possible that participants may use this time to air grievances, which comes with its own ethical implications, but also may run the risk of transgressing professional boundaries. Aiyegbusi

(2012) explores how the insider researcher may be at risk of transgression of professional boundaries. During an interview where a grievance is raised, against a colleague or about a service user, the interview may become more of a gossip rather than solid research. The importance of remaining professional is stressed. There are already pre-existing professional boundaries with forensic patients, and the difficultly of working as a practitioner researcher with these strong boundaries approach to care delivery one should remain cognisant of (Kelly & Wadey, 2017).

Research is primarily conducted by people in positions in power. Psychologists, psychiatrists, and medical trainees. While they may have an insider researcher approach, it is important to understand their position within the multi-disciplinary team. They only visit the ward to meet with patients sometimes once a week. Patients and staff will and do, interact with members of the MDT team on a different professional level. The current researcher is a member of the treatment team, knowing the team well, and also a member of ward staff who works with the patient population daily, not just a MDT professional who visits the ward solely to deliver interventions.

Table 1. Summary of Findings of Humphries et al 2023 Systematic Review

Authors	Country	Method	Context in Forensic Care	Thematic Findings
Askew et. al., 2020	UK	**Interpretative Phenomenological Analysis**	Patients' experiences of seclusion rooms.	"intense fear," 'not getting the care I needed," 'I am being abused" and "power struggle."
Barnao et al 2015	New Zealand	Thematic Analysis	Patients' perspectives of rehabilitation.	"The person centred approach," "the nature of relationships with staff," "consistency of care," "awareness of the rehabilitation pathway," "agency," and "coping strategies."
Bowser et al 2018	UK	Thematic Analysis	Patients experiencing boredom	"Mental health and motivation," "Restrictive environment," "Responsibilities" and "Nothing to do."
Brown et al 2014	UK	Thematic Decomposition	How patients manage their sexuality	"Exclusion," "Territorialisation," and "Amputation,"
Craik et al, 2010	UK	Constant Comparative Analysis	Institutional restrictions on occupational engagement	"Previous Occupations," "Current Occupations," and "Future Occupations/Hopes"
Di Lorito et al 2018[1]	UK	Thematic Analysis	Patients experience of aging in secure care	"Self-agency," "Activities," "Social life," "Practical matters," "Recovery," "Physical Health," and "Service Improvements"
Horberg et al 2012	Sweden	**Lifeworld Approach / phenomenology**	Experiences of patients own life situation	"Non-caring care," "Pockets of Good Care," "Strategies" "Struggle against Resignation," "An Existence Characterised by Tension" and "Longing"
Koller & Hantikainen 2002	Switzerland	Content Analysis	Patients experience of privacy in hospital	"Meaning of Privacy in General," "Relationship to and with other people," "Scope of relationships," "Control" and "Infringement of Privacy."

Table 1: *Summary of Findings of Humphries et al 2023 Systematic Review*

Authors	Country	Method	Context in Forensic Care	Thematic Findings
Lord et al, 2016	UK	**Interpretative Phenomenological Analysis**	Factors influencing therapeutic engagement	"Different worlds," "what the individual brings," "what the therapy entails," and "control"
Marklund et al, 2020	Sweden	Content Analysis	Patients experiences and perceptions of care	"I know what I need to Recover," "A need for meaning in a meagre existence," "A need to be a person in an impersonal context," and "A need for empowerment in a restricted life."
Meehan et al, 2006	Australia	Content Analysis	Patients perceptions of factors leading to, and how to prevent aggression	"Environment," "Empty Days," "Staff Interactions," "Medication" and "Personal Characteristics."
Mezey et al, 2010	UK	Content Analysis	Patients perceptions of the concept of recovery	"Definitions and Understanding Recovery," "What helps to bring out recovery," and "Impediments to Recovery."
Olausson et al 2019	Sweden	Thematic Analysis	Patients perspective of their personal space and room.	"Striving towards normality," "being anchored and protected," 'being at-home and homeness" and "being in communion and meaningfulness"
Olsson et al, 2014	Sweden	Content Analysis	Patients describing their trajectories in care	"The high risk phase," "The turning point phase," and "the recovery phase."
Tomlin et al, 2020	UK	Thematic Network Analysis	Exploring what patients find restrictive	"The antecedent conditions to restrictive phenomena," "restrictive phenomena themselves," "how these are enacted," "how these phenomena were subjectively experienced by patients," and "the consequences of these phenomena as expressed by patients."
Walker et al, 2019	UK	Thematic Analysis	Patients views of living in enhanced medium secure care, in comparison to medium secure	"experiences of current placement versus previous placements," "relationships with staff," "challenges of living with other women" and "having a voice - being involved in care and treatment."

Table 1: *Summary of Findings of Humphries et al 2023 Systematic Review Table X.X Summary of Systematic Review by Humphries et al 2023*

Authors	Country	Method	Context in Forensic Care	Thematic Findings
Zhong et al, 2019	China	Thematic Analysis	Perceptions of needs of long stay patients	"hopelessness," "loneliness," "worthlessness," "low mood," "sleep disturbances," "lack of freedom, and "lack of mental health intervention."

Note: Adapted from Humphries et al, 2023 and elaborated upon by author. Papers highlighted in bold have used an phenomenological approach.

Table 2. Summary of Findings Boolean Phrase: (systematic review or meta-analysis) AND forensic AND staff AND experience, no delimiters

Authors	Country	Method	Context in Forensic Care	Thematic Findings (if applicable)
O'Dowd et al 2023	UK	PRISMA	experience of violence risk assessments and management processes	"The Patient as a Person," "The Caring Relationship," "Multidisciplinary Working," and "Reliance on Clinical Intuition."
Hassan et al, 2022	UK	Grey Literature Search	Physical activity in forensic settings	n/a
Oates et al 2020	UK	Integrative Review	Factors affecting recruitment and retention of staff	"Engagement with the patient group." "The ward social environment," "Impact on the nurse," and "Implications for practice."
Mullen et al, 2022	Australia	Mixed Methods Appraisal Tool	Understanding the effectiveness and implementation of "Safewards"	"Training," "Implementation Strategy," "Staff acceptability," "Fidelity," "Effectiveness," and "Consumer perspectives"
Maguire & Taylor, 2019	UK	Literature Review	To understand implementation of trauma informed care in non forensic settings	"Education for trauma-informed practice" and "Applying theory into practice."
Tomlin et al 2018	UK	Systematic Review	Conceptualising restrictive practices	"Individual," "Institutional," "Systemic," and "Antecedent conditions."
Newman et al, 2021	Australia	PRISMA-ScR	Exploring occupational traumas that mental health nurses experience	"Physical," "Verbal," "sexual," "Self harm" and "vicarious " traumas.
Doyle et al 2017	UK	Systematic Review	Exploring the component parts of ward social climate.	"System Level Factors," "Staff Level Factors," "Patient Level Factors," "Environmental Factors," and "Social Climate Factors"
Stanton & Rose, 2020	USA	Integrative Review	Currently and formerly incarcerated mothers	n/a

Table 2 *Summary of Findings - Systematic Reviews Boolean Phrase: (systematic review or meta-analysis) AND forensic AND staff AND experience, no delimiters*

Authors	Country	Method	Context in Forensic Care	Thematic Findings (if applicable)
Odes et al 2021	USA	Literature Review	frequency of violent or aggressive behaviour towards healthcare workers in inpatient psychiatric settings in the United States	n/a
Hui et al 2013	UK	Systematic Review	Explores the prevalence of coercive measures and factors associated with their use.	n/a
Koops & Briken, 2018	Germany	Systematic Reviews and Meta-Analysis	?	n/a
Ashton 2021	UK	Empirical research	not forensic	n/a
Eidhammer et al 2014	Norway	Systematic Review	Service user involvement in risk management	n/a
Fletcher et al. 2021	New Zealand	Integrative review	Causes of violence and agression, from viewpoint of staff and patient	n/a
Baker et al 2013	UK	Empirical research	experience of care of 5 female patients who have self harmed	"the traumatized individual'," "'interrupted maturation process'," "'the hidden experience'," "crossing the line," "individual and systemic repercussions," and "nascent potential protection."
DuBose, 2020	USA	Empirical research	non forensic	n/a
Laukkanen et al 2019	Finland	Integrative Review	nursing staffs' attitudes towards containment methods in inpatient psychiatric care	"Affective component of attitude" and "Cognitive component of attitude"

Hui et al 2013	UK	Systematic Review	as above	n/a

Table 2 *Summary of Findings - Systematic Reviews Boolean Phrase: (systematic review or meta-analysis) AND forensic AND staff AND experience, no delimiters*

Authors	Country	Method	Context in Forensic Care	Thematic Findings (if applicable)
Ireland et al, 2018	UK	Systematic Review	not forensic	n/a

Note: Researchers own.

2. Methods

2.1 Design

This qualitative research project explores meaning making processes and personal experiences with long stay forensic mental health patients and the staff that deliver that care. In order to best explore these processes and experiences, a qualitative approach that explicitly explores lived experiences is most suited for this study, namely Interpretative Phenomenological Analysis (herein IPA) (J. A. Smith et al., 2009, 2022; J. A. Smith & Nizza, 2022).

Howitt & Cramar (2008), note that IPA is not about how we talk about experience, but instead concentrates on what our experiences are. Nor is it particularly interested in how language is used in itself, but it is interested in what people can tell us about their experience through language. Nor is it a study of the intricacies of conversation, nor of symbolism and discourse, but rather there is emphasis placed on personal life experience. "IPA is a qualitative research approach committed to the examination of how people make sense of their major life experiences" (J. A. Smith et al., 2009, p. 1). It is a method that is rooted in the philosophies of phenomenology, the study of experience, and of hermeneutics, the study of interpretation.

The primary aim of this research is to explore the accounts of lived experience of participants from within the hospital setting. Through individual interviews with two subsamples, staff and patients, the study employs the suitable and relevant methodology: the phenomenologically and hermeneutically informed data analysis method, Interpretative Phenomenological Analysis (IPA).

2.2 Epistemological Position

This research adopts a hermeneutic phenomenological epistemology with use of the qualitative interpretative data analysis method, Interpretative Phenomenological Analysis

Philosophical Underpinnings

Hermeneutics is the study of interpretation, which was studied systematically by Schleiermacher (2008) and their work on grammatical and psychological interpretations with a primary focus on theology and the interpretation of religious texts. Heidegger (2008) and Gadamer (1975) expanded and contributed to this field and explore the preconceptions upon which interpretation occurs. Smith explores Heidegger's work in further detail, and notes that "interpretation is never a pre-suppositional apprehension of something presented to us" (J. A. Smith et al., 2009, p. 25).

Phenomenology is a philosophical approach rooted in the philosophy of Husserl, and also Heidegger and Gadamer. It is the philosophical study of experience and people's perceptions of the world and the perception of "things in their appearing" (Langdridge, 2007, p. 12). The similarities and differences in the work of Husserl, Heidegger, Gadamer are discussed in detail by Laverty (2003), where there is an exploration of the ontological positioning of each philosopher. From Husserl's concept of umwelt and phenomenological deduction to Heidegger's "being in the world," both are rooted in the philosophical exploration of experience. Gadamar's (1975) concept of fusions of horizons, explore this one step further. "However much a person tries to understand, may leave open the truth of what is said, however much he may dismiss the immediate meaning of the object and consider its deeper significance instead." That is, to explore, not in trying to not find truths, but rather finding what is meaningful. His concepts of fusions of horizons are particularly pertinent given the double hermeneutic approach employed in IPA; true interpretation and articulations of phenomena sits where two or more person's horizons of understanding intersect.

Justification for this approach

Interpretative Phenomenological Analysis, is rooted in these two philosophical underpinnings; hermeneutics and phenomenology. Smith et al., (2009) note that one key value of phenomenological philosophy is its ability to provide us with a rich source of ideas about how to examine and comprehend lived experience. This epistemological positioning and related data analysis method is justified in the current work. This research aims to explore the lived experience of participants, patients of a long stay medium secure forensic hospital, and the staff that treat them. This method of analysis is particularly suited to these smaller, under researched sample populations and the exploration of their experiences.

2.3 Method of Data Analysis

2.3.1 Interpretative Phenomenological Analysis

The chosen qualitative method for data analysis of the two research sub-samples is Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Larkin, 2009, 2022; Smith & Nizza, 2022) This method is concerned with the phenomenological and interpretative exploration of lived experience. It does this by exploring the phenomena through a double hermeneutic approach. This double hermeneutic involves the researcher interpreting an experience of an individual, which the individual themselves has interpreted as their lived experience.

It is therefore necessary for the researcher to approach an individual's account of the participants experience void of personal values, beliefs, or preconceptions, and interpret their experiences in state of epoché or with bracketing. This is the suspension of the researcher's perceptions, to circumvent confirmation bias, that is the confirmation of the researcher's own beliefs and biases, to best explore the world of the subject, void of these prejudgements.

"Putting it in brackets shuts out from the phenomenological field the world as it exists for the subject in simple absoluteness; its place, however, is taken by the world as given in consciousnesses" (Husserl, 1927 as cited in Smith et al., 2009, p. 13). IPA seeks to understand in detail how an individual experiences a phenomenon from a perspective within a particular context and is concerned with ways in which people make sense of their experience and attach meaning to life events" (Smith, et al, 2009). Reid et al., (2005) note, IPA is the exploration of lived experience coupled with a subjective and reflective process of interpretation. Any inferences that are drawn from the data are done so cautiously, and with an awareness of the context and culture within which the study is situated.

This method is "particularly used for understanding under-examined phenomena or novel phenomena, or that which is difficult to explain. For this purpose, a lived-experience account of the meaning-making processes of the research participants can provide a very rich and detailed understanding of the phenomena from a particular perspective. Thus, shedding light on the phenomena and opening other avenues of exploration" (British Psychological Society, 2018).

2.3.2 Analysis Procedure

In keeping with the traditional Interpretative Phenomenological Analytical framework laid out by Smith et al., (2009, p. 79, 2022, p. 75), this study employed the prescriptive analysis stages that is required for robust analysis.

After the researcher conducted each interview, some short researcher reflective notes were also recorded to aid in analysis. Each of the interviews were transcribed by the researcher. Time was spent reading and re-reading the transcript. The researcher than made some initial notes, alongside some voice recorded reflective notes.

With these, some more detailed descriptive annotations were added to the transcripts; these notes are aimed at highlighting the objects which structure the participants' thoughts and experiences. These descriptive comments are elaborated upon at a later stage in the analysis. Then with a focus on linguistics, the researcher made commentary based on the linguistic nature (J. A. Smith et al., 2009, p. 88) of how the participants' presented their lived experiences within a sociolinguistic context. This was done in order to pay attention to and to be cognate of, the particular sociological factors that may have influenced language both of the researcher and of the research participant. Notes are taken pertaining to language choice (vocabulary, nuances) and language function (fluency, hesitation) all within the context of the social roles of the interviewees and interviewer.

Conceptual commentary is then added, which tied together the earlier basic comments, descriptive comments and alongside the linguistic commentary, the researcher employs an interpretative stance which can "may often take an interrogative form" (J. A. Smith et al., 2009, p. 88). These interpretations are made with reference to the researchers own reflective notes and will draw inevitably from the researchers own experiential and professional knowledge, but with an active and conscious sense of self-awareness.

With these initial annotations and reflective notes, alongside the descriptive, linguistic, and conceptual annotations, the researcher then further engaged with the text, and took an overview of the transcripts once more, to ensure that the text was explored thoroughly and to ensure that all possible avenues of interpretation were explored. There is an example of a transcript having undergone this process presented in appendix D.

Theme Development

Emergent themes are then developed from these annotations and commentary. These themes are a confluence of interpretation, of annotations, of reflections and of being aware of the wider

context of the participants' experienced world. These themes are usually expressed as phrases that captures the psychological essence of the piece in a concise and pithy way. The theme is therefore not a representation of the participants lived experience, but rather is, "a synergistic process of description and interpretation. Whilst initial notes feel loose, open, and contingent, emergent themes should feel like they have captured and reflect an understanding" (J. A. Smith et al., 2009, p. 92).

Superordinate Theme Development

Searching for commonality across these themes leads to the creation of superordinate level themes; those that share parallel and similar understandings are grouped together. During this process, some themes are realised and seen from other perspectives and perhaps renamed, and some are discarded. The concepts of abstraction; where similar meaning themes are clustered, and renamed as a group accordingly, and subsumption; where a selection of themes clustered together, seem similarly related to one of those very themes, and renamed accordingly.

Considering the sample size of each subsample, the researcher in this study, paid some attention on the concept of numeration. Whilst often associated with other more descriptive qualitative research methods, Smith et al., 2009 does highlight its use in IPA style research. How one should not overfocus or overemphasise the frequency of themes in this style of analysis, but there is credence for this approach particularly if the interview style is open-ended and unstructured. This numeration or frequency, can only possibly give an insight and identify some level of importance in the analysis, particularly with a larger sample.

The aim however with IPA, is to present a rich and deep understanding of the lived experience. In contrast to numeration, there is also scope in highlighting the "gem" (J. A. Smith, 2011) which is described as "a rare utterance of specific relevance, with particular analytical leverage." Superordinate theme development is primarily driven by credence and significance in the

research participants' account of their overall experience, superordinate theme development is therefore rooted not primarily in thematic frequency but predominantly in analytical leverage.

Working Across Cases

Working with larger samples, calls for a number of extra stages and nuanced adjustments. The analysis may shift to assessing what were the key emergent themes for the whole group. There is also scope within the framework of the IPA approach to search for emergent themes at case level and hold off in searching and exploring for superordinate themes until this group stage analysis. For these larger studies, it is important therefore, to measure reoccurrence across cases, hence the reasoning for the numeration approach adopted at case level analysis, but always being aware of the importance and precedence of analytic leverage.

2.3.3 The Ideographic Approach

Interpretative Phenomenological Analysis is concerned with the lived experience of individuals, and their idiographic take on the world. This approach focuses on and gives credence to understanding and exploring individual cases, accounts and lived experiences. This is in contrast to nomothetic approaches which focus on trying to assert and discover findings that can lead to wider generalisations, often in an attempt to prove or disprove hypotheses.

"IPA's idiographic focus also means it comes into its own when one wishes to examine participants' accounts in great detail. A good IPA study offers a pattern of convergence and divergence across participants, showing with some dept, both the experiential themes that the participants share and the individual way each theme is manifested for different people" (J. A. Smith & Nizza, 2022, p. 76). This is done not to prove or disprove hypotheses, but rather in response to a research question that requires deep exploration with participants, in understanding a particular experience.

It is a non-nomothetic approach, it is “not concerned with establishing laws nor generalisations that can be valid for a population” (J. A. Smith & Nizza, 2022, p. 8). Furthermore there is commitment and overarching importance placed on the detail, and depth of analysis. Smith et al., (2009, p. 29) further explore idiographic approaches and generalisability, noting that IPA does not “eschew generalisations: but rather prescribes a different way of establishing those generalisations. Nomothetic approaches can be “actuarial and probabilistic, dealing with group averages rather than particular cases. Datan et al., (1987) quote Kastenbaum in noting that “such analyses produce indeterministic statical zones that construct people who never were, and never could be,” which is against the underpinnings and aims of idiographic and phenomenological research. Whilst nomothetic approaches may be concerned with generalisable consensuses, the idiographic approach that IPA employs, is not concerned in data saturation nor cross-case generalisation.

2.3.4 Double-Hermeneutic Approach

Considering IPA’s philosophical underpinnings are in hermeneutics, it is important to pay specific attention to the phenomena of the double-hermeneutic. Smith et al., (2009, p. 35) describes this as, “the researcher making sense of the participant, who is making sense of x.” The researcher is an active agent in the analytical process and should employ a balance of “empathy and questioning” when asserting interpretation. There is a need to take a centre ground when applying the interpretative element to the analysis. Successful IPA research combines both stances, it is empathic and questioning. Interpretative work is considered appropriate so long as it serves to “draw out and disclose” meaning of experience (J. A. Smith et al., 2022, p. 30). There is an obvious need to be aware of this methodological peculiarity, and to perform reflexive work throughout the analysis, to ensure interpretations and the subsequent themes and superordinate themes, are truly emerging from, and being discovered from the idiographic data of the subjects’ lived experiences.

Reflective and reflexive elements were conducted throughout the interview, analysis and write up procedure. The researcher in this case, took audio recorded reflective commentary after participant interviews taking note of how the experience was for them. Reflective notations were made whilst conducting transcript analysis, and further notations whilst refining subordinate and superordinate themes. During the final writing up process, further reflexive commentary was made in justifying and verifying the final theme construction, and final abstraction and subtraction processes. All appropriate methodological considerations when working within a hermeneutic circle, i.e. data is a part and is also part of a whole (J. A. Smith et al., 2009, p. 28). Also, appropriate self-conscious critique, appraisal, and evaluative exercises in investigating the researchers own subjectivity, in pursuit of a robust and truly representative analysis, abiding by the methodological underpinnings of the IPA methodology. A final researcher reflexive was then conducted on the project as a whole with a specific focus on contextuality, methodology and wider interpersonal reflections.

2.3.5 Insider Researcher Position

Introduction

Insider researchers are those who conduct research from within their own personal world; within their social circle, neighbourhood, workplace or industry. This gives the researcher an understanding that is far beyond scholastic, and rather more nuanced with intrinsic understanding of the participants' experiences. Insider research, (Costley et al., 2010) offers the researcher a more nuanced understanding of the research topic. Smith et al. (2009, p. 36) note that "thus the IPA researcher is, in part, wanting to adopt an "insider's perspective," see what it is like from the participant's view, and stand in their shoes… to stand alongside the participant, to take a look at them from a different angle." From Smith et al.'s (2009) exploration of this position, one can see that it is suitable to assume in this research, but it is also important to be aware of specific methodological and ethical conundrums that may occur.

However, the researcher, knowing the participants well and for many years, allows the researcher to pick up and understand nuances in languages, personal quirks and more. This greater, and more nuanced understanding to what is being said is particularly useful when employing an interpretative phenomenological approach, and the reflective element of this method, also lends itself to a reflexivity exercise that allows one to become aware of the intricacies of insider researching.

The bracketing or epoché; the suspension of preconceptions and preconceived ideas is central to the phenomenological exploration of text and is an important methodological consideration when employing Interpretative Phenomenological Analysis. These processes can be enhanced by the insider researcher position, as it can be argued, that one may be more aware of what could be considered these preconceived ideas and beliefs, and in insuring a robust hermeneutic circle. The privileged position of being an insider researcher, lends one a more nuanced and attuned interpretation of text; in parts and in the whole, meanings and counter meanings, all in insuring a reflexive and phenomenologically robust and sound interpretation of text, and subsequent interpretation of participants' lived experiences.

Methodological & Procedural Implications

There are many practical and pragmatic advantages to this approach, particularly given the specific population sample of this study. It can give a greater flexibility to the timetabling of research. Participants are not held to specific times, and interviews can be attempted many times, which is important given the specific nature of this sample. Staff working in this setting are particularly busy and cannot often offer a specific time or date. Conversely, the patients may or may not be open, available, or ready for an interview at a specific time, and interviews may need to be organised on a reactive short-term basis. Being in the privileged position, the insider researcher can organise these meetings at short notice, in a more casual fashion, and can better gauge the willingness and ability of participants on any given day. This more casual approach to

the organisation of these interviews, may leave participants more relaxed, and free when interviewed.

Procedurally, there are also particular conditions and specific clarification needed when working within this remit. It is made explicit at the start of each interview that these meetings are not part of the researcher's clinical or professional work, but rather for the researcher's own academic development. There is a need to pay attention to researcher positionality, power and subjectivity (Mullings, 1999). To the patient participants, there are caveats made to specific risk elements and an explanation of how these risk elements may need to be communicated to staff if needed. There is also the need to be aware of patients wanting to appease the researcher, feeling pressured to agree to interview, and perhaps not wanting to be interviewed on a more formalised basis, that which is beyond the normal and usual professional working relationship that the researcher and patient participant may have.

There is also the need to explain to staff participants the same, and manage the dynamics of interviewing staff who are your seniors and your juniors. There is also the need to be aware of their preconceptions of you as a colleague, and now as a researcher, and how they may be reluctant to partake in your research, but perhaps passively accept to partake. They may also feel pressured into agreeing to the researcher's request for interview, and may or may not feel obliged to participate.

Therefore, ensuring a level of researcher reflexivity is imperative, to guarantee self-awareness and helping to appreciate participants' motives for partaking, and indeed to ensure you are not being too presumptuous in your expectations of them. These presumptions and can and may lead to a lack of depth in analysis, a lack in objectivity, and a failure to fully reflexively explore all interpretations and all avenues and possible articulations of participants' experience.

There is argument for the insider/outsider researcher dichotomy being too simplistic a position, and how one is neither insider nor outsider, but somewhere in the middle (Breen, 2007). How one may have insider knowledge, but not specifically exposed to, nor have the same pragmatic experience of a given phenomenon as the as research participants. This is in contrast to the outsider researcher, who may have little or no insider knowledge, but may rather offer the research participants an avenue to research, which is void of insider interpretation, and is done so in in the face of anonymity. Working with an outsider researcher may be preferential, particularly when working with sensitive topics, that pertain to the care delivery, that the researcher is themselves delivering.

2.3.6 Reflexivity

In order to balance the intricacies of not only adopting the insider researcher position, but also using a method that relies on in-depth interpretative analysis with a hermeneutic dimension, it is important to have robust reflexive element throughout the work. The researcher in this incidence, kept reflective audio commentary after each interview to also address the double hermeneutic dimension of this work. These self-reflections were based loosely on approach taken the Gibbs Reflective Cycle, which encourages the inclusion of feelings, analysis and evaluation in the reflexive work (Lia, 1988). Analysis of transcripts were shared with research participants to further aid in reflection on the creditability of representation of the interpretation of the lived experiences of participants.

Transcripts were annotated with reflective notations, and theme organisation was also further annotated with reflexive commentary. This aided in the final theme generation, and through the aided with the processes of divergence and convergence in the overall final substructions of superordinate themes.

Throughout the findings element of this work, there will be a representation of this reflexive work, which not only addresses the double hermeneutic element of the method, but also acts as a reflective element to help maintain awareness of the peculiarities of the assumed insider research positioning adopted in this work. There is also a final structured reflexive element, with a focus on each; the personal, interpersonal, methodological and contextual elements to the work, as directed by following the final discussion of results.

2.3 Materials

This research involved face to face interviews conducted with mental health service users, and mental health staff that work with them.

Both participants from the patient and staff subsample, were provided with information leaflets, and consent leaflets prior to interview, these can be found in appendix C.

The interviews for both staff, and for patients, followed an adapted indicative topic guide, the framing and delivery of which, was adjusted after a short pilot phase with participants of each subsample, and a debrief interview, these can be found in appendix B.

These interviews were conducted using an encrypted voice recording device, and transcribed verbatim by hand, by the researcher. An example of which can be found in appendix D.

Data analysis was first done through paper transcript annotation and physical paper-based theme organisation, examples of this analysis can be found in appendix D.

When themes began to emerge, these were then transferred to the virtual whiteboard system, Miro (Khusid, 2022) for further organisation, integration, substruction and superordinate theme

generation and development. This aided the iterative approach that IPA adopts and helped with working within the hermeneutic circle framework and advisory committee feedback. Examples of superordinate theme generation and substruction can be found in appendix D.

2.4 Participants

This research project was conducted with two subsamples, in line with IPA design, a subsample of staff (n=11), and a subsample of patents (n-15), across the two subsamples (N=26), One participant withdrew from the study before data collection. There was no drop out or withdrawals requested before advanced stages of data analysis began, and there was neither any request to withdraw data afterwards.

2.4.1 Staff Subsample

The staff subsample comprised of mental health professionals (N=11).

The sample of mental health professionals ranged from different professional disciplines; nursing assistants, registered mental health nurses, activity coordinators, occupational therapists, and others, from differing levels of responsibility; those with no professional registration, to managerial level. 11 staff members were recruited and interviewed.

Inclusion & Exclusion Criteria

Inclusion Criteria

Staff were of any gender, age, and level of responsibility in their role. Staff were from any socio-cultural background and were from the multidisciplinary team, of nurses, social workers, occupational therapists, medics, and psychology staff who have experience of working with patients in long stay forensic care.

Exclusion Criteria

Participants needed to have English as a proficient spoken language, and this was due to the method of analysis used. Interpretative Phenomenological Analysis is concerned with hermeneutics and meaning prescribed to experience. As there is a double hermeneutic present in the method of analysis, the researcher and participant need to have a common proficient language. Although not used, the use of an interpreter or translator would have added an extra level of interpretation.

Procedure

Recruitment

Members of the staff subsample were approached individually and presented with information about the study, how it was part of the researcher's own academic work, and not related to their professional role in any way. The researcher explored the aims and objectives of the study, and potential participants, if they were interested in partaking in the study, were given an information leaflet and interview date was set for about one week after this initial meeting.

Interviewing

On the day of interview, the researcher met with the participant, and a briefing procedure involving the reviewing information leaflets and reading aloud of consent forms, to ensure informed consent. This paperwork was then signed by both parties, and the participant was given a copy to keep.

If when interviewing, the participant as to become distressed in anyway, the researcher stopped the recording device, enquired as to their wellbeing, and to check if they wished to continue. If not, the meeting immediately stopped, and they were offered a debrief interview and leaflet if they so wished.

Post Interview

When the interview came to an end, the participants were offered a debrief interview. This was to discuss feelings brought about during the interview, and to give the opportunity to speak about things that they feel important, that were not addressed during the interview.

It was also to offer a space to explore whether the patient continued to consent to the audio recording being transcribed and used in analysis.

Participants were also directed toward several contacts if they felt they needed support after the interview.

Location of Research

Interviews with professionals were held in nonclinical areas of the hospital where privacy was insured. Nonclinical areas of the hospital setting pertain to areas where there is no patient access, and often are personal or bookable office space.

Remuneration

Each professional that agreed to meet for an interview were offered a 10£ Amazon voucher, as remuneration and as a token of appreciation for partaking in the research, and this was agreed by ethics committees.

2.4.2 Patient Subsample

There were 15 participants in this subsample in this research project. Participants were resident on a long-term rehabilitation ward, within the same medium secure setting, of which there are 16 patients at any given time. They were identified for interview with the ward’s nursing teams, for suitability and to ensure their ability to consent. 15 patients were recruited, and one withdrew before interview.

Inclusion & Exclusion Criteria

Inclusion Criteria

All research participants from the patient subsample, were above the age of 18 and residing and receiving care within the medium secure setting are over 18 years old. All patients in this setting identified as male and were residing on the same ward.

Exclusion Criteria

Participants needed to have English as a proficient spoken language, and this was due to the method of analysis used. Interpretative Phenomenological Analysis is concerned with hermeneutics and meaning prescribed to experience. As there is a double hermeneutic present in the method of analysis, the researcher and participant need to have a common proficient language. Although not used, the use of an interpreter or translator would have added an extra level of interpretation.

Before recruiting and then again before interviewing, the researcher consulted with treating staff to explore whether patient participants had the capacity to consent to partaking. All patients were deemed having capacity to consent.

Procedure

Recruitment

The researcher met with the patient's team to identify patients who may be suitable for the study, and to identify any issues pertaining to capacity to consenting. Introductory conversations were had with identified patients, and they were briefed on what the research was about, its aims and how it formed part of the researcher's personal academic studies and how it was not part of their care provision in any way. It was made clear that their participation was voluntary, and that they would be at no disadvantage whether they partook or not.

If they agreed and wanted to participate in this research study, they were given an information leaflet further outlining the study and its aims, and an interview date was set for about one week after this initial meeting.

Interviewing

On the day of interview, the researcher again liaised with the patient's treating team, to see if the patients had capacity to consent, and partook in a verbal risk assessment with the nursing team, whom the researcher also work with professionally so could actively partake in this process. This was a verbal handover of current patient presentation and mental state, to ensure it was safe to conduct the interview.

The researcher met with the patient participant, and a briefing procedure was conducted with each in–patient participant before the start of each interview. This involved the reviewing and reading aloud of consent forms and information leaflets, to ensure informed consent. This paperwork was then signed by both parties, and the participant was given a copy to keep.

If when interviewing a patient, they were to become distressed in anyway, the researcher stopped the recording device, enquired as to their wellbeing, and to check if they wished to continue. If not, the meeting immediately stopped, and the patient was offered a debrief interview, and leaflet, if they so wish.

Post Interview

When the interview came to an end, the participants were offered a debrief interview. This was to discuss feelings brought about during the interview, and also give the opportunity to speak about things that they feel important, that were not addressed during the interview. It was also

to offer a space to explore whether or not the patient continued to consent to the audio recording being transcribed and used in analysis.

Patients were asked at the end of the interview, whether there was anything that they wanted the researcher to hand over to their care team. Patients were also directed toward a number of contacts, if they felt they needed support after the interview.

Location of Research

Interviews were conducted on the hospital site in a clinical area, given the sectioned status of the patients that were interviewed. These interviews were conducted in a room in the hospital where there was minimal interruption from others, and sufficient silence to ensure a good quality audio recording.

Remuneration

Each patient participant that agreed to meet for an interview received a 10£ voucher for Amazon, or a high-street clothing store, as remuneration and as a token of appreciation for partaking in the research. This was agreed by ethics committees and this amount is commensurate with other research and patient involvement activities within the hospital.

2.5 Ethics & Permissions

University of East London UREC Permissions.

Ethical permission to conduct this research was sought and granted from the University of East London. Amendments were made before research commenced with the patient subsample, as

the facilitating hospital requested for clarifications and language simplifications to be made on the participants information leaflet.

UREC Ethics Permission Granted:

- UREC 1617 47
- Amendment ETH1819-0159
- Amendment ETH1920-0005

East London NHS Foundation Trust Permissions

This research, given its case study structure, idiographic nature and vertical generalisability, local permissions were sought and granted by East London NHS Trust's Research Department. Changes were sought that would further clarify elements on the participant information sheet, and a simplification of the language used was considered necessary by the hospital, considering the sample population.

East London NHS Foundation Trust, Research, Innovation and Service Development Granted:

- Reference: Finding Meaning in Secure Care: An IPA (Interpretative Phenomenological Analysis) version No 3; dated 15/05/2019
- Reference: Revised PIS (participant information sheet); dated 23.07.19

Certification of ethics, and amendments, are found in the appendix A.

2.6 Data Protection

Both sub-samples participants, patients, and professionals, were permanently de-named, and were prescribed a numerical value during the transcription and analysis process to help retain confidentiality and anonymity. Any information that was shared during the course of data collection, that would pertain to the information of the participant or to another, was redacted during the transcription process. During the write up of final results, unrelated fictional name-based identifiers were ascribed to each participant to aid in the flow and reading of transcript excerpts in the results section of this thesis.

All University and NHS ethics stipulations pertaining to data management and protection were abided by, and data held in accordance with EU General Data Protection Regulation (GDPR) (EU Parliament, 2016) and subsequent UK GDPR law (Information Commissioner's Office, 2018).

As stipulated by ethics agreements, confidentiality was maintained unless a disclosure was made that indicated that the participant or someone else was at serious risk or harm.
Patient participants were made aware on the consent forms, information forms and before interview, that any disclosures indicating that any participant of the research, or someone else, was at serious risk or harm, that this information would be shared with the treating team, of which the researcher is a member. In any case, there were no such disclosures made that needed such action.

2.7 Advisory Committee

With analysis complete, draft discussion work on the alternative care plan structure was created, the researcher consulted with previously interviewed mental health staff, service users and the academic supervision team, to assist and further explore the research findings and the use of relevant care plan literature and how this can be used to produce a new care plan framework informed by the findings of this study.

The aim of this advisory committee is to further explore the results of both subsamples and to develop an alternative framework for care or alternative care plan suggestions, specific to the long stay forensic patient population; one that caters and acknowledges the nuances and particulars needed in order to deliver effective care. This will draw together, the professional input from clinical staff, the views of the patents they treat, and academic input from the researcher and supervisory staff.

This went toward developing an understanding of care planning, that is not simply a reaction to an adverse clinical event as with the CPA but one that redefines the aims of the care planning system.

3. Findings

3.1 Staff Subsample Findings

The analysis from this subsample of staff, was to uncover five superordinate themes. “Acceptance of futility” explores the experiences of staff knowing and coming to terms with the futile nature of their role, outdated in its practically, and redundant to wider society. “Becoming More and a Therapeutic Relationship” explores how staff know they are more than simply caregivers for their patients, and offer more to their patients, that just being a professional caregiver. “Firefighting rather than treating” investigates experiences of working in this environment where treatment of mental ill health seems not to be the priority. “Realisation of the challenge,” aims to show how staff adjust to survive in this environment. “Acting a means of self-preservation” explores how staff forge meaning in what seem to be alternative personal goals and change their behaviour accordingly.

Superordinate Theme – Acceptance of futility

One would think that staff working in highly specialised, and specially commissioned forensic mental health services, that one would be working in a safe, new, and modern facility. Staff think that they are entering into a healthcare system where they can make a difference to the lives of the patients that they serve, in a modern public healthcare system, using interventions and planning for care. The reality is that these staff work in the same buildings, that were once the old asylum buildings of yesteryear. They also soon realise, that the practices and methods of treatment are also from another century. But they are stuck with this system, behind its bureaucracy, and with a realisation that their job is outdated, unfulfilling and ultimately futile.

This is a theme highlights the archaic system that patients are expected to recover in, and in which staff are expected to aid that recovery. How nothing has changed over the last few decades, and about how first-line treatments are the same as in the 1960's. The staff seem

aware of this, and work to that expectation, perhaps blindly. There is also a sense of the staff subgroup's frustration at how there is no reward for their work with patients, and how there is no alternative for these patients. There is also a hinting sense of the workhouse mentality, where the same treatments, restrictions and unsuitable environments, and the idea that these patients are merely being kept there.

Subordinate theme – No Better Alternative

A subordinate theme, on how the system appears to be the same as the Victorian system of yesteryear, and how staff know this. They are aware, that their interventions, methods of work, the buildings they work in, are all reminiscent of, and historical artefacts of, a bygone time. They are working in an ever-ageing enclave of medicine, that has changed extraordinarily little since its inception.

Mel - we'd have one side with the patient's phone, so someone came in for a visit of parents always just came and there's only one room. if you visit a relative, and all of these unwell people come up to you. and you're trying to just visit your relative, imagine!

Mel, a nurse, is aware that the ward is a place where visitors may feel unsafe and feel frightened. She highlights how there is merely one room, perhaps one room safe enough, for a visit to happen. To have family and friends visit on a ward where there are substandard facilities, along with other patients frightening relatives, the nurse seems to feel a sense of shame or embarrassment at what she is able to provide for the patients' families, visiting when they come to see their loved ones. It sounds like an asylum of yesteryear.

Researcher: Why is it so badly organised?

Mel: For many reasons, where do you begin. Badly staffed, cos the people in charge are nurses and should not be nurses. Badly staffed, cos there isn't enough money – its an inpatient unit! The pot of people to select from is getting worse. No one is qualifying as a nurse, so you just get to pick from a bad bunch.

The quality-of-care provision, is not simply not one of poor quality infrastructure, and blame is also apportioned to hospital management and frustration is clear to see. Ella feels let down by her colleagues, not only in the working conditions that they have provided, but also, institutional, and managerial challenges of having staff who are without any training nor experience in this field. There is also frustration at the lack of quality within her team, with few staff members of quality nor experience.

Researcher: What kind of things do you do to help the patients get better

Ella: nothing, looking back on four and a half years, nothing!

Researcher: What's worked best?

Ella: Taking people outside and trying to keep them outside for as long as possible.

Not only is the hospital infrastructure and management a concern for Ella but also the interventions in which she is involved. There is such a sense of despair and hopelessness in the way she describes almost every aspect of her job, and this must affect her willingness to continue with the role. Being able to offer the best care you can, but knowing that it is substandard, must be particularly challenging, especially when working with such dejected client groups.

The specific critique on interventions not working is of interest. There is much discussion in recent years, of the importance of psychotherapies, and talking therapies, as front-line medications, beyond simply administering medications, that are not only sedative, but have their dangerous side effects.

Researcher: We are trying to foster recovery, how do we do that here?

Ann: Eh, I suppose, its a multi-tiered approach, a nice dose of anti-psychotics is usually first line, a nice dose of olanzapine!

They joke about this, an open secret, how we all know medication is still the primary intervention in inpatient psychiatry. Medications are still first line and are often administered

without the supposedly adjunct intervention of psychotherapy, nor rarely any other psychotherapeutic intervention. The medical model of yesteryear is something that is very obviously still present. This occupational therapist is a person who is particularly aware of this, with ward rounds being chaired by psychiatrists, who merely ask for, and appraise their input. They are also aware of this, and perhaps the ethics of the interventions they play a small part in, they acknowledge this on a higher level, and reflect on how they may be viewed by future clinicians, with a perceived sense of guilt or responsibility, almost nodding to the ethics of their own role.

Researcher: and it's still like that? Here are your meds?

Ann: And it's the first port of call…We will look back in 100 years time. I'd give anything to see how people look back at us, and see how we treat depression or schizophrenia.

Often with forensic admissions, people are at their worst mentally and present risk behaviours. This term used to describe anything from physical and sexual assault and self-harming. There is a need for very carefully planned communication and interventions. Sometimes, the there is need for restraint, to hold the patient securely by the arms, sometimes legs, and sometimes prone on the floor. Tam recalls a time of how surprisingly efficient and quick the team was.

Tam: within 2 seconds the rapid team were there restraining him on the floor and he went off to seclusion,

Tam, spent time communicating and working long term with a patient who was unwell, and the decision was made, to head immediately for the inevitable medical model. This patient was then restrained, and as they describe, and she felt worthless, much like how the patient might have felt.

Tam: I felt worthless, what was the point in me doing all of that!

Researcher: you were doing it because you wanted to get him out of hospital.

Tam: I know, but it's all backfired hasn't it, but now he is back on the PICU.

Here again, the experience of the staff, seem to be closer to a mirror image of 19th century psychiatric care, than they even realise. Having worked with this patient, with carefully planned, employing their strong interpersonal skill, and leveraging on their relationship with the patient to help them through a difficult time in their hospital stay, the decision was taken to simply revert to techniques of yesteryear, leaving this nurse feeling as if she has failed the patient. Her skill and relationship with the patient, has been nullified by her own colleagues, and conversely, the staff simply revert to what they feel work, restraint, and seclusion. She feels she has failed the patient, but also she has been failed by her colleagues.

Researcher I don't think that people have an idea about what happens in these wards, and about what the system is like. It's all just a little bit backwards.

May: I don't think its backwards, I just think it serves a purpose, and there is no better alternative

May, feels as if there is no better alternative to this archaic system. She doesn't think that the medical model is backwards, but rather there is no viable alternative. Serving a purpose, as once the Asylums did. Feeling as if there is no better alternative, and administering this kind of care, perhaps, she feels a sense of purposeless for her job exists as there is no better alternative. These patients who revolve and return, she feels as if her job is simply the better alternative.

May: What are we expecting these people to do when they are discharged… the long stay guys can't even have an argument without getting aggressive. Imagine them being a cashier in retail… You see the abuse bus drivers get.

The frank realisation and explicit understanding that discharge is the goal for her patient, but there is an internal grift as to what these people will do, or are capable of when discharged – as if they are acting against their own intuition, in helping their patient, to a detrimental end.

Subordinate Theme - Stuck behind Bureaucracy

The psychiatric hospital is an old an institution and along with psychiatry it is caught in time. Attitudes toward care and treatment, buildings, and facilities, and little else, has changed since its rise in popularity in the 1900s. Staff that work with these patient groups, face the same barriers to everyday care, that existed almost 100 years ago. In exploring modern interventions Ellie explores her experience.

Mel: The thing is, they only use 2 out of 252 approaches, IAPT and CBT… quick results therapy

Researcher: Any psychotherapy?

Mel: They only have psychotherapy if their referral was in, and that was 16 months ago, and dance movement, which was when you throw a ball at each other and talk about emotions….

Mel's frustration here, is shown through her humour. She knows that there is little to no psychotherapeutic input by services. There is conversely, very little uptake or very little desire, by the patient to engage; perhaps this is for the same reason. Patients may see engaging in dance and movement therapy, art, and drama therapy, with the same flippancy as Ellie. In her example, psychotherapy referrals are filled only 16 months after being made, which makes a joke of the system. Waiting 16 months for an intervention, that she knows still have little value. She feels as if time is wasted, and not just hers, but also the time of the patient. She also manages to capture how the intervention is far from therapeutic in any case, given the structure of the ward and hospital.

Ellie: 4 people in the activity toom with the art therapist, someone shouting into the room, someone inside the room shouting back, 2 families in the dining room waiting for a doctor… It's chaos all of the time

Sheila is also aware of the fact that patients are stuck, or not moving. She eludes here to an underling sense of exacerbation. They are not doing anything for their patient, and even says that they are not treating them.

Ann: he is blocking a bed for a prison transfer, who is on the verge of killing themselves... it would be one thing if we were treating him, but we are not doing anything for this person!

That "he" is blocking the bed for someone in need. I seem as if Sheila here, is alluding to a patient who is perhaps malingering, and that there is nothing that she can do. For she, and indeed the patient knows, that if patients are well, and if the law allows, they are discharged to the community or to prison. Two options, that for various reasons, many patients do not want. The patients can use the bureaucracy of the system to their advantage in securing the place and restrict their movement, something to which Sheila is well aware.

When waiting for their appointments, and for their eventual discharge, the patients are often stuck on a ward. These places are far from ideal, and far from the therapeutic and relaxed environment that one should perhaps expect when discharge is nigh.

Tam: and only sometimes can the ward be therapeutic, so the default is untherapeutic, so what is the point!

Researcher: What kind of things does the ward do that is therapeutic?

Tam: When you have a decent OT, that isn't on rotation and actually comes to the ward… When you put 21 unwell people together, or 10 unwell people and 10 well but demanding people who would be in person… then you have utter chaos.

But for some reason, it is good enough for the mental health patient population. He explains how here, the untherapeutic ward is default, and that it is seen as good enough, as there has been no change. The sense of helplessness he must feel confessing that the default is untherapeutic. The interventions that he puts in place are meaningless and worthless against the iatrogenic environment of the psychiatric ward. Tam tries to work positively in this environment, but "what is the point!" He also hints at the barriers and bureaucracy that prevents a therapeutic ward from forming, the patient mix of those who are unwell, and of prisoners who have recovered, sharing a space together.

In light of the strange ward of prisoners and unwell patients, June explores some rules and boundaries, Tal explores a more progressive move of late, that of mobile phone use. These are usually banned items in these hospital settings but there has been a move to make these more accessible, and permissible. A simple mobile phone, without internet access, are only a recent development within the forensic settings across the UK, but access to the internet is strictly forbidden.

Tal: we have phones now - but you don't know what they are searching,

Researcher: we caught someone searching for porn, why can't he search for porn?

Tal: That's what I mean!

Researcher: So now he can't use it

Tal: But why!

Tal shares, a time when a patient did smuggle a smart phone into the hospital and used it to search for porn. They were chastised and punished, for the smuggling of the smartphone, but also for viewing porn. This is something that is also heavily controlled and managed by staff, through the use of purported careful care planning. Tal herself, finds this moralistic challenge is again, founded in policy and procedures of the hospital setting, which ultimately, prevents the patients from further freedom and autonomy.

Even progressive moves within the system, are far from progressive. The system evolves and changes at a snail's place, and people like June, hired for her progressive views and outlook, realises that she is, working within a system that seems resistant to change.

The recent change in mobile phone use, is carefully care planned, and carefully managed. But these care plans are archaic, bureaucratic instruments for laying down law and used primarily in the administration of power.

May expresses similar frustrations to Tal, where porn usage, mobile phone usage, and other normally everyday activities and items, are planned for, controlled, and used as mechanisms of power.

Researcher: They come back, and what happens to the care?

May - the care plans stay the same, the same courses, the same staff, the same stuff, just madness.

Care planning normally includes the planning for psychiatric care, medications, interventions and setting goals. But they have had their remit extended and are now used as instruments of control under the guise of contractual-style agreements between staff. If the patient plays ball and follows the rules, they are allowed use of their pornographic materials, and allowed use of their mobile phone.

One staff member knows that these are items of pure bureaucratic instrumentation.

Researcher: The bureaucracy– what gets in the way?

May: I purposefully don't do paperwork, cos if I don't do it, nothing will happen anyways,

These care plans or tools of power are given to patients, for them to agree to, even if the patient refuses, they are still enacted upon. They are rule books, where the patient explains what they would like to happen with their care, with a plan of how the staff respond.

These plans, inadvertently take the form of a rule book, with passive input from patients, and agreed to rules that are used against the patient. These care plans change and advances so little and are very infrequently updated. May above, says that she purposefully doesn't update the patients' paperwork, and to no consequence. Her flippancy is telling, however, as everyone knows, they are not important in the scheme of recovery, and are nothing more than tools of bureaucracy, blame and funding. Lucy knows that these are tokenistic only, and are a audit tool

for when something goes wrong. They are so unimportant, and so irrelevant to long stay patients' care, they are not updated, for it won't affect the care provision.

May has accepted, that careplan creation is futile, as is its updating. Senior management don't seem to notice, patients don't feel a difference, and there is an awareness, that after all, it is a mechanism of control, rather than a plan for care.

Subordinate theme - The Same old Attendant

The professionals that were interviewed during this project, seem reminiscent of the old mental health ward attendants, who were there to simply keep the patients safe and busy, rather than treating their diagnosed illness, and helping in their recovery.

Researcher: What is it like working with the 20 or so guys, who are not unwell?

Zoe: So it completely takes away from any time for you to do anything else, never in getting them a house, what about looking after the people that you have to - those with a mental health issue.

Researcher: How do you feel, when someone is not unwell, just waiting on a house, starts lacking out at you?

Zoe: I try to understand it,

So much time is spent doing paperwork that could pertain to anything, from a referral to a dentist, to a housing application. Some tasks, like searching for hostel accommodation, or changing medication charts, are clearly the job of a social worker and doctor respectively. But those tasks that fall in between the professional cracks, are often left to nursing staff.

Zoe speaks of this expectation of her, and her more intimate knowledge of the system, and off the patient, than perhaps the social worker, has given her a very interesting view which she shares. She helps a patient with their accommodation, but during the process and thanks her closer relationship with the patient, feels as if the patient here, is simply using the whole system

to ensure that he is housed. A social worker may not quite have the same insight, only meeting with patients periodically. She feels as if the patient is using the system, for their own again, and for their own means, subverting the system, perhaps with feigning symptoms.

Researcher: How has your last week been?

Tam: Probably, the most stressful that I have ever had.

Researcher: o, in what way?

Tam: the level of care we are supposed to provide to our patients, we are unable to. That has frustrated everyone, and now we have unsatisfied patients and staff.

Elinor too says that they are supposed to be providing care to their patients, but this is taken up with paperwork, and socio-political issues that the people who find themselves on the ward are facing. They are not providing nursing care, not providing psychotherapies, they are simply attendants, keeping the peace, and completing the tasks akin to that of secretarial work. This must make her see her work in a very different light, one where her psychotherapeutic input is less meaningful for the patient, than the practical help she provides. She knows that the patients don't want her interventions, but simply, want her to complete simple practical tasks.

Researcher: What kind of things do they shout?

Zoe: Everything, they are just like, one guy the other day was like, I've been arrested 20 times, and I've been brought here so many times, and still you have not got me a house. I just went up to him, and said this is not a housing association!

Researcher: And how does it make you feel when you have people like that in your face shouting, cos they want a house?

Zoe: It makes you want to leave… that's not why I went into the job.

She shows an awareness of the exploitation of the system and is aware that some patients may be using the system to for their own personal gain. Here Ellis, recalls a time when confronted her patient, almost explicitly about this. To say this to a patient, only shows her frustration at the vocational job she has chosen, which must seem far from her expectation.

Considering their options as is the socio-political climate of the UK in the early 21tst Century, where social benefits and social care are severely underfunded. The psychiatric hospital system may have inadvertently become the new workhouse, for people unable to survive in the community, they come to live, and often, work, in the institution. Whilst patients are sectioned to remain in these hospitals, when discharge looks likely, the release anxiety sets in. At weekends, when the hospital is run solely by nurses is the hospital is at its most rested. It is only with the interference of medics, psychologists, and psychiatrists, aiming for patients discharge and eventual movement, is the hospital a place that is far from therapeutic. When all other professionals are absent, the hospital becomes a workhouse that many patients wish it to be.

Researcher: Are the weekends the same?

May: You notice a difference in the men during the weekend with no doctors, psychologists, everyone is more chilled out, even the staff!

Researcher: How do you think the patients deal with the difference with the staff approach on the weekend?

May: It must be confusing, its confusing for the staff… and as we say, you're not supposed to be friends and family, but that is how these guys see us, having both masks on, but then on the weekend, you have the chilled mask on.

The staff on the weekend, are more relaxed, in the absence of hospital managers and MDT team members. Lucia explores how this difficult custodian/carer dynamic is in reality, a folly. There is an expectation to discharge duties professionally, but there is something humane about the staff and how they act in the discharge of those duties, that the patients feel as if they are their family. Lucia, calling this her "chilled mask," perhaps, knows that this is another persona, on top of being a member of staff, a member of

Something about the patients wishing for it to be more like a workhouse, and without the input of the medics and more, is the hospital essentially that. One where the patients are happy.

Researcher Reflective

Working within the closed institution, of which the secure hospital is, requires you to rethink and relearn how to work. With the very specific rules and way of controlling the patients, you also find that the rules also apply to you too. You, like the patients, work within these rules, and this bring about inauthentic actions and practices. Your practice is bound by procedural bureaucracy, of which you much adjust your practice to. You must stick to simple seemingly nonsensical rules, and when these rules are broken, you realise how nonsensical they are, for there are no repercussions.

As Lucy spoke about this above, I realised myself, that I have also skipped and copied and pasted sections of paperwork, for I also knew that nobody would notice, or in fact, care. Neither superiors cared, nor did the patients care, that their care plan paperwork generally was of poor quality, and very poorly updated. Imagine a health system, where planning for care, is a matter of copying and pasting, and updating paperwork, is a simple change of date, and the use of thesaurus. Ensuring that the paperwork is in date, is all that seems to matter.

Sheila very openly and honestly, went straight for the medication intervention, and is very aware of its omni-importance, and that psychotherapies is only a second-rate intervention, for which there is a 18 month wait.

Patients complain of the side effects of medication, and you repeat the usual trope, that they are keeping people well, and that the medication is the least restrictive practice. This is the new thin veil that staff hide behind. That any intervention is now justified, as it is the least restrictive intervention that is safely done. Originally a mandate from the CQC, that all interventions need to impede on a patient's freedom in the most minimal of ways, has itself become subject to interpretation.

When analysing the transcripts for this theme, and the subordinate themes that emerged throughout, it made me as a clinician, refocus on how I also became a slave to this rhythm. How these wait times was considered normal, how medication was a given, how even my care planning was not the best it could have been. But that also got me thinking, why, over the years, that this was never addressed at any monthly supervision I received by superiors. All that mattered was that the care plans were in date and signed.

There was very little scrutiny, and I knew that. Through the analysis of this theme, gave me a space to reflect on my own practice, and was certainly more of a personal eyeopener that any clinical supervision I received. You seem to forget that careplanning is not just a simple administrative task. It is a deeper, important aspect of care, that carries little to no personal value for neither staff not patient.

Interestingly, the weekend atmosphere, where the patient and staff are more relaxed, and everyone gets along, gets you thinking. if the weekends go without incident, as they usually do, is the everyday incident prone ward, a reaction to the process of recovery; where patients know that they will move on from what they feel is their home.

Superordinate Theme – Becoming more than a Therapeutic Relationship

How staff have work with patients who are well, patients who are unwell, and people who are not patients. How frustrating it is for staff, who know they are collaborating with people who act under the guise of the patient. The deep acting patient that controls so much of the ward, and so much of the staff's time. How patients become more aggressive when it appears as if they are moving on. They start to relapse, hitting and feigning illness to prolong their inpatient stays. They will, at the same time, treat staff as their family. This theme focuses on the deep acting and mauvais-foi of the interpersonal interactions across the staff/patient group.

It is alas, worth noting that the patients start to see fellow patients and staff as family, usually a family as dysfunctional as the only one they know. Pushing their new found paternal and maternal figures to great lengths, like they did often their biological ones. Even after successful discharge, the eventual exclamation “everyone comes back”, resounds across the staff group. Patients are discharged, but know that under the guise of a community treatment order, they are merely an outpatient who can be recalled at any time. Returning to the hospital, to resume and restart the same therapies as before. They again, sit through these interventions, groups, and activities, with the same mauvais-foi.

But these patients are misplaced, they are “social” patients, with social issues, housing, financial, and familial issues. Entering the mental health system can afford people the opportunity of newer, sometimes better accommodation in the community. It can afford them respite from financial burden, and other personal issues. No bills, no worries about food, or what people think about you, and staff to speak with, who treat you with a degree of unconditional positive regard. Staff work on the assumption, that recovery is the end goal, but that is a fallacious thought, recovery is the goal of the staff. For patients, the goal is survival, to use the mental health system as a mechanism for survival and a semi-catalyst for enhanced access to the welfare state. This inadvertent abuse of the system is no surprise. Staff try to prepare them for

realities of the outside world, but it will never be easier, in the patients eyes', as being an inpatient. There are unrealistic expectations placed upon them, getting jobs, getting flats, returning to university or study, these are often spoken about, but rarely are a reality for the vast majority of the forensic patient group. They start to forget that this is a hospital, and it becomes their home.

Subordinate Theme – A New Family

The patients have found a sense of family within the institution. So have the staff that treat them. Both long stay, they have lived together as patients, and have worked together as staff. There is a stronger sense of connectedness amongst everyone, unlike what can be fostered on a short stay psychiatric ward. The family that is nourished by staff, is for some patients, the first solidly dependable family structure that the patients have had, and the staff are aware of this.

May: you are their family, for the long stay guys… One minute you're their family and the next you are asking for a drug screen….

Researcher: That must be strange, and messes with the trust?

May: You are trying to build up relationships with these people, so where do you stand?

Mental health staff working with these long stay patients, refer to and use the term "family". A term also reflected in the patient subsample. The nurses, doctors, and therapies staff are the patients' family, in void and in replacement of their own families. Some of the patients have committed violent acts against their own families, and there is often lack of unconditional positive regard from their biological families. Many patients have little, or no contact with the biological families. As staff are their family, often their only family. Staff know that they are held in that privileged position, and struggle with the balance of being family, and custodian.

Staff are held in some regard, but are also taken for fools, and sometimes, they know this. Hospital being the better option for some, and gaming the system to avoid being discharged is

a mutually understood phenomenon. They have to play along with the system of care, and some patients have adjusted how they act, to work within this framework.

Researcher: We all know people like this…

Ann: some are happily homeless on the street, but this is a much better option for them!

Researcher: So why do you think they work toward discharge then?

They know they won't get away with saying "I don't want to be discharged"

Researcher: Is it to make sure they don't move?

Ann: Yea, and for me, that is frustrating, they are forgetting this is a hospital!

The patients, blocking beds for people in true need, is a source of frustration for this staff member.

Some staff are showing awareness of the socio-political situation that these patients will find themselves in when discharged, many will have the support of hostel accommodation, but otherwise would be homeless and on the street. The staff know this, as do the patients, and for avoidance of the feared place the patients try to sometimes stay. The staff do continue with their futile drive toward discharge, the fetish that discharge is the goal of patients.

Zoe: I just broke down in the office!

Researcher: What was it like for you, to break down in the office?

Zoe: Really embarrassing, an for the staff that were on duty, I think it was quite an eye opener… one senior staff said to see me break down, was a sign of how far the team had fallen.

The relationship with these patients is one heavily laden in emotion and relatedness, and staff often exert wades of emotional toil to keep the relationships healthy and therapeutic. Becoming overly emotional and breaking down in the nursing station, seems to be a frequent happening. This is either because the staff care about their client group to such an extent, or the exact opposite. Perhaps the emotional expression is in essence, frustration at failing to deliver care

that they envisioned as being correct. The team falling apart, those leave to survive, and those that stay behind, break down.

Ann: if this was a physical health hospital, and someone said this is my home now, they would be laughed out of it!

Researcher: we all know people like this.

Ann: Well, I've had really frank conversations with these really stuck patients, and, they are homeless people, what I mean by that, is that they are happily homeless on the street, but this is such a better option for them.

Patients say that the hospital is their home, perhaps a way to try to connect with the staff on another more meaningful level. They are seeking a greater sense of emotional connection with the staff group, and purposefully yet slyly, reminding them they don't want to get "moved on". It is however met with distain by the staff, for their aim is for patient discharge. Hear things like this, only angers staff and makes the job more difficult.

Subordinate Theme - Aware of Failing

The system has ultimately failed the patients, and the patients are aware of this. It is clearly shown through their fear and anxiety around discharge. The system has further institutionalised them. The staff know this but work toward the discharge of patients in any case. Patients are discharged with treatment orders, supervision orders, recall orders and other methods of control. Patients will continue to need support after discharge, and many often face readmission, only to cycle through the system, and discharge pathway once more.

Ann: I'm probably the 10th OT that they have seen, they have seen it all before! and have failed it all before.

Researcher: they need something like a complex discharge team?

Ann: that's exactly it, I don't now why it doesn't happen!

Staff think that they will make a difference with this long stay population are ill prepared for the level of resistance that they will face. This occupational therapist says that the patients have failed at it before. Perhaps that is their aim. The patient wants to stay and seem as unable, unwilling or unfit to complete an occupational task in a meaningful way, without the help and structure of the institution.

Researcher: He said that if I didn't take him on leave, he would ask to be discharged

Lea: so go on then!

Researcher: And he started to scream at me!

Lea: It doesn't even make sense, it's funny really, when you see someone making progress, you see someone making progress, you know that they are going to relapse! it's not even a relapse, it's a relapse in quotation marks.

Failing at occupational tasks as it is put above, can be an attempt to stay in the care of the hospital. But also, patients start to refuse medications and therapies, in order to worsen their mental health. This can be done sometimes, to punish staff, or in protest to interventions. It can also function as a reminder for staff, as with the above example, reminding staff that they are still unwell. Making themselves unwell with the quick withdrawal of antipsychotic and mood stabilising medications they will relapse. Given their risk, this can result in physically assaulting a fellow patient, or a member of staff. If this is their history, and if charges are raised in court, discharge gets further away. The Home Office, who ultimately have the final decision on patient discharge, will not be willing to discharge a mentally disordered offender, who is actively refusing medications and assault people as a consequence.

Researcher: What do you do with these patients who won't stay out?

Mel: you can't do anything with them, try a new tactic? Nothing really changes… you won't make an impact, and then they come back.

To focus on recovery, discharge and progress through the system, is perhaps a erroneous aim for staff. These patients are chronically unwell, and in need of medications to stabilise their metal state. Medications are often passively accepted, and patients will explicitly say that they

will stop taking if moved on or discharged. This is seen by staff as not having insight into their condition, but perhaps hiding behind this language of “lacking insight.” They have no intention of leaving the care of the institution, for the aim is to not recover.

Researcher: what’s an example of being difficult to work with?

May – for me its those who self-sabotage… trick themselves into thinking that they want to leave, we all know they don’t want to leave… you know it’s a waste of time.

Some staff are more open, and perhaps more realistic with their view of the care system and the patients that they treat. How difficult it must be to come to terms with, and explicitly acknowledging that the patients don’t want to leave. As a mental health professional, your job is simply undermined by admitting that everyone knows patients don’t want to leave. Surely, that is the goal and aim of your job.

Researcher: Is there a time when you felt affective?

Tam: For a short while… but then again… as we always know, the community team let him down, we knew that would happen, the care coordinator was crap in the first place!

Staff and patients know that community care teams are not very engaging and will only have very minimal input and impact on their care. They will be seen by their care coordinators only for a weekly or fortnightly check-up. This will be a formalised meeting rather than the casual 1:1 time spent with patients in the hospital setting. This staff member recalls of a time when a patient was recalled. She knew that the patient would be recalled, and knew that he would be failed by the community team.

Researcher: What does that recovery look to you?

May What are we expecting of these people to do when they are discharged? - getting them back into the community and contributing, but the long stay guys, you can’t even have an argument without them getting aggressive. Imagine them being a cashier in retail!

The goal and aim of staff is to move patients on, but it is known to be impossible task. Even the most simple interactions can be an opportunity for argument, a point at where one can release aggression. From arguments over medication compliance, to simple time delays in organising community leave, aggression is very close to the surface of most patients. It raises easily to the surface over the simplest of things and these are the same people who staff are trying to work with. Knowing that any interaction can end up in argument, leads staff to act in ways that curtails their intervention's potency. Interventions are often most successful when there is a good relationship with the patient, and this inevitability involves a level of mauvais-foi. Changing your authentic self to engage patients in interventions.

There is a particular avoidance toward forensic mental health patients, for they are seen as risky and more dangerous than the average mentally unwell person. There are specific hostels that will accept forensic patients, and particular specialities and teams, for working with forensic patients.

Researcher: Is it like that everywhere?

May if you light a fire, it is seen as very dangerous, but if you're acute and light a fire, its serious... a small mistake, and they are kept in hospital for years longer than they need, and that's annoying. You feel as if you are wasting your time, not because of the fire setting, but because of the system.

Arson, murder, and other crimes are not seen favourably by hostels and supported accommodations, where there is often little in terms of security for the staff stationed there. Needing companies to take a forensic patient, means that the patient will be waiting some time for their discharge, as there are few places that accept patients with such risk histories. When they are discharged however, the realities of everyday life will become reality.

May: Imagine what these guys would do with their personality difficulties, and symptoms, and feelings of shame. How could they deal with that… everyone is rude to them, how will they cope.

And then we come along as staff, and say things like O don't worry, its going to be fine, moving these people on from where everything is lovey dovey! imagine starting a universal credit claim, you haven't got a job, I've worked so hard to get out of hospital to join this queue?

Having to work with the welfare state, with limited employment skills, and with cognition hampered by medication the staff member here, is aware of the realities of the world that their patient will have to face, and perhaps also knows, that the best place for the patient is within the confines of the hospital itself.

Subordinate Theme –The Non-Patient

While there is a greater sense of connectedness than on other psychiatric units and wards, the goal on the part of the staff, is to move patients on. There is a fetishist view that discharge and progress is the goal for patients, as it is indeed in the interest of the staff to see movement in patient populations. Alas for some patients, that is the very thing they fear, and sometimes, do not want. They can go to great lengths to ensure that they keep their family intact, and that can involve some maladapted methods of ensuring that they keep that sense of connectedness.

Moving onto lower secure wards, and progress, is sometimes seen as edging closer to discharge, and is great cause of consternation for many a patient.

Researcher: and then he would threaten you if you want to move him?

Ann: if you try to move me, I'll go to the PICU, let's get our resources then, and tell him that he is moving!

Researcher: messy

Ann: Yes, and a risk of him being injured, or staff being injured!

In this example recalled by the staff member, the patient with a very thinly veiled threat, that they will go to the intensive care unit, rather than moving to a lower secure ward. They were willing to assault a member of staff or a patient. This protest is a reaction to foreseen loss, perhaps the loss of particular staff they could confide in, the change in environment, or the edging closer to discharge. The anxiety may also be due to the change in cultural capital, and

they will have to build up new relationships with staff and patients. Relationships that are primarily transactional, and not genuine, aren't fostered, but rather chosen, and having to choose new people to form relationships with is difficult.

However, the willingness of the patient to suddenly turn on staff that they consider the "family," must be difficult and strange. You are at the time same, being rejected by the patient and being told that the patient wants to stay with you. You know the patient well, and work with them well, but don't reject nor move the patient on, for the fragility of the relationship is clearly and quickly seen. Maintaining these relationships, that are therapeutic yet merely transactional, must be difficult for staff to maintain.

Researcher: He is adamant that he is going to stay here forever, and he is going to be looked after by the staff he assaulted in order to stay!

Ann: He knows the system well, he can say on the one hand, I am making progress and I'm engaging with this, and then get to a point where they say, emmmm, I'm getting a little too close to discharge, so I'm going to kick a member of staff!

So normal is this, that it is known amongst staff that it is something that inevitably is going to happen, assaulting the staff they have come to know and perhaps see as family, are then only a mechanism themselves, in their plight to stay in care. This staff member speaks so openly, for it is no secret.

Others simply refuse to partake in therapies for partaking in these sessions may further their progression through the system.

Researcher: So why do you think they want to work toward discharge then?

Ann: They know they won't get away with saying I don't want discharge, they will be challenged on that… They will go to the café and gym, but will shut down every bit of therapy.. they are therapy resistant in my view… they don't allow you to access them, you can't set them goals, and that is frustrating.

The term treatment resistant, is thrown about for these patients, and it is not a fact that they are resistant to treatment, for psychotherapies require a level of personal engagement and

commitment with the therapist and process. Simply deciding not to go to a therapy session is sometimes misconstrued as treatment resistant, for they would rather to go the gym than meet with a psychologist. This isn't "treatment resistant," it is treatment resistance for partaking in the programme may bring about eventual discharge.

Researcher: You spoke earlier about when patients who should just be in prison, and not on the ward, what's that like?

Tam: some people are unwell, and should not be in prison, and then you have some people who don't have anywhere to go (when they leave prison), so they come to you. These are the ones that take the piss.

A peculiarity of the forensic system is that some people do not want to be seen as progressing though the system, as for them, discharge means being remitted to prison, so it is in their favour to remain unwell. Being unwell may have been their ticket out of the prison environment, and into an environment where you are nurtured by staff, there are less restrictions than prison, and it is often seen as a cushier ride than prison.

Researcher: So what do you think has happened?

Zoe: With the "new" patients we have, we don't know how to look after them… we now have drug and alcohol people, the council is so bad, we have people who want a house, and that's not our job, but it now our job.

You are then in a situation where you are dealing with the nonpatient, someone who is not unwell, and everyone knows it, but their feigning is only subject to the appraisal of staff, for there is no "test" for mental illness. If these patients become sectioned however, they are then subject to an indefinite treatment order, which inadvertently prolongs their incarceration. For these patients, who are not unwell, it can be the case, that they are simply criminal, and often continue with their criminal tendencies on the ward, and partake in trading and take advantage of the more unwell patients. Yet, the staff find themselves, having to treat these people, who do not require treatment, to the detriment of others. The staff can spend time, dealing with their criminal behaviours, rather than what they have trained to do, treat mentally unwell people.

Researcher: What's it like when you have to deal with somebody saying, "what's with that person pissing on the floor for?"

Zoe: It's so infuriating – this is a hospital!... People are sick! I can't stop you smoking weed, but the fact that you are bringing it onto a ward, you have no respect for any other person!

It is then these patients who are keen to engage in therapies, for this will prolong their stay in hospital, and as they are engaging, they stay within the hospital setting, rather than the prison service, and serve the remainder of their tariffs, in hospital rather than prison, leading to an easier journey through their prison sentence. Staff conversely, are happy to have a patient engage with their service, and this gives may give them a client to work with. Although they may have criminal tendencies, and are not unwell, they are willing to partake in therapy, giving the staff member meaning.

May: you are discharged, but not trusted!

But these treatment orders also bring about their own issues and problems, namely, a way of getting readmitted, they act like an insurance policy, and patients know that they can re-enter the care system, if they don't like their accommodation as this staff member notes.

Zoe: when they no longer like their 1 bed flat, they want something better, they want to be with friends, or something better they try to get admitted!

In trying to get readmitted, the patient can do several things, from refusing medications, to taking drugs, or committing an offense. Remittance is always easy for those who want to return.

Staff are aware of these intricacies within the system, and are keen to work with them in order to make sense of the reason why they remain as inpatients. Staff work toward discharge in a fetishist way, and patient play along with it to save face. Patients appear unwell, and manage their symptoms and aggression, and the staff know they are trying hard to hold it together. Some

patients are not even unwell, but the staff also play along with this. Moreover, when the patient is eventually discharged, they are then subject to a recall/CTO, for not even the Home Office is trusting of the clinicians' opinions.

There is often an overfocus on risk within the forensic mental health realm, and neither psychiatry nor risk, are true sciences. Nobody wants to take responsibility for the discharge of a patient, not even the patient themselves.

Subordinate Theme – Everyday Danger

The innate danger of the job is made clear, even in the job description, but people apply to work in these roles. There is detail of having to attend restraint and breakaway skills and training, yet people still apply, and want to work in these environments, and this is for several reasons beyond that of the job being one that is secure. It attracts people that want to make a difference. It also attracts those that have chosen this as a vocation, many having been trained with bursaries. Choosing to work with this level of danger, however, is something that is a choice.

Researcher: What is it like when this place is full of unsatisfied staff, unsatisfied patients, what does that feel like?

Tam: you're almost holding on for something to happen, just waiting for something to happen, then you can stop it, and then wait for the next thing to happen!

There is a constant feeling of angst, that something serious is going to happen, someone is going to get attacked, someone is going to be seriously injured. Ellie shares her experience of this, and it seems as if she is constantly just waiting for something to happen, without the use of the word "if." She knows that there is going to be an incident where she could be seriously injured, which is something she has experience of.

Tam: …and within the week, he was back, at the back of my building, waving the kitchen knives that I had provided him with.

A patient, who she worked with for a long time, toward discharge, has recently represented at the hospital waving the very kitchen knives that she had help him purchase. She speaks of this with such ease, and with a sense of calm, that only compounds how normal this abnormal experience is for her. These incidents are so normalised within the hospital system. Serious ones are often not reported to the police, racism, sexism, assaults, there is a move in recent years to report everything to the police, however. The situation leads one feeling powerless to act in response, as the police will only come to say, that these patients are unwell and in a strange way, above the law. With no support from the police, and with violence and aggression being part of the job, no wonder Ellie has a blunted response to her experience, it has become her normal.

Tal:: One of the ways that we are safe, is that the correct levels of staffing are maintained, and having bank staff properly induced and trained. I have worked in another hospital, and I have never felt unsafe going to an emergency!

The level of how this is normalised, is shown by June, who says that the support of her colleagues, gives her a sense of safety. Running toward a serious incident in preparation for possible restraint, is always a reason to feel unsafe, but the language used by her here, shows that she is caught up within the culture of it being OK, to be unsafe. Generally, when the emergency nursing team, or rapid response team is needed for a psychiatric emergency within a forensic unit, there is often an assault that takes place. People often go to hospital after getting punched or kicked by an unwell patient. But, never feeling unsafe, shows just how June has perhaps herself, become so used to the levels of violence and aggression, particularly when the police only repeat what you are thinking, they are unwell, and essentially above the law. But she also notes that it is important to have adequate numbers of staff and those who properly trained, both things she knows is lacking.

But there is another set of patients, who require much of the staff's time, those who are not mentally unwell. These patients are often caught up in the system, whether it be by delayed discharge, or that the medical teams don't find it fit for their discharge, nor return to prison.

Zoe: they are all quite critical of the patients who are unwell

It is these patients who are the most critical of the patients who show symptoms of mental illness. Their personalities shine through. Many patients are on very high dose medications, causing hypersalivation, tremor, stupor, and those who are unwell, are often unable to tend to things like personal care and self-care. The patients' criticality of those who are most unwell, often causes incidents of their own. Those less mentally stability may encroach on personal space, due to their disinhibition, may say or do things without a second thought. Those most well, often find them a hinderance, and have little to no understanding, or time, for these unwell patients, which causes issues for staff. Having to care for those most unwell, and having to address behavioural issues with those who are well. Peter says that they are critical of those unwell patients, and it is his job, to address this, which isn't the job of a nurse, doctor nor anyone else, to essentially parent an adult.

Tam- the entire music system, Xbox, 57 PlayStation games, all thrown away and by people who were NOT unwell!

Ellie, recalls a time when a PlayStation was thrown out of a window, by someone who was not unwell. The anger, aggression and violence, is not limited to those whom are unwell, but also who are frustrated at their continued detention. Stressing the "not", she is showing frustration for the time she has to spend with these patients, who simply need to be told off for what is simple bad behaviour. They share here, the everyday issues of working with patients who are not unwell, and the everyday issues they perpetrate, no health professional has signed up to deal with misbehaving adults.

Subordinate Theme – Strange Expectations

How are you expected to work within this environment? How you also expect yourself to work here? You read reports of these patients that are soon due for admission, you are shocked by the index offence, their criminal behaviour, and their psychiatric history, of violence and further risk behaviours.

Ann – "…and then meeting the perp, which is hard enough in itself, and then you have to somehow form a bond!"

You must, and are expected to form a bond and therapeutic relationship with this person, who will be under your care as a patient. You may feel as if this patient is best placed in prison, but those thoughts and feelings are placed to one side, and you deliver the care the patient needs, despite your own internal strife with your opinions. S5 says, that meeting these patients is sometimes hard enough, but then how you then have to form a therapeutic bond, founded on strong relations.

Alas, in forensic mental health, you usually have a rich forensic history, rather than poorly kept notes from previous admission. Getting accustomed to their notes, knowing previous behaviours, reading pages of risk reports are all seen as ways of staying safe.

Lea: it makes you feel safe, you know your admission way in advance, and you have their histories.

Emails, internal memos, care plans and everyday paperwork, often contain details of assault, rape, and other behaviours. Speaking about these things becomes normal, and with this, comes a sense of desensitisation. S5 says with shock, that the reports contain such graphic details, and

this is the person that you need to place aside all of those feelings and emotion towards, in order to foster a relationship with, and how this is expected.

Ann: you're going in to read emails, about rape and in intricate enough detail

Having breakfast, or your morning coffee, whilst reading about explicit patient risk histories is normal, and with this, some a sense of normality. You feel safe by knowing about their histories. Assaultive behaviours seem less risky, or less of a risk, than sexual assault. Murder is seen as bad as rape, kidnapping and hostage taking comes with specific prejudices. The language used changes the way people think about the violence and takes away from the enormity of the effect it can, and has had, on victims.

Even to the actions that the staff portray themselves. Restraining on these wards is something that can be an everyday occurrence, but certainly it is in the arsenal of skills and abilities of most mental health workers.

Mel: we get people who are restrained, and then they can't leave, and then there is chaos, turning the place upside down

Tal: It scares the life out of me, you just end up grabbing something during an incident anyway!

You run into incidents, often without knowing what is going on, and grab a limb, if you can find one, and try to ensure it isn't the limb of a colleague. Staff speak of being frightened during these restraints, and others certainly take a particular kind of pleasure from these events, as it gives them a chance to show their physical capital, muscle, bravado, and the patients know this. This can lead to particularly strange situations, where you are sublimating feeling and emotion into the force you are inflicting on these patients, with whom, you have intricate knowledge of, and knowledge of the crimes they have committed, and the traumas they have often been through themselves.

After the incident is finished, you then have to work with the patient as before. Try to restore the bond that you had, the relationship that you had. Placing feelings aside, even if someone was hurt, in order to work with each other.

The expectations placed on staff are unreal, and perhaps unsustainable. You are asked to set your prejudices aside, both your conscious and unconscious. You are to be expected to restrain the patient with whom you are building a relationship with, a relationship, that is used in a perverse way, to encourage the taking of medicines and depot medication. You are building up a relationship of persuasion. Being able to persuade a person, solely based on the relationships that you are building, in essence, it is a relationship built upon coercion and submission.

Subordinate Theme - Working with Awe

How I've managed to work and live within this strange environment, and how I've managed to work with the risk, and how I find meaning in it. You have built up these persuasively real relationships with the patients that you know and perhaps, hold a sense of resentment for, for the crimes and acts they have committed. You hold a powerful position in their life, writing reports, and presenting reports that could gain them discharge, and perhaps even, a remittance to prison, alas, the relation is build, and managed, somehow.

Working with these rebellious client group, can be made more palatable, if you are able to reframe the experience.

Ann: you're working with 170 odd people who don't give a shit about being politically correct, and its super refreshing to be honest.

Ann: - I know I have an antisocial side, and I find myself rooting for the bad guy sometimes.

Reframing the experience can indeed help understand the strange reality in which you are working. Simple projection here, can make working with this client groups easier, but these patients, also care very little, for the input you are having in their life, considering you are holding them against their will, and forcing medications, and restraining them. There is also an example of sublimation, whereby the staff member is also experiencing the job of the patients antisocial endeavours.

Comedy also seems to be a way of being able to deal with the low level trauma that the staff use to understand their realities.

Lea: - In A&E, and he started to shout, screaming that he has coronavirus, starting coughing on people, and they sectioned him - it's frustrating, but you can't help with laugh

When forensic patients are brought to A&E, it is often for acute medical attention. Due to the risk, there is usually five to six staff escorting the patient, who is electronically tagged, handcuffed and placed within a locked cell in a secure ambulance. The episode above, is a very simple example of the type of risk issues faced daily by staff, a stressful event for all concerned, but one that is merely laughed off.

Tam: - it sounds bad but it is true, apart from the days when you have good chats… I've never come home and said, O I've had a great day in work today!

When relief of the default "good" way to explain how the working day went, there is something awry. Never coming home to say that you've had a good day, relief seems to characterise a good day in work. When every day is traumatic, difficult, tiring, and just depleting, you eventually accept this as normal, and with that, you start to become desensitised to the reality of the hardship.

Ann: - I do feel as if it is getting progressively easier.

Easier in terms, of accepting reality. The desensitising is seen in both the staff and patients that they work and live within the environment. The patient can share with staff that they have been arrested many times and this is seen as normal by the staff member.

Zoe: one guy was like - I've been arrested 20 times, and I've been brought here so many times...

It can also be seen, simply, as exciting. Working with this client group is exciting, exhilarating, and interesting.

Ann: for me it's very exciting - I love the criminal aspect!

There are many ways in which the staff here, have learned and adapted to their place of work. From comedy, sublimination, projection, and through simple reframing, the staff here have been able to reorganise their understanding of reality, into one that is not as dangerous as in actuality. One that provides comedic relief, one that is interesting, and where relief is seen as something that is a sign of a successful day's work.

Researcher Reflective

Some patients are in the system so long, that they have recovered, but professionals seem to forget, that there is an antisocial, and criminal aspect to most patients in forensic settings.

Often, patients' index offences, are the reason that they are sectioned, but sometimes not. Patients sometimes become unwell in prison, and are brought to hospital for recovery, and sometimes, never leave, serve their sentence out in hospital, and get released through the mental health system.

You are then, not only working with mental health patients, but also with criminals, with criminal histories, with varying degrees of illness. You de-sensitise yourself to their criminal histories; stories of child rape, paedophilia, murder for cash, hostage taking. You are then expected to park your emotions to one side and treat the "patient."

I was threatened by a patient of mine, after I helped him purchase the wrong electric razor on Amazon. He broke into the office out of nowhere, pointed in my face, and said that he was going to have me killed. That he was going to make sure someone would meet me outside the hospital when I left my shift. I laughed it off and didn't even report it to the police! It was only many years later, when a member of the Met Police came to a team away day and was looking for experiences of staff. I shared the experience above, and the said that I should have certainly reported it to the police, for it is a very serious threat.

You try to prepare these patients for realities of the outside world, but it will never be easier, in the patients' eyes, as being an inpatient. I didn't even to think to press charges. As I write this theme, I

realise that I also perhaps enjoy the underlying danger and the strange enjoyment I get out of the job. That challenge of getting this difficult patient discharged will be some sort of fulfilment for me as a clinician.

I know of the unrealistic expectations placed upon these patients; getting jobs, getting flats, returning to university or study, these are often spoken about, but rarely are a reality. My colleagues know of these difficulties too; and as I analyse, I realise, that a discharge is almost like a trophy for me. The discharge of a potentially very dangerous patient, at high risk of relapse, to a world that will be difficult to live in. – look that I can achieve!

Superordinate Theme – Firefighting rather than treating

This theme explores why the staff stay in their role, considering the lack of fulfilment. It explores how staff find meaning in the strife and the discontent of their roles. How they realise they are not doing what they trained to do, nor wish to do. How they spend time on simple administrative tasks, always beyond their remit and job. And how when they burnout, they are partly blamed for not looking after their self-care. How the reliance on vocational calling, is something that the NHS can no longer rely on.

There is a sense of pride however, when the job does eventually go well, and there is a sense of dedication. But feeling like one is living to work, and whilst one feels as if one is not making a difference, contributes to the feeling of valuelessness. The work style is unsustainable, and staff feel constantly that they are working toward a breaking point.

Subordinate Theme – Firefighting

Staff feel as if they are a nurse, OT, or psychologist, for that is their job title, but in actuality, it is not explicitly what they do. In the forensic setting they are also an admin, a police officer, prison guard, or even a meeting chair. Skills that have been hard learned, years of professional training for skills that are underused, for instead, one is fuelling the autocratic machine. Preventing patients fighting and being only half the therapeutic staff member that one wishes to be, staff end up focusing on firefighting the everyday, rather than performing the job they had once imagined.

> *Lea: - Your not actively helping people move into the community, you don't know when the MoJ are going to let them go, so, you're basically, a prison guard*

Having trained for years, as a nurse, OT, medic, or psychologist, staff know in this setting, that they are ultimately unable to execute duties as one is always subject to the opinions and

objections of the Home Office. Feeling as if there is this extra layer of supervision on clinical decision making, and your inability to make executive decisions, gives this staff member a feeling as if they reduced to the simple role of a prison guard. On other days, the demarcation of the role is made clear; it is a one person show, you are an administrator, nurse, activities lead, everything.

Tam: - I'm running the ward myself some days. I'm doing the entire ward round, the entire management round, and doing leaves, and going groups all in one day. Like, NO! no! what is everyone else doing? Nothing.

There is obvious frustration here, for they feel as if there is nobody else working, or feels as if the workload is so immense, that there is just so much to do much of it above and beyond their role. They note that no one else is working or doing anything. The frustration of the workload, but also at their own colleagues for not pulling their weight. The everyday firefighting extends to working with colleagues in this way too.

In exploring how far this demarcation has come, this staff member makes the point, that there is no longer a housing service or drug and alcohol service in the area in which they work, they elaborate.

Zoe: – no houses so they come to us for a house, no ASU for a drug and alcohol detox.

Not only has the inpatient ward become a place for drug and alcohol detox and rehabilitation, but also a housing office. Staff are not simply helping mentally ill people become well, but also helping them and their social and economic issues, which is beyond their remit and knowledge. The level of job demarcation is not only leaving everyone doing everything, but also leads of a sense of frustration generally with their job role, and their sense of frustration should be directed at the wider societal issues that many of these patients face. This leads to a fundamental disparity in their role.

Zoe: – I just went up to him, and said that this is not a housing association!... I emailed my manager 2 weeks ago... can you make me and my colleague housing officers, cos that's all we do.

Addressing the issue with management seems to make no difference, for offering these services is seen as being proactive, and you may inadvertently be given the responsibility. The confusing demarcation of job titles, responsibilities and duties only confounds confusion around the meaning of the job. The aim is to discharge patients, but some don't want to leave. And deep down some staff know this. Few know that patients have their life chances hindered by socio-economic and political powers beyond your control. This must lead to a sense of a confusing job, where you are helping patients to move on, but at the same time, know that discharge is going to be a very difficult journey for patients, and this certainly extends to forensic patients, who will face the same fundamental socio-economic issues, if not more so.

Lea: - You literally go in to give people meds, open doors for them, and that's it! That's your day!

Perhaps, after some time within the system, one simply finds a sense of distain with the simplicities of their job, for there is no time for therapeutic input with patients, they feel as if all they do is open, and close doors whilst dishing out medications. A job they came in to do, to make a difference, has very quickly become a job they grow to hate. Finding no meaning in the role, for it is now certainly more akin to that of a prison officer.

May: – one minute you are their family, and the next, your asking for a drug screen.

Some acting like a prison officer to managing this strange custodian/carer relationship, some staff seem to be family members to some patients. Therapeutic input one minute, searching their room and asking for samples for routine drug screening the next. It is a strange trichotomy,

family, nurse, prison guard, all within the same person, further demarcation, and dilution of what their job, which is described perfectly as:

Zoe: – firefighting - we firefight through the entire day, we have very few people with mental health issues, mostly social issues.

This member of staff feels as if they are neither the patients' family, nurse nor prison guard, but rather they find themselves naming their job, most akin to firefighter. Fighting the pressures of the forensic system, the clerical issues of the hospital, and paperwork of the patient all on top of providing care of the patients. The role has become more than a healthcare professional, and staff find themselves firefighting in all directions, trying with a sense of futility, to do the best for their patient group.

Subordinate Theme – Never Being Good Enough

You are never good enough. The hospital always wants more, needs more, and you need to be willing to give it. There is support on offer, should you ever have to tap into it, and when you do tap in, its tokenistic and face value. The already unsustainable work style is stress filled and fuelled, and I must prove and strive that I am good enough for this work, not only to myself, but also to my superiors.

Zoe: who's going to sit down and do a datix? There is no time for a datix!

Then everyone gets pissed off at us, cos they are waiting for 6 to 10 weeks to even try and get them a house.

I've been able to give this man the start he needed in order to stay

Never good enough, even for themselves. This nurse here is frustrated, that they are prolonging the patients inpatient stay. Trying their hardest to help the patient is not only giving them more

work but help that isn't instantly received is also of much consternation for the patient. Not helping at all becomes the easier alternative, and one which they wished they had chosen.

Tam - Frustrating! You don't feel as if you are doing anything to help anybody, so therefore, what is your worth, you know. You feel worthless in a way

Constant frustration at the lack of perceived progression and progress of their patients, being stuck with paperwork, and meaningless admin tasks, is not the job they signed up for, nor fitted their expectation of the job. This nurse does not feel as if they are even helping their patients, and this only exacerbates their feelings of worthlessness.

Lea - : patients will say stuff, like we don't have enough activities. But how many times we've booked out the social spaces, bingo etc. does anyone go, No! If there's food, they might turn up

The sense of worthlessness is even felt when the staff do try to engage on a meaningful level with patients, in trying to organise activities. These are often poorly attended, for fear of showing a level of engagement that would warrant a definition of progress in care. Yet, the patient will complain about the lack of activities and meaningful engagement, something that they at the same time, will actively try to avoid. The staff know this, but need to action the patients' complaint.

Tam - , it just turns into a recipe for disaster and nobody feels validated and nobody feels , em, like they are doing anything good at their job. So yea, it's been difficult.

And with this lack of validation and lack of feeling good about their job, brings about other practical issues, like staff dis-satisfaction and increased absences from work. Feeling worthless at the job; where you don't feel as if you are making a difference and don't feel validated, leads to other further issues. You might work harder at the job, in order to make a difference. But to achieve this you need to work even harder which leads to eventual burn out or sickness.

Zoe - ... and then we burnout, and then we get told off for burning out.

Tam - And then you work too hard as staff members and then you burnout, and they you get a letter saying that you have been off sick.

Burning out, and taking time off for working too hard, is often construed as being “off sick”, and comes under the similar policies. In sickness terms, being burnt out is an illness, and you will be signed off sick with stress, rather than with burnout for working too hard. Even working harder and going over and above for the patient group, seems like a thankless job.

From start to finish, the job is thankless. Upon starting as a nurse, you are not trusted with medication, even your nursing degree is not enough. You are placed on a preceptorship to learn further skills. The practical implications of this is not lost on this staff member.

Tal - Preceptorship means nothing! If I kill someone on my preceptorship, I still lose my PIN.

From employment and preceptorship, a time in order and finesse your skills, you are still responsible for your mistakes, not yet trustworthy until you are “signed off,” leading this nurse to question the value of their degree and the time doing their degree. But this is also the first time they will work clinically, and they see a glimpse of the lack of autonomy that will have.

Tam - I always knew we were replaceable but, em, didn’t realise it was that quick. I gave in my notice the day before yesterday, and yesterday they had replaced me.

To resignation, with your replacement being ready by the next shift. This nurse truly felt as if she was totally replaceable, and if she was not valued by the patients nor staff, she treated and worked with. Being replaced immediately, having worked with clinical teams and patients closely, further leads to a sense of meaninglessness, for having the replacement ready so

quickly, says much about the hospital setting. Knowing staff turnover is high, but rather than tackling this, they simply have replacements ready.

Lea - He left, ... gave me a hug, and spoke to me, saying that he was so thankful that I was so kind. And he came back and thanked me. And I haven't heard of him coming back since... or have you heard a thank you... hahah nor have I heard a thank you, that is true. No one has thanked me!

The patients on the other hand, are more thankful it seems, and this staff member recalls of a time when a patient was thankful of the care they received, and conversely, the hospital never thanked them for their service. The thankless job, never being good enough, trying your hardest and becoming burnt out, being accused of going off sick, working for nothing, and not even being thanked for the job. "Nor have I heard a thank you, that is true. No one has thanked me."

Subordinate Theme – Detrimental Dedication

How this nursing/OT/psychology clinical based role is only a job, no longer a vocation. You learn in university and not on the job. There is still an underlying sense of sistership, but this is quickly depleting. There is a sense of it being acceptable to act as the ward Sisters of yesteryear would have, managing staff with hierarchical self-importance and feeding on lack of confidence. These staff members are professionals, and if they were in any other profession, the need to please would not be the same.

And, it is only a job. Living to work, or working to live. These roles were once vocations, nursing, and medicine. The NHS relies on the characteristics of vocational work today, that you are dedicated to the job, but it is only a job, and one that is beneficial in other ways, for experience and perks.

May - ... going to conferences every other day, if you're a senior nurse, you are in meetings all day. What about working on the ward.

Some staff, particularly those more senior, yet clinical staff, find the time to be in endless meetings and conferences, while their subordinate staff work and burnout. The endless meetings in healthcare, yet no progress seems to be made. They stay in their job, nor for the financial renumeration nor for the fulfilment, but for the ease.

Mel - : it was a mixture of a few things. obviously, I realised I didn't want to be a clinical psych, so the experience of the NHS wasn't any longer benefiting.

This member of staff was in the clinical setting, in order to gain experience for their clinical psychology application, and as soon as they realised it wasn't for them, they resigned their role. The healthcare system can no long er rely on people feeling as if their vocation will keep them in the job.

Mel - I was frustrated, I was doing the work of everyone, I was being attacked by patients, I was not being supported, so I just turned around, and was like, that's it, I'm done. I would do anything but be here.

This same person, only there for the experience, was attacked by a patient, and that was their final straw, before handing in the resignation. The lack of support they felt was a deciding factor. Those who do care, burn out.

Mel - we rarely had an OT. the psychologist we have now, is on the brink, but she's good, she went away for a month just to take some time out, but she's not going to last longer

Those who do care, end up leaving as they become so unwell, and burnout, that they can no longer continue with the role. Those that do continue with their thankless jobs, find other higher meaning in their role, beyond that of an alternative motive for staying.

May – its been a good experience, insightful, learned loads, you now, scary, monotonous.

And there are some who will stay and still go over and above, perhaps they have yet to come to terms with the frank reality of their role.

Zoe – I felt as if I let the team down, and I didn't want to leave, but I was told that by my shift coordinator that I was told to leave 3 hours ago,

Perhaps they should have listened to the senior staff on shift, to do home, rather than feel as if you've let anyone down, a feeling that removing the emotion from the role, may lead to a longer tenure in the role. And when the day does do well?

Cat: and you've a good day, what's that like when you leave work? When the day has flown well?...
Zoe: nothing spectacular!

A good day in work, is nothing spectacular, despite the scope of what a good day should and could be. The discharge of a patient, creating a real personal connection with a patient, helping someone over a personal hurdle, a patient confiding on you. A good day is nothing spectacular.

Researcher Reflective

For those that still think they can make people well, and help patients recover, they time is nigh. These OTs, nurses, managers, are supposed to help patients recover from their mental illness, but find themselves, acting as prison guards. In forensics, there is the dichotomy of acting as a custodian and carer, something that I always found difficult to understand, after seeing it in a video at my induction training many years ago. It was only after many years of working, did I truly understand this.

When I started, I didn't know of the power that the Ministry of Justice have over the clinicians in forensic settings. Everything needs consent of the MoJ, from transferring hospitals, discharge and more, the clinicians themselves don't have total autonomy over their actions. Staff share their experiences of building up relations with patients, and the next minute, supervising a drug screen; carer and custodian. As the years progressed, staff also become their own administrative staff, and took on more and more paperwork, leaving even less time for therapeutic intervention. Above, a colleague shares their experience of how the ward had become a housing office, with patients seeking different ways to access the crippling housing system in East London. With diminishing housing stock, and little suitable housing for those who need specialised care and input, the hospital has become a way of subverting the welfare system, and the staff know this.

You then, cant plan for your day's work, for one day you are a nurse, housing officer, redeployed to another ward, or supervise a patient on a community visit. It is impossible to plan your day or week,

and you become a slave to the rhythm, of firefighting, and unlike firefighters, you never feel a sense of thanks nor do you think you are making any real change.

Superordinate Theme - Realisation of the challenge

How staff have not only had to learn to work with the deep acting patients, but also with their colleagues, and also with the system as a whole. How staff are restricted in their autonomy as a professional by policies and procedures, and by their colleagues. How staff change over time, to survive working within such an institution. Those who are career focused, aim for non-clinical promotion. And how staff, over time, simply become disillusioned with the entire system, and wonder if they can make a difference at all.

Subordinate Theme – Staff Not Able

The staff group also speak of their team, and how they are working with people who are simply unable to complete their tasks, which make them feel unsafe at work, exacerbate issues with patients, but also simply, difficult to work with.

Researcher: thinking about everyone, what has it been like?

May – you are telling (professionals) something about the patients, and they are telling you about boundaries etc. all the nursing staff that have cop-on all roll their eyes, cos you know they are talking rubbish.!

Nursing staff spend most time with their patients, but when they go to give opinion about their interactions and about the patients' presentation, this nurse feels as if they are shut down by the wider MDT team, and their opinion is nullified. Why would they continue to work within this realm, when their voice is not heard.

Tam: If I had been there, with other people from the ward, we could have been able to deal with them in a different way, but again, they just went for the most restrictive option. They look at him as if he is a threat.

As this staff member explains, having a good relationship and knowing patients is key to successful management of patients, and taking the most restrictive option with patients, is often

done out of fear and lack of knowledge of their symptoms and behaviours. Not listening to the staff members who best know the patient, perhaps due to their level of experience or rank amongst the team, is often a down fall when trying to manage patients.

Being unaware of a patient's risk is easy, you must get to know them, talk and chat with then, and truly get to know them. It is easy to read their risk assessments; items of paperwork that are often copied and pasted from previous admissions and previous reports, a photomontage of copy and paste.

Tal - I looked at the risk assessment, and it was done in 2017, She asked whether she needed to update it! – I was like seriously? The risk assessment is the most important thing!

Having this risk assessment outdated by close to 5 years is obviously unacceptable, but when asking a nurse about this, the junior nurse, asked whether it needed updating. The constant barriers to common sense work can't be something that is endemic in psychiatric nursing.
And sometimes the only way to get out, and get relief from the constant barrage of nonsense, is to go off sick.

Tam - And then you work too hard as staff members and then you burnout, and they you get a letter saying that you have been off sick. Well of course I've been off sick! I can't fucking deal with your bullshit, you know what I mean!

Researcher: What is it like when you get that letter in the post?

Tam: It just shows that you are just number..

It is no secret amongst teams, that people simply do not turn up for work, when the team they are rostered to work with are not up to the standard, or able for the job. People will feign illness in order to continue within their role, for working with unable staff can bring about an unsafe environment, where you will be overworked, burn out, and the never ending possibility of getting assaulted by a patient is heightened.

Subordinate Theme – Feigning Teamwork

The team will always be disjointed; not everyone will see eye to eye, and not everyone will be on the same playing field. People have their own vested interests for being in the job, and those will only have care about their roles. A job is a job, and no longer the vocation of yesteryear. People are keen to advance in their career, people are keen to please management, people want an easy ride; healthcare is not the behemoth of good will that is often portrayed.

Tam - So yes, they will say that if you have a good relationship with your managing team, they'll owe it to formality, you know how it goes. O I have to have this meeting blah blah blah, which you do, yes I understand

Meetings, supervision, and sickness monitoring is another example of the Follie au deux, discussed previously. Nobody cares if you are sick, but for reasons of human resources, and paperwork, check in meetings are performed, supervision is conducted, but this is just a formality, and no real support is offered, just another tick box exercise Today you are being supported by management and by the hospital, but you know you are not truly being supported, and the management know that too.

These members of management, were once clinical staff themselves, nurses, occupational therapists, psychologists, but now with managerial roles, but without the experience of managerial expertise.

Tam: Its' like a power thing, its very much a power thing. The power has gone to their head. They used to be good nurses, and I knew then as nurses, and I had just started

A once good front line member staff, is now sucked into the machine that is the NHS, and along with that comes the new manager, who is also keen to please, and exert their new found power. The vocational aspect of their job does not extend to simple management of staff members, for there is no sisterhood in healthcare, the vocation no longer exists, the staff a contracted to do a job, and the strange management structure of clinical staff having power over the other, does not work.

Ann - no one tells me, nursing management sometimes tell OTs to sit in day areas.

Researcher: But they aren't your manager.

Ann: I know… I won't have my timetable done by someone who isn't my manager.

This occupational therapist recalls a time, when a nursing manager was giving them instruction to someone that they don't line manage, nor have any responsibility for, nor any business in telling them what to do. They exert their new found power in ways that perhaps, mirror the power they exert in the clinical setting as psychiatric nurses, but this is misplaced.

When it comes to managing patients, the same is seen, over vigorous staff simply do what they find fit, without any consultation.

Tam - and the man is screaming and shouting and banging and kicking...and they haven't been giving him the space like I had said, to give him space. They hadn't been following what I had said to follow when he gets himself in that state and instead, they were encouraging him to act out,.

Recalling a specific incident, this staff member, had previously written a plan for when their patient becomes unwell, and is in need to very specific help. The staff on shift that day, simply done what they deemed fit, for fear of their safety, took a overly restrictive approach to tackling this patient, and were actually being counterproductive in the management of his behaviour,

rather than simply leaving the patient with some space, further damaging the patient staff relationship here. They later say:

Tam - There is no input, no empathy, there is no wanting to get to know that person and to help that individual person they want to just follow the protocol of just giving meds doing a housing form.

The lack of empathy may be a product of burnout, but perhaps something more sinister, they simply do not care about getting to know the individual that they are there to treat. They are more interested in getting through their day's work, and leaving one time, than truly delivering the care and attention that their patient group needs.

Zoe – They said that to see (me) break down, shows how far the team has fallen, how were not having the right support.

There seems to have been a shift over the course of the time this member of staff has been working, and it's a change that they have noticed over their tenure. Perhaps this is related to the governmental push to hire into the profession, where it is now very easy to become a psychiatric nurse, or occupational therapist who wants to work in mental health. Once a degree requiring interviews and examinations, it is now more of a lottery, where you are almost bound to win. And for the other professions, why would you choose forensic psychiatry, when you could apply your skills in pharmacy, occupational therapy, psychology, and medicine, to people who want to receive your help.

Tam Em, it can be quite lonely. In that you only have one or two other people you are working wanting to help people

This leaves the staff members who are in a precarious position, of being perhaps the only person on shift, who cares about their job; something that the patients will and can pick up on. Which

leads to you becoming their favourite member of staff, to the distain of others' and to the concern of management; are you not boundaries enough, or are you allowing patients to get away with things, in a sort of defensive argument.

Subordinate Theme – Silo Working

The lack of support does not only come from your own team, but from other agencies, that are either unwilling, unable or they, themselves, so not care either. The lack of support here, is referring to the support not received by the front line staff, those with the most contact with patients and those who spend the most time, and know the patients the most.

The lack of support starts at the very beginning of the journey, where this nurse describes management not even having the time to sign them off.

Tal: I had it passed as in everything was signed off, but had not finished the year. So I was made start it again! So I'd been qualified for 9 months, and then it took we another 2 months before I could do meds there! Because no one had the time!

This nurse shares the experience of being a nurse for almost one year, before she was able to do the job themselves., without the supervision of a senior nurse, and all because management simply did not have the time to sit down and complete some paperwork with them. The feeling of simply not being cared for by management, is perhaps something also experienced by the patients themselves. There is a wider issue with support from the wider MDT team. With a sense of them not being present on ward, and their opinions and ideas, being so disjointed with the team that treats the patient the most, nurses,

Zoe The problem is its really difficult, they have this false sense of entitlement, they have this false idea of how things are.

Doctors, psychologists, and others, who meet the patients perhaps only weekly, seem to think that they have a better grasp of the patient, than those who work with the patients daily. This is confounded by the fact, that on some wards, occupational therapists and psychologists are on rotation.

Mel: – I was on a ward where the OTs were on rotation... the psychologist we have now, is on the brink... the prior psychologist's input was shit… there was no social worker, they were shit.

Notwithstanding the lack of social work input for patient that perhaps need it the most, rotational staff, on long stay wards; by the time the patients have built up relationships and have managed to trust a healthcare professional they are moved on, but still, the staff member will still consider their ideas and notions of the patient, more thoughtful, more important, and more valuable. The patients are also aware of this rift within their clinical team.

Lea - They'll make decisions that go against what the nursing staff have already said, and that hugely undermines the nursing staff. And the patients learn that, and they just say, ah, Ill just talk to the doctor.

Overriding what has already been agreed, leads to many issues, and completely undermines the value of the contact nurses have with their patients, and makes the relationship untrustworthy. No point in asking a nurse something when the doctors can override decisions made. The rift continues to widen within the team, but that rift continues with other agencies, not directly involved in patient care.

Tam - We don't have the greatest support from the police system, the police say that they are unwell, even though you are telling them otherwise.

Oftentimes, there is a need for police presence on the wards, whether it be to charge a patient with assault, sexual or physical, or to interview staff as witnesses. Sometimes, they are needed

in their crowd control capacity, and hostage negotiation skills are sometimes needed, but they often, delay and sometimes refused to help, for their belief is that the forensic hospital is a kind of prison, able to fend for itself, whilst the opposite is true.

Zoe – you have to tell them you have a hostage situation before they will send someone.

This nurse recalls of a time, where they have had to scream and plea down the phone to the emergency services, barricaded into the nursing station, with patients wielding weapons. Eventually after much delay, the recourses need to do this job well and safely, is needed disjointed.

Researcher Reflective

As a member of staff, you must learn how to survive within this system. After years, you learn that the whole system is simply harbouring dangerous patients, some of whom, will get discharged, and those that are, will return. Those that remain in the hospital, think it is their home, until they are moved to another hospital to offer respite for staff. You eventually learn that you are not going to change the system, and you want to continue in the role for which you have studied hard, and perhaps even still see it as a vocation. I have had peers, who have very quickly moved up through the managerial system, perhaps to survive the lack of satisfaction, and to live with the vocational decisions that they have made.

Whilst those career managers will also be, there are many managers within the NHS who are first and foremost clinicians, with little managerial experience, which perhaps explains the lack of scrutiny. I always found it strange, for young staff to climb the managerial ladder, when they have studied to become clinical staff. As I examine and reflect on my experience, it was so that they could make their job work for them. Perhaps they were seeking a more meaningful role, or perhaps, it was because they simply hated their clinical role. The staff with good skills and abilities are quick to climb, which leaves inexperienced and disengaged staff to do the clinical work.

Superordinate Theme - Acting as a means of self preservation

How long stay staff are also as institutionalised as their patients, how staff become so disenchanted with their jobs, their integrity diminishes. They start to find ways to make their job easier by skipping corners and having to work with the everchanging systems. It isn't noticed that staff skip corners, as their superiors don't notice nor care, for they can't keep up with the perpetuality changing systems of governance either. All of the staff, managerial and front line, are also playing in their own follies, where everyone knows, that no one cares.

Subordinate theme – Playing with Responsibility

To survive within this workplace, one needs to adapt and adjust one's methods of working. You must gain the new skills and abilities to work within such an environment, where there is always an alternative motive for doing something. To make sense of the career they have chosen, new skills and actions are seen and this makes the workplace even stranger.

Mel – I'd go in and not want to do that, cos sometimes I didn't just want to be in charge, and those would be the days that things wouldn't get done. I didn't want to stand up and take control then, cos in the end it isn't my job.

There is no one in charge. There is not one single person that oversees, many decisions rely on consensus, overseen by a consultant psychiatrist. However, they only line manage the medical team, and have no say over nurses, OTs, or psychologists. The lack of chain in command, often leads to the person with the most conviction to take decisions and to argue their case. The most willing staff member takes control of shifts they often work beyond their remit; they are there to perform other activities. Executive decisions are taken without any real risk, as the responsibility for poor decision making is spread amongst the team. This leads to a sense of having an unusual responsibility, and oftentimes, those with said responsibility, are not quite ready for it.

Tam - O, quote on quote from the manager of the PICU, he's been a very naughty man, and he can't get away with what he's done. Bearing in mind the man is sick!

This staff remembers a time where a senior was speaking to an unwell patient, in an overtly and patronising way. Not only does the patronisation of a patient irk this staff member, but also how a patient "can't get away with it" referring to a violent event. When staff members, whether through need or through sheer ignorance act like this, there is obvious frustration, but also no logic reasoning.

Tam: you don't have all of these personal issues that they bring to work, like what all the crap teams do. Do you know what I mean. They don't all bring their personal shite with them.

From time to time, staff make unusual comments like the above, and those with rationality will see that stress and burnout leads to these behaviours. Sometimes these are the same senior staff who are telling those from other disciplines what to do and how to do their job. This staff member shares that staff often bring personal issues to work. Everyone has personal issues as this nurse realises, and reflects on how personal issues are precipitated in the stressful reactions to adverse work events. Teams then need to support each other, whilst also supporting their patients.

Ann: -. I'll help out, and I've done leave, and anyone that knows me, you know. With OT, its way more of a grey area. We are in and out of sports, physical health, leave, in and out of education, employment team. There is a huge cross over. I find that new OT's find it difficult to establish themselves on the wards.

The overstepping of responsibility may rampant, but this may be due to not one single person in charge. There is not one person taking overall responsibility for clinical decision making, and that lack of professional guidance and tutelage brings about a workplace that is not demarcated

and confusing for those trying to do their part. Overzealous nursing and medical staff may inadvertently give, the OT for example, more work that they would otherwise like to take on, able to take on, or simply work that they don't get paid for. This lack of demarcation is shown as frustration, by this OT. How "grey areas" of work-based responsibility are not managed by one person, bringing about the everyday challenges that are particular to clinical teams. Suddenly not being able to take on responsibilities, or tasks from your MDT teammates are misconstrued, so one may find oneself in a team who are no longer willing to go over and above, but they are not unwilling health professionals. and thanks to someone who does not manage them, and speaking about the way things work is not always the best course of action.

Tal: - I want you to have my back, and that is why he accused her of bullying because, she saw something that she didn't like.

For some people being asked to do some simple tasks is classed as bullying. This then dampens the true meaning of the word, which is a true human resources issue, but it is used as a tool so often that it is a mechanism that is simply ignored and chastised for its use. This staff member knows that bullying within the NHS carries certain connotations, and it is a laden word. Being accused of bullying is a tool that some use, in their experience, of seeking personal goals or ambitions. And if bullying is not reason of the day, ageism may be.

Lea: and they say things like, you can't talk to me like this, you are younger than me, you can't tell me what to do, I know how to do my job, well, fucking do it then!

Being told what to do by junior colleagues, or those with less experience, can also be irksome for some of this staff members colleagues. Asking again here, a staff member to simply perform daily tasks and duties, is met with a response laden in ageism. This staff member reacts with expletives, but not in a way that counteracts the discrimination, but rather in a manner that suggests a level of expectation.

Tam: And you tell them the reasons why without trying to obliterate the entire ward in the process you know, you have to keep some things quiet.

For fear of being accused of upsetting the status quo of the ward, everyone stays quiet, and only airs the most pertinent issues, in a way that appeases all. Serious issues are pushed aside, and human resources issues are dealt with in a substandard manner. Staff unequipped to deal and work with a complex team of people, and indeed a complex cohort of patient, are left to manage themselves. In exerting a sense of managerial flair, one is met with resistance and tools pertaining to discrimination. This leaves staff trying to understand how to manage their own teams, and work within their own teams, a extra level of bureaucracy that is simply not needed in a forensic setting, already laden with risk. Trying to find a sense of meaning in their peers reactions, that is beyond resigning it to burnout.

Subordinate Theme –Lack of Skills

Perhaps the reasons some act this like this, is because your work colleagues simply lack the skills and abilities to do their job effectively, and some simply don't care.

Tam: Because people don't, it feels as if people don't care. Right now, with all of the difficulties we have with our shortage of staff and the different patients that we are getting, it's just like people don't care anymore

The changing patient group here, perhaps is a reference to the changing patient behaviour, which is often a precipitate of staff patient relationship; if they are not on good terms, the patients tend to take an "us and them" mentality to the care delivery, rather than one that is co-created. For this member of staff, they know that staff not caring means for a changing patient dynamic that will make everyone's role more burdensome.

Tam: - , if someone had just come in and sat down with him and talked with him, for 5 minutes, quietly, away from everything, he wouldn't have needed to go to seclusion, the whole thing could have been managed better,

Staff sometimes then take inappropriate or disproportionate actions when intervening with a patient. This staff recalls of a time, where a patient was failed, rather than simply sitting with the patient and talking through concerns, the patient ended up needing seclusion. Perhaps a precipitate of shortages in staffing and staff burnout, but also a professional failing. This staff member knows that they will need to do much work in order to build this once therapeutic relationship.

Tam: They know that person is going to do to the psychiatric intensive care ward, its just a matter of time they think so they just let it happen.

The same person explores that staff let some people become more unwell, so they don't have to look after them, allowing patients to relapse, sending them to another more secure ward for treatment. Perhaps out of fear, but also perhaps out of lack of skill. But some of these skills are unteachable, and passing responsibility for a patient to another team colleague is almost contemptuous for this staff member.

Tal: don't you remember when we discussed getting the speaker out whenever we could, even things like that, it was only once a week. Why can't we do this whenever!

Simple tasks to keep patients busy, are either seen as not important, or the staff are just too busy with their paperwork. Keeping 15 music loving patients happy with a music system is a simple thing to do, but even after prompting staff that this intervention works, it still does not happen, much to the dismay of this staff. Simple proven interventions are passed over, almost obliviously.

Tal: - . I said to her, this is how I would do it. Bearing in mind I have only been qualified for a year. I'm not the most experienced nurse not he world. But it's common fucking sense! I said what I would do, is this that and the other.

This nurse here, is dismayed at the lack of ability of their colleagues, highlighting how some colleagues seem to lack self awareness on their level of skill, but perhaps also the humility to accept this. Newly qualified and new to the job, this nurse was not only dismayed at the colleagues they had to work with, but also their attitudes.

Tal: - And you know why I think they are shocking, they've come out with this false sense of I know what I'm doing...

Having a false sense of confidence, lack of humility and lack of self-awareness, working with patients with psychosis and personality, is not a mix that works well. Working with these client groups requires a great deal of intricate work practice and nuanced language and behaviour. When confronting staff about this, the word respect is often thrown around.

Lea: - no, I say that respect needs to be earned, and if your dumb and lazy, I'm not going to respect you!

Being a nurse, doctor or otherwise, does not in itself command respect, but that is something earned by this member of staff, who is very clearly frustrated, that respect beyond mere pleasantries is something almost demanded by some staff. A tightly knit staff group, of professionals that are able to interact well, notice nuances in patient behaviour and discuss these during professional meetings are the keys to good relational security on the forensic ward. A breakdown in professional relationships, due to the lack of skillset needed, leads of a sense of dismay which then leads to the encouraging of these staff to do very little.

Lea: - …, you are counting down the minutes until you can go home. Or you find yourself leaving the office, and letting them stay in their doing the paperwork, at least you can have time with the patients, and someone sane to talk to!

It is safer, easier, and more effective, for some staff members to stay away from patients, and these are the staff that themselves would prefer to do paperwork. They lock themselves away in the office, and have minimal contact with patients, which makes worse, their already small package of skills and abilities. The deskilling of these staff then is confounded by their lack of interest in their own job.

Lea The long stay staff are institutionalised more so than the patients. They'll do something, and you might question why, and they'll just say, that's how its done

They refuse to change, not because of difficulty, but simply because they lack the experience or knowledge or will, to relearn refocus and change their work practice. This senior member of staff, highlighting and exploring everyday practices, is simply to her amazement, the old trope "that's' how it is done." With such little regard for improvement, there is a lack of awareness, and lack of humility compounded by unwillingness to change, brings about issues when it does come to intervening with patients.

Lea - I think the power gets to some peoples heads! O, I'm the nurse in charge! O, I'm suspending your leave, you need to wait for 30 mins before leave. O don't speak to me like that! Even though they are asking something reasonable, like why has my leave been suspended.

Petty rules, rule enforcement and being unreasonable are order of the day for the staff members that no longer take an interest in their job. They have no drive nor desire to be in their job, and the staff members who may have a scintilla of will left, are picking up those pieces, burning out faster, and leaving the role earlier, which perpetuates this attitude for it survives.

Subordinate Theme - Surviving the Job

The only way to survive this workplace is to make the job as easy as possible, and this sometimes entails making the decision to take on extra work, and sometimes, to take on less.

May: but they don't build the trust do they – you'd be in the job for a while, and just don't move around, or get to the next band.

Sharing experience of this member of staff, they tell of those members of staff who don't like the clinical aspect of their job very much, simply work hard to get promoted, as the further up you go, the less clinical work you do. The higher up the chain of command, the less patient contact you have, so working harder, makes the job easy.

Tam - Sit in the office on their phone, the band 6s will sit in the doctors office and book flights or sit on the phone and talk to people about their other business. Ehhh, then you'll have s staff member who will sit down the back of the ward and will say that they are checking up on people when they are not

Some others, simply refuse to do any work, and will blatantly sit in the nursing office or station, or doctor's office, and not lift a finger the whole shift. This may draw criticisms from colleagues and peers, but they are doing the same. Being disengaged helps you stay in the job for longer.

Tal - : Band 5s make the shift, and you get so many of them that just don't want to do anything, apart from meds, and even at that, they say that they can't do two lots of meds in a shift, and you even get that with new people.

Simple job responsibilities then become problematic like administering medications more than once in a day, whilst doing practically nothing else. While they are registered nurses with a PIN, some try very hard to do as little work as is possible. And this is a smart move. The more you show the less you are able, the lazier you are, the unskilled you are, the less work you are given to do, and the less responsibility you are ultimately given.

Lea: no, they wouldn't! no one knows how to admit, how to scrutinise section papers, no one even knows how to use the computer systems!

You may be moved to a quiet sedentary type of ward, as you will be safer there, safer to work there with the lack of skills that some staff have. The lazier you are, the easier your work day ends up being.

You then, as a member of staff who cares, will burn out, keeping the ward safe. Those who work the hardest and those who are most dedicated to the job, leave. Those who are still there, are there because they have found their own way to survive, through careful watchful laziness.

Mel: and then you might sometimes overexert to keep the ward flowing well, and safe

Mel, here share with us that she overexerts to keep the ward safe, and flowing well. Without this overexertion, the ward will not flow well and will not be safe. The over exertion becomes a de-facto norm, and then an expectation. Either, one needs to find a way to survive the job, whether this be through professional self-regulation, or by simply resigning.

Researcher Reflective

Staff start to act in strange adaptative ways to work with the colleagues, who are also acting with the same sense of inauthenticity. Staff become so disenfranchised by their job, that they simply no longer know how to be a clinician. They seem unable to engage with risk assessments in a meaningful way, perhaps knowing they are useless and outdated, – and seem unable to engage in any critical conversation on care planning.

I have had arguments with management over how safe it would be for a patient to have a brush in their room to clean the floor. A patient with no risk behaviours nor assaults on staff in years, was not permitted to have his own brush in his room, for it was deemed risky. Another patient who was in the community every day for 5 days, for 6 hours each time, was not permitted to be outside for 6 or 7 days.

A patient who was mandated by the MoJ to be in handcuffs when leaving the hospital, and who was mandated to be in a secure vehicle with a prison cell, was brought to hospital in a taxi with no cuffs, and the staff member hid behind the mantra of least restrictive practice.

Staff hide behind risk assessments that have been conducted and have not updated. Refusing patients access to things like pornography as a care plan has not been conducted nor risk assessed for. Staff say that the shortage of staff is the reason for everything, from paperwork not being completed, to simple tasks not getting completed, to delays in treatment and care. Changes in governance and the ever

growing mound of paperwork and audits, to ensure that you are doing your job properly, actually is counterintuitive, and hinders progression.

Shortage of staff is no longer believed as an excuse, and people will say that "everywhere is short," and this then starts to become normal. Nurses don't believe each other, shortage of staff is normal, paperwork is never completed. This constant stress leads to further firefighting, and nothing is done with real quality, and staff find ways to continue work with their colleagues.

3.2 Patient Subsample Findings

Below is a presentation of the themes that were uncovered through the analysis of this sample. Namely, "Control as a Mechanism of Self Preservation" is a theme that explores experiences of how patients maintain control and meaning in their lives, in spite of the many rules of the closed institution. "The Outside World as the Feared Place" explores how the seemingly global aim of discharge and integration into the wider community, has specific long stay patients. "Leverage in Relationships" explores experiences of interacting with staff, and how these relationships are used as leverage and are far more complex than the patient-carer relationship. And "Hiding my Internal Reality from Others" explores how patients have a very acute grasp of how they portray themselves in order to maintain a multifaceted self-image that is bearable. Each superordinate and corresponding subordinate themes are explored with reference to quotations from the patient sample.

Superordinate Theme – Control as a Mechanism of Self-Preservation

Sectioned patients have things, "done to them," and they are powerless to act against this. They have learned to accept passively, instruction, rules, and care plans, as to revolt would result in more rules, more plans, and more time in care. Rules can be seen as infantilising, care planning can also be a very passive process, but to speak up or out of turn can result in consequences. The careplan, is seen as a tool and method of control and maintain power over the self as if it were an "agreed" rulebook. Patients are constantly reminded of boundaries and behavioural expectations, and this changes how one acts and interacts with others. Having to relearn how to act and interact, furthers this sense of losing control and a sense of authentic self. The way in which some patients act, or the way they are forced to act, is a source of shame and being chastised by staff for these actions, further shames the patient. Being patronised is normal, being infantilised is normal, all done through procedural structures and staff of the institution

and through the guise of careplanning. But seasoned patients have adjusted to these rules and regulations, and understand them more than the staff enforcing them.

Subordinate Theme - Working with Rules & Regulations

Rules, rule in the closed institution. With its many rules and regulations, from rules on everyday practicalities, to the close control of behaviour. These rules have to be learned, in order to live and thrive within the institution. Boundaries, rules and coercive control are normalised.

Sid - they are trying to bring forward boundaries, and make sure you don't break them. if you can't live within the boundaries here, how are you going to stick to them out in the community. if you do break boundaries in the community, there are consequences. what they are trying to do, this is a boundary, you can't do this, and if you do, you will be punished, sometimes they meet half way

Living with what are known colloquially as boundaries, are rules imposed by the institution, and the staff within them. They are very often broken, without consequence as the patient here eludes to; sometimes you may meet halfway. These rules are to help maintain safety but are seen as provoking and troublesome by patients, and indeed sometimes by staff. Some rules overstep human rights, like restricting money and personal effects. Patients have restricted or supervised access to many items and family visitation. Practical things like USB ports are blocked for fear of patients using them to some subversive feat. Abiding by these rules and boundaries are akin to following the rules and norms of society by this patient.

Often rules are imposed, and seem trivial, even to those who have been subject to them for many years. Waiting for access to restricted areas of the ward are often a source of contention.

Fin - I said that women, she cuts people off, and then she makes you wait half an hour so you can get toast , and you can't even get into the kitchen, she doesn't treat people with respect!

Waiting for simple things like tea and toast, are usual. Patients ask at times for restricted items, during what is known as protected time. The patients know that there is no access to restrictive areas during specific times, but will use this an opportunity to express anger and frustration at the greater restrictions imposed on their lives, the loss of liberty. Staff imposing rules are seen as difficult and less favourable, but there are multiple layers of rules to follow, one is that of the patient hierarchy.

Tim - They are in here the same as me, you ain't better than no one else, were the same in here! I mean, that 50 year old guy, he's not above me, were in the same place. You know what I'm saying! None is better than anyone!.

Older patients, those with more serious offences, and those with a reputation for violence, command a sense of respect, and it is in sense alone. The rules and regulations of the closed institution are far more nuanced and deeper than those imposed explicitly by staff. Between the patients, rules are understood in terms of capital, medical and criminal histories, criminality, and personal leverage truly rule the ward.

Subordinate Theme – Using Prison Tactics

The medium secure unit, is a hospital, but is primarily a place where prisoners, or mentally disordered offenders are held for treatment. People are left in a state of flux, neither patient, nor prisoner, nor both. Some act as if they are in prison, in order to maintain a sense of personal agency; they are not a patient, not a service user, and not unwell mentally. Others, come to hospital and thrive criminally, taking advantage of other patients who are vulnerable.

Ned- you take advantage of what you can, take what you can take, don't trust none, you know what I mean. Be on your guard 24/7.thats not a good mentality have in a place like this.

DJ is talking about living on a hospital ward, but sounds like he is talking about prison, with the methods and skills you have to learn and gain, in order to survive. There may be a hint of

paranoia in this thought process, but it certainly a paranoid thought seeking to protect him. The wards can be dangerous, often with gang members, drug pushers and dealers, criminals, and of course, patients. Acting criminally can protect the self physically and reputationally, but can also help the self, in maintaining an image and persona of being dangerous, a criminal gang member. This helps keep the self-image of much social capital that in reality, is meaningless when one is a sectioned patient in hospital for many years.

Ash - nah, when I first came to the ward, I asked the guys about who the troublemakers were, and people what will help, and people that will use you. When time comes for payment, it doesn't come, a lot of problems and arguments.

Ash, a forensic patient with a particularly long time in care, knows exactly how to survive in the hospital setting. In a frank exchange, they explore with me some of the techniques they use when coming to a new ward. They share how there is a need to figure out who the "troublemakers" are and those that will "help" you. Of course, these terms are laden, "helping" and "troublemakers" could have double meanings in this case, perhaps they wish to know who the trouble makers are! They also share how loan sharks operate on the ward also a lucrative business for there is little disposable income on the ward.

Researcher: what's not easy about living here...

Ben: I'm incarcerated. I don't have my freedom...

Researcher: but what is it about the hospital that is difficult...

Ben: I've answered that already.

Having this aggressive demeanour could be seen as a way of trying to maintain the self, the self-concept, and cultural capital – a "hard man" on the ward and not someone who should be messed with. But conversely, it could be that speaking about the difficulties of the ward are too difficult. He is subject to rules like all other patients, but does not have the same capital as others, and this goes against his own concept of himself. In order to express himself in a way

which portrays and projects an ideal image of himself, he becomes aggressive not only to avoid the question to which his own truthful answer would go against his own self-image, but also becomes aggressive to uphold this very same image.

Ned - And I've literally served 16 years on this, for a minor 2.50 street robbery, where the judge said that if I was to give you a normal sentence, you'd have got 2 years,

Even during this interview, Ned, still needs to uphold the image of being aggressive and dangerous, reminding me about the time he has spent on the ward, in services and in prison, for what was "only" a robbery. There is also a sense of pride in the time served, considering it adds to his prison façade, and indeed feeds into how to survive in prison, showing how dangerous one is.

Another prison tactic, trusting no one, is certainly a way to maintain your own personal safety, although you may be classed as paranoid by staff, the face of the matter. In realty, the ward is full of people who are dangerous, criminal, and who are only living together. because they are forced to.

Researcher - what it's like living with the others...

Tim: ah, most of them are full of shit, I don't care about them! They go on like they are your friend, and that, and then they are caught smoking, they blame you, even though you have nothing to do with it!

Daisy here, knows that many of their patient colleagues are "full of it." She seems very aware of how some patients act and seems to have a very broad grasp of how nobody cares for each other, if they do its feigned, and that anyone can be used as a tool for escaping blame.

Subordinate Theme – Working with Infantilisation

In imparting blame on others, using others for one's own gain, and pretending to be friends with your patient colleagues, seems as if one is using mechanisms to survive that are more akin to a delinquent children, rather than adults. However, patients are infantilised by the staff that work with them, and this precipitates said behaviour. However, this infantilisation works in many ways. By becoming helpless, and giving in to the system of rules and regulation, allows the patient to work within a framework that they believe and feel they are in charge of. They act with feigned helplessness. With this infantilised demeanour, in order to perhaps win favour of staff. Staff will often offer protection to those patients who are seen as unable, weak, or vulnerable, or those who simply are seen as "good" patients who follow rules and regulations of the institution.

Sam – they'll offer suggestions, like going down to the garden, they'll try and find you a job, but I couldn't do that.

The passive language used by Sam here, may be seen as someone who is unable. They say how staff can offer a trip to the garden. The very simple activity of visiting a garden is an activity far from the taste of this patient. Sam also notes that the staff will try and find a job for patients, but he instantly says that he is unable to do this. This multifaceted answer, could pertain to the sheer unwillingness to engage with this activity, or not partaking for fear it could be seen as progress. It could also be construed as a reaction to refusing to partake in a job, which would be meaningless for Sam, not paid and not fulfilling in any way. A menial job, to simply keep him occupied. In order to restore control, it is easier to simply imply that he "couldn't do that." Looking and seeming not able rather than being aggressive, and forthcoming, is another method of preserving the self, in a way which is often seen as more favourable by staff.

Another patient, who is more independent, and who is in contact with friends and family in the community is seen as acting with a sense of subversion, when expressing any kind of private individuality.

> *Fin: I go into the toilet, I use my phone for 30 minutes, and the nurse, keeps asking me why I'm going to the toilet all day.* I'm like, hold up, it's my room.

As this patient is seen as someone who is more forthcoming, confident, and perhaps at times, aggressive in this demeanour. He is accused of being subversive, when seeking somewhere quiet to use his mobile phone. The simple lack of trust between staff and patient in this case, leads to confrontation; a prolonged private telephone call is treated with suspicion. The closed institution, with its rules and regulations brings about these strange infantilising behaviours, seen by both staff, and patients. The petty rules, guised as safeguards, methods of trying to stay safe with the hospital, only act as a method of exacerbating the often traumatic memories of these long stay patients.

> *Tom - 10pm for the phone, and on weekdays, you had to be in your room from 12pm, and during weekends, you can stay up till 1am, and you could leave your room at 6am. in the acute settings, you were put in your room at 9pm, and you were locked in. they'd bring tea around 10, and pass it through a keyhole. and then, yeah, yeah. some dodgy times.*

Tom explores a snippet of a previous hospital admission, where he was passed tea through a hatch, described being locked away, being put in his room and sticking to very strict timeframes. Some patients then learn to live within these rules, and even come to like them, for it makes sense. For others, these rules are seen as temporary, particularly as they recover and move through the hospital system. When they try to grow beyond these old rules, they are then seen as people who are rule breaking or being subversive. The process of recovery is confused; for regaining liberty does require less of these rules, and a more relaxed environment that fosters individuality. Perhaps, acting in this infantilised fashion, and being treated like an infant by staff, is simply easier. it makes living in the hospital predictable, but it is far from the real world.

Subordinate Theme – Seeking Stability

Being on a constant journey is a theme that emanates throughout this sample. In its simplest form, this manifests in not even knowing where you are doing to end up.

Ben - I like it here, and yea, I am institutionalised, but I'm not going to allow myself to become more institutionalised. I've been in hospital for [+10 years], and eh, to get discharged tomorrow, I wouldn't know certain things

Having no discharge date, whilst not quite serving a prison sentence, waiting for your mental health to appear well enough, waiting to become less risky, waiting to become less violent and more predictable, and seeing your peers serve many decades, leaves one with no sense of timeframe, and no sense of discharge. Patient x notes that they "like it here," and there is a realisation that he would find it difficult in the community if discharged.

Don - I've been living in here for the past 10 years, and I've been on every ward, in his hospital.

Living for ten years in his hospital and saying this with a sense of pride, to maintain the little cultural capital that he has, in order to protect the self, from the essential loss of time, freedom and choice. This sense of price goes some way in helping him maintain his sense of self, this prowess is meaningless when discharged.

Sid: moving from high dependency, to acute, to rehab, to a less restrictive environment. or in my case, from high secure to medium secure, and maybe straight to a hostel for me? or maybe to low secure to a hostel then. A transition that is more gradual, cos I've been in hospital for a while

Playing around with ideas of possible discharge routes, leaves this patient to seem confused, and rightly so. The avenues for progress and for moving on, are numerous and often impossible to predict. This also depends on mental health, funding, and other services' abilities to take

patients, at what is often short notice. This patient even notes that he would prefer a transition that is gradual, perhaps knowing the bumpy ride that is ahead.

Tom: I haven't been in the community since 2011, and it was difficult, but it is getting easier

This patient had not been in the community, since 2011, and has missed out on cultural and societal growth over the past decade. He will be released into a world, that is confusing, new, unknown. He is aware that the gradual trips into the community have been difficult, and this would certainly attack his self-concept, but insists that the transition is becoming easier. Reminding me as a clinician that he has not been in the community in a decade, also goes some way in reminding me, of the large challenge he has to face.

Max - like you don't know where you are going and all of that. I spoke to [another patients name], and told me that I hadn't been referred yet to [place of discharge], and that made me feel upset. He said that there were no rooms available there at all!

Patients try to find out who is moving on next, and try to figure out how and what to do in order to either, move there, or indeed stay. When beds become available, there is a flurry of phone calls between patients, and each try to figure out what is the next move, as if it is an action of stealth by the staff. There is a flurry of worry, who is next. Overall, the decision to move patients is entirely within the hands of staff, and this is often a junction where people feel rejected and dejected. Patients at the same time, fear this rejection, fear moving on, and use mechanisms to slow this process down, in order to live with some level of control, and ultimately, stability, in their lives.

Researcher Reflective

The patients seem to take a passive role in their care, not out of need but rather it seems to come from a place of dejection.

Passive in their input, they know that people simply don't care about them, and always at the back of their mind, is progression which means moving, discharge and fundamental life change.

In my experience of working with patients, and updating their risk and care plans, they just seem to see it as something that is a tick box, and they are probably correct. At the same time, as I write and reflect I realise, that they may feel as if they have no control over their lives, but they do. They are choosing NOT to partake in these care plans, for this means that their status quo changes. They passively accept the treatment, as this maintains the status quo, and use mechanisms that they have some to learn and know, in order to maintain a sense of self.

You see the usual prison behaviours, hard man bravado, trading, and attitudes in the forensic setting. To advance in treatment, may mean a move for a patient and that would mean they have to restart the building up of this capital and reputation all over again. In order to engage with this kind of behaviour, staff need to be aware of the inner workings of the ward, the interpersonal dynamics between staff and patients, in order to fully grasp with it means to live on the ward, but alas, the staff are too busy auditing the quality of mattresses.

I felt through the collecting of this data, its analysis and writing, that patients find a sense of calm within the calamity of their care. And once it is found and the patient becomes more relaxed in their life world, it is time for change once again. The constant journey of recovery lends to little stability, and patients thrive to find stability. This is done through the mechanisms that they have come to know through the use of carefully learned mechanisms with which staff have not fully grasped nor understood.

Superordinate Theme – The Outside World as the Feared Place

The hospital can be seen as a haven, for it is their home. Having lived there for years, some fear moving on. Stability has been found in their lives, sometimes for the first time. But they feel as if they must try to "move on," and show their peers and staff that they want to move on. There is such an overarching sense of not knowing, whether this be what happens next week, or next year; what changes in medications are next, when they can visit family next. The sense of unknown permeates into every aspect of their live, it manifests in insecurity. Moving on from a place of security, to starting anew.

Members of the public are not half as respectful, understanding or forgiving as the doctors and nurses, that once controlled every aspect of their lives. There is also a sense of fear and apprehension, in readjusting to the outside world, learning new skills and new rules, very different from the institutionalised world in which they are used to. One not run by social capital, heavy personal regulation with the oversight of medical and nursing staff, but one run by responsibility for the self, in a world in which they are free.

Subordinate Theme – Moving on from the Safe Haven

The hospital is considered, and understood to be a safe place, where patients feel comfort, and feel cared for. They often want to move onto other institutions or delay their discharge to remain within the confines of their institution. Frank suggests that there is no rush to get discharged, as when rushed, or when he knows there is change of progress, he often tries to sabotage. He is quietly reminding me and suggesting that there is literally no point in rushing him, as it will not only end up being futile, but dangerous.

Max: yeah, I suppose there is no point in rushing into (discharge).

Ash - keeping myself busy, not getting mixed up with old friends and gangs, and getting out o my area. I might get into the wrong crowds again. I might live on a farm!

From one place of structured rules and rigidity, to another, from hospital to farm. Perhaps it is the comfort of the known, and the restrictions on one's freedom that is so appealing to June, why would she want to leave. She even mentions to me here, that she might get involved in the wrong crowds, which for her would be gang related violence. This is partly a selfcare exercise, as they were never involved in gang violence, but also trying to justify how their current state of affairs is favourable, and certainly better than the community setting to which they will eventually be discharged to. There is an underlying threat, thinly veiled, that they might get into the wrong crowds, reminding me, as a clinician, of my own responsibility.

Ash - its hard, my sister has kids now, and my mum has passed away... is it easy to stay in touch... no

Ash also reflects on how life has moved on, and how their sister has kids, and about how they have lost their mother. Enquire as to whether they can keep in touch, she simply says no. Often there is talk of speaking to and rekindling old familial relations, but this is often not possible, due to historical family violence or other personal traumatic issues. Jill knows that the rekindling of relationships will not be easy, and might even face resistance, but ultimately know that this is a futile exercise.

The outside is new, unusual, and unknown. Patients often have no contact to external agencies of true meaning just the ones that they passively partake in to please professionals and to ensure that they are playing along with the system. Nor do many have family, and many leave their friends behind, as inpatients. The need to have friends move in with them, the need to tell me that they would need that company if discharged, leaves me as a professional feeling as if they are not ready, but also that they are very factually telling me so.

Sam - living on your own, that's tough! That's why I've asked by friend to come live with me. I'd need company, to keep things going. Id need someone to live with, not by myself, id lock the door, turn everything off, and sleep, sleep, sleep.

And freedom comes as a shock, with this newfound freedom comes responsibility. But alas, Anne knows that there are mechanisms of returning them to hospital at any time. The freedom perceived is the freedom understood by the inpatient, it is freedom in name alone. Overarching responsibility still firmly in the hands of clinicians and the Home Office.

Pat - it was a bit of a culture shock when I got here. It's a lot different, more freedom.

Max notices that there is a fellow patient, recently discharged, that returns to the hospital to partake in sports. Not only might this make the patient feel as if their transition is pleasantly slowed, and made more gradual, but this is also appealing to Max herself. The chance to return to the hospital to partake in sport with friends, and the security of knowing that they can return to the safe space is an approach that Max seem viable for herself. They even speaks about wanting to accompany this ex-patient, for fear of having to do this themselves.

Max - I might do the same as him, and come back on Fridays, with him. cos he comes every Friday, and if he doesn't mind, I might join him, if I go to basketball, if he doesn't mind escorting me.

Subordinate Theme – Hospital as the Best Alternative

Hospital can be seen as the easier ride, void of the true prison rules, prison frameworks and prison guards. It is in reality not easier, but different. There are the same fences, walls, but there are bedrooms and psychiatric nurses. Some patients are transferred to hospital, for assessment, some feign, believing that the hospital setting is easier than prison. In reality, they serve the same purpose, albeit, with the forensic mental health hospital being mandated to force medical interventions. Imprisonment

Pat - it has got a massive prison fence around it, it reminds me of prison! Feel trapped looking at that! That garden down there, isn't too bad, its more relaxing, but the other garden, prison!

Researcher:- what's different between this place and a prison...

Pat: its hard to say.

Hospital is often a place of sanctuary, where care is delivered, but this is not the case for the psychiatric hospital, where it is often the case that treatments are often forced upon patients, and passive acceptance is common. The brutality is still present however, it is different and more psychological and subversive, than the obvious brick and mortar prison.

Ash - at first its hard in hospital! You must watch out for people who are more, and at different stages in their treatment. Em, a but worrying, cos you don't know what the people, patients and staff are like, and, you have to start trust building, and

In prison it is assumed that criminals are dangerous, and one knows how to act almost without learning. In hospital, it is different. There is a need to learn who to trust, which staff to trust and which ones you can work with. One realises, the hospital is not dissimilar to prison at all, but perhaps more complex.

Tim - : its scary! I was standing next to someone the other day, felt my instinct was to go for him, but I held myself. I looked at the guy, and walked away, it would have been a bad situation!

There may be a sense of paranoia here, but the patient he was referring to is someone who was dangerous, and someone who had a history of randomly assaulting people. The ward environment is both a hospital with unwell patients and prisoners with criminal histories; something that patients are very aware of. The primary reason for the removal of prisoners to hospital, is for treatment under a psychiatrist, and the hospital's team of health professionals, however absent they may see, and Sean below, has their own opinions on leadership.

Sid - we see them in ward round, community meetings, and then they bugger off, but the nurses are always here. It's the same thing in prison, the screws are always there, 24/7, and if you see a governor, for decision making, they make the decisions. like in any organisation. the leaders are scum.

There are similarities to prison, both in the patient mix, and indeed in how staff operate. There is a need also for the patient to see the hospital as prison, in order to keep their sense of pride, but there is also an acceptance, that they are on a course of treatment that is easier than prison, cushy even.

Jon- its not been too bad, a bit more freedom, more cushy in certain cases.

Explicitly put, the hospital is seen as cushy, and having more freedom in some areas. Many patients do come from prison, or other secure hospitals. Many are in services for such a long time, they have limited contacts and relationships beyond the services that they have come to know so well. Many have precarious housing and employment in the community, and with that backdrop, one can see why the secure hospital setting is seen as cushy.

Subordinate Theme - Discharge is not Freedom

There is a sense of being aware of the realities of discharge, and the socio-political issues that one will be faced with upon discharge. From living in run down mental health hostels, to being overexposed to drugs and alcohol. Discharge or release, does not attract the image of gasping for freedom as one leaves prison after serving a sentence. This patient feels as if they are trapped within the confines of the hospital, as moving on and getting discharged is a worse option, they will be still stuck within the confines of the mental health system in its broadest sense.

Ned - nah, I don’t want to live in a ghetto drug den, I don’t want to live in a place like that. You're trapped.

Doug knows that he will be discharged to supported accommodation, and subject to community treatment orders, will be under community mental health teams, and still partake in some recovery based activities. Noting that he would be trapped, he knows that the care system extends beyond discharge from hospital. Not only that, but he would be trapped in a drug den, knowing that he would be discharged to a setting from once before, he became ill.

Researcher - what are you going to do with your spare time?...

Tim: I'll do what I'm doing now on my leave! Go and enjoy myself

When asked about what they will do with their new spare time, this patient says that they will continue to visit the usual mandated places of activity that they once visited as patients. I know as a professional he does not visit this place of activity when he says he does, but with his new found freedom, and spare time, he plans on conducting the same monotonous tasks he once did, or did not. He has no plans nor ideas for his new found spare time, only the same activities that he one did as a patient, almost in acceptance of the concept of still being a patient.

When asked about discharge and about freedom, with the "world being his oyster," Damian says that he didn't think that was the case. He says that he just wants to get out, and do his own thing, to which, he is unable to say what this is. Being able to have the choice to do what one wants, a void that he will have to find mechanisms of filling.

Interviewer: Sure, the world will be your oyster!

Tim: I don't know about that; I just want to get out and do my thing! Everyone's got a bit of hope!

He also is aware that the world will not be his oyster, considering he has a forensic risk history, serious criminal record, and is perhaps aware of the stigma that comes with the physical and psychical presentation of being a mentally unwell person, who is under community supervision.

Ben however, feels as if they are institutionalised, and that they fight to not allow themselves to become more so. She is at a stage where she is about to be discharged, and perhaps now there is a realisation of how institutionalised that have become, and about how they have found a homestead in the place they are about to leave!

Ben - I like it here, and yea, I am institutionalised, but I'm not going to allow myself to become more institutionalised. I've been in hospital for [+10 years]

Not allowing oneself to become more institutionalised after a decade of being in hospital will be a difficult task. The outside world has changed so much, and they have adjusted to incarcerated life over the course of a decade, that the processes of deinstitutionalisation and recovery are perhaps, too difficult to grasp. In defiance, Ned frames this as seeing light at the end of the recovery tunnel.

Ned - it brought me hope, that there is light at the end of the tunnel, and not just a black hole.

The concept of the black hole of discharge, helps reframe the concept further; discharge to a place you no longer know, have few connections, friends nor family. Discharge is the aim of the hospital setting; Ned once saw that as being on a path to a black hole. Discharge is not freedom, it is seen as a journey to a black hole. A black hole of homelessness, joblessness, and iniquity, one of unknowns and unwanted liberty.

There is also a sense of pride with this patient, in the sense of being classed as risky, rather than unwell, perhaps easier to maintain a persona in his way.

Sid - yeah, it's about risk for everyone! if you are risky you won't be released, although some people who are risky get released sometimes! Every country does it different. if you're a psychopath, you will get released if you're not as risky."

Being known as risky, is seen as another form of cultural capital within the patient sphere, where you are risky, rather than unwell, gives more of a sense of bravado. Being kept in hospital because you are dangerous, rather than unwell, is also easier for the self to live with.

Subordinate Theme – Being Unfixed

Moving around from high secure to low, to medium and back to low secure, beings about an innate sense of not belonging, and having to become accustomed to new ways of life, and of living. He reminds me, that he used to keep in touch with his old care team, and tries to build relations with his new team, another new team. Another team of unknown professionals, and unknown patients to live with.

Jon - so I moved from a place that I was used to, and that's [High secure hospital], and it was hard at first, and if you remember, I used to keep in touch with the staff there.

And upon moving, you must relearn rules of the institution, which patients have cultural capital, which patients and staff will support and work with you. You are constantly starting again, all whilst trying to preserve the self. There is a sense of not belonging, and not being integrated into the team of patients, and work must be done to ensure that you make yourself known, and your capital must be earned.

Max - like you don't know where you are going and all of that. I spoke to [another patient] and told me that I hadn't been referred yet to [place of discharge], and that made me feel upset. He said that there were no rooms available there at all!

And when you are moving on to the community, you face similar issues to when you move ward or hospital. In the community, external agencies are not keen to support you for the forensic patient label brings with it much laden and misunderstood meaning of danger. There are agencies that will try to pass on the responsibility of a forensic patient, considering the great expense and resources that they would draw. Local councils that are already struggling within this current socio-political climate of austerity, will argue and attest to their responsibility to funding patient placements in specialised forensic settings.

Pat - But no one wants to pay my funding, two boroughs, but my solicitor is on it, might have to go to court! They must cooperate! I'm going to leave it 1 or 2 weeks, and then chase it up.

Ultimately, left in the dark that is most difficult. Patients must wait for legal teams, for reports from the home office, for funding panels and for their local authority; for all of these agencies in order to start the discharge process.

From simple day to day trips to the community and whether these will go ahead, to timeframes for care delivery and discharge dates. The whole inpatient stay is one of being unfixed. A life without deadlines nor discharge date. The chaotic nature of the hospital, it seems as if decisions are made at the last minute, leaving patients wondering, left in the dark, and ultimately left insecure.

Ben - well I don't know how long left I have to do here... well, there is no limit, its based on the amount of leave you have, and if your using leave, you're outside so much, why are you here. and then they look to move people on

Even when a patient is discharged, there is then a sense of not knowing what they will do when discharged. Here, Damian says that they will always have something to do, perhaps wishing that they will constantly be kept busy. For not keeping busy may bring about their old, and now forgotten, criminal behaviours. On the day where one might find themselves more unwell.

Don: they don't know where they are going. The way I look at it, when I'm in the community, I'll always have something to do. If I fall ill, I'll do it another day.

Perhaps, he is speaking to the clinician in me, but he is telling me that he will always have something to do, but at the same time, he and I know, that the opposite is true. Lack of money, lack of family and friends, and the stigma of being a forensic patient, it will also be difficult to find employment.

Don: I'm one of these people who doesn't get unwell. mentally, spiritually, or physically. I might do something wrong. but straight away, I rebound, and come back to the person I am now

There is also a sense here, that whilst he says that he won't become unwell, there is a real risk that he may become so. He also alludes to doing something wrong, but then rebounds, but knowing this person's history of violence and criminal behaviour, it is difficult to not interpret this as him not willing taking responsibility for what he may consider, "bad" behaviour, which is outside the realm of psychiatry, and into the criminal.

Researcher Reflective

The outside world for the patients is referred to the community. This use of language already separates them from the rest of the world, and they refer to themselves, and the staff too, as not being part of the community. The outside world is treated as a foreign place, where you can't behave in the way you would with staff on the ward. I remember bringing a patient into the community on escorted leave, and I was worried at first, as we didn't have the best relationship. I felt as if he would be as confrontational on the street as he was with me on the ward. I was surprised.

It was as if by transformation, he became the nicest guy. On the bus to where he was from in London, we spoke about tattoos for hours, and what he wanted to get next. I couldn't believe how being outside of the hospital would change him. When I returned to the hospital, none of the staff were surprised, and all said that he was lovely when out of the grounds – I couldn't understand.

But over the years, I found this to be the case in almost all circumstances. Patients were so much more relaxed when outside, even in busy shopping centres and buses and tube trains. But in the hospital setting, the community was something that they had to work for and almost worried about. As I was analysing this in the patient subsample, I had paradoxical views.

It wasn't being in the community that they worried about, it was the system of care in the community. The accommodation they would be mandated to live in, the people in those hostels, getting in touch with friends and having to explain their life. Their original sectioning brought them from a place of ill health, to one of safety. The more I write about this, the more I feel as if the patients want their freedom, but also, want to live in the hospital, with the structure and rules that maintain a status quo, that would be impossible otherwise. They want to be in the community, as that is what everyone wants for them – me included.

They have become used to the regime of the hospital, and that was a sort of comfort. That there were people who seemingly cared, and people who were void of prejudice.

Superordinate Theme – Leverage in relationships

This theme focuses on the peculiar paradoxes that appear in the data. Wanting to leave hospital, and wanting to stay, how staff are seen as bad, but also good. Patients feeling glad for the care they've received, but also hatred for the system that provided that care. Not wanting to partake in activities, but then complaining about the lack of activity. How relationships are guided by boundaries and rules, but also rely on personal relations. How patients employ mechanisms that leverage on interpersonal relationships and act inauthentically to seem as if they want discharge, and seem as if they are engaging with careplanning, while their authentic selves simply want status quo.

Subordinate Theme – The Good-Bad Paradox

Patients can easily see the good aspects of their inpatient stay, and what they consider bad aspects of their inpatient stay. It is oddly simplistic mechanism of explaining and exploring the world in which the patients live, and find themselves in; things are divided into good and bad. Simplistically put, good aspects of their inpatient stay are easier than in the community. And hard aspects like that of missing family and friends. This patient says that staying away from family was hard for them, but conversely it was staying away from them that enabled them to get on medications, and getting 'sorted out". There may be a myriad of reasons for saying this, but it may be that family, while supportive, it is difficult to recovery. Perhaps to allow oneself to believe that one needs help, it is therefore easier to be away from the family in a paradoxical way.

Ash - in some ways, its easy, and in other ways it can be hard. Cos eh, you are away from family, friends, and everyone you love, that's the hardest but, being away from your family. The easiest thing about it, getting on meds, getting sorted out, and eventually moving into the community.

The paradoxical dichotomies continue with staff that these patients work with. Good staff bad staff, within the same person, is a common attribute seen, that staff are good or bad, or both, depending on what it is they are trying to do or the patient,

> *Tim - they are there to listen when you want to talk you know what I mean, that's a good staff! Caring bad staff – you can't get water, you can't get into the kitchen,*

This patient recalls a time when he was denied access to water, as the staff member was busy doing something else. When staff fall in line with what the patient wants, they are considered good, and when they cause any sort of hindrance, they are then instantly considered bad. The staff therefore, are seen as both bad and good, and both. This then has implications for the way in which patients portray themselves, in order to illicit either side of the staff member.

Being good and bad, being easy and hard, the simplified way of thinking about the way in which staff approach and deal with patients, and indeed, the way in which they try to make sense and understand the inpatient way of life, is simple splitting.

> *Tom - it was not all good experiences, but I am glad I have experienced that I have, you cant buy it. but it's happened, and I'm going to move on with my life.*

Being glad to have experienced what one has – being an inpatient for a protracted amount of time, and being glad to have experienced the long term patient for close to fifteen years. This is a mechanism seen as trying to understand the staff and fellow patients that they live with, but also the hospital setting in which they live. It also extends to their very understanding of their lived experience, splitting into oversimplified language. Perhaps, this stunts their own understanding of the gravity of their experience, or a lack of understanding that is perhaps conscious on some level, as it is easier to live with. It is negating the nuances of their own lived experience.

Joe - what we can do. what can we do. apart from cooking, or making cards, or painting pictures, or what else can you do

The oversimplification extends to practical everyday activities. Meeting with professional are seen as infantilising, activities run on ward are clearly ingenuous; making cards, painting pictures and simple cooking, as this patient points out. Perhaps there is an undercurrent within the institution, that supports, perhaps not purposefully nor consciously, an infantilisation, a return to a childlike state, for these patients.

They then, as they live within this system, become more childlike, and regress to point, where simple defence mechanisms like splitting are all that is available to protect the self.

Subordinate Theme – A Folie a Deux

There is a Follie au deux, an act of two, whereby the patient and staff that treat them, skirt around important issues of care. Both parties know that each other is acting in bad faith, both parties play along with the disingenuous, and plan care, with both parties knowing it is all done in bad faith. Patients are invited to meetings, that would go ahead without their presence in any case. The patients feedback, but it is not an important aspect of their care, for what they think and say, is all said in bad faith.

Tim - the ward rounds and CPAs and stuff like that... a load of rubbish – I mean, they dance around issues. I have issues I want to bring up, they start their jargon,

This patient knows that these progress meeting are a load of rubbish in their terms, as they are just seen as another meeting. In long stay care, there are multiple meetings like this, with the goal of progressing the care pathway. Patients know that the meeting will have minimal impact on their care, and so too, do the staff that attend them. When this patient brings up issues that are important to him, like medication reductions and access to the community, the professionals dance around these issues, and start their jargon.

Tim - tension! They are sitting there, it's a horrible situation, very official, they can do anything! I just have to keep doing what I'm doing!

There is a sense of being powerless in these meetings, and not being able truly say what you want, as you feel as if will be ignored or dismissed. This patient says that they can do anything, leaving them in a very powerless position. They are aware of the overarching power and control that the system has over them. Sitting in a meeting with 5 or 6 professionals, all looking at you and asking questions, pointing out your flaws and congratulating you on petty successes. It is infantilising and leaves the patient feeling in a position void of power. It is this void of power that is filled by the need to gain cultural capital on the ward.

Pat - The consultant put it to me the other day, and they put it to me, that I might still be violent!

This patient was almost perplexed when accused by their doctor, that they still might be violent, in spite of him being on course for discharge. This not only unsettled his own self-concept, and self-understanding, but at the same time, the doctor undermined perhaps, his own understanding of the patient, with the patient being cogitate of this. The patient feels as if the questioning was confusing. But also knows, that the doctor knows, that he is still violent. This could bring about a sense of comfort, knowing that there is no plan to advance these patients care, no changes in care. The doctor, conversely, also knows that saying this, will keep the patient safe, and "boundaried," the term used to describe rules and setting limits.

Jon - basically, at first, we'll I'm a paranoid guy, so I moved from a place that I was used to, and that's [High secure hospital], and it was hard at first, and if you remember, I used to keep in touch with the staff there.

When patients to move to another hospital, they often keep in touch with their former care team, in order to keep contact, and to keep some sort of relationship alive. The transient nature of the relationships that are build up over time, are almost destroyed as a patient moves on. Not only are they placed in precarious positions in these relationships, but you are also moved away from care teams to new ones.

Tim - it's been, hard at points, good at points. My illness, my mentality goes up and down the whole way, I've been up and down the whole way.

With patient-staff relationships are more complex than they first seem. Patients are trying to come across as "hard men," perhaps because they know take a very passive, almost submissive role in their lives and there are acts in reaction formation to their reality. They are infantilised by the system in which they live and are not trusted by the professionals that they work with. They are seen as childlike in the way they understand and organise their world, and are often compared to as children in the way in which they act. This is a self-fulfilling concept, that patients are treated like children, and then act like children, with the behaviours and psychosocial mechanisms that go along with the infantilisation process, lying, being disingenuous, acting in bad faith and splitting. But they are further compelled to act in this way, by not being trusted by the system, nor by their caregivers, and are seen at ward round and CPA meetings for their weekly telling off or congratulatory meeting. The staff infantilise; the patients become infantile, and begin to use the simplest of psychosocial mechanisms to control and have some say in their lives.

Subordinate Theme – Prolonging Incarceration

The hospital with its restrictions and rules, is a place where liberty is controlled by the staff, and mechanisms of the institution. Patients will say that the hospital setting is helping them, but not in the mental health sense of the term, it is helping them in another way. Some patients have found a way to subvert the system for their own personal aim and objective.

Sam - I'm not trying to get out! That prevents me from doing things, is, not motivated! I'm not motivated! Go get up and go within me. Maybe its just me personally! I cant keep taking medication all the time

This patient explicitly says that they are not trying to get discharged. They are not motivated to move on and not motivated or perhaps, able, for their own liberty and responsibility. But there is the ongoing paradox, of not wanting to play by the rules, by wanting to stop medication, but also, playing by the rules in order to stay.

Pat - : they try to get into your head, they try to get you paranoid, not you though! They try to get you para, and that sort of shit!

This patient blames staff for making them paranoid, and for getting into their heads. There is no reason for believing this, and perhaps, is a way of saying, that they are paranoid, but are unable to attribute, or unwilling to attribute this to their own mental health, and then blame the very staff, that they want to look after them. They want to be cared for in the institution, but conversely, blame the staff for their own paranoia, and yet, seek their care.

Tom - I was on a certain section for 28 days or whatever, and I was there, and a few months later I was discharged, and they found me a flat, and, yeah, I was hanging around with people I met in there,

It is often the case, that these patients receive thorough aftercare, and when they are discharged often receive hotel accommodation, that is funded, and then further support with publicly funded accommodation. In spite of being discharged, and living independently, this patient wanted to return to the hospital, and did so, after committing an offense whilst not mentally unwell.

Learning to live within this environment, is a skill that is learned, learning to live with others, in what is often the same quest, to stay on the ward and not move on. Living on the ward with patients and with staff, and having to come across as a hard man, whilst also coming across as vulnerable enough to warrant the continuing inpatient stay, is a difficult task to balance.

Ned - what about other staff, arts therapy, psychology etc... I find them very helpful; they help me come out of myself... I don't like psychology... what does help... just being the way we are now, having a chat, we talk, we chat, we blend, we mix, we help each other out.

The practical help, i.e. every day interactions, are seen as more helpful, that what the hospital specialises in, i.e. psychotherapy, psychology, arts therapies etc. Could this illude to the concept of wanting to stay in care, and how engaging with these services may be seen as a course to discharge.

Sam - if I'm off the depot, ill do well.

This patient says, inadvertently, that if they come off their medication, that they will do well. In doing well they mean; they will stay in hospital for that is their goal. If they were to stop taking this depot medication, they would certainly become floridly psychotic. Coming off medication is seen as something that people would like to achieve, but most know it is certain that they will continue to take antipsychotics for the majority of their lives, and will try to have them removed from their regime, but will ultimately like to stop take these medications in order to become

unwell, and then stay longer in the institution. Conversely, there is an element of trying to ensure that it looks to your peers, as if you want to move on, and want the freedom and personal responsibility that you so desire.

In trying to live with fellow patients, who are trying to come across to each other as strong individuals, there is a sense of competition amongst the group, with those having higher political and cultural capital, while others are at the bottom of the pecking order.

Jon - its not just people being unwell, you get a lot of idiots here.

Tim: One of the guys here, just walks around when he's outside, doesn't talk to anyone! He just circles around the streets. And then he comes back, and says he doesn't enjoy leave!... he has no hope!

Patients are aware of the different levels of patient wellness, and are aware that some are there in order to remain there, not to seek discharge. The patients are aware of each other's strife, and aware than not all want to leave, which then in turn means they have nothing to lose, and act with this sense of self. Staff are there to help, and how the patients work and understand the strange relationship that is built over time.

Ash - staff have been very supportive, about giving advice, and are good at attending to our needs. Staff are easy to get along with. If it's yes with staff, it's a yes, if it's a no, tis a no! if I ask you for something, I don't go around asking another member of staff to get another answer

Staff are supportive, but again here, it's in attending to simple needs, and not to the psychological issues nor symptoms that the staff are there to assist with. I am aware as an insider researcher, that the patient here, is also alerting me to the fact that he plays by the rules, and that if he was to request something, and the answer was no, that he would accept that answer and not ask someone else in seeking a more favourable response. This highlighting of his

following of rules, is yet, another example of the infantilising willingness and want to come across as following rules, and he is alerting me to this here.

There is also a way in which the staff are seen, as catalysts for emotions that are attached to unfavourable actions by staff.

Tim - when you ask for something, they make you feel guilty! Some one this morning, having a go at man, I was like, come on, you're not here to do that!

Asking for something and not having it met with immediacy is seen as a way of exerting some unfavourable emotions, and this is attributed to the staff's actions, rather than the understanding the psychological reasons for the feeling.

Ben - the staff are really good, but I've had problems with staff. With a few staff, but I don't want to say any names.

In trying to keep favourable relationships, this patient declines to name particular staff members with whom he has issues with. These professional-patient relationships, seem to be built on foundations that are multi-layered, not just about delivering care, but also not delivering care (caring, but not aiding in recovery). Being easy to work with, but also not being easy to work with (nice and easy with the everyday, but difficult when it comes to real change in care delivery).

Tom: there are good and bad people, and people with certain characters. I've had staff I haven't liked, and staff who haven't been very nice

Again here, there is a very simple split, of staff that are liked, and not. Black and white thinking here almost prevent the thinking of staff, as more than good or bad.

Moe - Yeah. I don't know why they made up those things about me, what they were trying to do, so I didn't get along well with them, the staff here are more helpful, they are more helpful, yeah.

Here, he is saying that the staff are more helpful, in so far as they have continued to detain him, which is his goal, for continued detention. He says that bad staff made up stories about him, to return him to his place current detention, but this is something that he was keen for, but needs to save face, and the cultural capital he seems to hold for himself, maintaining the self-capital. Again, here is a sense of trying to keep me onside, by saying that my colleagues are more helpful than the others.

Researcher Reflective

The paradoxical elements of the data is something to reflect on here. The patients see staff as good and bad. Discharge is good and bad. The system helps then and doesn't help them. They want to partake in activities, but also do not.

In this theme, one patient even explicitly says that he is not trying to get discharged but does work toward discharge. Perhaps this paradoxical view of the system is a method of ensuring that they retain the status quo. Needing to engage just enough to not be seen as non-engaging by staff. Just enough illness to remain in hospital, but well enough to have leave to the community. Living paradoxically ensures that the patient is moving at their own pace.

But this also leaves staff guessing, as to whether the patient is ready for the next stage of recovery, whether that be extra hours community leave, or discharge itself. This mechanism of ensuring they have some sort of control over their life, is one that many patient use. I have completed care plans and paperwork for CPA meetings, only for the patient not to attend the meeting the very next day. They never had the intention of attending, but sat with me at length to ensure the paperwork was done – again, dong just enough.

They know they are wasting my time, and I am left guessing as to whether they are. As I explore the data, this paradoxical way of living ones life has become more prevalent, and more obvious to me as a reader, and was something that I only actually was able to name through the analysis of this data.

Superordinate Theme – Hiding Internal Realities from Others

Living within the hospital, the patients have gained a number of skills and tactics in order to keep control of their life. They "walk the walk" and passively accept all treatments, in order to maintain the status quo. They very tactfully question care plans and treatments, as without the restraint one may result in consequences. They remind each other that they can be violent and had a dangerous past, in order to maintain the sense of self. This is in order to show their social capital, and protect a fragile sense of self from the challenges of others. When speaking of recovery, some may say they hope to move on next summer, but often know timeframes that are unachievable, and purposefully set goals that are unrealistic. There is a negative spin on everything, therapies offered and the way in which they portray themselves in ward rounds. Well, but not well enough. Recovered, but not recovered enough. They play along with narratives of recovery, and attend therapies sessions, engaging passively. They engage well, but not well enough. This is to ensure that the status quo is maintained, and gives a sense of control over one's progression and where and when they move. The real driving forces and intentionality of the patient is one that is deeply hidden.

Subordinate Theme - The Mechanisms of Self Care

There is a large level of passive acceptance, a common term in psychiatry. Often, it is in relation to passively accepting forced medication, but the concept can be used to explore how people act. The term can also be used to explore the act of accepting treatment, orders, or rules, in such a way that implies you would otherwise refuse. You know you must take the medication, or the agree with the rules, and it is implied that whilst you don't agree with them, you play along with them.

Sid - as far as hospital is concerned, when it's hard, is when the care team is trying to give you medication that you don't want, and you think you don't need.

Not only does Sid not want this medication, but also thinks that he doesn't need it. Over the years of institutionalisation, they passively accept. This patient shows how it is difficult to work with the team when they are acting with our best interest. The medical team is trying to give medications that the medical team know the patient doesn't want, and that the patient thinks they don't need. This passive acceptance is key to maintaining care of the self. This passivity is seen elsewhere, to ensure that one is portraying the character in a Goffman like subservient patient.

Joe - I'll put on a fresh tee-shirt, and go to the office to go on leave, and they'll be like, O you had that on yesterday. I'd say, I've just put this on fresh, you cant win man, with some staff, you get me. I'm not going to complain about it, that's not my style.

Joe feels as if he is being treated unfairly here, but he does not feel as if he is able to confront the staff who are making this unfair remark. They control the self, and the way they are perceived. This is to stay within the rules, in the staff's "good books," but also acts as a mechanism of self-control. The patient controls themself, for fear of ramification, but also in fear of their own impulsive reaction. Rather than arguing a valid point, they let the reprimand slide, again showing the ability to not act on impulse, but rather with a sense of great control.

Ash - : when you try to explain something to them, they try to twist it, to provoke you, and if you jump onto it they try to give you an injection.

Tim - But I wear a lot of it, cos I have leave, so just leave me alone. I don't even answer back, I'm just like, ah yeah, whatever!

Ash here, feels unable to speak to the staff in the way that they wish, for fear of reprisal, in this case, the symbol of the injection is used as the symbol of power that is restricting him from being his true self. Whilst injections are not used flippantly, the symbol of control is realised and recognised by the patient, and they control the self-knowing what possible consequences could ensue. The threat of ramification is an inexplicit tool leveraged on by staff to control, but also by patients too, in a mechanism that have of controlling the self.

Tim also, says explicitly that he wears a lot of it i.e. takes it all on the chin, or fear of losing his leave, his permission to visit the community. The thing that he has worked for and now greatly values, has for him now become a dog bone, a symbol of power, and a tool to demand his obedience. For if he does not follow instruction, or refuses treatment, his liberty and freedom is further restricted. His little liberty is used as a tool, and as a reward for good behaviour. This control of liberty and inexplicit coercion, only serves to remind the patients of the iatrogenic effects of their treatment to date. The imposition of punishment, only brings about thoughts of the psychiatric system, working against them.

Ned - I was on block, level 5, PPE, shield team. The riot gear, a dog, barking, scary! When they used to come into my room, I'd be in my room, suffering from psychosis, they'd get their shields and bang them against the doors.

For Ned, this is the fear, from an iatrogenic source, that is keeping him from acting his true self, and that is the possibility of dogs, shields and riot squads, being used to ensure he acts inline. His is a historical factuality for him, and indeed an option used in last resort. Now, the underlying unspoken threat of refusing medication, protesting, or speaking up and out against staff action, is seen as change in mood, perhaps requiring further medication, or 1:1 time with staff to investigate what is wrong. All this time, staff are unaware that it is they who are the issue and underlying cause of the unconscious re-lived trauma.

There is also the feeling of simply not being good enough for the staff, The patient in this case, thinks they should act as a model citizen, or feels as this is the expectation by staff.

Tim - and they come to you expecting this model citizen, you know what I mean, go away from me!

There does seem to be a constant harassing by the nursing staff of patients. Whether it be their room hygiene, their personal hygiene, dental care or otherwise, not feeling good enough is a source of shame for this patient. In order to care for the self, the patient simply disengages. This

could also be true for their eventual discharge; patients are expected to be citizens, who pay tax, have a job, go to college and live normal life.

Situations are created where, when asking staff for things, unusual behaviours are seen. He might get instantly aggressive, and not being able to sympathise with the usual staff shortages, or varying skill sets in staff. There is an exploration of how this patient almost expects tasks done at his request, and with no thought for other responsibilities that staff may need to complete.

Joe - ah, you can have a laugh, have a chat, make the time go easier, you know. and there are certain staff that get you out on leave, straight away, when you need to go out. other staff will delay, delay it. some people can do the paperwork in 5 minutes, some take 2 hours! It varies you know

But when I, as a dual role researcher and staff member, he reminds me that he considers certain staff to be his friends. And speaks with me in this way, as I am one of those members of staff who completes paperwork in a matter of minutes. I read this as his frustration of years of waiting for everything, including simple administrative tasks, but also as a way of venting frustration, and he can't get in trouble or reprimanded for complaining about staff's lack of speed in administrative procedures. He expects staff to be able to tend to his needs promptly, but this expectation is not reciprocated.

Joe - certain staff are my mates, still. that's how I look at it!

He knows saying this would be considered, "breaking boundaries," and also, I feel as if he is saying this, in order to have some sort of control over me, rather than for me to feel as if he considers me a friend. A way of remining me, that I am in his good books, and that I should stay there. Mates look after each other, and he will look after me, as long as I look after him, a heavily veiled threat, and perhaps a glimpse into his self-care mechanisms, even during the process of this interview.

Subordinate Theme - The Narrative of Self Care

The way in which patients speak, and the language with which they live within, helps them understand their reality, in a way that helps maintain the self in an optimal light. More prisoner than patient, and anything that helps the maintain the social capital that they have sought to create.

Ben - there is nothing wrong with me, I don't need to be here.

This is something that has been repeated by this patient for his entire admission, despite being found guilty in court of very serious offences, and then, being removed to hospital for treatment, with diagnoses of both psychosis and personality disorder. For this patient to be able to live within his own narrative, helps maintain, for him, their own safe world. Not admitting to having a mental illness, and superficially speaking about himself in this way, helps him maintain the tough guy narrative. He feels as if he doesn't need to be in hospital, and that may be true, but the alternative for him, is prison. He exclaims this, as if he is beyond the patient label, and is more suited to prison, using his capital as a dangerous person to bolster his narrative of himself.

Max, when we speak about moving on, and getting discharged, is keen to let me know that he is no rush into getting into the community.

Max – yeah, there is no point in rushing into it…

After decades in care, Max says that there is no point in rushing, but also he has no desire to rush. But again, language like this keeps a level of control in the sense of self. It alludes to a lack of control in discharge, but also that there is no point; so he won't worry himself or linger on the topic. One of his closest friends who attends his meetings and ward rounds, is keen for him to move on and Frank simply plays along with this. Any progress made, is attributed to his friend, this then means that the patient is taking no responsibility, nor does he want, to move on.

Max: he speaks for me at my CPAs and ward rounds.

When he visits the community on day drips, he says that he is not able to go further than the local area only, and attributes this self-inflicted restriction on a painful leg rather than his sheer unwanted discharge, and need to appear as if unable. His friend wants discharge more than Frank, and this causes a strange strain on their relationship. When they meet each other in the community, Frank comes across as disinterested. He wants the escorting staff to see he is unable to manage in the community, and acts in a way that his friend is not used to seeing. He tries very hard to ensure that he is not seen as well enough to move on, to the detriment of his personal relationships. The need to maintain the self-narrative, is now damaging his personal relationships.

There is also a tainted recollection, of what is true and fiction. Some patients, when recalling their histories, often add some extra details, extra danger, to ensure that the created façade is maintained.

Ned - when I was here the last time, it was every patient for themselves. People going around kicking people, getting a pool ball thrown at you or something. You haven't got the same patients.

I happened to be working on the ward, when this patient was here the first time, and this is certainly not a true recollection. The ward was certainly calmer than now, and had a greater number of older patients, and many patients who were very rested and settled in their mental state. It was not the stereotypical image of the mental health ward, that even he believes. This also acts as a method of seeing oneself in a more dangerous light, in a fake sense of cultural capital on the ward. This also acts as an excuse in a way, he was sent back to high secure hospital for destroying the ward after being by staff. He seems to remember the ward as being an unsafe place, in a way of justifying his violence. But it also serves the purpose of setting an unreal

backdrop against which he lives; of having to live in a dangerous psychiatric ward environment. Having to act and present as dangerous maintains the narrative of power.

But sometimes as patients reminisce, they speak of their experience with a strange sense of fondness.

> *Sam - When I was in [high secure] I was on loads of mediation, and it was compulsory to go to the gym. You had to go to the gym, you had to shower in the morning, you had to change your clothes, you had to take medication, had to play basketball, table tennis, tennis, basketball, weights, fucking hell! By the end of it all, I thought I was going to be Arnold Scherzinger*

There is also a fondness when recalling life experience, here, Irene, speaks of their experience in high secure hospital, and indeed, with rose tinted glasses. The hospital where, they says they were given ECT and other treatments against their will, but it is still recalled fondly, to protect the self from the sheer reality of his experiences. They also laugh perhaps in reaction formation, to the trauma and iatrogenic interventions he was subject to.

> *Sam- When I see the reports, I say, that I hope I'm not as bad as all of that! But its written there in black and white! I'm no like that anymore! I'm trying to keep tat out of my mind!*

The reality of their experiences, when seen in black and white, is often too upsetting. It is an old version of the self, one that is unmedicated, and one which is no longer the case. This is something that you often see, in the same way the recovery journey is seem through rose tinted glasses and humour, personal forensic history seems too difficult to handle.

This may be seen through way the patients often refuse psychology sessions particularly when it pertains to history and index offending behaviours. Ian must find it difficult to speak about his past, but possibly, it is the hospital and the journey through the system, rather than his history and offending behaviours, that is difficult and emotionally draining. Many patients refuse to speak on a more therapeutic level about their symptoms and illness, and oftentimes, the reason

given, is not wanting to go back. For going back, and reflecting, diminishes the narrative of self-care that has been created.

Tom - I get frustrated sometimes, of talking. I've been talking for so long. for over a decade! I keep telling my psychologist, but at the moment, I'm just not int he mood. I've done so much!

Tom - yeah, I'm more of a check in guy! hahaha. I goes back to old stuff. I know it's in my head already, and its opening old wounds

The assumed narrative continues, with the adoption of therapeutic language from professionals. Using terms like adapted to medications, rather than being forced for take them, so you passively accept. Tom simply refused psychological input, but conversely, he is able to speak with me quite openly about his traumas and history. Maybe this was because of the relationship we had, or because he knew that this interview was not part of his care. I was surprised with the frankness with which he spoke, as I too, know of his personal difficulty with his past. He seems to understand his history and past in his own way, and that is enough for him.

Protecting the self from one's history, with one's assumed narrative helps with living in the hospital and helps deal with the underlying trauma of reality. The language and words used, is a simple, yet seemingly effective way of exploring this concept.

Researcher: What will be most tricky about staying out?

Ash – Temptation, drink and drugs, In the last place I was in I was offered them, and I was able to say no. it's all over London, outside here even.

He seems to be reminding himself, that London is full of iniquities, but that he is now able to say no to alcohol and drugs. But he is also reminding me, as staff, of the difficulty that he will face, staying away from these substances, and seems to be seeking admiration for being able to control himself. This is all in the backdrop of him actually admitting to taking drugs a few months previously. He speaks here, almost lying to himself, in order to maintain the soothing narrative

and overall respect for himself. But he also must know he is lying to me, but the narrative is so protective that it takes precedence.

The language continues to provide comfort for these patients, but also offer insight into their way in which they are thinking. Rather than saying that he has been forced to take medication for so long that now I just do, they say that they have adapted. There is also a sense of passivity with the choice of wording, and subtle agreement with the system of rules.

Joe - , like you WANT to get out and you want to get through to a hostel, and get that sorted, and all that sort of thing, getting leave or whatever.

It would be a mistake for professionals to assume that discharge is the goal for every patient, and this patient knows that is a desire of some, but not all patients. The "want" to move on and get out is not a universal one, and Joe hints at this here, showing an enhanced understanding of the complex situation. The need to want to move on, is again, another element of protective narrative

Patients use of language here also shows awareness of their mental illness, in their own way. This patient, without medications, would be hyperactive in his own words.

Tim - : if I wasn't on meds I'd be a lot more hyperactive! Put it that way.

But in reality he would become very paranoid, aggressive, violent, and relapse almost certainly. It is language used like this, where patients often feel able to ask for reductions and withdrawals in medications, feeling as if they would only, or merely, become hyperactive. There seems to be a double entendre with the use of this term hyperactive, jokingly referring to "let's put it that way." Living within this created language, leads of actions, thoughts and decisions, that are nonsensical to professionals, but are believed by the patient. If this patient was to seek reduction in medication, and if it were granted, they would become seriously unwell.

The careful use of language and specific use of learned vocabulary, ensures that the patients are shielded from the reality of their situation, and as a result, live in a world in which there is careful portrayal of the self. This protective narrative is not always rooted in fact, sometimes it is nonsensical , but it is always protective. This is also seen when patients speak of future expectations, of moving on onto hostel accommodation and moving on from the hospital setting

Researcher: what about yourself?

*Ned: : Its tricky – getting mixed up with the same people. What I'm saying, we need to go to a small place, where there isn't so much influence, and you put your head down at night, without come c*nt coming back to kick your door in at night.*

This idea is not entirely accurate. He would be living in an admittedly, subpar hostel accommodation designed for mental health patients, but the getting mixed up with the same people, is not something that will happen. He has been in hospital for many years, the same people have either moved on or are in prison, or have matured. There is a narrative that he will revert to his old 20 year old self, after a decade or two in a hospital setting. It is this negative experience, rooted in history, that somehow adds to the protective narrative. If he was to leave hospital, he would be attacked and would mix with those he wishes to avoid.

Researcher Reflective

Hiding internal realities, and ensuring that one is in charge of the self, stems from the aforementioned paradoxical view of the world. The need to ensure that the patient holds onto the scintilla of control that they have.

They will act in ways that are inauthentic to make sense of the sacrifices that they have to make to ensure that the status quo is maintained for their lives. They need to ensure that little changes day to day, to ensure that the staff treating them have a view of them that the patient is trying to portray.

I remember a time when a patient hit the office window in order to show that he was unwell, but then when he was not permitted to leave for the community that day due to his violence and aggression, the was quick to say that he was messing with staff. Sometimes, the patient has not always correctly timed their outburst of feigned aggression.

This has become a very related to the concept of the care of the self. People managing expectations and portraying a character or image that is acceptable to the general population, to what end however? To ensure that they maintain their image of capitalist hierarchy. Or whether this pertains to the image of "themselves."

This is referred to in some profession circles, as containment; when the patient feels contained, they act in the way we expect them to. This very passive view of the patient, is an ill guided one. The patient is trying to understand what the staff members' reaction will be to an outburst of aggression or psychosis. When we play along, and offer the expected reaction, that is seen as containment. So who is a step ahead. A seasoned veteran patient who knows when to scream in their room, or a staff member who acts in the way the patient predicts.

I remember a specific example of this, when a patient screamed in his room, staff went and checked on him, and he was telling them about how the voices were causing him trouble. They offered that he stays on the ward for the day, and the patient was adamant that they weren't troubling him that much. Another time, the same patient was screaming in his room, we left him alone. He later in the day, asked me whether I had heard him screaming earlier. Was this in order to elicit the response that he was expecting from the staff. What I'm trying to explore here, is how institutionalisation is a process that is perhaps further worsened, by our lazy and ill thought reactions to behaviour, that makes mauvais foi a mechanism for patients to use for their own gain and control. Our predictable reactions are used as mechanisms of control by patients.

3.3 Theme Trees & Data Validation

Figure 1. Staff Subsample Theme Tree

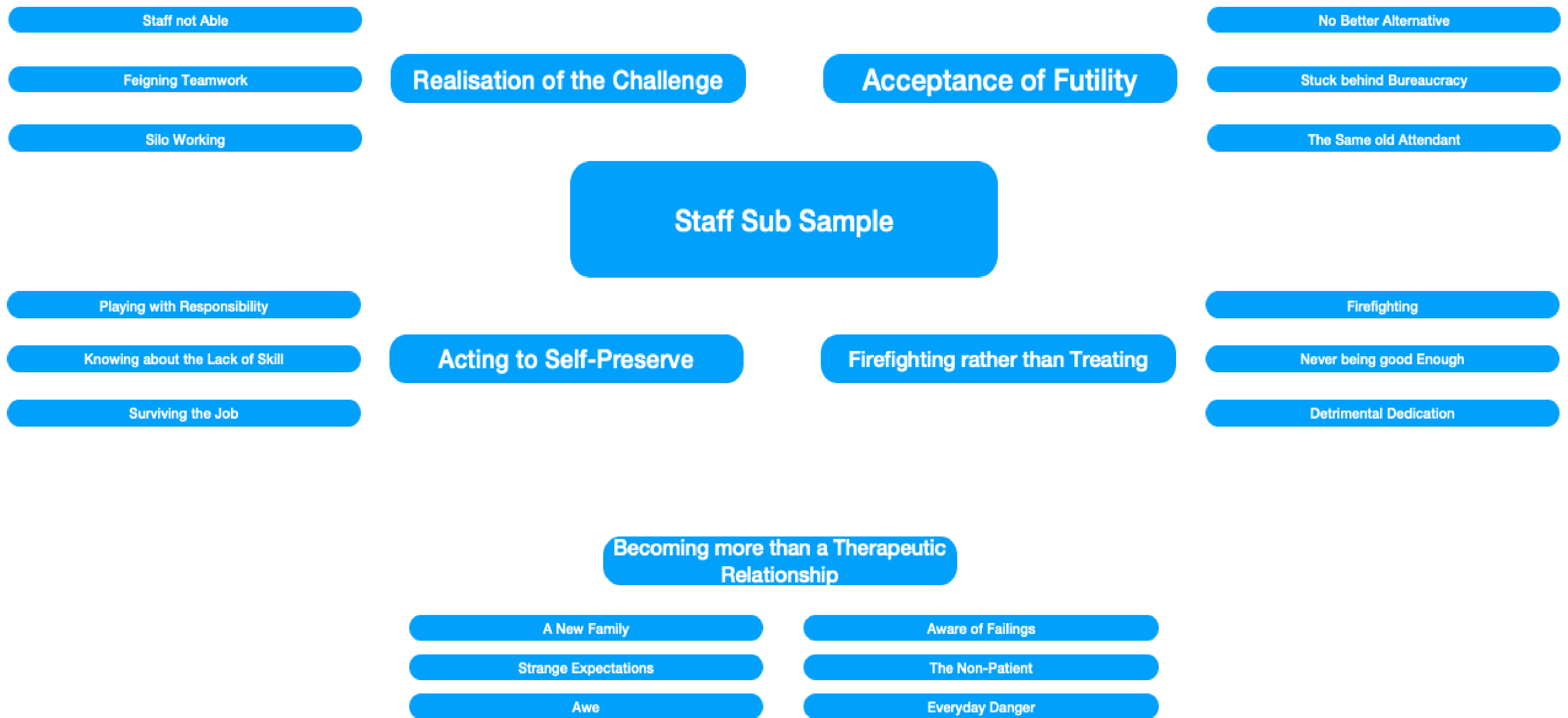

Figure 2. Patient Subsample Theme Tree

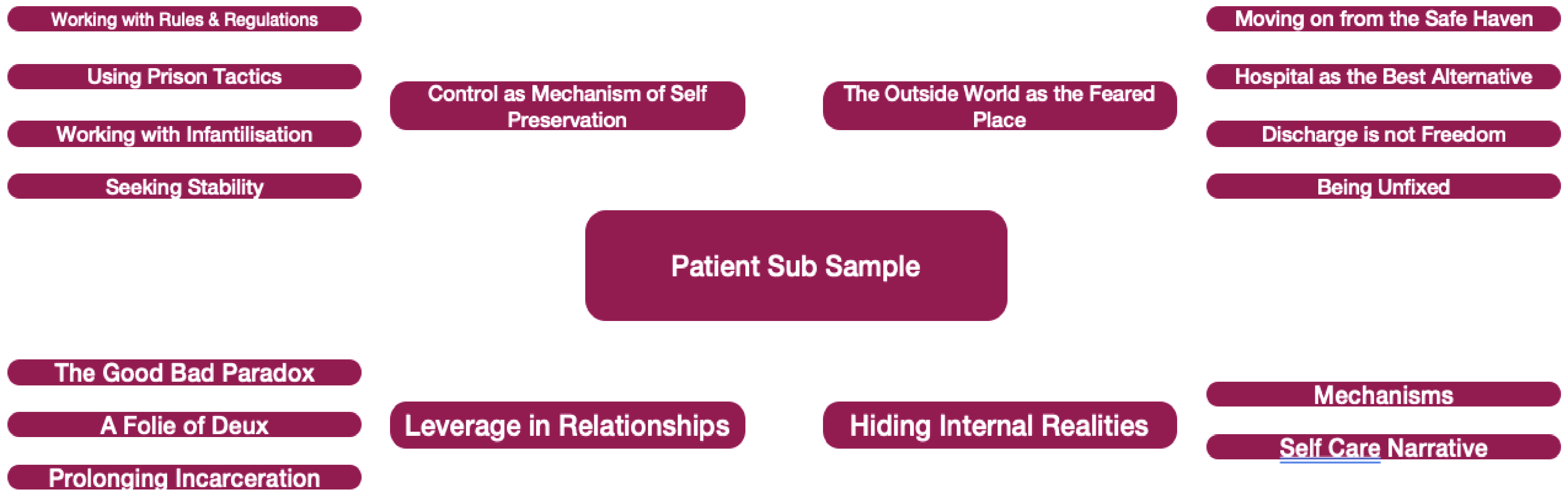

Figure 3. Staff Subsample Theme Validation

Staff Sub Sample Theme Validation	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Acceptance of Futility		X	X	X	X	X		X	X	X	X	X	X	X	X	X
No better Alternative			x		x	x		x	x	x	x	x	x	x	x	x
Stuck Behind Beueaucracy			x	x	x	x		x	x	x	x	x	x	x	x	x
The Same Old Attendant		x	x					x	x	x	x	x	x	x	x	x
Firefighting not Treating	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X
Firefighting		x	x				x	x	x	x	x	x	x	x	x	x
Never being Good Enough		x	x	x			x		x	x	x	x	x	x	x	x
Detrimental Dedication	x	x				x		x	x	x	x	x	x	x	x	x
Realisation of the Challenge		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Staff not Able			x	x				x	x	x	x	x	x	x	x	x
Feigning Teamwork		x	x		x				x	x	x	x	x	x	x	x
Silo Working		x	x	x		x	x		x	x	x	x	x	x	x	x
Acting as Means of Self Preservation			X	X	X	X	X	X	X	X	X	X	X	X	X	X
Playing with Responsibility			x	x	x	x	x		x	x	x	x	x	x	x	x
Lack of Skills			x	x			x		x	x	x	x	x	x	x	x
Surviving the Job			x	x		x	x	x	x	x	x	x	x	x	x	x
More than a Therapeutic Relationship		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
A New Family		x			x			x	x	x	x	x	x	x	x	x
Aware of Failings			x		x	x	x	x	x	x	x	x	x	x	x	x
The Non-Patient		x	x		x			x	x	x	x	x	x	x	x	x
Everyday Danger		x	x	x					x	x	x	x	x	x	x	x
Strange Expectations				x	x	x	x		x	x	x	x	x	x	x	x
Awe		x	x		x		x		x	x	x	x	x	x	x	x

Figure 4. Patient Subsample Theme Validation

Patient Sub Sample Theme Validation	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Control as a Mechanism of Self-Preservation		x	x	x	x		x	x		x		x		x	x
Working with Rules & Regulations				x								x		x	
Using Prison Tactics		x						x				x			x
Working with Infantilisation					x					x				x	
Seeking Stability		x	x	x	x		x								
The Outside World as the Feared Place		x	x	x		x	x	x	x	x		x			x
Moving on from the Safe Haven							x	x	x	x					
Hospital as the Best Alternative				x		x		x	x			x			
Discharge is not Freedom		x										x			x
Being Unfixed		x	x			x	x		x						
Leverage in Relationships	x	x			x	x		x	x	x		x	x		x
The Good Bad Paradox	x				x			x				x			
A Folie a Deux						x			x			x			
Prolonging Incarceration		x			x	x		x	x	x		x	x		x
Hiding Internal Realities from Others	x	x		x	x		x	x		x		x			x
Mechanisms	x			x				x				x			x
Narrative of Self Care	x	x			x		x	x		x		x			x

4.Discussion

This chapter aims to address the aforementioned research questions briefly before offering a theoretical and empirical discussion; findings are presented in reference to key relevant extant and recently published literature, which is in keeping with the Interpretative Phenomenological Analysis methodology.

4.1 Addressing Research Questions

How to long stay forensic mental health patients find meaning in their lives?

Patients experience their lived world within the confines of the closed institution. It is their institution. In order to survive, and inevitable thrive in this setting, the patients have learned "control as a mechanism of self presentation." That is controlling their narrative, and how their life is directed is still possible, and they will certainly do that. They can control their own life, how staff and others interact with them, and do this by stretching the rules, that they know well. They are not powerless in their life, nor do they take a passive route through it, they are surprisingly in charge. Whilst their sense of transience through the system, is something that can somewhat control, there is still a sense of loss of personal and social capital, and relearning when arriving in a new environment. The new rules, written and unwritten are relearned, and prison tactics are used in order to make sense of their world, and to maintain their personal habitus. This is maintained through the use of very intricate passive, but powerful discursive and dialogue between those who live and work within the hospital setting.

The outside world is a feared place, but this is for many reasons. The hospital is the safe haven, having lived there for many years, it is what the patients know, and it is where they have built their lives, relationships and are ultimately safe. The fear of moving on, is the ultimate fear of

being transplanted back into the community from decades ago, they once lived. Having to not only catch up with technology and other practicalities, these patients also must fight the same socio-political and economic battles they once did, for the outside world has not changed much in decades when it comes to the social justice issues the most mentally unwell face. There is an understanding that discharge is not freedom, for there will still be forceable medications, supervised accommodation, healthcare professionals, and specific forensic friendly accommodation and curfew periods. There is a sense of sameness, so why bother with it. Familiarity may breed contempt, but at least it is an easier than being unfixed. Everything seems temporary when there is discharge. Accommodation is only temporary, staff members are only intervening temporarily, and there is less permanency with interventions and staff members when in the community. Trusting few staff over decades, and suddenly, one is expected to work with a number of changing staff brings its own interpersonal issues. Being unfixed is a continuation of the journey they have already experienced in hospital, and the community is now seen as too similar.

There is a need to leverage relationships. There is a mutually understood inauthenticity in relationships. Relationships are both beneficial, and detrimental, and with this paradox there is a fine balance maintained. Patients often have difficult relationships with family, with other patients and with staff and there is a multiple folie a deux. People are used when they are useful, but what is useful is not what you may expect. Enabling a patient to stay in care, by staff invoking symptomology or getting into a fight with a fellow patient all show the skillset that some patients have gained and used to avoid progression.

There is a hiding of the internal reality for patients. They use mechanisms of self care in order to maintain the status quo that they are content with. This involves much passive acceptance, of what you disagree with on an existential level, in order to keep some level of control. This then runs into a self care narrative, where even the language used is believed by the patient,

on a level that is deeper than simply lying to oneself, as this maintains social capital, and makes reality more bearable.

How do staff that work in long stay forensic mental health find meaning in their roles?

There is an acceptance of the futility of the job, and of the role. Staff are aware that they are only containing patients, and this is done as there is no better alternative. Staff are inundated with bureaucracy, and that has become their main job; completing audits, paperwork and updating care plans, not looking after patients. They have become the attendants of the mental health wards of yesteryear, and they are aware of their lack of impact on patient health.

The role involves being more than a staff member for the patients, and some feel like their new family, and feel for the patients and for the failings of the system. The system failings have precipitated in patients who have found themselves on mental health wards, using the system for their own gain. For those patients, the staff are not family, but rather obstacles for their own goals. If staff care too much, patients may see that they are trying to discharge them, which whilst the goal of staff, is not the goal of all patients, leaving staff in a strange position. Working with these strange situations, coupled with the everyday danger, leads to a sense of disconnectedness, which leads staff viewing their job with a sense of awe, for this is no other way to explore nor explain the complicated job they find themselves in.

This leads to firefighting, and staff spent their time fighting the problems that these patients cause, the problems that the system has caused, and the overarching socio-political issues that the mental health system faces. This in turn, leads to staff feeling as if they are not good enough, for their job is so multifaceted, their attention cannot be on patient care and its delivery. But their dedication to the job, once a vocation, leads them to burnout.

There is a realisation of the challenge, and this is one that was not expected. Some staff are not equipped with the skills necessary for working with such a client group, and some realise this. Others go about their role, discharging their duties badly, causing further issues for the staff that continue to firefight. This leads to teams that are supporting each other, but supporting and correcting mistakes are seen as two sides of the same coin. This leads to teamwork that is led by few members of the team only, and teamwork and collaborate working is feigned, and silo working ensues; people come to work, complete their specific duties and leave, teamwork collapses and staff learn to cope with that.

They act as a means of preserve their willingness to do the job. There are then alternative motivations reasons for completing tasks, for going to work, working certain shifts, and even feigning lacking skills to complete the job. All of this to survive the role and make sense of the bizarre environment that staff find themselves in.

4.2 Discussion of Findings & Extant Literature

Patient Subsample

Featuring greatly in the research, are the rules, regulations and restrictive practices seen in these settings. Bowser et al.'s (2017) exploration of the restrictive environment and living within the confines of the restrictive environment. Brown et al.'s (2014) work on sexual expression, and how this is "amputated." Horberg et al (2012) does pay attention to these "strategies" in noting that patients adjust their behaviour to "get what they want," and explore how patients don't show their personalities and hide their true selves, in order to survive the hospital setting. Di Lorito's (2018) concept of self-agency, refers to how patients are in control of their destiny, and in control of the "little things," and how "perceived control was totally in the hands of the staff." The current research would argue that patients have much more control over their lives than explored in previous research, and that the patients understand the level of control they

have over their lives, within this very specific context. Mechanisms of control is also explored by Lord et al., (2016b) where a patient participant explored partaking in therapeutic activity, "…if you are forced to do it, you are not going to put the effort into it." Not engaging in therapeutic activity whether forced or not, will maintain a sense of status quo that may offer the patient a sense of security and stability, while at the same time maintaining control over their lives.

Olausson et al., (2019) find that the patient room is seen as "anchoring and protecting and is characterised as homeness and being in communion and meaningfulness." As the patients learn to live within this environment, they are then only going to be moving on from this safe haven and sense of communion when discharged. Di Lorito's (2018) concept of self-agency pays reference to the future and being unfixed; "The future scares me a bit. That's why I'm not in a hurry to leave." The same paper also pays reference to prison remittance, and how one can be remitted to prison after forensic treatment, calls into question the autonomy they have over their own life journey. Patients in Mezey et al.'s (2010b), study found that the ward is considered home or even a sanctuary by some patients, and the expected journey toward discharge, is frightening, for they know the inevitable, "I'm just going to go out there into a bed and breakfast or something." Not bring in a hurry to leave, the future as the feared place, and discharge to substandard accommodation without employment and substandard monetary and social support, are all known tenets and are of considerable consternation for the patients in the present study. The paucity of research on these important challenges to discharge are not intricately understood, and the present study gives further insights into how and why, patients say within the hospital simply as their preference, contrary to professional and presumed expectation. Olsson et al., (2014) does call for staff to be aware of and adjust to, patients' needs in care, particularly when planning and implementing forensic care, to help avoid "lingering progression" and "slow in coming readiness" amongst forensic patients.

The nature of relationships with staff are seen as central to understanding the patient's perspective in Barnao et al.'s (2014) work, but also in Koller & Hantikainen, (2002), who highlight the relationship to and with other people and the scope of these relationships, within the context of privacy in hospital. The concept of leverage in relations expands and offers further insight indicating that these relationships are more intricately woven and possibly far more complex that previously understood. The concepts of folie a deux, and of the good bad paradox, give further insight and a framework for understanding how patients interact with staff. Olsson et al., (2014), explore how patients try to cheat the system, act and "say what (the staff) wanted to hear, and behave all appearance." The current research finds this also, feigning in order to appease staff, and to maintain a sense of self control.

"I now what I need to recover," a concept explored by Marklund et al.'s. (2020) paper, perhaps can be explored further, the research is lacking the depth of what this might mean. In the present study, it is highlighted that the patient does know what they need, but how this need might not match staff expectation. Craik et al., (2010b), note of the differing language used by patients to describe occupational therapist, and "other staff," similarly, Lord et al., (2016b), also find this difference, describing psychologists and psychiatrists as professionals, and different from "other ward staff." Negative relations with staff are explored by Mezey et al., (2010b), patients explore the infantilisation processes and intolerance of these "other ward staff." This strange and unusual way of describing and ascribing labels to staff by patients, is explored in the current work through the concepts of the good-bad paradox, and how patients and staff interact with a sense of folie a deux. To ensure the two-way relationship facilitates an easy and preferred passage for patients through their recovery journey. Further research is needed to fully understand how relationships are used as tools for leverage, beyond being described as boundaries.

Askew et al.'s, (2019b), themes of intense fear and of being abused, are seen in this study, and in a broader application than just in the context of seclusion room usage. Patients in this study use mechanisms that are learned over time, that seem to almost nullify these feelings of abuse normalise these as a mechanism of self-care. Horberg et al., (2012), find themes of "struggle against resignation" and an "existence characterised by tension." These experiential themes which are tenets of the patients' internal realities are controlled by skills that the patients have attained, skills which have become normal, to nullify these also, these feelings and struggles of resignation, and existence being characterised by tension. Di Lorito's (2018) paper explores patients concerns around employment, and how they are aware of the challenges they face, the bravado-like discourse of the forensic patient, whilst protective, is still rooted in reality, and insights into barriers they face are easily seen.

Staff Subsample

Laukkannen et al.'s (2019) systematic review of literature, explores attitudes toward patient containment, citing various studies where staff felt as if they were helpless, regretful, and felt guilt and pity toward patients. Coercive techniques in controlling patient behaviour are explored, with seclusion room and use of physical restraint taking particular pertinence. Conflicting attitudes toward their use, efficacy, ethics, and justification confounds the sense of the outdated practices; staff know that there is no better alternative, and that they can be described as the simple old fashioned asylum attendant. The aforementioned literature citing careplanning failures further compounds the idea of being stuck behind bureaucracy, for all stakeholders know the little value these instruments of bureaucracy hold, yet yield such time and power, regulating the staff to a sense of relegation, they are simply an attendant.

Coercive measures are discussed by Hui et al.'s (2013) systematic review, they note of the distinct lack of empirical research on coercive measures, but there is an overfocus in this systematic review on interventional restrictive practices, the use of seclusion and mechanical restraint, and the threat of their use as a coercive tool. The current research reframes what this coercion could look like. Sometimes staff are seen as family by patients, and this comes with unwritten expectation which acts as a method of subversive coercion that is not prevalent in present literature. Staff may collaborate with the malingering patient, the non-patient, leveraging on these relational coercive methods in order to ensure the ward environment remains safe for all. The ward social climate is well researched and reported in Doyle et al.'s, (2017b) systematic review noting of the balance needed, and the skills needed by staff, to control for security yet remain therapeutic. They note of The Good Lives model, and of the Therapeutic Community approach, two very specific methods for controlling for safety whilst being therapeutic for patients. But in reality, these models of care are only delivered on particular personality disorder wards with trained staff. This leaves other wards to inevitably offer, by default, an uncontrolled version of these models of care. Without these frameworks to support staff, uncontrolled subversive coercion takes hold, and the therapeutic becomes more than simply patient and staff. This is evident in Fletcher et al.'s (2021) integrative review, where staff highlight the importance of being "likeable," and the need to "gain rapport," to collaborate well with patients, and the self-identified issues pertaining to interpersonal communication, inadequate listening and a lack of negotiation skills. Staff are aware of the skills they lack, and aware of their failings.

Rather than offering therapeutic intervention for the patients, staff report acting like firefighters, preventing fights, stopping assaults, and dealing with everyday violence.

Causes of violence and aggression is explored by Fletcher et al.'s recent (2021) integrative review. Staff note that service delivery factors, policies and resourcing, staff interpersonal and

communication skills, or lack of, and patients' diagnosis and personality all contribute to incidences that take away staff, from therapeutic engagement. Oates et al.'s (2020b) integrative review also highlights the exposure that staff are subjected to, the violence and aggression, both verbal and physical, and also of the sexual violence that staff are subject to. The same review finds that having a higher sense of self-esteem and higher self-confidence, could moderate the adverse feelings of these assaultive behaviours. The author hypothesises that those who are resilient enough, can cope with higher level trauma and assault well; almost as if one must be resilient enough to allow sexual and physical violence to not affect the self. This only adds to the concepts of never being good enough and having detrimental dedication to the job. This workplace trauma is further explored by Newman et al., (2021), with a focus on direct exposure, and through vicarious trauma, highlight the levels of violence and aggression staff are exposed to. They recommend the use of ward rotation, or a secondment to non-clinical work, a known tool used for those staff unable to do their job, their failures highlighted for all to see, again adding to the sense of dejection that staff feel as they firefight on the ward.

The aforementioned work by Oates et al., (2020b), explores how those who are resilient enough are less affected by the traumas of working in a forensic unit, this implies that there are those who are not resilient enough, and are seconded to administrative tasks as also previously described. There is a sense of staff not being able, that permeates throughout the subsample, and staff are aware of each other's failures, whether this be in interpersonal skills, negotiation skill, or the simple inability to use computers.

Exploring perspectives of involuntary treatment orders, Goulet et al., (2019) found themes resulting from the analysis are: an involuntary treatment orders as leverage to manage compliance and risk; legal concerns; learning to play the game; building a therapeutic relationship in a coercive context; positive and negative impacts of treatment orders; family

involvement; and discharge. They discuss, how the therapeutic relationship can be coercive, which is paradoxical, but that patients learn to play with this paradox. These findings are somewhat similar to Goulet et al.'s research, which also explores the concepts of coercive therapeutic relationships, but this is a concept that is under researched within the corpus of work more widely, and this is in spite of the importance of professional boundaries and the attention paid to relational security in forensic settings.

Van Ginneken (2016), explores with inmates, how they make sense of their lived experience. While being incarcerated was a fundamental change in their assumptive worlds, it was noted that finding meaning in the experience and using it as a catalyst for personal development and contributed to a positive reconstruction in identity, with implications for positive post traumatic growth. In exploring post traumatic growth in this context, Vanhooren, 2017, explore with 10 prisoners, the loss and finding of meaning whilst incarcerated. They find that prisoners experience the usual existential angsts of, loss, shame, guilt, and despair, and adjust to their new surroundings as a matter of choice and responsibility. Reported areas of growth in this study were noted as having higher levels of self worth, new found strengths, new relational skills and a changed meaning in life. From the current study, it can see how self worth and these new found strengths are understood in a more nuanced way. Strength is perhaps viewed through the guise of earned cultural capital, new relational skills pertaining to the folie a deux and deep acting skills needed in order to survive the environment. The changing meaning in life may pertain to the adverse view, that discharge or release is the ultimate goal, but these life goals are ones that are presumptive, and moralistic.

Vanhooren et al., (2018) explore with a large prison inmate population sample, what predicted positive post traumatic growth. They note characteristics of emotional support, religious coping and searching for meaning as helpful coping strategies. They also note that behavioural

disengagement was a predictor for negative post traumatic growth. The same authors, Vanhooren, et al., (2017) explore in a phenomenological way, post traumatic growth in a sample of sex-offenders. While they note that prison forces prisoners to experience change, it is noted that emotion support during this time is a positive factor, and taking responsibility for their crimes was to help therapeutic engagement and in post traumatic growth. They also explore, (Vanhooren et al. 2018) how existential therapies can foster meaning making and post traumatic growth in prisoners. It is said that one participant of the research," developed a more nuanced set of meanings and a richer pallet of coping skills that enabled them to live their life in a more meaningful and in a better adjusted way". Could this also be explored through the results of the current research. Coping skills and living a more meaningful life within the confines of the closed institution. They have learned the skills in order to adjust to their new prison environment, these skills have then enabled a life more meaningful. Post traumatic growth within the confines of a closed institution is surely a readjustment to behaviour and the gaining of new skills to be able to survive and thrive within this new environment, these skills are explored in the present work.

With the current movement in inpatient care, focusing on trauma informed care, (HM Gov, 2022b), perhaps this approach could be expanded, to explore the existentially informed concept of post traumatic growth within the context of care planning. This would need health care professionals not only be aware of the history and experiences of patients have caused the traumas that have precipitated mental illness, but also require them to pay attention to the iatrogenic effects of the hospital system on the patients they treat, and the specific adjustments they make to their lives, and the news meanings they make. This is because these are all created within the context of a closed secure setting and could be a cause of further institutionalisation. These new coping mechanisms and meanings, are all created from with a closed institution and their applicability are not always transferable to the wider community. It would also require

professionals to be cogitate of the socio-political environment into which the long stay patients will be discharged and equip their patients with the ability to grow beyond the adversity they will face.

The CPA explores and plans with these patients, the neoliberal and moralistic totems, of finances, education and employment. Hare-Duke et al.'s (2018) study explores how and why these long stay patients are not discharged in good time. They note that patients move around the system, rather than out of it. They note of the high number of patients with learning difficulties contributing to this high length of stay, but this was not the case with the sample in this study. With this sample, the issues, and fears of discharge, seem to be pertaining to acceptance in society for who they are. In any case, Hare-Duke proposes that there is a need to identify and facilitate more effective treatment in order to discharge long stay patients from secure settings. They propose that a national strategy for the management of this patient group might assist in this, and this has yet to happen. Tovey et al., (2022) explore with those discharged, what it was like seeking employment, and find two overarching themes. Stigma as a Barrier to Employment explored the impact of the disclosure of the sexual criminal record at interview and the enduring stigmatisation the participants faced as a result of the 'sex offender' identity. In the second theme, Autonomy and Control, participants sought to explain the personal significance of being employed, and how their inability to secure employment had resulted in the loss of autonomy and the introduction of self-isolating behaviours. Participants in the study said they felt 'better off' in prison at times, due to the lasting effects of social exclusion. The patients in the current study, may feel this also, particularly as some have even more heinous crimes and histories. It is safer, easier and life is more conceivable when one stays within the hospital system. There is a fear of the outside world, and the reasons for this are seen in the studies. Some patients are moving from an environment that they have learned and adapted over many years to a new environment. In the community, where stigma is rife, they

know that the coercive mechanisms they have used to survive in hospital will simply not work. They are unable to draw down on their cultural and personal capital, for it is not valued in the community, but rather stigmatised. What some relied on in the hospital to keep them safe and to maintain power, is now an obstacle to employment and living in society more widely.

Perhaps, this also gives an insight into recent UK Government plans to encourage those with mental health issues into work (HM Gov, 2022a). The plan is to connect those with mental health problems, to employment advisors in helping them seek work. They also note that employment advisors and therapists will work together so that person can return to or find work easier – driving economic growth. The UK health minister at the time of that press release, also notes of the "virtuous circle between work and health," and the NHS national mental medical director notes of, "offering employment advice from experienced advisors through our Talking Therapies services across the country is a fantastic and important development, especially in times of economic challenges and increased need for mental health support." Talking therapies and IAPT services, now offer career and job advice. But what they miss, is that it is not the symptoms of mental ill-health that is preventing their participation in the workforce, it is much more nuanced than that.

The current study highlights the degree to which these patients manage their own impressions, particularly when in a peer group setting. There is a reluctance to seem as if one is engaging with the care planning system, but there is also a need to appease the staff members and this could be explained through Hochschild's established concept of deep acting (Hochschild, 2012). There is also perhaps a sense of bad faith (Sartre, 2003) on the patients' front, but also a sense of folie au deux. In further application of these concept, Colquhoun (2018) in their study of a sex offender treatment programme find that impression management and peer comparisons were barriers to patient involvement in dramatherapy. This study explores the use of

dramatherapy in an attempt to increase patient empathy, emotional awareness and victim awareness, with a mentally disordered sex offenders population. Whilst the intervention may be well intended, it is important to be aware of the participants' intentions and their authentic participation to avoid falling into a folie a deux. There is a tendency to be seen as participating within the care planning structures, but also trying to manage one's projected image particularly when those with sexual offences have the least capital on which to draw. This example, those sexual offenders have the least respect amongst their peer group, but also know that the wider society and discharge is something that is fearsome. In order to keep a sense of control, the patient will engage with the care planning system and dramatherapy intervention, not only in order to gain some capital and meaning through staff interactions, but also perhaps as a mechanism for prolonging their stay.

Chiu et al., (2020) also explores concepts relating to image management by those leaving services. They explored post prison life, including opportunities, challenges and support received from services. Four over-arching themes were constructed: the nature of support and services, the difficulty of staying out of trouble, the importance of family and the need to act the "tough guy". The participants reported being extremely under-supported. They were often hostile about staff who they felt were too focused on their previous crime. Participants felt under supported by their supportive teams, and the authors recommend that there is a better understanding of the lives within the wider social context in formatting discharge pathways The present study also argues for a more nuanced understanding of this. It is imperative to understand the patients' true intentions and meaning making mechanism within the hospital setting. For failing to take this into account, just leads to the usual, neoliberal, moralistic care pathway, to discharge and to community integration, something which is of particular difficulty for these patients.

In attempting to understand patient experience further, alternative exploration with inpatients Verstegen et al., (2022) explored experiences of victimization during mandatory psychiatric treatment. They found that patients were not only exposed to both physical violence and verbal aggression by other patients, but also to a more ubiquitous flow of micro-aggressive comments. This means that victimization processes, which for most patients started much earlier in life, continue during forensic psychiatric treatment contributing to the iatrogenic effects of inpatient care. Intrapersonal consequences include fear, hypervigilance, reactive aggression, flashbacks and avoidance and withdrawal. There needs to be a further nuanced understanding of the inpatient experience in order to plan for care, and the present research contributes to what appears to be a field in need of updated research. A higher level of trauma sensitivity in forensic mental health care is thus required. Patients adapt to these negative experiences and have learned to live and thrive in these settings, but these skills are not transferable. Verstegen is right to recommend further exploration in inpatient experience and Chiu is correct in recommending further exploration of their experience in the wider social context in furthering the understanding of the transition into community settings.

These sociocultural barriers that forensic patients face, is only confounded by the well researched socioeconomic barriers that many patients have already faced, and will face again upon discharge. Freely available statistics from NHS Digital (2022) explore deprivation rates, and one is up to x8 more likely to be detained if living in the some of the least deprived areas in the UK., with these statistics being consistently high across the last decade. This highlights the social justice issues that are beyond that patients are aware of and trying to avoid. The socioeconomic situation of the participants in this study must be seen in the wider socio-political neoliberal-conservative environment of the present day.

This reflects the findings of this current study where, participants seem to not want to leave hospital, for fear of getting involved in crime, the fear of being in sub-standard and inappropriate accommodation and the overall fear of feeling insecure and unsafe. The fear of not having the financial means to support oneself, nor the perceived ability to maintain employment. Patients in this study, through personal choice and freedom, have decided to remain in the hospital setting, it is the least worst option. They have taken responsibility for their self preservation, and are maintaining a favourable position. They have removed themselves from the society in which they know they will face stigma, but this stigma is not seen as a strength or something used for personal gain or cultural capital on the ward environment, and so the cognitive dissonance this creates is as complicated as it seems.

Gillespie et al., (2021) interviewed patients at a high secure forensic hospital and asked questions about their experiences of familial support. Results indicated four superordinate themes; Connection, Growth, Power, and Ambivalence. Interestingly, there was little talk of familial support in the current study, and rather, there was little conversation pertaining to family. Rather, discharge and moving on was seen from within a context of fear and new found independence that seemed difficult for the patients to come to terms with.

4.3 Theoretical Discussion

A theoretical discussion is now presented, with reference to some key relevant theoretical papers, to further explore the findings of this current study.

The forensic hospital is a hybrid of a mental health hospital and prison, with patients who are often display risk behaviours severe enough to warrant their incarceration. They are often prisoners serving custodial sentences, and are always held against their will in a secure hospital setting. They are treated primarily by psychiatric nursing staff; qualified and unqualified,

psychiatrists, psychologists, occupational therapists and other therapy staff. Everyone works together on the care plan approach, with the ultimate aim of improving mental health, and discharging a person who will be able to contribute to society, as evident through the neoliberal approach the current system has.

In order to understand the complexities that this system brings about within the confines of the total institution, it is important to explore the lived experience of those within such an environment, and doing this though the lens of philosophers and sociologists of yesteryear, who once explored these similar systems.

Many patients have lived within this closed system for many decades, and have their own ways of surviving this setting. It is important to understand some of these existentially rooted methods of self preservation and survival, given the specific context of this particular total institution.

Sartre (2003, p. 649) in an attempt to describe what is to be acting in mauvais-foi, or in bad faith, it is important to understand the three stages of being. Being in itself (etre-en-soi) refers to objects in the external world, a mode of existence that simply is. It is not conscious, so it is neither active nor passive and harbours no potentiality for transcendence. This mode of being is relevant to inanimate objects, but not to humans, who Sartre says must always make a choice. Being-for-itself (etre-pour-soi) is transcendence and essence, what you are not, but what you will become. Being-for-itself is conscious of its own consciousness but is also incomplete. For Sartre, this undefined, non-determined nature is what defines man. Since the for-itself (like man) lacks a predetermined essence, it is forced to create itself from nothingness. Being-for-others (I'être-pour-autrui) is the idea that one's consciousness is brought out though the interactions with others.

This concept is particularly applicable to the current research. Patients, it could be said are acting in bad faith, using the system to make their criminal justice journey easier, or in order to remain in the hospital system, rather than discharge. This is done by collaborating with the staff, who to a certain extent, are also complicit in facilitating these bad faith narratives and actions. The concept of mauvais-foi or acting in bad faith is the act of going against one's own essence, denying personal freedom and acting under expectations. These patients are fostering a relationship with staff, that is built on this concept. Working toward discharge, whilst not wanting it. Staff are helping to deliver recovery and a road to discharge, but also know, that this is not the patient's goal. With similar and related concepts De Beauvoir (2015) explores ambiguity and freedom. She asserts that man is fundamentally free, a freedom that comes from his "nothingness," which is an essential aspect of his ability to be self-aware, to be conscious of himself: the nothingness which is at the heart of man is also the consciousness that he has of himself. The patients and staff in this sample, are fundamentally free to make personal choice, within the confines of the secure hospital. The patients are free to work authentically toward discharge, but can also act authentically, albeit inexplicitly, toward staying in the hospital system that they know well. It is important to be aware of prejudicial moralistic values and assumptions that moving through the system and discharge are the ultimate aims for patients.

Staff also, can authentically deliver care through careplanning, but they too know, that these care plans are not up to date, are only mechanisms of bureaucracy, and are not fit for purpose. Rather than challenging this status quo, they collaborate with them, inauthentically delivering care that they know is not what the patient wants, but also one that shows little efficacy, and held in contempt. Knowing this, some staff find meaning in alternative activities related to the their role, or find a sense of greater meaning in moving through managerial ranks, away from clinical work.

Hoschild (2012), further explores this concept of authenticity describing it though the concepts of deep and surface acting, and concepts of the real and false portrayals. Surface acting pertains to method acting, pretending to be a sitcom character for example. This opposed to deep acting, where the actor, actively suspends the usual reality testing, as a child does at play, and allows a make-believe situation to seem real. In this sample, it could be said that the long stay patient is an agent of deep acting. Hiding their internal reality from others through self care, hiding their angst for the outside world and fear of it. Leveraging on the thinly veiled therapeutic relationships with the staff, and all with a level of self control, to ensure that the status quo does not change.

Some act as the strong and brave, prison transfer, to be feared on the ward. But the reality, is that they possess much internal fear, fear of the outside world, and all of this is only compounded by the symptoms of mental ill-health. The same is also true for staff. With knowledge that their narratives of patient recovery, care plan writing, and psychoeducational and psychotherapeutic interventions are futile and instead they act as staff. For they also know, that some patients want to remain in hospital; they must find a new meaning in their role and often find extra-curricular activities to keep interest, often with a focus beyond that of delivering psychiatric treatments to mentally ill patients.

Bourdieu's (1980) concepts of the habitus and of capital may also be applied to understand this setting. The concept of symbolic capital is that which is not physical, but which is symbolic - prestige, trust, looking like the big person. This is different to cultural capital, which may be one's academic achievements, or place of work. These are then separate from economic capital, which may be wealth, size of home, nice car etc. "symbolic capital is valid even in the market. A man may enhance his prestige by making a purchase at an exorbitant price, for the sake of his

point of honour, just to show he could do it, but he could have also taken pride in managing to conclude a deal without having given out a penny in cash" (Bourdieu, 1980, p. 119).

Doxa is the term used by Bourdieu to understand imposed rules within a field, and according to the people in that the social group will evaluate an individual and ascribe their position in that field, their legitimate position. Doxa and habitus limit the actions of the agents within a field. Keeping the status quo of the doxa will result in people conserving the rules of the doxa, and those attempting to conserve the doxa are the agents of the field who make use of capital to impose rules of the doxa that favours them all in order to prevent those who transform the doxa.

Putting this in context, in exampling the social field of a mental health hospital. Both staff and patients imposing the rules of the doxa in order to keep the status quo. A patient or member of staff may try to do things differently, may try to change this status quo of the ward and in doing so. The staff, or patient, can draw upon their capital (social, symbolic, cultural) in restoring the doxa; imposing rules that favour them to prevent the patient changing the field. A particular type of capital, institutional cultural capital, is something that a patient or member of staff may draw upon. A patient or indeed staff member with a particular persona, reputation; tall and broad that has a character of being heavy handed with patients may draw on their cultural capital as being heavy handed, and symbolic capital in their height and stature, along with their earned reputational institutional cultural capital therefore restoring the doxa and preventing change. The very same can be said of patients, who can draw on their violent histories, criminal histories, and size and stature in ensuring that the doxa is maintained. There is very minute reference to these types of capital and the reference to it during the present research. Patients often remind each other of their dangerous pasts, and sometimes remind the staff that treat them. They use their histories to control the doxa, and staff maintain the status quo as a result.

The full significance of Foucault's ethics of care, and care of the self has not yet been thoroughly researched in the field of modern mental health (Starkey & Hatchuel 2002) as most research and current psychiatric practice is based on the moralistic and normalised concepts of recovery and discharge, and the planning toward those very aims. However, all of these are based on seemingly mutually understood conceptions of what a careplan should do, which is to plan for recovery.

Care plans are mandated currently in many NHS mental health settings and these are in turn related to expert ideas about how recovery should be standardised. By contrast, the present study focused on a critical examination of care practices currently directed by the Care Programme Approach, in order to allow a nuanced examination of its assumptions in what recovery is, an idolised form of recovery, the unattainable object of desire. There is obvious applicability of Foucault's notion of the care of the self in the current research, not only throughout the patient subsample, but also with the staff subsample.

This notion of critical ontology of the self is a particularly relevant concept for this study as it allows for a careful examination of processes of engagement with the care plan within the care team and the patients from the perspective of those engaged daily in such practices. The ontological dimension of this concept is therefore also directly aimed at exploring the phenomenological and interpretative lived experiences of staff and patients. It has enabled an exploration of how patients and staff find meaning with these overarching assumptions of their roles.

In contrasting this Foucauldian concept of care of the self, with the assumptions and expectations on both patients and staff within the context of the Care Programme Approach,

one can see that a new sense of meaning is found by both parties. Patients find such a sense of meaning within the confines of the hospital setting, that they don't want to leave, and the staff, for their own reasons and for their own very specific motives, facilitate their protracted incarceration. Staff and patients are seemingly in total opposition to the global assumptions of psychiatric treatment, and in stark contrast to the original aims of the Care Programme Approach; recovery, treatment and discharge.

Ronald Laing, the Scottish psychiatrist, with an anti-psychiatry holistic approach to the whole person, rather than seeing the patient as set of symptoms. He said that these patients could be in a state of low ontological security. "The ontologically insecure person is preoccupied with preserving rather than gratifying himself: the ordinary circumstances of living threaten his low threshold of security" (Laing, 1965 pp 43). This makes understanding the preoccupation, ruminations, and paranoia that those suffering from psychosis have, more existential in its understanding, but it also could be expanded to understand the patient's appraisal of their socio-political situation and their willingness to remain in hospital, surviving and preserving the self in the face of a neoliberal recovery journey. The petrification of entering the outside world, i.e. knowing that you are unable to face and live up to the expectations of the general public and society more widely. Patients may find solace from petrification staying in the hospital setting, but in doing this may then fall victim to staff engulfment, i.e. living within the discourse of others. The patients may then play along with this discourse inauthentically, in caring for the self, projecting an image of themselves, that benefits and maintains a state and sense of ontological security void of depersonalisation.

In contrast to the above theoretical discussion, Szasz (1989), posits that mental illness is a myth. That the way some people behave and act is justly in response to life experiences, and that it is not mental illness. That medicine should not be taking away the liberty of people, for that is

not medicine's role in society. First do no harm, yet the role of psychiatry and the interventions within this branch of medicine are well known for their iatrogenic effects. The absurdity of the forensic unit and its recovery dialog; so rooted in neoliberalism and moralism, that is appears to forget that is primarily a hospital, to treat people and their illnesses. Yet, in order to do this, staff plan for their patients' education, housing, careers, hobbies and more. Szasz also explores the malingering of patients in these settings, and perhaps, some of the findings of this present study can breathe new light onto what this malingering may look like. It is not malingering in the general sense of the term, but rather one that ensures ontological security, one that cares for the self by deep acting, inauthentically and in bad faith, levering on gained capital to maintain the doxa. All to ensure that the patient is, in their mind, insulated from the world that they fear, insulated from further ontological insecurity, which brought about illness in the first place.

4.4 Research Reflexivity

This reflexivity takes its structure from the phenomenologically and hermeneutically informed structure by Walsh (2010) and elaborated on by Olmos-Vega (2023). Whilst there are reflective elements throughout the findings chapter of this work, this final reflexivity aims to address the study overall, whilst also being aware to the authors role as an insider researcher.

Personal Reflexivity

This piece of work was conducted as part of my PhD studies and stemmed from working in forensic mental health for close to 4 years, at the start of the work. Studying part time whilst working in the same setting, this brings the total time close to a decade, and how little advancements have been made in that time.

I had worked in other mental health settings, and research settings before embarking on a career in forensics. It was my experience of working with special needs children, asylum seekers and adult learners with learning difficulties, within a research capacity, that edged me toward working with these people clinically. I took on the role in forensics, knowing it would be a challenge; it was made very clear even in the advert, that the job involved physical restraint. My first day, I sat and read patient notes, in huge binders, and some of what I was reading was harrowing – and then I met the patients. They were all fine! And I wondered why they were still in hospital- this was the start of my research proposal.

I got to know the patients, and over time, they all got used to me, and me to them. They were generally all very kind, and willing to show me the rules and regulations, and were always keen to point out when I was doing something wrong. The longer I worked there, the better we got to all know each other. The relationship I fostered with the patients over the time I worked

there and indeed over the research project, became so much more relaxed, that I would have ever imagined – which again made me wonder, why these people were still sectioned in a secure mental health hospital.

In exploring this with the patients and staff I knew well, I was adopting the insider research position, which required me to undertake research into the specific dynamics that I would have to manage. I wondered whether, the patients and staff who I build up a relationship with, that was both professional, but as always with closed institutions, was more than a simple client-professional relationship. I wondered if the patients, and indeed staff, would be able to explore with me, some of the fundamentals of their experiences, of living and working in the hospital setting. I wondered whether I could allow the professional me to fall back, and for my student mode to shine through. This was confounded by the hospital, highlighting the particular boundaries that I would have to be very aware of when interviewing as a student – and how this could confuse the professional relationship. It appears as if it did not – not one bit.

The patients and staff were very willing to sit and speak with me. The patients were particularly forward with their experiences, and spoke about their journey through the hospital system, in more detail with me, than ever before. Perhaps if I wasn't a member of staff for a few years beforehand, everyone would have been more reluctant, the hospital in granting permission, the patients in agreeing to interview, the staff in agreeing to interview, and for them to contribute to analysis also.

How willing everyone was, how rich everyone's contributions were, make me ponder further, why are these patients still in hospital, and why the staff don't conduct any research.

From the day I started in the role, to the day I left, I saw many patients come and go. Many patients returning to the ward, many for the second round of treatment in so many years. I also saw many staff come and go, and many did not return. In spite of all of the new staff that were recruited over the years, the treatments and interventions, remained largely the same. Glad that I could at least in some part, contribute to that change.

Interpersonal Reflexivity

I wondered if there would be a willingness to partake in my research. Whether they were wanting to partake, because they knew me, and wanted me to do well? With the patients, I was particularly aware of the position of power and control I had, and this made it difficult for me to ask the patients, but when I got going, the patients were more than happy, and more than willing to a recorded interview.

When I met with staff, they were also willing to discuss their experiences of working and delivering care, and this was done even with the time constraints that many NHS professionals have, everyone managed to find time for me, for an interview. People to my junior, and people to my senior. Everyone was very frank, open, honest, and to my surprise were able to move beyond the usual complaining of the job, that we all enjoyed.

My insider researcher role here, perhaps also helped. The interviews were often scheduled, and rescheduled and rescheduled again, and it was this flexibility that ensured that nobody was forced or coerced into an interview. Patients were often not in the mood at the agreed time, which was fine, and of course there were no issues in rearranging, and this was done in a casual way without which led to casual interviews where people spoke frankly. The casual approach, also enabled to me interview, those patients that would often refuse to partake in such a study, and their very open and honest contributions only added to the piece of work.

I was also able to understand the nuances in the specific language that they used, participants weren't asked for clarification. I suppose, that if you are not familiar with the very specific population of the forensic setting, you would not receive the required permissions to even enter the ward to conduct the research, let alone interview the patients. I felt as if the patients were agreeing for interview, because they trusted me, and I was also equally honest with what I would do with the information collected. I felt as if this openness was down to mutual respect, built up over years of working together, that an outsider researcher, would simply not have been able to achieve. The same goes for the staff sample. Years of mutual respect built up over time, allowed me to receive the permissions from hospital management, but also from the staff that agreed for interview.

In this study, the term MDT does refer to the same generic term, but when referred to in the findings chapter, by the staff and patient sub-samples, this term generally refers to the MDT team that are not ward based, i.e. Psychologists, Psychiatrists, Occupational Therapists, and more broadly, those who are present and contribute to care delivery, primarily via the patients' ward round meetings. Whilst technically members of the MDT team, nursing staff, domestic staff and other ward based staff are, in common parlance, not referred to as members of this MDT. This is something that I as an insider research was aware of throughout, but appears to be a phenomena that is missing from the extant research corpus. I felt as if staff felt as if they were part of the MDT, but that patients did not think nor believe they were. This perhaps offered a different presentation by patients toward non-MDT staff, and differing staff experience by profession – my insider researcher position allowed me to be cognizant of this.

I did not experience the strange boundary issues that the hospital asked me to control and be aware of, not did I experience any changing dynamics because of the interviews. Nor the strange

power dynamic of trying to please and appease me, that can be found in insider researcher literature. Whilst I was aware that these could have been the case, given my position of power in the while process, I felt as if genuine responses, well-meaning questioning, frank and openness in expectations and a mutual respect across all parties, led to quality interviews. The subsequent analysis could have been only made possible, considering all of this.

The staff are difficult to interview, considering how busy they are. The patients are difficult to interview given their inherent posed danger and mental ill-health. The permissions were difficult to receive, considering the dangers of the workplace and typical NHS bureaucracy. But my insider research positioning in this incidence, not only made the research possible, but also led to an enjoyable experience for me, the patients, and the staff – I was not expecting such positive feedback afterwards.

Methodological Reflexivity

This study was conducted from within an interpretative phenomenological epistemology, with Interpretative Phenomenological Analysis as the method employed, through an existential framework and lens. This approach allowed me to not only explore the lived experience of the patients and staff, but the level of reflexivity and reflection required during the analysis method also served two purposes.

Not only did the reflective elements of the analysis help with the self-checking and reflection of interpretations, but it also acted as a way of ensuring that my insider researcher approach was also controlled for, in a reflexive way. This was of particular use when applying for permissions with the hospital. In exploring the lived experiences of participants that I already knew well in a hospital setting in which I was already working for close to a decade. The IPA method calls for

reflectivity, as did the hospital, in ensuring that I was aware of a possible change in dynamics with the patient group.

I was shocked by being asked to simply the wording of the patient information leaflets and consent forms. These were approved by the university, and edits were required by the hospital to ensure that the patients could understand and comprehend the information leaflets. There was perhaps two assumptions here; an assumption that patients wouldn't be able to understand information leaflets, and also perhaps, an assumption that I as a researcher, had not already accounted for this in the design of these participants leaflets and consent paperwork. It made me reflect, as to whether the research office at the hospital trust, thought that their patients did not understand simplified English, or whether they thought that other researchers had previously not take this into account. In any case, knowing the patients well, I felt vicarious offence.

Contextual Reflexivity

This study started in the 2010's where there was movement in the mental health treatment toward community care, reducing restrictive practices, and personalised care. There were also movements in adopting quality improvement methods into every day working and recovery collages as a new intervention. All of this this was all in the backdrop of a number of deaths in psychiatric care, and well reported scandals. Throughout the course of this research, there were even more exposé like documentaries on British TV, giving the wider public an insight into how some of these hospitals are run.

These changes only ever amounted to sticking plaster remedies to the wider institutional and social context in which the current system of care seems inadequate. There seems to be an underwritten expectation that patients with long standing psychiatric illness, living in hospital

settings for decades, with criminal histories, are going to live normal lives in the community, with a job, rental agreements, family contact and friends. The recovery model is based toward securing those tenets.

Patients are leaving a hospital setting, that has become their home and refuge. Their symptomology will probably never be in remission, their supported accommodation will always be substandard, their criminal histories will hamper employment, their friends are still in hospital, and many have no contact with family. This is in spite of the wider socio-political environment with the cost of living crisis, rising costs for food, foodbank usage and rising interest rates.

In contrast, forensic settings, are not community based and by definition are restrictive places, where personalised care is personalised in name alone. I felt from the outset of this research, the moralistic and implicit neoliberal approach to what the staff expected of patients. Some patients knew that life outside of the hospital setting, would be unbearable, or simply impossible. Staff would say, that certain patients “wouldn’t survive in the community” – jokingly referring to their general attitudes and common place argument. But there is also in that joke, a realisation, Albeit, less frankly put, that the staff know these patients won’t be able to thrive in the community either; both patients and staff know this, yet we still work toward this recovery model.

4.5 Strengths & Limitations of this Research

A strength of this study is in its originality. The researcher conducted all interviews, with patients and staff that they knew, as an insider researcher. Methodologically, this enabled patients and staff to partake at their will. Interviews were often rescheduled at last minute, and this flexibility led to some patients, who would often be disinterested or otherwise engaged in

activities or visits to the community. Research was often done during unsocial hours, i.e. outside of the 9-5 working day. This led to the often unheard voice in research adds to the originality and strength of this piece.

On another methodological and ontological note, research is often conducted by members of the MDT team, who see their patients very infrequently in comparison to ward staff. Research in the field of psychology and psychiatry, is often published by psychologists and medical doctors. The researcher in this case, was a member of ward based staff, who was with patients most working days. In contrast, MDT team members, sometimes see their patients, once per week for thirty minutes; for a ward round, or planned one to one intervention, and relationships are often more performative. The more familiar relationship in this case, led to a sense of frankness when talking about lived experience, with both the patient and staff subsample. Humphries et al., 2023, does note that many research studies fail to elaborate on the relationship between the interviewer/researcher and the population sample.

A limitation of this study, is its very specific population sample. Long stay forensic mental health patients form a very small proportion of the general forensic population, which itself, is small in comparison to the overall psychiatric patient population. Statistics available from NHS Digital (2022) show that 53,337 people in the UK, who were subject to sectioning under the Mental Health Act in 2021/22, only 222 (0.005%) of those people were subject to forensic sections. Whilst the majority of those on civil sections are short term detentions of a median of 30 days, the 222 subject to forensic sections will see them in the forensic hospital system often for years, and is an overall larger cumulative amount. Perhaps there is no specific care planning research done to cater for this specific group of patients, because the sample is so small, and research benefit too few, although this is not an ethically sound reason to not conduct such work.

The aim of IPA style research, is not to produce a set of generalisable findings, but rather to offer a nuanced and insightful exploration of the lived experience of a given sample population. These findings can offer insight and promote understanding of an under-represented sub-sample of the overall mental health in-patient population. Whilst it may be said that the findings of IPA studies can be considered “vertically” generalisable; for its ability to shed light and to enhance understanding of a given phenomenon or lived experience. This can offer researchers phenotypes for future work. IPA research is not, nor is it intended to be, generalisable nor nomothetic, but to rather offer findings rooted in ideography and to offer insights to promote wider understanding.

Even the most recent applications of care planning in the form of the CPA based Dialog+ (Mosler et al., 2020) is designed for use with general psychiatric populations and applied to forensic patients in spite of this futile approach to the simple transposition of such models of care. This study is not a mere transposition of a non-specific care plan approach, nor is it a regurgitation of the Care Plan Approach, but rather a piece that tries to argue that future care planning frameworks are beyond our current understanding of the forensic setting. Research need to be done, informed by phenomenology and the insights that are afforded us through these approaches, in spite of the small population sample that may benefit from it.

Another limitation of this work, and implication for future work, was the under exploration of expectations of staff, and their presumed and assumed roles and responsibilities. Future work could focus on staff expectations of their respective roles and responsibilities, and the actualisation of these as they began working. This could offer further insights into role expectations and actualisations. This would offer a richer contextualisation and overall richer insights into the impetus and motivations for their chosen career pathway, and their willingness to continue.

4.6 Implications for Future Research

Following from the theoretical and empirical discussions presented above, a final researcher multifaceted reflexivity and strengths and limitations, some implications for further research is presented, followed by final conclusions

Implications for Phenomenology in Care Plan Design & Clinical Practice

Taking a phenomenological approach to understanding longer stay forensic patients, can help show us the intricate power dynamics and the mechanisms that patients may use to maintain the little control they have over their life. This approach to understanding patients can show us how complicated and intricate inter-personal relationships are on the ward, between both patients and the staff that treat them. We can also gain a more illuminating understanding of the patients' and indeed staffs' lived experience and how recovery and moving toward discharge is viewed and understood by both. It is these intricate understandings that will advance care plan design, toward one which is truly engaging, meaningful and one that takes a greater appreciation for the patients' often complex and traumatic life experience. With this greater appreciation thanks to adopting a phenomenological approach, we can begin to deliver care, with a more nuanced, thoughtful, empathetic and truly person centred approach; the patients we treat deserve that, over fitting their care into a standardised, yet so-called personalised, "care plan."

Across the NHS, there is a current move away from the CPA approach in care plan design, but only in the community and not in inpatient forensic services. In recent position papers on this (NHS England, 2019; 2022), there is no reference to this change applying to the forensic

population. This is in spite of the CPA's obvious downfalls and in spite of the document referring to the CPA as being a tool which has functioned as a hinderance in delivering quality care, with an overly bureaucratic, administrative and data collection burden, with a move away from care planning, to risk reduction. There is risk of being stuck in a plan continuation bias; so much time and effort has been put into the enactment of the CPA, that it is now difficult to move away from without revealing obvious failures.

The document also refers to the CPA's last review of 2008 some 15 years ago. The position statement also refers to the lack of job description for the care coordinator, the very person who reviews and enacts the care programme approach for any given patient. A freedom of information request in reference to the above work, (NHS England, 2023), also explores how there is an identified need for training in competencies in care coordination. Some thirty years after the introduction of the CPA, there is a realisation for the need of training in the care planning methodology. After 30 years of using this framework, the NHS state that "there is little evidence to suggest that the implementation of the CPA has led to high-quality care planning when it is used, and in general there is a need for services across the country to significantly improve the quality and relevance of care planning for people with moderate to severe mental health problems" (NHS England, 2023, p. 5).

Annex A of the same document (see appendix F), highlight some issues with the CPA, from the variation in how the planning system is applied, how it leads to the creation of crude depersonalised two-tier care planning system. How it lends itself to a significant bureaucratic burden, and how it is misused and becomes inadvertently, a risk management tool. How the planning of care is static and of poor quality and lacking the co-production that the NHS so dearly values. How there is a lack of integration in other clinical aspects of care delivery, and

how there is no balanced biopsychosocial approach to care planning. Yet, this care-planning system has been in place since for 30 years without change nor improvement.

In the same FOI request, it was also made clear that forensic services were excluded from the recently released position statement, keeping forensic patients under the same care planning system that the NHS itself, has acknowledged needs updating and overhauling. There are also inconsistent recommendations on the use of risk assessments in these settings. Nice, (2022) , explore in new guidelines, that there should be a move away from risk assessment tools and scales, and toward formulation. The HCR-20, and many other risk assessments are scaled, and formulation elements are often at the informed opinion and opinions of an MDT team, the very people who have the least contact with those patients. The proposed movement toward dynamic formulations is simply more of the same. Drastic change is needed and a shift in the understanding of what recovery in these institutions means for patients needs revisiting, phenomenological exploration of patients' lived experience is poised to direct this very needed shift.

Cartwright et al., (2022), highlights that no research has previously addressed past traumas and current admissions to secure services from the perspective of service users. The present research pays specific attention to the managing of experiences of secure care and patients' past experiences, in a way that sheds light on interpersonal dynamics and recovery processes within the secure hospital. It is imperative that staff are very aware of Cartwright' et al.'s research, which shows that research with these patients, can direct the very care that staff aim to deliver, as the present research, rooted in phenomenological exploration, has aimed to also achieve.

Occupational interventions, tasks, and therapies, can be seen as therapeutic but can also be seen as punishments. Morris et al., (2016) offer caution on exploring what these interventions mean for patients, particularly when seen in the context of rehabilitation, retraining and education in a neo-liberalistic framework and eventual discharge. This present research shows that some patients see activities as pathway to discharge, hence inadvertently seen as a punishment, thwarting the will of the patient. This study also adds to this concept, as therapy as punishment, as it can be seen as a way toward discharge, and a journey to recovery and all of the assumptions that entails. Further research needs to be rooted in patients' experience of these interventions, and the staff experience of their delivery and receptibility, in being aware of how interventions can be inadvertently iatrogenic.

In the little research published on the topic, Holley et al., (2020) suggest that planning care for long stay patients in secure psychiatric settings should take account of the differing stances patients adopt towards engagement and progression, individualised opportunities, avoiding treatment repetition and maintaining continuity in key professional relationships. Foster (2022) in response to Khan & Tracey (2022) , note that the lack of research in patient engagement and carer engagement in care planning, may be due to the very fact that they were simply not engaged, or that the patents and carers refused to engage, for they know of the task is one of bureaucracy, and a meaninglessness task.

Refocusing on quality of life may be appropriate for some long-term patients who are unwilling or unable to move on. For some long-term patients, they posit the notion that purpose built and purpose designed long stay setting may be appropriate, and this view is not one which is evident amongst the research, but something that could also be deduced from the present research sample. There is an assumption that recovery entails discharge and a new found individual freedom, but these are not always the tenets that long stay patients hold in unison with wider society, for they find this freedom in the ability to choose to stay in secure care.

Findings from the present study would also warrant further research into this concept of longer stay forensic residential units, and the staff that work in the field, should be cognisant of this possible peculiarity in devising care plans, advancing clinical practice and interventions.

Macinnes & Masino, find that psychoeducational and psychosocial interventions did not reduce violence/risk in forensic settings (MacInnes & Masino, 2019). The aim of rehabilitation needs to focus on symptom reduction; psychoeducation and psychosocial interventions surely don't aim to focus on violence reduction and risk reduction. This again, highlights how the forensic setting, and the people that work within it, forget that it is a hospital designed to treat mental illnesses, not criminality or offending behaviours. The Care Programme Approach is designed to support those mental illness in the community, in improving the quality of one's life, and mental health symptomology. Applying it to a forensic population, offering interventions that are not necessarily researched for applicability and appropriateness with this very specific client group is a disservice. There is scope for interventions to be evaluated for their efficacy with this specific forensic population, for it is important to suspend the common idea that discharge and neoliberal recovery is the aim of all patients.

Criminality and violence are criminal justice issues. Patients who are violent, even when unwell, are disposed of via the criminal justice system; mentally ill patients can be charged with offences and brought to court. There is therefore a need, to implement criminal justice procedures suitably, rather than conflating criminal and violent behaviours as a precipitate of mental ill-health. If the forensic hospital's goal is to reduce criminality, it needs to plan to do that. Criminal behaviours need criminal justice interventions, not those that are designed to improve of one's mental health. Further research needs to examine the suitability of returning of patients to prison when appropriate. The forensic hospital should be for those who are unwell, as any hospital is.

Care plan design needs to be done in conjunction with forensic patients and the staff that are acutely aware of this hybrid criminal justice. The present research highlights the total fundamental inapplicability of the CPA in forensic settings. It is nigh on impossible to deliver a framework of care devised for community patients, to long stay forensic patients. This research highlights some of the very important existential nuances, that need acute understanding, that are needed in devising treatment framework that is specific, research based, trialled, and has validity and evidence of applicability. Taking a phenomenological approach in first understanding the patient experience, should be a prerequisite in designing these interventions, in advancing care, in improving clinical practice; this is overdue. A revisit of how these improvement programmes are devised is needed, and insuring that the voice of the patient, and the staff that will treat and implement plans, is heard.

Implications for Phenomenology in Education & Training

Taking a phenomenological approach to understanding longer stay forensic patients, can help show us the intricate power dynamics and the mechanisms that patients may use to maintain the little control they have over their life. This approach to understanding patients can show us how complicated and intricate inter-personal relationships are on the ward, between both patients and the staff that treat them. We can also gain a more illuminating understanding of the patients' and indeed staffs' lived experience and how recovery and moving toward discharge is viewed and understood by both. It is these intricate understandings that will advance care plan design, toward one which is truly engaging, meaningful and one that takes a greater appreciation for the patients' often complex and traumatic life experience. With this greater appreciation thanks to adopting a phenomenological approach, we can begin careplanning with a more nuanced, thoughtful, empathetic and truly person-centred approach; the patients we treat deserve that.

There is explicit and obvious need for all staff in forensic settings, to undergo specific training and education, on relational security and jail craft (Peacock et al., 2017). Whilst it is something that is often learned on the job, it needs to be explored and become part of formal training. Learning a very particular skillset on the job, where there is such risk at stake, is far from ideal. It is dangerous and not therapeutic for patients, particularly when staff misunderstand interpersonal dynamics and are not receptive of moments of high receptiveness (De Gauna et al., 2015), can lead to patients not feeling the therapeutic connection that is necessary for rehabilitation to occur in these closed settings. Patients in the present study, reflect this, with them feeling as if staff are simply there to enforce rules, and how they are enjoying doing that. A more nuanced understanding from this phenomenological perspective may afford professionals a understanding of patients' lives and experiences that is more empathetic and overall, more therapeutic.

There is a need for further specific formalised training in this field, that is mandated for anyone working in such settings. Frameworks like See Think Act, (Department of Health, 2010a) are available to forensic teams, but such relational inter-dynamic training needs mandating. There is also scope for this training to implement some of the theoretical and phenomenological argumentation made in this research and challenge the fundamental assumptions of the forensic mental health system, and recovery narratives more generally. There is also identified improvements highlighted by Markham, 2022, within the context of the use of relational security, which also draws attention to the role of power, patient collaboration and the patient staff relationship in ensuring that the tenets of See Think Act are used as viable and useful tools within the context of a forensic unit. They call for relational security to be seen as, as important, as physical, and procedural security, and highlight the attitudinal changes that may be needed from within the staff cohort.

Longer stay patients in forensic care, are generally older than the general forensic population, as in this present research. Walker et al., (2022b), highlight the need for specific attention and a review of concepts like recovery. There are needs beyond that of recovery, and they broadly mention institutionalisation, physical health, and cognitive decline as specific issues. They also posit the idea of specific training for staff working with these older populations, with input from geriatric medicine. If working with a specialised client group of an already specialised area of mental healthcare, surely staff working with these patients need very specific training that focuses on the specific needs of the patient, rather than what staff and wider society think is important. But it is not only clinical training that is required, it is also important to have a true understanding of their lived experience as a foundational basis in order to foster a truly therapeutic environment and for relationships to flourish. This is highlighted by Seaward et al., (2023) with their call for research into perspectives of incarcerated older patients, in

understanding the difficulties of reintegrating into wider society. The nuanced view in the present study, gives an insider view into what the patient sees as important and meaningful, and often this is in contradiction of the wider societal view. The present research explores recovery with this sample and finds that the concept is much more complicated and nuanced than commonly thought, showing the value of research from this phenomenological approach.

There is also a need to explore the history of forensic settings, and their place and meaning in wider society. In order to understand the wider socio-political issues that these patients face, a knowledge of the secure hospital system is needed, and then can care planning be informed by the particular jurisprudence that is void from care planning. Many staff members in forensic settings, have no formal nursing, psychology, or psychiatric training. Whilst this is not an issue in itself, and it is often these staff members who offer the most therapeutic relationships for their patients, there is a need for them to understand the greater socio-political environment surrounding the patient’s life and lived world. There may then, be a more nuanced understanding of some patients’ willingness to stay in hospital, proclaiming that they will never leave, or even, to understand the strange and unusual behaviours that are often assaultive and a precipitative of discharge anxiety.

Furthering that, there should be an acute awareness of socio-cultural and socio-economic antecedents and consequences of being a forensic patient, and how this needs to be explored in a wider context when training staff. Difficulties in securing housing, often insecure and difficult to attain employment, are both antecedents to the patients becoming unwell, but also a precipitate of them being in the hospital system for many years. Patents may be aware that they are returning to a life, in which they first became unwell, and know that the hospital is the best choice for them. There needs to be an acute understand of this.

Ançel et al., (2022) say that nursing students find care plans difficult to use but seem to see their value. They note how care plans are obstructive, and how they are robotic, boring, and not engaging. It suffices to say, the patients who much partake in their creation, must also feel the same. Care plans needs to be specific, engaging for the patient, and meaningful for the patient, where they can see the value, it can pose. Rather than engaging with its creation on a purely tokenistic level in acknowledgment of its sheer bureaucratic nature, staff and patients should plan for what the patient needs to lessen symptomology. If nursing students find these care plans difficult to use, how is a chronically unwell, long stay patient, to engage and contribute to its completion, particularly when the staff and patient themselves, are actually planning for two different journeys.

Forensic mental health is a system primarily set up to enable the recovery of mentally ill offenders, and to protect the public from the risk that they may pose. Primarily through the use of medicine, psychotherapy and the physicality of the secure hospital unit, the system aims to slowly reintegrate patients into the community. While the history of the total institution and the asylum seems to have moved so little in the last century, it is the introduction of medicine and that has been the primary driving force in the recovery focused narrative. The healthcare management class, have implemented a model of healthcare which is transactional, tokenistic and so simplified, that staff are now focused on targets, goals and professional management. They have forgotten, or perhaps never truly understood the complexity, history, and nuances of these institutions. Until only recently, these complex places that were the subject of examination of philosophers and sociologists, this is something that needs to be invigorated. A revisiting of our understanding of these hospitals is overdue, for their function in society has changed somewhat since the primary and theoretical research of Goffman and others aforementioned. Phenomenological exploration is poised ideally for this.

While commissioners and senior management have concerned themselves with the implementation of medicine, frameworks, and guidelines for care, they seem to have negated understanding the intricate interpersonal dynamics that occur in these closed institutions, something that was so well chronicled and understood by Goffman and others. Bourdieu's concept of the field and capital, Sartre and DeBeauvoir's inauthenticity, Deleuze & Guittari's deterritorialisation, Foucault's care of the self and Fromm's alienation. The study of the intricate interpersonal dynamics and meaning making processes of the people living and working within the institution is something that is forgotten about. With such a relevant critique, a philosophy of mental health treatment, informed by the very philosophers that originally explored this, needs to be taught to professionals during their training, and indeed, refreshed with the changing function that the forensic mental health system has assumed in society. A phenomenological approach can afford us an insights beyond systematic and bureaucratic box-ticking mentalities, toward a model of care that is truly meaningful and effective.

"Evidence-based practice is often not implemented in nursing for reasons relating to leadership**"** (Clavijo-Chamorro et al., 2022). Interventions and how care is planned for, needs to be rooted in research and evidence. Student mentors experienced that participating in peer mentoring had been strengthening the road to becoming a professional nurse. Student mentees experienced that participating in peer mentoring had been strengthening the studying and learner role in clinical placement (Jacobsen et al., 2022). What is taught, needs to be evidence based, and from staff with experience; those that have not been lost to budget cuts. They also must have the experience and acute understanding of the socio-political history of these institutions, before becoming a peer mentor for new starters in the field.

Implications for Phenomenology in Forensic Settings & Public Health

By exploring and understanding the lived experiences of forensic patients, and the staff that work in the field, from the perspective of phenomenology one is afforded a more nuanced view which is more empathetic to the subtlety of this very particular field of mental health care. Having a heightened awareness of the experience of those in the system not only allows for a greater understand of their experience of illness, but also of the systematic injustices that many of these patients face. It is the responsibility of those working in the field, to address the hermeneutical injustices in forensic mental health and advocate against these injustices in the wider public health sphere. There is a need to move away from presumptions and assumptions in delivering care, away from neoliberal and moralistic care pathways, and to refocus on the systemic inequalities in wider society that contribute to trauma, mental illness and criminality. Only when the wider hermeneutical injustices that are ingrained in forensic care are addressed, can we truly understand what we should be aiming to deliver; meaningful care and interventions that address true inequalities in public health. Phenomenological approaches can offer us a re-humanisation of care, the lost human touch, an insight into care delivery which is not only more empathetic to patient experience, but one that is truly compassionate and kind.

O'Shaughnessy (HM Government, 2023) has recently been commissioned by the UK Government to explore research and clinical trial provision in the UK's NHS. In his article (O'Shaughnessy, 2023) he notes that less trial activity means fewer patients access to effective treatments, and significant costs to the NHS. Apart from the necessary change in attitude of patients, clinicians, managers and politicians have toward research, he highlights the untapped appetite to take part in research if only the bureaucracy can be cleared away, and time can be afforded o those staff who wish to partake and perform in such research. The malaise of research within the NHS has traditionally been attributed to bureaucratic barriers, but can also be attributed to a lack of capacity, whether this be time or willingness. There is also perhaps, a

lack of research skills within the workforce, with traditionally, only those with education in medicine and psychology having been explicitly taught research skills when training. Those with the intimate knowledge of careplanning and its application are front line staff, so it would be conducive for front line staff to undergo some research skills and training to foster this research environment that O'Shaughnessy wishes proposals for review. There then might be advancement in the care planning field and the CPA and care planning more widely, 30 years after this implementation, and phenomenological methodologies are well placed to deliver re-humanised approaches to future research in this field.

Hospital management do not need to be clinical staff, but rather those that are professional managers who have specific training in running businesses. Clinical staff need to be in clinical settings, to prevent their loss to the management class, but also to ensure that experience stays on the front foot, for with this experience, there may be some awareness of the way patients and staff use the system to their own aim. There is a drive to hire nurses from abroad to work in the UK's NHS, considering there is very much a shortage in nationally trained health professionals. Hiring these staff members from abroad, not only comes with the culture shocks these staff experience but also with its own specific issues for forensic mental health long stay patients (Callister et al., 2020). Not only will these new recruits have to become accustomed to the cumbersome IT, records management systems, and other NHS bureaucratic systems, but they may also come with a lack of understanding of the very specific socio-political and social justice issues that these patients face.

Political theory of what is acceptable to the general public, and how the care planning system falls within the smallest Overton window of policy, with no stretch into the degrees of acceptance. The policy of care planning is neither popular, sensible, acceptable, radical nor unthinkable. It falls within the smallest mainstream window of thought, which is void of radical

change, and perpetuates a sense of sameness. There is a need for a shift in the Overton window as to what recovery is, and what expectations are for all involved in long stay forensic care; a re-exploration is in dire need.

In a qualitative meta synthesis by Callister et al., (2019), describes caregiver perspectives of care coordination for patients discharged from the hospital with five main themes emerging; suboptimal access to clinicians after discharge, feeling disregarded by clinicians, need for information and training at discharge, overwhelming responsibilities to manage appointments and medications, and need for emotional support. Findings from this meta synthesis suggest the need for clinicians to engage with caregivers to provide support, training, and communication after hospital discharge (Callister et al., 2020). The current research reflects some of these concepts, particularly when one explores the overwhelming responsibilities that patients suddenly face, albeit with the support of caregivers.

Hasnain notes that staff will inadvertently rely upon anecdotal experience and less well-established information while managing patients (Hasnain, 2010). Falcus & Johnson (2018) working with patients with personality-disorders, they make argument for more specific forensic evidence based treatment. Tomlinson (2018) reviews the use of dialectical behavioural therapy, a common intervention with those with personality disorder therapies within forensic inpatient services. They note of the importance and efficacy of the therapy, noting that this is only preliminary evidence that DBT has the potential to reduce recidivism risk in criminal justice systems, in spite of its use being widespread. This is also in ignorance to the willingness and motivations of patients. Merkt et al., (2021) call for further research into the dual role of the psychotherapist in a custodial setting, in supporting staff to develop truly therapeutic relationships. Khan et al., (2015), highlight the further research needed in pharmaceutical interventions for those who have committed sexual offences. There is a simple, and obvious

need for research based evidence for the choices in care planning, interventions and patient pathways in forensic mental health care, something that phenomenological research avenues can not only offer meaningful insights on, but would also offer us the paradigm shift that is needed in this field and offer us phenotypes for future research that would afford us foundations onto which we can build truly meaningful and effective spaces for recovery.

MacInnes & Masino (2019) examine evidence for the use of psychological and psychosocial interventions offered to forensic mental health inpatients, the authors note that current practice is based on limited evidence with no consistent significant findings. Klinglemann et al., (2019) explores the experiences of patients and clinicians regarding specialisation of teams and personal continuity of care and find that there is no evidence of differences in patient outcomes between either approach. Schoppmann et al., (2023) finds that the staff in their study, questioned the applicability of this approach, in a custodial setting, they claim that they are uncertain that recovery orientated practices and care planning can be introduced at all in such an environment.

Approaches to choosing a treatment team are not based in research, psychosocial and psychological interventions that have no consistent evidence on effectivity, DBT having only preliminary evidence for effectivity with forensic patients, and staff replying on techniques with only anecdotal evidence of effectivity when managing patients. Care planning too, with little evidence on effectivity on how successfully they plan for care, particularly in forensic settings. There is a need for evidence-based and effective interventions, care planning and decision making; those that are rooted in research and with proven effectivity.

The lack of research in designing interventions is not unique to forensic settings. The SIM; Serenity Integrated Monitoring model, adopted by some NHS Trusts, and recently denounced

as unethical, sees the police being used to turn away frequent attendees at mental health hospitals using often harsh treatment of patients, and coercive methods to discourage attendance of patients in need, showing the de-humanisation of the current mental health system and the need for a re-humanisation in research that phenomenological approaches can afford us. House, (2023), also highlights the need to manage the balance between pressures for innovation in the National Health Service against those for evidence-based and patient-centred practice." The model has since demised, but its implementation and the harm done, was again, void of any research basis.

There is an obvious and overwhelming need for research-based interventions and research based care-planning, and this present research rooted in the phenomenological tradition shows that when that work is done, one can have a nuanced view of the situation. Through adopting this approach we are afforded a view that is enriched, enhanced and more empathetic and understanding. With these insights and phenotypes for future work, we can truly advance patient care delivery, ensure it is meaningful, effective and sustainable.

4.7 Conclusion

This study aimed to explore the lived experience of the staff and service users, in order to better understand their lived world, in order to direct care advancements. This study appears to be the first, that has explored the lived experience long stay forensic mental health patients and staff that treat them, in this broad sense, not restricted with a specific aim of exploring positives nor negatives of care as is well described and researched in the literature. This has offered future researchers phenotypes for future research, and a argues for a call to return to phenomenological explorations of these complex environments and systems; before we try to advance patient care, we need to truly and authentically understand the lived experience.

We can conclude that care planning in forensic mental health, has been adopted from general community psychiatry. This is then applied by staff in forensic settings, to an effort to plan for care. Planning for care using the care programme approach (CPA), negates to consider the very considerable socio-political obstacles and challenges that long stay forensic mental health patients face. But rather, having this broad understanding of the patients' lives rooted in phenomenology, illuminates that the forensic hospital serves a very different purpose, and is experienced very differently than professionals may understand.

For professionals, delivering care is not helped, efficiently directed nor enhanced by the CPA. For through the exploration of their experiences, it can be seen that the care plan is a mere tool of bureaucracy. It is revealed that their working day is one of firefighting, delivering very little in the way of care, and ultimately feeling ineffective and as if they are doing a bad job.

In uncovering of the folly of the forensic hospital; staff are aware that some patients may use the system for their own gain and ultimately as a tool for survival. Discharge is not the aim for

all patients, but it is ultimately the job of staff. Both staff and patients try to work toward that aim, sometimes both authentically, and oftentimes both in bad faith.

If care must be planned for formally, then there must be an effort to take into consideration, the very specific psychosocial, socioeconomic, and neo-liberal political aspects of recovery that long stay forensic mental health patients face. Not only is there a need for staff to garner skills and abilities to be fully aware of institutional interpersonal dynamics on the ward, but additionally, the intricate and nuanced social barriers that their patients face upon discharge, and of which their patients are already very aware and ensure that their stay perpetuates as a means of survival. Returning to phenomenological research methodologies in understanding recovery and treatment from an existentialist framework, can offer us a new foundation onto which, we can deliver meaningful care; this reframing is needed if we are to truly change care delivery for the better.

In order for the forensic hospital to effectively deliver for long stay forensic patients, it needs to function more like a hospital and less like a hospice. For it to serve as society's place for historically dangerous and mentally ill offenders, and for those patients to feel safe and wish to stay, is a societal injustice to those patients and the staff that work with them.

The current model of care for these long stay patients, is providing a final institutionalising refuge, that speaks to the workhouses of yesteryear. The more things change, the more they stay the same. The classical liberal age of 18th century and the neo-liberal movement of the 20th century, has brought us full circle.

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6. Appendices

Appendix A – Ethics Documentation

Appendix B – Interview Schedules

Appendix C – Information & Consent Paperwork

Appendix D – IPA Thematic Journey

Appendix E – Forensic Mental Health Contextualisation Vignettes

Appendix F – Freedom of Information Request Documentation

A Ethics Documentation

University of East London UREC Approval and Amendments

26th July 2017

Dear Luke,

Project Title:	**Finding Meaning in Forensic Secure Care: An Interpretative Phenomenological Analysis**
Principal Investigator:	**Dr Luis Jimenez (DoS) and Dr Lucia Berdondini**
Researcher:	**Luke Quane**
Reference Number:	**UREC 1617 47**

I am writing to confirm the outcome of your application to the University Research Ethics Committee (UREC), which was considered by UREC on **Wednesday 22 March 2017.**

The decision made by members of the Committee is **Approved**. The Committee's response is based on the protocol described in the application form and supporting documentation. Your study has received ethical approval from the date of this letter.

Should you wish to make any changes in connection with your research project, this must be reported immediately to UREC. A Notification of Amendment form should be submitted for approval, accompanied by any additional or amended documents: http://www.uel.ac.uk/wwwmedia/schools/graduate/documents/Notification-of-Amendment-to-Approved-Ethics-App-150115.doc

Any adverse events that occur in connection with this research project must be reported immediately to UREC.

Approved Research Site

I am pleased to confirm that the approval of the proposed research applies to the following research site.

Research Site	**Principal Investigator / Local Collaborator**
UEL interview rooms and participants' home	Dr Luis Jimenez (DoS) and Dr Lucia Berdondini

Approved Documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
UREC application form	2.0	17 July 2017
Appendices	1.0	7 March 2017
Post Interview & Debrief – Service Users	1.0	7 March 2017
Post Interview & Debrief - Professionals	1.0	7 March 2017
Information letter - Professionals	1.0	7 March 2017
Consent form - Professionals	1.0	7 March 2017
Information letter – Service Users	1.0	7 March 2017
Consent form – Service Users	1.0	7 March 2017
Interview schedule/ indicative topic guide - Professionals	1.0	7 March 2017
Interview schedule/ indicative topic guide – Service Users	1.0	7 March 2017
HRA certificate MRC	1.0	19 July 2017
HRA – Does my project require review by a Research Ethics Committee?	1.0	17 July 2017

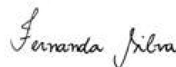
Approval is given on the understanding that the UEL Code of Practice in Research is adhered to.

The University will periodically audit a random sample of applications for ethical approval, to ensure that the research study is conducted in compliance with the consent given by the ethics Committee and to the highest standards of rigour and integrity.

Please note, it is your responsibility to retain this letter for your records.

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

Yours sincerely,



Fernanda Silva
Administrative Officer for Research Governance
University Research Ethics Committee (UREC)
Email: **researchethics@uel.ac.uk**

University of East London

Dear Luke

Application ID: ETH1819-0159

Original application ID: UREC 1617 47

Project title: Finding Meaning in Secure Care: An Interpretative Phenomenological Analysis

Lead researcher: Mr Luke Quane

Your application to Psychology School Research Ethics Committee was considered on the 8th of May 2019.

The decision is: **Approved**

The Committee's response is based on the protocol described in the application form and supporting documentation.

Your project has received ethical approval for 2 years from the approval date.

If you have any questions regarding this application please contact Research, Research Degrees and Ethics.

Approval has been given for the submitted application only and the research must be conducted accordingly.

Should you wish to make any changes in connection with this research project you must complete 'An application for approval of an amendment to an existing application'.

Approval is given on the understanding that the UEL Code of Practice for Research and the Code of Practice for Research Ethics is adhered to.

Any adverse events or reactions that occur in connection with this research project should be reported using the University's form for Reporting an Adverse/Serious Adverse Event/Reaction.

The University will periodically audit a random sample of approved applications for ethical approval, to ensure that the research projects are conducted in compliance with the consent given by the Research Ethics Committee and to the highest standards of rigour and integrity.

Please note, it is your responsibility to retain this letter for your records.

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

Yours sincerely

Fernanda Silva

Research, Research Degrees and Ethics

University of
East London

Dear Luke

Application ID: ETH1920-0005

Original application ID: Application ref: UREC 1617 47 & Ammendment ETH1819-0159

Project title: Finding Meaning in Secure Care: An Interpretative Phenomenological Analysis

Lead researcher: Mr Luke Quane

Your application to Psychology School Research Ethics Committee was considered on the 10th of September 2019.

The decision is: **Approved**

The Committee's response is based on the protocol described in the application form and supporting documentation.

Your project has received ethical approval for 2 years from the approval date.

If you have any questions regarding this application please contact your supervisor or the secretary for the Psychology School Research Ethics Committee.

Approval has been given for the submitted application only and the research must be conducted accordingly.

Should you wish to make any changes in connection with this research project you must complete 'An application for approval of an amendment to an existing application'.

Approval is given on the understanding that the UEL Code of Practice for Research and the Code of Practice for Research Ethics is adhered to.

Any adverse events or reactions that occur in connection with this research project should be reported using the University's form for Reporting an Adverse/Serious Adverse Event/Reaction.

The University will periodically audit a random sample of approved applications for ethical approval, to ensure that the research projects are conducted in compliance with the consent given by the Research Ethics Committee and to the highest standards of rigour and integrity.

Please note, it is your responsibility to retain this letter for your records.

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

Yours sincerely

Fernanda Silva

NHS Ethics Approval

PRIVATE AND CONFIDENTIAL

Prof Frank Röhricht
– Research, Innovation & Service Development
Chair Ethics Committee
East London NHS Foundation Trust
Website: http://www.eastlondon.nhs.uk

08th August 2019

Re Study: "Finding Meaning in Secure Care: An IPA (Interpretative Phenomenological Analysis) version No 3; 15/05/2019 with revised PIS dated 23.07.19

Dear Luke Quane,

Following the review of your proposal by ELFT's ethics committee I am happy to give Chair's approval for this project.

No ethical issues identified within the revised version of the project description.

Best wishes

Frank Röhricht, MD FRCPsych
Consultant Psychiatrist & Associate Medical Director
Honorary Professor of Psychiatry
East London NHS Foundation Trust

020 7655 4000
0777 3352374
www.mus.elft.nhs.uk
frank.rohricht@elft.nhs.uk
Trust HQ, 9 Alie Street, London, E1 8DE

We care We respect We are inclusive

Chair: Marie Gabriel Chief Executive: Dr Navina Evans

B Interview Schedules

Staff Subsample Indicative Topic Guide

Interview Schedule/Indicative Topic Guide

Professionals

1. Intro Session
    a. Greetings and introductions.
    b. Questions about this interview schedule.
2. The Workplace & The Hospital
    a. How has this experience, working in this hospital, been for you?
    b. What does the working day look like? *(How is that for you? What happens during the day?)*
    c. What is it like working in a hospital like this? *(How does it feel? Its effect on you? Emotional? Physical?)*
3. The Staff
    a. What have the staff been like as work colleagues? *(What's good about that, what's bad about this? What are they like to work with?)*
    b. How do you know when the team is working well together? *(Not work well? What is that like for you? How does it make you feel? Staff patient interactions?)*
    c. Can you tell me about an experience of when the team did (not) work well? *(What was that like? How does that effect you?)*
4. The Patients
    a. What is it like working with these patients? *(What does it mean for you to work with them? Is it difficult/easy?)*
    b. Can you talk to me about a time that was difficult (rewarding) when working with these patients? *(how was it difficult/rewarding? How does that feel when its difficult/rewarding? What was that experience like for you? How was that emotionally for you?)*
    c. Is there an example of a time when you found yourself being particularly effective (not effective) in rehabilitation? (*what is that like? How does that make you feel?)*
5. Delivering Care / CPA
    a. What is your personal experience of delivering care in your specialism? *(OT, PSYCH, NURSE, PSYCHIATRY, SOCIAL WORK etc. What does work? Not work? Helpful? Not helpful?)*
    b. In your own words, what is like working in a multi-dicipilinary team? *(Feeling valued? Listened to? How does it feel when you make a difference/not?)*

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   c. Can you think of a time when the care plan approach to care has worked well/not worked? *(what worked? didn't work? What is it like when it works/doesn't work? How does it feel?)*
6. Rehabilitation & Recovery of Patients
   a. What kind of things do you do in the hospital to help rehabilitate patients? *(how do you do this? What works, what does not work?)*
   b. Can you share with me a time when a particular intervention made a real difference to a patient (help them rehabilitate)? *(what went well, what didn't go well, how does it feel for you as a professional?)*
   c. What does the patients' recoveries mean to you? *(in relation to the CPA? How do you feel when someone is getting better? Satisfaction?)*
   d. What in your view, helps the most in recovery? *(what works, what doesn't, what stops, hinders?)*
7. Staying out of Hospital
   a. Can you tell me of a time when a patient stayed out of hospital? *(what worked, how did it feel for you? What worked for the patient and for you?)*
   b. What is it like for you when a patient returns to care? *(how does it make you feel? What do you think are the reasons for them returning?)*
   c. What are your feelings on patients who purposefully plan and succeed in returning to care? *(how does that make you feel?)*
   d. Are there any changes in their care when the patients return? *(are there new interventions, new medications? Any change? New careplans? How do you feel about those changes if any?)*
   e. How do professionals address returning to care? *(What can be done in your view, how can it be done? Changes? New interventions? Ongoing aftercare?)*
8. Debrief – questions on separate schedule.
9. Researcher voice reflective.

Patient Subsample Indicative Topic Guide

Interview schedule/indicative topic guide

Service Users

1.
Existential World
How has your experience of being in this hospital been for you so far? What does this mean to you?
Can you tell me how an ordinary average week-day is for you at hospital?
How is an ordinary weekend day for you? (what happens, how is that for you.)

2.
Environment Creation

The Staff
What have the staff been like?
(What works? Does not work? Do you communicate to staff? What about? How is that? Helpful? How?

The Patients
What is it like living with people who are unwell?
What does this mean to you?
(Is it easy difficult? why? how? have friends? Does they help?)

The Hospital
What is it like living in a hospital like this?
(Restrictive? Difficult? Easy? What makes it so? How is that for you?)

3.
Care Delivery
How is your experience of the care provided?
(What works? Does not? Helpful? Not helpful? Why? Nursing care? Psychology care? Medicine? Explore?)

4.
Rehabilitation
What kinds of things do you do in the hospital to get better?
(Useful? Why? How? Groups? Activities? Leave? Feel better after?)

Do you feel as if activities, groups or sessions help you get better?
(How? Effective? Experience? Interesting? Frustrating?)

5.
Recovery

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What does recovery mean for you?
(explore, what will change? remain the same? want to change? How?)

What helps in recovery?
(What has helped? Explore? What can the hospital do? Change? Explore?
)

6.
Staying Out

Can you tell me about an example of you staying out of hospital?
(What worked? What did not? What would you want/prefer to do/have as part of being out of hospital?

Plans for when you leave?
How long have you been in this hospital? Do you have life plans after you recover (e.g., leave this open for them to look at this in context, as this would not only be restricted to recovery from ill mental health symptoms but also about their quality of life overall,e.g., does this include them still counting on family/friends, social support/financial support/ legal support?

What will be most difficult about staying out of hospital?

Staff Subsample Debrief

Post Interview & Debrief

Professionals

Post Interview

1. How do you feel having completed the interview?
2. Do you have any concerns or questions about the process of the interview or the research in general?
3. Do you feel that the questions were biased in any way?
4. Do you think that the questions asked were open, enabling you to express yourself freely
5. Did I in any way influence your responses?
6. Do you feel that you were able to talk about areas that are important to you?
7. Were there any questions that you think I should have asked or that you wish I had asked?
8. Do you have any recommendations or observations about what would make this interview more effective?

Thank you for your valuable contribution to this study and I hope you enjoyed taking part in it.

Debrief

As part of the interview transcription process I will use a unique participant name or ID number to protect your identity. I am the only one who will have your name and contact details, and they will be destroyed after the end on the research project.

The information I gather from your interview will only be shared in an anonymised way with my supervisor who will not be able to identify you. Anonymised interview transcripts from your interview may be included and will be read by examiners and readers of my research if it is published.

In case the interview process has brought up any distressing feelings and you feel that you need further support to process them, you can contact any service from the list below. There, you will find adequate support and people that are willing to help you with this:

ELFT Employee Assistance Programme
Contactable on freephone number: 0800 282 193 or
By visiting their website on www.ppconline.info.

Forensics Human Resources
Internal Human resources department: 0208 510 2005

Patient Subsample Debrief

Post Interview & Debrief

Service Users

Post Interview

1. How do you feel having completed the interview?
2. Do you have any concerns or questions about the process of the interview or the research in general?
3. Do you think that the questions asked were open, enabling you to express yourself freely?
4. Did I in any way influence your responses?
5. Do you feel that you were able to talk about areas that are important to you?
6. Were there any questions that you think I should have asked or that you wish I had asked?
7. Do you have any recommendations or observations about what would make this interview more effective?
8. Is there anything that you would like me to hand over to the nursing team.

Thank you for your valuable contribution to this study and I hope you enjoyed taking part in it.

Debrief

As part of the interview transcription process I will use a unique participant name or ID number to protect your identity. I am the only one who will have your name and contact details, and they will be destroyed after the end on the research project.

UEL University of East London

The information I gather from your interview will only be shared in an anonymised way with my supervisor who will not be able to identify you. Anonymised interview transcripts from your interview may be included and will be read by examiners and readers of my research if it is published.

In case the interview process has brought up any distressing feelings and you feel that you need further support to process them, you can contact any service from the list below. There, you will find adequate support and people that are willing to help you with this

Complaint form
These are available on-ward

The Care Quality Commission
The CQC are contactable on free-phone 0300 061 6161

Advocacy
Numbers for patient advocacy by Mind, 0800 011 6114

PALS
Numbers for PALS, a patient advice and liaison service. 0800 783 4839

C Information & Consent Paperwork

Staff Subsample Information & Consent Paperwork

Information Letter
Professionals

University of East London
Stratford Campus
Water Lane
Stratford
London
E15 4LZ

Research Integrity
The University adheres to its responsibility to promote and support the highest standard of rigour and integrity in all aspects of research; observing the appropriate ethical, legal and professional frameworks.
The University is committed to preserving your dignity, rights, safety and wellbeing and as such it is a mandatory requirement of the University that formal ethical approval, from the appropriate Research Ethics Committee, is granted before research with human participants or human data commences.

Director of Studies
Dr Luis Jimenez
School of Psychology, UEL, Water Lane, Stratford, London
l.jimenez@uel.ac.uk

The Principal Investigator
Luke Quane
School of Psychology, UEL, Water Lane, Stratford, London
l.quane@uel.ac.uk

Consent to Participate in a Research Study
The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in this study.

Project Title
Finding Meaning in Forensic Secure Care: An Interpretative Phenomenological Analysis

Project Description
The purpose of this project is to explore and understand your experiences of the process of recovery within long term, medium secure, forensic mental health services.

University of East London

You will be asked a series of questions by the researcher, and the conversation (face to face research interview meeting) will be audio recorded. The interview will last no more than 1 hour, after which there will be a short debriefing session with you.

There are no envisioned hazards nor risks to highlight.

You are not likely to experience after-effects, discomfort or distress during the research

It is not envisioned that you will require any aftercare

Confidentiality of the Data

Your confidentiality will be maintained unless a disclosure is made that indicates that you or someone else is at serious risk of harm. Such disclosures may be reported to the nursing team.

All data will be anonymised after interview and during transcription. All identifying information, explicit or implicit, will be de-named.

All electronic data will be stored on encrypted hard disks, to which only the researcher will have passcodes. All paperwork related to the project will be stored in a lockable filing cabinet, to which, only the researcher will have access.

After project completion, and after a time stipulated by ethics, 36 months, hardcopy paperwork will be shredded to the standard 'DIN 4.' This ensures that paperwork is cross cut to particles of a size of 4x40mm.

All electronic data will undergo secure disposal. Research files will undergo 'overwriting' after which, the electronic files will be completely irretrievable.

Data generated in the course of the research will be retained in accordance with the University's Data Protection Policy.

Location
University of East London, Stratford Campus

Disclaimer
Your participation in this study is entirely voluntary, and you are free to withdraw at any time during the research. Should you choose to withdraw from the programme you may do so without disadvantage to yourself and without any obligation to give a reason. Please note that your data can be

withdrawn up to the point of data analysis – after this point it may not be possible.

University Research Ethics Committee
If you have any concerns regarding the conduct of the research in which you are being asked to participate, please contact:

Catherine Fieulleteau, Research Integrity and Ethics Manager, Graduate School, EB 1.43
University of East London, Docklands Campus, London E16 2RD
(Telephone: 020 8223 6683, Email: researchethics@uel.ac.uk)

For general enquiries about the research please contact the Principal Investigator on the contact details at the top of this sheet.

University of East London

Consent Form
Professionals

Finding Meaning in Forensic Secure Care: An Interpretative Phenomenological Analysis

Mr Luke QUANE, Dr Juis Jimenez – Director of Studies

Please tick as appropriate:

	YES	NO
I have the read the information leaflet relating to the above programme of research in which I have been asked to participate and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.		
If participation is to be audio or video recorded, please state this and ask participants to confirm they consent.		
I understand that my involvement in this study, and particular data from this research, will remain strictly confidential as far as possible. Only the researchers involved in the study will have access to the data. *(Please see below)*		
I understand that maintaining strict confidentiality is subject to the following limitations: Your confidentiality will be maintained unless a disclosure is made that indicates that you or someone else is at serious risk of harm. Such disclosures may be reported to the nursing team.		
Anonymized and de-named quotations may be used in publications.		
Findings may be published in peer reviewed journals, a thesis and presentations.		

University of East London

It has been explained to me what will happen once the programme has been completed.		
I understand that my participation in this study is entirely voluntary, and I am free to withdraw at any time during the research without disadvantage to myself and without being obliged to give any reason. I understand that my data can be withdrawn up to the point of data analysis and that after this point it may not be possible.		
I hereby freely and fully consent to participate in the study which has been fully explained to me and for the information obtained to be used in relevant research publications.		

Participant's Name (BLOCK CAPITALS)

…………………………………………………………………….

Participant's Signature

………………………………………………………………………………………..

Investigator's Name (BLOCK CAPITALS)

…………………………………………………………………..

Investigator's Signature

……………………………………………………………………………………….

Date: ………………………….

Patient Subsample Information & Consent Paperwork

Information Letter
Service Users

University of East London
Stratford Campus
Water Lane
Stratford
London
E15 4LZ

Research Integrity
The University adheres to its responsibility to promote and support the highest standard of rigour and integrity in all aspects of research; observing the appropriate ethical, legal and professional frameworks.
The University is committed to preserving your dignity, rights, safety and wellbeing and as such it is a mandatory requirement of the University that formal ethical approval, from the appropriate Research Ethics Committee, is granted before research with human participants or human data commences.

Director of Studies
Dr Luis Jimenez
School of Psychology, UEL, Water Lane, Stratford, London
l.jimenez@uel.ac.uk

Researcher
Luke Quane
School of Psychology, UEL, Water Lane, Stratford, London
l.quane@uel.ac.uk

Consent to Participate in a Research Study
This letter is to give you the information you need to decide whether or not to partake in a research project.

Project Title
Finding Meaning in Forensic Secure Care: An Interpretative Phenomenological Analysis

Project Description
The purpose of this project is to explore and understand your experiences of the process of meaning making within long term, medium secure, forensic mental health services.

You will be asked a series of questions by the researcher, and the conversation that is had will be audio recorded. The interview will last no

more than 1 hour, after which there will be a short debrief interview. This debrief session is to explore your experiences of partaking in the study. It is also a space for you to ask final questions, and for the researcher to enquire as to your wellbeing before ending.

There are no envisioned hazards nor risks to highlight as part of your engagement in the research study.

You are not likely to experience after-effects, discomfort or distress during the research

It is not envisioned that you will require any aftercare.

The investigators have passed appropriate Disclosure and Barring Service checks, Criminal Records Checks.

Participation in the research will have no impact nor benefit on your treatment, and does not form part of your treatment.

Why You, and Why Take Part?
You are being invited to take part in this research which aims to explore the range of meaning making processes in long stay mental health patients, as it is important to understand how you have experienced being a long stay patient in secure hospitals and how to best support you.

Confidentiality of the Data
Your confidentiality will always be maintained unless a disclosure from yourself indicates that you or someone else is at serious risk of harm. Such disclosures will be discussed with you first and may be reported to the nursing team if needed in order to support you and keep everyone safe.

All information discussed at interviews (also known as "research data") will be anonymised after each audio recorded interview and during transcription. All identifying information, explicit or implicit, will be de-named. This means you identity will remain anonymous.

All research information will be stored electronically on encrypted hard disks, to which only the researcher will have passcodes. All paperwork related to the project will be stored in a secure filing cabinet at the University of East London, to which, only the researcher will have access. The director of studies will have access to the anonymised data only.

After project completion, and after a time stipulated by ethics, 36 months, all related hardcopy paperwork will be shredded to the standard 'DIN 4.'

This ensures that paperwork is cross cut to particles of a size of 4x40mm before this being disposed of.

All electronic data (audio recordings) will also undergo secure disposal. Research files will undergo 'overwriting' after which, the electronic files will be completely irretrievable. Audio recordings will be done on an encrypted recording device and will undergo secure disposal when transcription is complete.

Research data generated during the research will be retained in accordance with the University's Data Protection Policy, with the Principle Investigator, Luke Quane (contact details below), responsible for the confidentially of the data.

Location
The John Howard Centre,
London,
E9 5TD.

Reward
If you choose to partake, you will be rewarded with a 10£ high street clothing voucher.

Disclaimer
Your participation in this study is entirely voluntary, and you are free to withdraw at any time during the research. Should you choose to withdraw from the programme you may do so without disadvantage to yourself and without any obligation to give a reason. Please note that your data can be withdrawn by you letting me know you do not want your data to be used in the research up to the point of data analysis, 2 weeks from the interview date after this point it may not be possible.

Concerns or Complaints
If you have any concerns regarding the conduct of the research in which you are being asked to participate, please contact:

Catherine Hitchens,
Research, Research Degrees and Ethics Subcommittee (RRDE)
Research Integrity and Ethics Manager,
Graduate School, EB 1.43
University of East London,
London E16 2RD
(Telephone: 020 8223 6683, Email: researchethics@uel.ac.uk)

For general enquiries about the research please contact the Principal Investigator:

University of East London

Luke Quane
Researcher
University of East London
School of Psychology
Arthur Edwards Building, AE G.17
Water Lane
London
E15 4LZ
Email: l.quane@uel.ac.uk

There are further points of contact on the Debrief Leaflet attached to this information booklet.

What Happens After this Study?

After the researcher has completed this study, it will form part of the researcher's PhD thesis, and anonymous excerpts of data may be used in publishable works, poster presentations and possible journal papers. Your data will remain anonymous in any case.

The audio recordings will be securely destroyed when they are transcribed, and paper transcriptions will be securely held at the University of East London for 3 years after the project's completion. After this three years, they will be securely shredded.

University of East London

Consent Form
Service Users

Finding Meaning in Forensic Secure Care: An Interpretative Phenomenological Analysis

Mr Luke QUANE – Researcher
Dr Luis JIMENEZ – Director of Studies

Please tick as appropriate:

	YES	NO
I have received copies of the following documents: • Information Letter • Consent form • Interview Schedule • Post Interview & Debrief I have the read these documents relating to the above programme of research in which I have been asked to participate and have been given a copy to keep.		
The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.		
I understand that this interview will be audio recorded, that the audio file will be securely deleted when transcription is completed, and that the transcription document will be held in secure physical storage at the University of East London for 36 months after completion of the project. This will then be securely shredded after the 36 months.		
I understand that my involvement in this study, and particular data from this research, will remain strictly confidential as far as possible. Only the researchers involved in the study will have access to the data. *(Please see below)*		
I understand that maintaining strict confidentiality is subject to the following limitations:		

University of East London

Your confidentiality will be maintained unless a disclosure is made that indicates that you or someone else is at serious risk of harm. Such disclosures may be reported to the nursing team, as explained above.		
Anonymised quotes may be used in publications. Your name and any reference to your name or anyone else will be anonymised/ de-named.		
The findings from this research may be published in peer reviewed journals, a thesis and at presentations.		
It has been explained to me what will happen once the programme has been completed.		
I understand that my participation in this study is entirely voluntary, and I am free to withdraw at any time during the research without disadvantage to myself and without being obliged to give any reason. I understand that my data can be withdrawn up to the point of data analysis and that after this point it may not be possible, the window for withdrawing information is 2 weeks from the interview date		
I hereby freely and fully consent to participate in the study which has been fully explained to me and for the information obtained to be used in relevant research publications.		

Participant's Name (BLOCK CAPITALS)

…………………………………………………………………….

Participant's Signature & Date

………………………………………………………………………………………..

Investigator's Name (BLOCK CAPITALS)

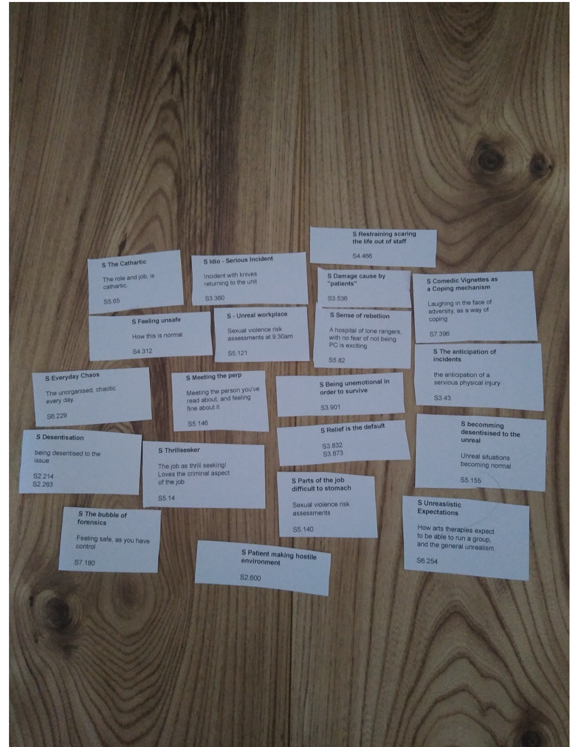
LUKE QUANE

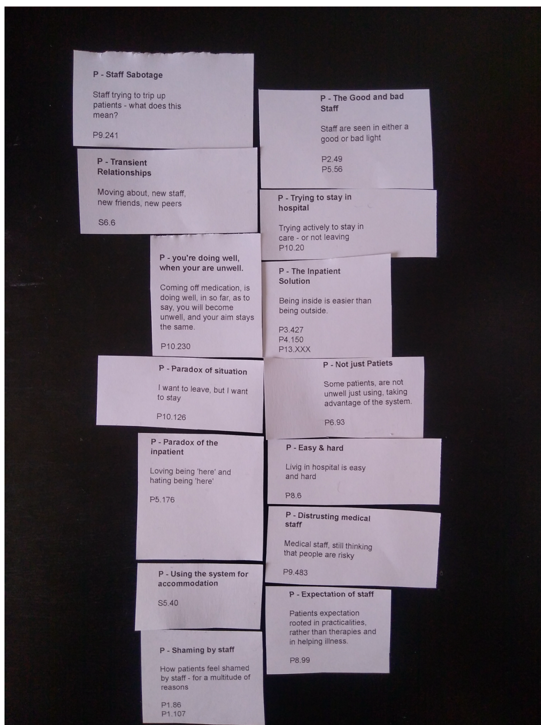
Researcher's Signature & Date

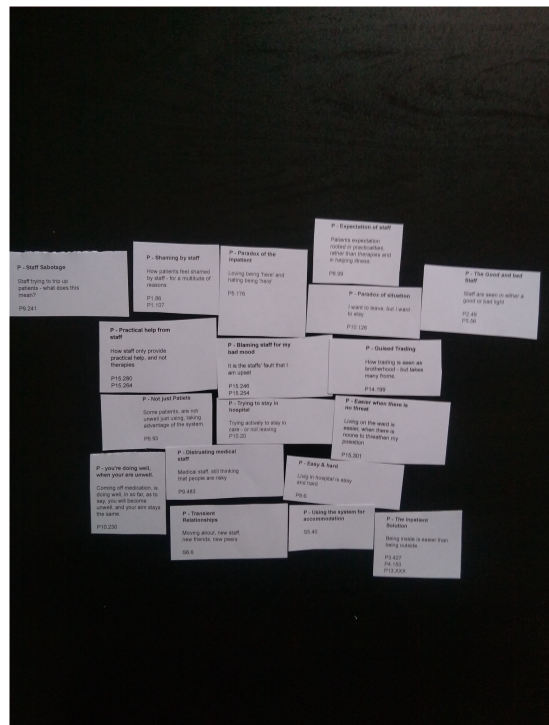
………………………………………………………………………………………

D IPA Thematic Journey Examples

Early-Stage Analysis







Theme Organisation

S4.40

IPA Themes

S3.1094

IPA Themes

IPA Themes

IPA Themes

IPA Themes

S Non Therapeutic Ward

S3.965

IPA Themes

S Dysfunctional nurse

unwillingness to work

S3.812

IPA Themes

S Focusing on Targets

Seclusion and targets on BAME patients

S3.595

IPA Themes

S Staff not knowing patients

S3.429

IPA Themes

S Working beyond remit as normal

S No satisfaction in job

S3.821

IPA Themes

S Disengaged nurses

Why so? not caring?

S3.718

IPA Themes

S Power hungry staff

As nurses become managers, they become disengaged

S3.563

IPA Themes

S patients knowing they'll be let down

S3.353

IPA Themes

S Relief is the default

S3.832
S3.873

IPA Themes

S Lonely within the team

Feeling lonely within the team

S3.691

IPA Themes

S Iatrogenic Interventions

S136 suite

S3.454

IPA Themes

S The impossible job

S3.296 impossible to complete all tasks every day

S No need to nurses

S3.846 no need or nurses, as they ahve so little impact anyway

IPA Themes

S Team not listening

Not being listened to, only by those in charge

S3.616

IPA Themes

S Misplaced patients

S3.485
S3.492

IPA Themes

S Idio - Serious Incident

Incident with knives returning to the unit

S3.360

IPA Themes

S Being unemotional in order to survive

S3.901

IPA Themes

S Taking personal issues to work

And using these as excuses

S3.792

IPA Themes

S Damage cause by "patients"

S3.536

IPA Themes

S Disillusioned Staff

Language example - calling a patient naughty.

S3.380

IPA Themes

S Knowing that you are replaceable

and how that feels

S3.942

IPA Themes

S Consultant knowing of incomptent nurses

S3.646
S3.657
S3.663

IPA Themes

S lack of police support

S3.517

IPA Themes

S Misplaced staff & patients

both misplaced!

S3.386

IPA Themes

P - adapting to survive

Changing behaviours to survive in the institution

P15.45

IPA Themes

P - The Clean Slate

People not knowing you/ your history, as a supportive aspect.

P10.149

IPA Themes

P - I'm Violent

The need to remind me that he is violent

P10.43

IPA Themes

P - Distrusting medical staff

Medical staff, still thinking that people are risky

P9.483

akin

easier to say that prison and hospital are the same

P15.54

IPA Themes

P - Fear of lonilessness

The fear of being alone when discharged

P10.193

IPA Themes

P - The False Big Man

Portraying the image of the Big Man - in order to gain, or retain, some sort of social capital.

P10.68
P10.89

IPA Themes

P - Whats next?

Not knowing whats next in recovery, when, and what is a mystery, until the last minute.
P9.535

IPA Themes

patient, they are reinforcing the belief, that the patient has of themselves, being violent

P15.115
P15.119

IPA Themes

P - youre doing well, when your are unwell.

Coming off medication, is doing well, in so far, as to say, you will become unwell, and your aim stays the same.

P10.230

IPA Themes

P - Moving on to another institution

Moving from hospital - to another or to a shared accommodation as better than discharge

P10.53

IPA Themes

P - Prison or Hospital

Using prison language, and acting like your in a prison, but not liking it, when you are reminsded of being in a "prison"

P9.358

sectioned

Understanding reality as serving time - rather than being sectioned

P15.66

IPA Themes

P - Length of time

P15.7
P15.31
P15.134

IPA Themes

P - We are all dangerous

The reality and understanding, that he is dangerous, and he is in hospital because he is dangerous.

P10.100

IPA Themes

P - Trying to stay in hospital

Trying actively to stay in care - or not leaving
P10.20

IPA Themes

IPA Themes

P - Im violent - not unwell

telling me that they are violent - rather than unwell - easier to live with that concept?

P15.24
P15.75
P15.86

IPA Themes

P - Blocking out my History

Not accepting ones history, not paying attention to it, blocking it out - as a way to survive?

P10.105

IPA Themes

P - Learned Helplessness

saying that he is not able - couldnt do that

P10.8

IPA Themes

P - Fear of freedom of

IPA Themes

P Hospital is Easier

Hospital is easier - but HOW?

P15.33

IPA Themes

P - Paradox of situation

I want to leave, but I want to stay

P10.126

IPA Themes

P - Speaking fondly of difficult stiuations

Like when P10 - spoke and laughed when talking about the gym

P10.20

IPA Themes

P - Doubt & Apprehension

When you arrive to a ward first

Superordinate Theme Organisation

ST P Powerless & Passive

How the patient has things, "done to them," and they are powerless to act against this. They have learned to accept passively, all instruction, rules, and careplans, as to revolt, would result in more rules, more plans and more time in care. Many rules are infantalising, careplanning can also be, but to speak up, or out of turn, can result in consequences.

IPA Superordinate

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Close

ST S Making sense of the unreal

Feeling unsafe becomes normal, walking into a ward, with people who are unpredictable, and with staff that you dont fully trust or belive have the abilities to help you in a time of need.
The day is full of unorganised chaos, and noone is in control, or have the skiolls to be. THe level of desentisitation is so, that disgusting histories, actions and more, are seen as funny, in a defence as to...

IPA Superordinate

ST P How I manage my life

In the newest picture - this superordinate theme is starting to split into 2 themes - one of defense mechanisms and understanding the self, and the other of mechanisms of Working with staff
...
0Living within the hospital, they

ST P Paradoxical inpatient world

The newest picture here, there may also be a split in the superordinate theme, into "how i make meaning here" and "how i am treated here"

A world that they want, and not want to be in.

Some patients have suggested that they surrendered their freedom for an "easy" way of

P - Prison Language

The use of language, and behaviours, that portrays an image of bring in prison. These patients work toward "release", but ultimately want to stay an impatient. Prison language

P - The Passive Patient

Passively accepting medication, directions, opinions and critique

P12.168

IPA Superordinate

P - Hospital as Respite

ST P - The Outside World

There is a sense of fear, fear that could be confused with and compounded by, the underlying sense of paranoia that some feel and experience; that others may judge and be judgemental toward them.
Not knowing when they will

ST P The Prisoner Mentality

Hospital is seen as prison, entering a new ward or environment, you are to be weary of your peers, build trust in a place that is filled with doubt, fear and paranoia. Maintaining the attitude that one is in prison, also perhaps, acts as a anti-infantalising mechanism, where bravado and perceived revolt can be seen as gaining social capital from/amongst peers.

IPA Superordinate

P - A New Indepedence

getting discharged to not where I was before, but with the support of the hospital, i.e. in practical terms.

P13.353
P10.193

ST Uncategorised

IPA Superordinate

ST S Working within the system

NO need for nurses, they ahve so little impact anyways
Staff dont even know their patients.
MDT are in the clouds!
THere is an unwillingness of staff to work, or an inability
Lacj of MDT presence
Lonely within the team, and lon
Nonchalong management
Staff more difficult than patients
Disjointed team
lack of police support
Feeling the need to say that you feel respected
The fallen team
Feeling...

IPA Superordinate

ST S Working with my team

due to the inability or inaction, or simple lack of skill, there i have had to take control of the ward, and function as its manager on occasion, although, I dont get promtoed, by poorly skilled colleagues do. there are staff who are unwilling to do their work, and this is common. there are staff who are simply lazy and not asilled to do their job

The nursing hierarchy is one which is stringent,...

IPA Superordinate

ST S Why am I even here

the role is futile, and there is no satisfaction taken from the things that are done, the inteventions make, and the changes made to tohers. the oay and renumeration is bad, and the job leaves people feeing like a prison guard, rather than a nurse.
The role is satisfying but not interesting, i know I am replacable and that highlights the futility of my role, and indeed my existence in the role.
I...

IPA Superordinate

ST S How they stay as inpatients

how frustrating it is for staff, who know they are working wiht people who act under the guse of the patient. the mauvais, deep acting patient that controls so much of the ward, and so much of the staff's time.
How patients become more agressive, when it appears as if they are moving on. how they are fine, and acting normally, until, that is, that they find they are moving on. They start to...

IPA Superordinate

ST S The archaic system

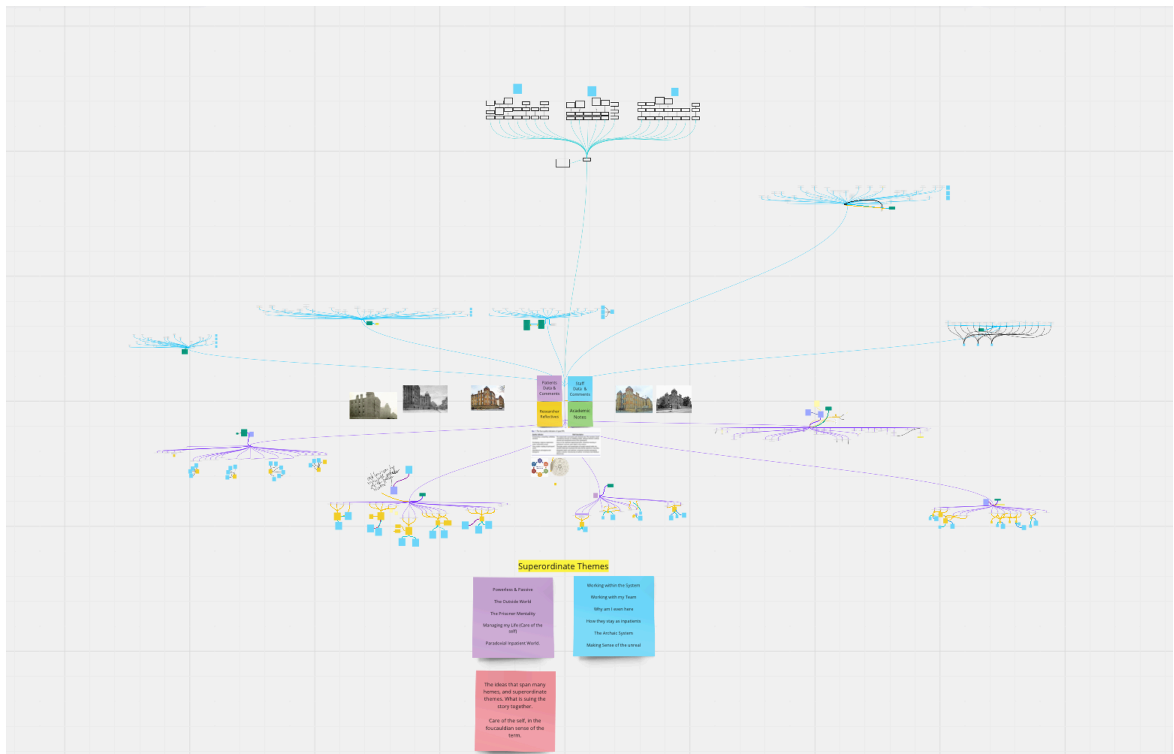
working in the single side room for everything, no striucturally suited
Knowing that youll be underdtaffed, and working on that assunmption
Same treatemnt = same results - expecting something else, therapies on repeat.
What is even being treated? - everyone looking forward to the relaxing weekend.
Restrictions on basoc sivil liberties.
poor provisions, no arts therapies, nothing widely available....

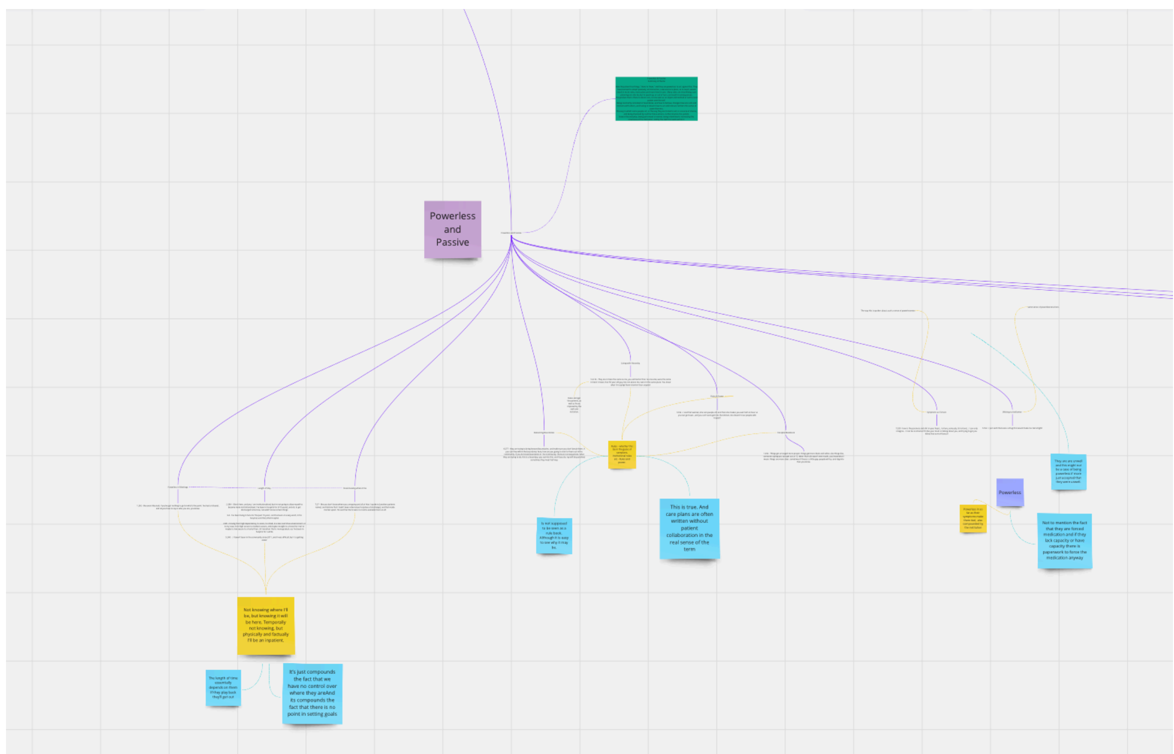
IPA Superordinate

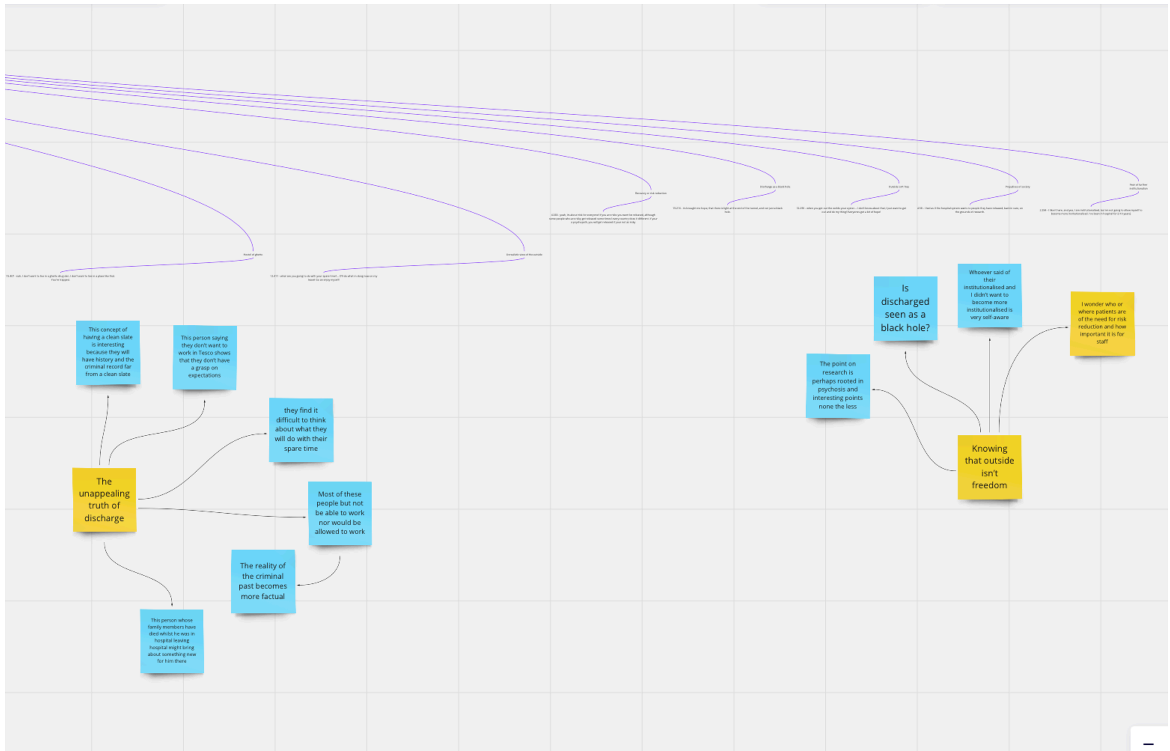
ST P Uncategorised

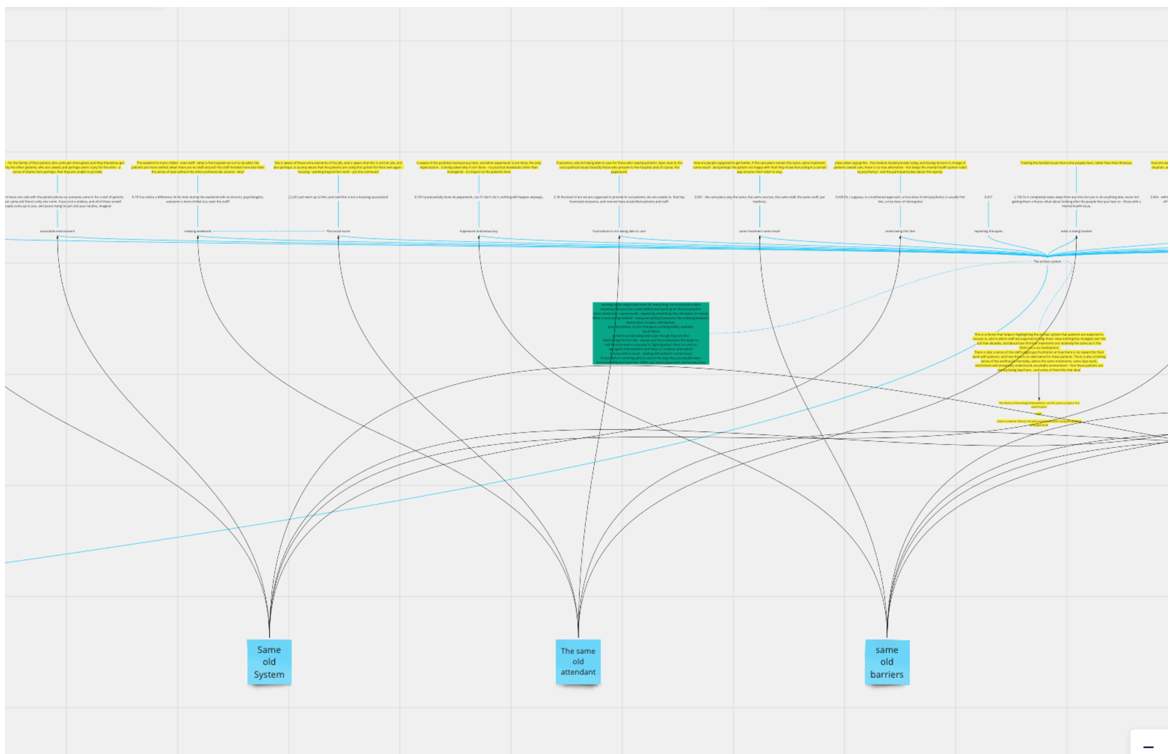
These are yet to be categorised

Superordinate Theme Development






This concept of having a clean slate is interesting because they will have history and the criminal record far from a clean slate
This person saying they don't want to work in Tesco shows that they don't have a grasp on expectations
they find it difficult to think about what they will do with their spare time
The unappealing truth of discharge
Most of these people but not be able to work nor would be allowed to work
The reality of the criminal past becomes more factual
This person whose family members have died whilst he was in hospital leaving hospital might bring about something new for him there
Is discharged seen as a black hole?
Whoever said of their institutionalised and I didn't want to become more institutionalised is very self-aware
I wonder who or where patients are of the need for risk reduction and how important it is for staff
The point on research is perhaps rooted in psychosis and interesting points none the less
Knowing that outside isn't freedom


Same old System
The same old attendant
same old barriers

Example Transcript Analysis

Line No:	Transcription Participant Code: P1	Exploratory Commentary	Emergent Themes
333–340	P: and you get to meet friends that you know outside from before, you know. and they arent all bad. not all friends you meet outside, from the past are negative. when I was outside last, I was 19 20, but were all big guys now, were all 34-35, all men now, not little kids, like 20 years ago, you know.	-was warned by staff against this. -Tells me they aren't all bad, assumes I think they are? *telling me this, as he thinks that my view of his friend is not a good one? - how does this make his view of me? Is this also the views team = he views the team as not liking his peer - and how this must feel*	*Unfavourable staff view*
341			
342–343	R: yeah, people canm mature into their behaviour.		
344			
345–346	R: when poeple talk about recovery, what is that?	-Recovery.	
347			
348–361	P: its when you need to get your head sorted, so you know where youre at and what you need tyo do. and put work into your future, put effort into doing some activites, and something like that. so you can move forward you know. its what you've got to do. dont look at the past, ive had a lot of shit happen to me in the past, ive done a lot of shit in the past. im not analysing any of that, im thinking forward you know. thats what youve got to do, think forward, think positive, and if there is an oppoirtunity to do something, do it.	-The need to get sorted. -Effort to work forward. grudge held against whats done to him. -grudges, moving forward. -things done to him.	*The need and "having" to recover*
362			
363–364	R: and thats what it is? Everyone has something different to say about it.		
365			
366	P: its different for each person	-tries to end interview here - exhales in frustration	
367			
368	R: how can we help you with it?	*Finds talking about this frustrating, as he exhales when I continue to ask. He wants to end the interview here.*	
369			

Line No:	Transcription Participant Code: P12DM	Exploratory Commentary	Emergent Themes
184–185	R: what about the guys on the ward, what its like living with the others?		
186			
187–196	P: ah, most of them are full of shit, I don't care about them! They go on like they are your friend, and that, and then they are caught smoking, they blame you, even though you have nothing to do with it! And they get away with it. They come and threaten me, and they let others away with it. For the second time! I'm going to tell the doctors to stop victimising me!	-peers full of shit. -no trust-no comradeship. *trusting noone is easier? - these are not friends - only people that are out for themselves? - i wonder how far this perpetuates into his life? feels like staff also vicitimise him?*	*Trust no one*
197			
198–199	R: some of the guys must be alright though?		
200			
201	P: there are some good guys		
202			
203	R: what makes the good guys good?		
204			
205–210	P: one of my boys, was saying that I am too sane for this place! You know what I'm saying! The people in here, one minute they are your friend, a nd the next minute, they are against you. That's the weirdo shit you have to put up with!	-everyday issues *The everyday weirdness, you have people, who's mood, presentation, and feelings toward you, change each day - how does this make him feel? if paranoic himself, this must confound his symptoms?*	
211			
212	R: do you think that's their sicknes?		
213			
214–220	P: nah, tis their attitudes, and their own delusions of grandeur! They are in here the same as me, you aint better than no one else, were the same in here! I mean, that 50 year old guy, hes not above me, were in the same place. You know what I'm saying! None is better than anyone!	Personality vs disorder / psychosis argument here *is he attempting here to explain the hierarchy? also feels the need to tell me that people are on a level pegging - or should be - although, I know this is not the case, there is always a hierarchy int he system , and perhaps, someone who is closer to the to[, might feel as if they can say something like this here.*	*Patient hierarchy*

Line No:	Transcription Participant Code: S3	Exploratory Commentary	Emergent Themes
37 38 39	circling the office like vultures, just waiting for something.	Acting like vultures 37 "Like vultures"	
40 41	R: I know it, I know it exactly!	Anticipating the worst Harm? Anticipation for worst	Anticipation of incident
42 43 44 45 46 47 48 49	S: That is what it feels like. You're almost on hold until something happens. You are just waiting for something to happen so then you can stop it, to then wait for the next thing to happen, so you can then stop that. There is no therapeutic care, the ward is no longer therapeutic.	42 Just waiting for something to happen - what it must be like to work under these conditions. 46 Just waiting for something to happen and reacting to it! - not therapeutic cos of this - non therapeutic - reactionary rather than therapeutic	
50 51 52 53 54 55 56 57	R: What is it like living there, O no, not living there, feels like it sometimes though. What is it like working there, when people are not receiving care, and people not giving care. What's that like? You work in that environment. What is it like working in it?	50 Self reflection - I referred to it as "living there"	
58 59 60 61 62 63 64 65 66 67 68 69 70	S: Frustrating! You don't feel as if you are doing anything to help anybody, so therefore, what is your worth, you know. You feel worthless in a way. Because what you are doing is not helping, and you are doing what you are meant to be doing, and what you're being told to do, just about, but you're not getting the results you are meant to be getting. So therefore, that leaves you feeling, dissatisfied with what you've done. You're not meeting your purpose.	58 What is your worth, not helping = worthless what are they doing that makes them feel worthless - reactionary care/input maybe 63 Not getting results - in which context care these results failure 69 Not meeting purpose	
71 72	R: Can you give an example of a time that was dissatisfying at work? A specific		

Line No:	Transcription Participant Code: S5	Exploratory Commentary	Emergent Themes
297 298 299 300 301 302	sense. Ill help out, and ive done leave, and anyone that knows me, you know, I'll help out as much as possible, but I wont be told wat to do, it that makes sense.	again having to defend his worth. Feels as if nurses don't value, understand the experience - not just games + fun	Defending worth
303 304 305	R: I don't know why nurses are telling you what to do anyway!		
306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321	S: we see it a lot with new OT staff. The role is so wavey. Like with psycholgoists, are on the ward for their one to one, and their group, and then they leave. Their one ot ones with the patients are the same with social workers, they talk about issues with money, their friends family, and then they leave and that is it. With OT, its way more of a grey area. We are in and out of sports, physical health, leave, in and out of education, employment team. There is a huge cross over. I find that new OT's find it difficult to establish themselves on the wards. If they have a very... emm...	- unclear job role - tricky - grey => role ambiguity - jack of all trade role? -> like the nurse? - Difficult to establish oneself	Role Ambiguity. Induction mode. (tough learning phase @ start.
322 323	R: shit!		
324 325 326 327 328 329	S: nah, a very forward kind of eh, domineering management team how are used to things being done like this and that and are very used to things being done quickly	- Forging a role for oneself	forging a role
330 331 332	R: and then you just flal into it cause you don't know how everything runes.		

Figure 5. Sample Pseudonyms

Patient Subsample Pseudonyms

P1 – Joe
P2 – Ben
P3 – Don
P4 – Sid
P5 – Tom
P6 – Jon
P7 – Max
P8– Ash
P9 – Pat
P10 – Sam
P11 – Withdrew
P12 – Tim
P13 – Moe
P14 – Fin
P15 - Ned

Staff Subsample Pseudonyms

S1 – Cat
S2 – Zoe
S3 – Tam
S4 – Tal
S5 – Ann
S6 – Mel
S7 – Lea
S8 – May
S9 – Jan
S10 – Mia
S11 - Ali

Patient Subsample Master Theme Tree

Superordinate Theme	Superordinate Summary	Subordinate Theme	Subordinate Summary	Supporting Quotations	Insider Researcher – Subordinate Theme Reflections	Insider Researcher – Superordinate Theme Reflections
Control as a mechanism of self-preservation	People may think of prisoners in different ways, from passive to violent, and from devious to obedient. Forensic patients, often with convictions for serious crimes, murder, sexual offences and serious assaults, are often seen with a sense of unwarranted fear. The patient themselves also see each other through this shield of bravado, often reminding each other how dangerous they are, and how much cultural capital they can command. The reality is that they have very little command over their lives, for they are both prisoner and patient. They take a very passive role in their lives, and try to make sense of this, and find meaning in their lives, through very	Seeking Stability	Powerlessness is a theme that emanates throughout this sample. In its simplest for, this manifests in not even knowing where you are doing to end up.	*2.284 - I like it here, and yea, I am institutionalised, but I'm not going to allow myself to become more institutionalised. I've been in hospital for [+10 years], and eh, to get discharged tomorrow, I wouldn't know certain things* *3.4 - I've been living in here for the past 10 years, and I've been on every ward, in his hospital, and the [other hospital* *4.38 - moving from high dependency, to acute, to rehab, to a less restrictive environment. or in my case, from high secure to medium secure, and maybe straight to a hostel for me? or maybe to low secure to a hostel then. SA transition that is more gradual, cos I've been in hospital for a while* *5.240 - . I haven't been in the community since 2011, and it was difficult, but it is getting easier* *7.27 - like you don't know where you are going and all of that. I spoke to [another patients name], and told me that I hadn't been referred yet to [place of discharge], and that made me feel upset. He said that there were no rooms available there at all!*	Trying to capture here, the sense of not knowing, and how the patients past has not been one that has been planned, not can they plan for the future. In fact, not even staff know where their patients will be in 6 months, let alone next year. Its true actually, that responsible clinicians don't even have total power over the discharge of their patients. No one knows, and this leads to a sense of nothingness.	The patients seem to take a passive role in their care, but not out of need, but rather it seems to come from a place of dejection. Passive in their input, as they know that people simply don't care about them, and always at the back of their mind, is progression means moving on or discharge. In my experience of working with patients, and updating their risk and care plans, they just seem to see it as something that is a tick box, and they are probably correct. At the same time, as I write and reflect I realise, that they may feel as if they have no control over their lives, but they do. They are choosing NOT to partake in these care plans, for this means that their status quo changes. They passively accept the treatment, as this maintains the status quo. You see the usual prison behaviours, hard man bravado, trading, and attitudes in the forensic setting. To advance in

Patient Subsample Master Theme Tree						
Superordinate Theme	Superordinate Summary	Subordinate Theme	Subordinate Summary	Supporting Quotations	Insider Researcher – Subordinate Theme Reflections	Insider Researcher – Superordinate Theme Reflections
	particular and peculiar methods of meaning creation.	Working with Rules & regulations	Rules rule, in the closed institution, with its rules and regulations, from practicalities, to the close control of behaviour. These rules have to be learned, in order to live and thrive within the institution.	*4.277 - they are trying to bring forward boundaries, and make sure you don't break them. if you cant live within the boundaries here, how are you going to stick to them out int he community. if you do break boundaries in the community, there are consequences. what they are trying to do, this is a boundary, you cant do this, and if you do, toy will be punished, sometimes they meet half way* *14.52 - I said that women, she cuts people off, and then she makes you wait half an hour so you can get toast , and you can't even get into the kitchen, she doesn't treat people with respect!* *12.214 - They are in here the same as me, you aint better than no one else, were the same in here! I mean, that 50 year old guy, hes not above me, were in the same place. You know what I'm saying! None is better than anyone!.*	You have to being in and inforce rukes, that often change – which shows how they are often wrong. There are rules, practical rules, that need to be followed – i.e. not crossing a locked door. But there are unwritten rules, like if you have been rude to a nurse, you can expect to be ignored, or receive less favourable treatment,	treatment, may mean a move for a patient and that would mean they have to restart the building up of this capital again. In order to engage with this kind of behaviour, staff need to be aware of the inner workings of the ward, the interpersonal dynamics between staff and patients, in order to fully grasp with it means to live on the ward, but alas, the staff are too busy auditing the quality of mattresses.
		Working with Infantilisatio n	Patients are infantilised, by the staff that work with them, and if one is not powerful enough, also by the patients they live with. However, this infantilisation works in many ways. Becoming helpless,	*Iggie – they'll offer suggestions, like going down to the garden, they'll try and find you a job, but I couldn't do that.* *Dick: I go into the toilet, I use my phone for 30 minutes, and the nurse, keeps asking me why Im going to the toilet all day.* *Michael - 10pm for the phone, and on weekdays, you had to be in your room from 12pm, and during weekends, you can stay up till 1am, and*	It's not a bad thing, it's something that works, in many ways for the patient, in an advantageous way. Being made a baby, by the staff, is a way for the patient to further understand the power dynamic, that they are	

Patient Subsample Master Theme Tree

Superordinate Theme	Superordinate Summary	Subordinate Theme	Subordinate Summary	Supporting Quotations	Insider Researcher – Subordinate Theme Reflections	Insider Researcher – Superordinate Theme Reflections
			and giving in to the system, of rules and regulation, allows the patient to work within a framework that they believe, they are in charge of. They are acting with feigned helplessness. And with this infantilised demeanour, in order to win favour of staff, as staff will often offer protection to those patients who are seen as unable, weak, or vulnerable.	*you could leave your room at 6am. in the acute settings, you were* ***put*** *in your room at 9pm, and you were locked in. they'd bring tea around 10, and pass it through a keyhole. and then, yeah, yeah. some dodgy times.*	at the receiving end of.	
		Using Prison Tactics	The medium secure unit, is a hospital, but also a place where prisoners, or mentally disordered offenders are held for treatment. People are left in a state of flux, neither patient, nor prisoner, nor both. Some act as if they are in prison, in order to keep a	*DJ - you take advantage of what you can, take what you can take, don't trust none, you know what I mean. Be on your guard 24/7.thats not a good mentality have in a place like this.* *June - nah, when I first came to the ward, I asked the guys about who the troublemakers were, and people what will help, and people what will use you. When time comes for payment, it doesn't come, a lot of problems and arguments.* *Researcher: what's not easy about living here...* *Justine: I'm incarcerated. i don't have my*	The reality is that many are prisoners, as well as patients, and many have serious convictions. Not trusting each other, and ACTUAL prison tactits – is this even a hospital?	

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			personal understanding, that they are not a patient, not a service user, and not unwell mentally. Others, some hospital, and thrive criminally, taking advantage of some other patients, who are vulnerable.	*freedom... Researcher: but what is it about the hospital that is difficult... Justine: I've answered that already.* *DJ - And I've literally served 16 years on this, for a minor 2.50 street robbery, where the judge said that if I was to give you a normal sentence, you'd have got 2 years,* *Researcher: what it's like living with the others...* *Daisy - most of them are full of shit, I don't care about them! They go on like they are your friend, and that, and then they are caught smoking, they blame you, even though you have nothing to do with it!*		
		Hospital as The best Alternative	Hospital can be seen as the easier ride, void of the fences, walls, cells and prison guards. It is however, not easier, but different. There are the same fences, walls, but there are bedrooms and psychiatric nurses. Some patients are transferred to hospital, for assessment, some	*Duke - it has got a massive prison fence around it, it reminds me of prison! Feel trapped looking at that! That garden down there, isn't too bad, its more relaxing, but the other garden, prison!* *Researcher -* *what's different between this place and a prison...* *DJ – its hard to say* *Jude - at first its hard in hospital! You must watch out for people who are more, and at different stages in their treatment.*	*It is often the case that patients think that hospital is easier than prison. But they will never say that they have purposefully moved to hospital for the easier ride.* *In reaslity, they are extending their stay in services, and perhaps they know that.* *They will say that it is the same as prison, in*	

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			feign, believing that the hospital setting is easier than prison.	*Jude. - em, a but worrying, cos you don't know what the people, patients and staff are like, and, you have to start trust building, and* *12.434 - : its scary! I was standing next to someone the other day, felt my instinct was to go for him, but I held myself. I looked at the guy, and walked away, it would have been a bad situation!* *Sean - we see them in ward round, community meetings, and then they bugger off, but the nurses are always here. Its the same thing in prison, the screws are always there, 24/7, and if you see a governor, for decision making, they make the decisions. like in any organisation. the leaders are scum.* *6.114- its not been too bad, a bit more freedom, more cushy in certain cases.*	*order to feel as if they are not patients.* *There is a constant referral to prison – which the hospital is not. There are no prison guards, no batons, no lockins. It is the easier ride, but often a longer one.*	
The outside world as the feared place	The outside world, outside of the hospital grounds, is colloquially known as the "community." This is where the patients are brought to help integrate back into the wider community and world. It could be assumed, that patients, having been in	Moving on From the Safe Haven	The hospital is considered, and understood to be a safe place, where patients feel comfort, and feel cared for. They often want to move onto other institutions or delay their discharge to remain within the	*Frank- yeah, I suppose there is no point in rushing into (discharge).* *June - keeping myself busy, not getting mixed up with old friends and gangs, and getting out o my area.* *I might get into the wrong crowds again. I might live on a farm!* *Jill - its hard, my sister has kids now, and my mum has passed away... is it easy to stay in touch... no*	The hospital is seen as a safe place, in comparison to the community, but also safer than the prison from where many came. Is there just a basic humanistic need for safety? Is it that the outside world is unsafe as they are ill –	The outside world for the patients is referred to the community. This use of language already seperates them from the rest of the world, and they refer to themselves, and the staff too, as not being part of the community. The outside world is treated as a foreign place, where you can't behave in the way you would

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	hospital and prisons for many years, that the aim of their recovery journey is living as an independent individual once again. This is something that the patients themselves will explicitly say is their aim and goal, but the actuality of the situation is more complex and not as straightforward.		confines of their institution.		and therefore there is a sort of recognition of hteir mental illhealth – which is very rarely publicly acknowledged.	with staff on the ward. I remember bringing a patient into the community on escorted leave, and I was worried at first, as we didn't have the best relationship. I felt as if he would be as confrontational on the street as he was with me on the ward. I was surprised. It was as if by transformation, he became the nicest guy. On the bus to where he was from in London, we spoke about tattoos for hours, and what he wanted to get next. I couldn't believe how being outside of the hospital would change him. When I returned to the hospital, none of the staff were surprised, and all said that he was lovely when out of the grounds – I couldn't understand. But over the years, I found this to be the case in almost all circumstances. Patients were so much more relaxed when outside, even in busy shopping centres and buses and tube trains. But in the hospital setting, the community was something that they had to
			The outside is new, unusual, and unknown. Patients often have no contact to external agencies of true meaning just the ones that they passively partake in to please professionals and to ensure that they playing along with the system. Nor do many have family, and many leave their friends behind, as inpatients	*Ian - living on your own, that's tough! That's why I've asked by friend to come live with me. I'd need company, to keep things going. Id need someone to live with, not by myself, id lock the door, turn everything off, and sleep, sleep, sleep.* *Anne - it was a bit of a culture shock when I got here. It's a lot different, more freedom.* *Veronica - I might do the same as him, and come back on Fridays, with him. cos he comes every Friday, and if he doesn't mind, i might join him, if i go to basketball, if he doesn't mind escorting me.*	Moving on, usually to the community but also sometimes to prison, is feared. Therte is a fear of even mving between different wards, let along from hospital to hospital – is this related to the cultural capital that is earned by the patient? Having to learn to survive again?	
		Discharge is not Freedom	There is a sense of being aware of the realities of discharge, and the socio-political issues that one will be faced with upon discharge. From living in run down	*Doug - nah, I don't want to live in a ghetto drug den, I don't want to live in a place like that. You're trapped.* *Douglas - what are you going to do with your spare time?... I'll do what I'm doing now on my leave! Go an enjoy myself!*	Discharge – the eventual discharge from all services, is sometimes seen as the next stage. The word signifies being in the community in your own home – the	

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			mental health hostels, to being overexposed to drugs and alcohol.	*Sam - yeah, its about risk for everyone! if you are risky you wont be released, although some people who are risky get released sometimes! Every country does it different. if you're a psychopath, you will get released if you're not as risky."* *Anne - its brought me hope, that there is light at the end of the tunnel, and not just a black hole.* *Interviewer: Sure, the world will be your oyster!* *Researcher: Sure, the world will be your oyster* *Damian: I don't know about that; I just want to get out and do my thing! Everyone's got a bit of hope!* *June - I like it here, and yea, I am institutionalised, but I'm not going to allow myself to become more institutionalised. I've been in hospital for [+10 years]*	reality is different, low secure, hostel accommodation and supported accommodation, all come before. Perhaps it is this journey of intransience that is the feared place, a life of a vagrant, with no fixed abode unable to work. There is also unfounded statements in exploring this, not being sure that the world is their oyster, the community being a black hole, just stick to what im doing.	work for and almost worried about. As I was analysing this in the patient subsample, I had paradoxical views. It wasn't being in the community that they worried about, it was the system of care in the community. The accommodation they would be mandated to live in, the people in those hostels, getting in touch with friends and having to explain their life. Their original sectioning brought them from a place of ill health, to one of safety. The more I write about this, the more I feel as if the patients want their freedom, but also, want to live in the hospital, with the structure and rules that maintain a status quo, that would be impossible otherwise. They want to be in the community, as that is what everyone wants for them – me included. They have become used to the regime of the hospital, and that was a sort of comfort. That there were people who seemingly cared, and people who were void of prejudice.
		Being unfixed	Moving around from high secure to low, to medium and back to low secure, beings about an innate sense of not belonging, and having to become	*Jade - so I moved from a place that i was used to, and that's [High secure hospital], and it was hard at first, and if you remember, I used to keep in touch with the staff there.* *Steph - like you don't know where you are going and all of that.*	There is also a sense here, of the unfixed care received, not just where physically they will be. They also here, have no real idea of their	

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			accustomed to new ways of life, and of living. He reminds me, that he used to keep in touch with his old care team, and tries to build relations with his new team, another new team. Another team of unknown professionals, and unknown patients to live with	*Nina - But no one wants to pay my funding, two boroughs, but my solicitor is on it, might have to go to court! They must cooperate! I'm going to leave it 1 or 2 weeks, and then chase it up.* *Anne - well I don't know how long left I have to do here...* *Damian:, they don't know where they are going. The way I look at it, when I'm in the community, I'll always have something to do. If I fall ill, I'll do it another day.* *I'm one of these people who doesn't get unwell. mentally, spiritually, or physically. I might do something wrong. but straight away, i rebound, and come back to the person I am now*	future, but neither does the funding bodies! Becoming unwell – and not being able to manage, Damian here, has unrealistic views. Perhaps, there hasn't been any throught about these future situations, perhaps they never think/thought that they would get there – having freedom again – so there is no real plan!	
Leverage in relationships	One may think that patients and staff work together in the ultimate aim of discharge. In forensic services, there is a special credence placed on the quality and authenticity of the therapeutic relationship, i.e. that patient and staff are open and honest in their dialogue. Whilst the dialogue may be truthful, is is more complex. There	The good bad paradox	Simplistically put, good aspects of their inpatient stay are easier than in the community. And hard aspects like that of missing family and friends. This patient says that staying away from family was hard for them, but conversely it was staying away from them that enabled	*8.6 - in some ways, its easy, and in other ways it can be hard. Cos eh, you are away from family, friends and everyone you love, that's the hardest but, being away from your family. The easiest thing about it, getting on meds, getting sorted out, and eventually moving into the community.* *12.154 - they are there to listen when you want to talk you know what I mean, that's a good staff! Caring bad staff – you can't get water, you can't get into the kitchen,* *5.176 - it was not all good experiences, but i am glad i have experienced what i have, you cant*	*How hospital is bad and good – in its simplist way. The hospital is the place that keeps me away from prison, but it not where I want to. Be.* *It's the nurses that keep me well, but they impose all the rules.* *There is a simple splitting technique*	The paradoxical elements of the data is something to reflect on here. The patients see staff as good and bad. Discharge is good and bad. The system helps then and doesn't help them. They want to partake in activities, but also do not. In this theme, one patient even explicitly says that he is not trying to get discharged but does work toward discharge. Perhaps this paradoxical view of the system is a method of

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	is an inauthenticity that is inexplicit yet mutually understood.		them to get on medications, and getting 'sorted out".	*buy it. but its happened, and im going to move on with my life.* *1.309 - what we can do. what can we do. apart from cooking, or making cards, or painting pictures, or what else can you do*	*used in many aspects, in order to make sense of their reality.*	ensuring that they retain the status quo. Needing to engage just enough to not be seen as non-engaging by staff. Just enough illness to remain in hospital, but well enough to have leave to the community. Living paradoxically ensures that the patient is moving at their own pace. But this also leaves staff guessing, as to whether the patient is ready for the next stage of recovery, whether that be extra hours community leave, or discharge itself. This mechanism of ensuring they have some sort of control over their life, is one that many patient use. I have completed care plans and paperwork for CPA meetings, only for the patient not to attend the meeting the very next day. They never had the intention of attending, but sat with me at length to ensure the paperwork was done – again, dong just enough. They know they are wasting my time, and I am left guessing as to
		Folie a deux	There is a follie au deux, an act of two, whereby the patient and staff that treat them, skirt around important issues of care. Both parties know that each other is acting in bad faith, both parties play along with the disingenuous, and plan care, with both parties knowing it is all done in bad faith.	*12.304 - the ward rounds and CPAs and stuff like that... a load of rubbish – I mean, they dance around issues. I have issues I want to bring up, they start their gargon,* *12.368 - tension! They are sitting there, it's a horrible situation, very official, they can do anything! I just have to keep doing what I'm doing!* *9.483 - The consultant put it to me the other day, and they put it to me, that I might still be violent!* *6.6 - basically, at first, we'll I'm a paranoid guy, so I moved from a place that i was used to, and that's [High secure hospital], and it was hard at first, and if you remember, I used to keep in touch with the staff there.* *12.05 - it's been, hard at points, good at points. My illness, my mentality goes up and won the whole way, I've been up and down the whole way.*	*This is a sider element to living and working in the ward. Bad faith interactions perendinate into each element of any transaction. Whether you are trying to keep staff, or patients happy, you go against your own intuition and free will, in order to maintain a fragile sense of status quo.*	

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		Prolonging Incarceration	The hospital with its restrictions and rules, is a place where liberty is controlled by the staff, and mechanisms of the institution. Patients will say that the hospital setting is helping them, but not in the mental health sense of the term, it is helping them in another way. Some patients have found a way to subvert the system for their own personal aim and objective	*10.20 - I'm not trying to get out! That prevents me from doing things, is, not motivated! I'm not motivated! Go get up and go within me. Maybe its just me personally! I cant keep taking medication all the time* *9.241 - : they try to get into your head, they try to get you paranoid, not you though! They try to get you para, and that sort of shit!* *5.40 - I was on a certain section for 28 days or whatever, and I was there, and a few months later i was discharged, and they found me a flat, and, yeah, I was hanging around with people i met in there,*	*Patients speak to me, saying that the staff are helping them, but I cant help but to feel that HELP is a laden term.* *Help can mean, helping the patiets reach their OWN aims, rather than what help might mean to the average person.* *Helping me get a flat.* *Helping me stay in hospital – whether this be inadvertent.*	whether they are. As I explore the data, this paradoxical way of living ones life has become more prevalent, and more obvious to me as a reader, and was something that I only actually was able to name through the analysis of this data. Infantilising process Good-bad basic defence mechanism, Splitting as a defence mechanism Trying to remain as inpatients - Capital (cultural), and the maintained of this self-capital through self-denial.
			Learning to live within this environment, is a skill that s learned, learning to live with others, in what is often he same quest, to stay on the ward, and not move on. Living on the ward with patients and with staff, and having	*15.280 - what about other staff, arts therapy, psychology etc... I find them very helpful; they help me come out of myself... I don't like psychology... what does help... just being the way we are now, having a chat, we talk, we chat, we blend, we mix, we help each other out.* *10.230 - if I'm off the depot, ill do well.* *6.93 - its not just people being unwell, you get a lot of idiots here.*	*The very skillful tactics used to avoid moving on, and in order to stay, just unwell enough, not engaged enough, just too dangerous enough.* *But also, seeing that when people do move on, and have community leave,*	

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			to come across as a hard man, whilst also coming across as vulnerable enough to warrant the continuing inpatient stay, is a difficult task to balance.	*12.328 One of the guys here, just walks around when he's outside, doesn't talk to anyone! He just circles around the streets. And then he comes back, and says he doesn't enjoy leave!... he has no hope!*	*these patients may return, and share their despondency of their experience of the community.*	
			How staff are there to help, and how the patients work and understand with the strange relationship that is built over time	*8.99 - staff have been very supportive, about giving advice, and are good at attending to our needs. Staff are easy to get along with. If its s yes with staff, it's a yes, if it's a no, tis a no! if I ask you for something, I don't go around asking another member of staff to get another answer* *12.134 - when you ask for something, they make you feel guilty! Some one this morning, having a go at man, I was like, come on, you're not here to do that!* *2.49 - the staff are really good, but i've had problems with staff. With a few staff, but I don't want to say any names.* *5.56 - there are good and bad people, and people with certain characters. I've had staff I haven't liked, and staff who haven't been very nice* *13.140 - Yeah. I don't know why they made up those things about me, what they were trying to do, so I didn't get along well with them, the staff*	*There is also a sense here, that perhaps the language used is for me. How the staff at this hospital are better, nicer and more accommodating.* *One is very keen to show me that he follows the rules when I enforce them – well thank you very much!* *There is an issue with staff, but why? – is it that they cant run circles around certain staff? Staff making up things about them? The patients have learned to work with the staff they don't*	

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				here are more helpful, they are more helpful, yeah.	*like, and it all seems more complicated than simply having a staff – patient relationship –* *it is more transactional, than the average clinician-patient relationship.*	
Hiding the internal reality from others	Forensic patients, often with their criminal histories, have to keep face, and appear strong and frightful to a certain extent. In reality, many are suffering from the positive symptoms of psychosis, and have personalities that foster unhealthy relationships. They therefore must adapt to their surroundings, and to their relationships, that leads to what is essentially a controlled sense of self and self denial.	The mechanisms of self care	There is a large level of passive acceptance, a common term in psychiatry. Often, it is in relation to passively accepting forced medication, but the concept can be used to explore how people act. It is the act of accepting treatment, orders, or rules, in such a way, that emplies you would otherwise refuse.	*4.16 - as far as hospital is concerned, when its hard, is when the care team is trying to give you medication that you dont want, and you think you dont need.* *Daisy- i'll put on a fresh tee-shirt, and go to the office to go on leave, and they'll be like, O you had that on yesterday. I'd say, I;'ve just put this on fresh, you cant win man, with some staff, you get me. I'm not going to complain about it, thats not my style.* *June - : when you try to explain something to them, they try to twist it, to provoke you, and if you jump onto it they try to give you an injection.* *Daniel - But I wear a lot of it, cos I have leave, so just leave me along. I don't even answer back, I'm just like, ah yeah, whatever!* *DJ - I was on block, level 5, PPE, shield team. The riot gear, a dog, barking, scary! When they used*	*How the patients use complex mechanisms in order to live in the every day.* *How staff – seem to put patients down, and the patients have to go along with it – for they may seem as being in opposition to their wishes.*	Mechanisms of self care and ensuring that one is in charge of the self, stems from the aforementioned paradoxical view of the world. The need to ensure that the patient holds onto the scintilla of control that they have. They will act in ways that are inauthentic to make sense of the sacrifices that they have to make to ensure that the status quo is maintained for their lives. They need to ensure that little changes day to day, to ensure that the staff treating them have a view of them that the patient is trying to portray. I remember a time when a patient hit the office window in order to show that he was unwell, but then when he was

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				to come into my room, I'd be in my room, suffering from psychosis, they'd get their shields and bang them against the doors. *12.181 - and they come to you expecting this model citizen, you know what I mean, go away from me!* *1.333 - ah, you can have a laugh, have a chat, make the time go easier, you know. and there are certain staff that get you out on leave, straight away, when you need to go out. other staff will delay, delay delay it. some people can do the paperwork in 5 minutes, some take 2 hours! It varys you know* *1.199 - certain staff are my mates, still. thats how I look at it!*		not permitted to leave for the community that day due to his violence and aggression, the was quick to say that he was messing with staff. Sometimes, the patient has not always correctly timed their outburst of feigned aggression. This has become a very related to the concept of the care of the self. People managing expectations and portraying a character or image that is acceptable to the general population, to what end however? To ensure that they maintain their image of capitalist hierarchy. Or whether this pertains to the image of "themselves." This is referred to in some profession circles, as containment; when the patient feels contained, they act in the way we expect them to. This very passive view of the patient, is an ill guided one. The patient is trying to understand what the staff members' reaction will be to an outburst of aggression or psychosis. When we play along, and offer the expected reaction,
		The narrative of self care	The way in which patients speak, and the language with which they live within, helps them understand their reality, in a way that helps maintain the self in an optimal light. More prisoner than patient, and anything that helps the maintain the	*2.256 - there is nothing wrong with me, i don't need to be here.* *Frank – yeah, there is no point in rushing into it…* *Frank: he speaks for me at my CPAs and ward rounds.* *June - when I was here the last time, it was every patient for themselves. People going around kicking people, getting a pool ball thrown at you or something. You havnt got the same patients.*	A simplier – and different to the theme above – this is how the patients use LANGUAGE – to either fool themselves or the staff. They use language that helps maintain their sense of self – rather than the mechanisms or physical things they	

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Superordinate Theme	Superordinate Summary	Subordinate Theme	Subordinate Summary	Supporting Quotations	Insider Researcher – Subordinate Theme Reflections	Insider Researcher – Superordinate Theme Reflections
			social capital that they have sought to create.	*Irine - When I was in Broadmoor I was on loads of mediation, and it was compulsory to go to the gym. You had to go to the gym, you had to shower in the morning, you had to change your clothes, you had to take medication, had to play basketball, table tennis, tennis, basketball, weights, fucking hell! By the end of it all, I thought I was going ot be Arnold Scherzinger* *Ian - When I see the reports, I say, that I hope I'm not as bad as all of that! But its written there in black and white! I'm no like that anymore! I'm trying to keep tat out of my mind!* *Michael - I get frustrated some times, of talking. I've been talking for so long. for over a decade! I keep telling my psychologist, but at the moment, im just not int he mood. ive done so much!* *Michael - yeah, im more of a check in guy! hahaha. I goes back to old stuff. I know it's in my head already, and its opening old wounds* *8.436 - em, I've been on them so long I've adapted!* *1.222 - , like you WANT to get out and you want to get through to a hostel, and get that sorted, and all that sort of thing, getting leave or whatever.*	do and decisions they make, in order to maintain the perfect self.	that is seen as containment. So who is a step ahead. A seasoned veteran patient who knows when to scream in their room, or a staff member who acts in the way the patient predicts. I remember a specific example of this, when a patient screamed in his room, staff went and checked on him, and he was telling them about how the voices were causing him trouble. They offered that he stays on the ward for the day, and the patient was adamant that they weren't troubling him that much. Another time, the same patient was screaming in his room, we left him alone. He later in the day, asked me whether I had heard him screaming earlier. Was this in order to elicit the response that he was expecting from the staff. What I'm trying to expore here, is how institutionalisation is a process that is perhaps further worsened, by our lazy and ill thought reactions to behaviour, that makes mauvais foi a mechanism for patients to use

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				12.34 - : if I wasn't on meds I'd be a lot more hyperactive! Put it that way.		for their own gain and control. Our predictable reactions are used as mechanisms of control by patients.
		False belief	Some are under the long held belief, that their medication does not work, and that they would be the same without any high dose any psychotic, or mood stabilising medications.	*15.429*	This needs to be incorporated into the above ? enough to be its own theme – perhaps not with simply one quotation.	

Staff Subsample Master Theme Tree						
Superordinate Theme	Superordinate Summary	Subordinate Theme	Subordinate Summary	Supporting Quotations	Insider Researcher – Subordinate Theme Reflections	Insider Researcher – Superordinate Theme Reflections

Acceptance of futility	One would think that staff working in highly specialised, and specially commissioned forensic mental health services, that one would be working in a safe, new and modern facility. Staff think that they are entering into a healthcare system em wher they can make a difference to the lives of the patients that they serve, in a modern public healthcare system. The reality, is that these staff work in the same buildings, that we once the old asylum buildings of yesteryear. They also soon realise, that the practices and methods of treatment are practically from another also from another century.	*No Better Alternative*	A subordinate theme, on how the system is the same as the Victorian times, and how staff know this. They are aware, that their interventions, methods of work, to the buildings they work in, are all reminiscent, and historical artefacts, of a bygone time. They are working in an ever-ageing enclave of medicine, that has changed very little, since its inception.	*Ella - we'd have one side with the patient's phone so someone came in for a visit of parents always just came and there's only one room. if you visit a relative, and all of these unwell people come up to you. and you're trying to just visit your relative, imagine!* *Researcher: Why is it so badly organised?* *Ella: For many reasons, where do you begin. Badly staffed, cos the people in charge are nurses and should not be nurses. Badly staffed, cos there isn't enough money – its an inpatient unit! The pot of people to select from is getting worse. No one is qualifying as a nurse, so you just get to pick from a bad bunch.* *Researcher: What kind of things do you do to help the patients get better* *Ella: nothing, looking back on four and a half years, nothing!* *Researcher: What's worked best?* *Ella: Taking people outside, and trying to keep them outside for as long as possible.* *Researcher: We are trying to foster recovery, how do we do that here?* *Sheila Eh, I suppose, its a multi-tiered approach, a nice dose of anti-psychotics is usually first line, a nice dose of olanzapine!* *Researcher: and it's still like that? Here are your meds?* *Sheila: And it's the first port of call… I'd give anything to see hoe people look back at us, and see how we treat depression or schizophrenia*	A theme, where the staff are simply doing the job of yesteryear, and there is a sense that they know that they are only doing what their "attendant" colleagues done many years ago. In the same buildings, in the same hospital sites, the staff do, what they done many years ago. They know they aren't providing medical, nursing, OT or psychological care – so what do they think they are prviding?	Working within the closed institution, of which the secure hospital is, requires you to rethink and relearn how to work. With the very specific rules and way of controlling the patients, you also find that the rules also apply to you too. You, like the patients, work within these rules, and this bring about inauthentic actions and practices. Your practice is bound by procedural bureaucracy, of which you much adjust your practice to. You must stick to simple seemingly nonsensical rules, and when these rules are broken, you realise how nonsensical they are, for there are no repercussions. As Lucy spoke about this above, I realised myself, that I have also skipped and copied and pasted sections of paperwork, for I also knew that nobody would notice, or in fact, care. Neither superiors cared, nor did the patients care, that their care plan paperwork was of poor quality, and very poorly updated. Imagine a health system, where planning for care, is a matter of copying and pasting, and updating paperwork, is a simple change of date, and the use of

				Elizabeth - within 2 seconds the rapid team were there restraining him on he floor and he went off to seclusion, I felt worthless, what was the point in me doing all of that! *Elizabeth: I felt worthless, what was the point in me doing all of that!* *Researcher: you were doing it because you wanted to get him out of hospital.* *Elizabeth: I know, but it's all backfired hasn't it, but now he is back on the PICU* *Carlie: I don't think its backwards, I just think it serves a purpose, and there is no better alternative* *Carlie: What are we expecting these people to do when they are discharged… the long stay guys can't even have an argument without getting aggressive. Imagine them being a cashier in retail… You see the abuse bus drivers get.*		thesaurus. Ensuring that the paperwork is in date, is all that seems to matter. Sheila very openly and honestly, went straight for the medication intervention, and is very aware of its omni-importance, and that psychotherapies is only a second rate intervention, for which there is a 18 month wait. Patients complain of the side effects of medication, and you repeat the usual trope, that they are keeping people well, and that the medication is the least restrictive practice. This is the new thin veil that staff hide behind. That any intervention is now justified, as it is the least restrictive intervention that is safely done. Originally a mandate from the CQC, that all interventions need to impede on a patient's freedom in the most minimal of ways, has itself become subject to interpretation. When analysing the transcripts for this theme, and the subordinate themes that emerged throughout, it made me as a clinician, refocus on how I also became a slave to this rhythm. How these wait times was considered normal, how

		Stuck behind Bureaucracy	The psychiatric hospital is an old an institution and along with psychiatry it is caught in time. Attitudes toward care and treatment, buildings and facilities, and little else, has changed since its rise in popularity in the 1900s. Staff that work with these patient groups, face the same barriers to everyday care, that existed almost 100 years ago.	*Researcher: Any psychotherapy?* *Ellie: They only have psychotherapy if their referral was in, and that was 16 months ago, and dance movement, which was when you throw a ball at each other and talk about emotions* *Ellie: 4 people in the activity toom with the art therapist, someone shouting into the room, someone inside the room shouting back, 2 families in the dining room waiting for a doctor… It's chaos all of the time* *Sheila: he is blocking a bed for a prison transfer, who is on the verge of killing themselves... it would be one thing if we were treating him, but we are not doing nothing for this person!* *Elijah: and only sometimes can the ward be therapeutic, so the default is untherapeutic, so what is the point!* *Researcher: What kind of things does the ward do that is therapeutic?* *Elijah: When you have a decent OT, that isn't on rotation and actually comes to the ward… When you put 21 unwell people together, or 10 unwell people and 10 well but demanding people who would be in person… then you have utter chaos.* *June: we have phones now - but you don't know what they are searching - we caught one searching for porn, why cant he search for porn?*	*How there were always barriers to treatment, but now those barriers are just bureaucracy, paperwork, meaningless paperwork, and the usual medical bed blocking – which isn't actually that new!*	medication was a given, how even my care planning was not the best it could have been. But that also got me thinking, why, over the years, that this was never addressed at any monthly supervision I received by superiors. All that mattered was that the care plans were in date and signed. There was very little scrutiny, and I knew that. Through the analysis of this theme, gave me a space to reflect on my own practice, and was certainly more of an personal eyeopener that any clinical supervision I received. You seem to forget that careplanning is not just a simple administrative task. It is a deeper, important aspect of care, that carries little to no personal value for neither staff not patient.

				Researcher: They come abck, and what happens to the care? *Lucia - the care plans stay the same, the same courses, the same staff, the same stuff, just madness.* *Researcher: The bureaucracy– what gets in the way?* *Lucy: I purposefully don't do paperwork, cos if I don't do it, nothing will happen anyways,*		

| | | The same old attendant | The professionals that were interviewed during this project, seem reminiscent of the old mental health ward attendants, who were there to simply keep the patients safe, and busy, rather than treating their actual illness, and helping in their recovery. | *Researcher: What is it like working with the 20 or so guys, who are not unwell?*
Ellis: So it completely takes away from any time for you to do anything else, never in getting them a house, what about looking after the people that you have to - those with a mental health issue.
Researcher: How do you feel, when someone is not unwell, just waiting on a hosue, starts lacking out at you?
Ellis: I try to understand it,

Researcher: How has your last week been?
Elinor: Probably, the most stressful that I have ever had.
Researcher: o, in what way?
Elinor: the level of care we are supposed to provide to our patients, we are unable to. That has frustrated everyone, and now we have unsatisfied patients and staff.

Researcher: What kind of things do they shout?
Ellis: Everything, they are just like, one guy the other day was like, I've been arrested 20 times, and ive been brought here so many times, and still you have not got me a house. I just went up to him, and said this is not a housing association!
Researcher: And how does it make you feel when you have people like that in your face shouting, cos they want a house?
Ellis: It makes you want to leave… that's not why I went into the job. | *Not that they are attendants, but that they are new atetdnants – one suite to today's socio-economic and political landscape.*

Looking for housing
Sending dental referrals
Performing physical heath checks
Using the hospital as a mechanism for getting a home.

How the staff here have become the new age 21st century attended – making the patients fit into society. | |

				Researcher: Are the weekends the same? *Lucia: You notice a difference in the men during the weekend with no doctors, psychologists, everyone is more chilled out, even the staff!* *Researcher: How do you think the patients deal with the difference with the staff approach on the weekend?* *Lucia: It must be confusing, its confusing for the staff… and as we say, you're not supposed to be friends and family, but that is how these guys see us, having both masks on, but then on the weekend, you have the chilled mask on.*		

Staff Subsample Master Theme Tree

Superordinate Theme	Superordinate Summary	Subordinate Theme	Subordinate Summary	Supporting Quotations	Insider Researcher – Subordinate Theme Reflections	Insider Researcher – Superordinate Theme Reflections
Becoming more than a therapeutic relationship	One would think that the staff working with these patients, are the hard working mental health professionals that are often portrayed in the news, professional and courteous to their patients. Staff also enter the workplace, with their new professional registration, ready to act and work to the best of their ability. Instead, they enter a world, where professional boundaries are blurred, long term therapeutic relationships with patients are normal, and responsibilities, duties, and preconceptions exceed expectation.	A new family	The patients have found a sense of family within the institution. So have the staff that treat them. Both long stay, they have lived together as patients, and have worked together as staff. There is a stronger sense of connectedness amongst everyone, unlike what can be fostered on a short stay psychiatric ward.	*8.92 you are their family, for the long stay guys… One minute you're their family and the next you are asking for a drug screen….* *Researcher: That must be strange, and messes with the trust?* *You are trying to build up relationships with these people, so where do you stand?* *Researcher: We all know people like this…* *5.627 some are happily homeless on the street, but this is a much better option for them!* *Researcher: So why do you think they work toward discharge then?* *They know they wont get away with saying "I don't want to be discharged"* *Researcher: Is it to make sure they don't move?* *Yea, and for me, that is frustrating, they are forgetting this is a hospital!* *2.62 I just broke down in the office!* *Researcher: What was it like for you, to break down in the office?* *2.73 Really embarassing, an for the staff that were on duty, I think it was quite an eye opener… one senior staff said to see me break down, was a sign of how far the team had fallen.*	*The therapeutic relationship is no longer one where therapy is the aim. The relationship is more of a familial one. – and perhaps this is abusive, clouded sense of authority over another human.* *You are not only providing unconditional positive regard, but also MUST provide this, to stay safe. You adjust yourself in order to keep people calm, whilst being told by management, that you need to maintain boundaries, but everyone knows how safety is truly maintained.*	Some patients are in the system so long, that they have recovered, but professionals seem to forget, that there is an antisocial, and criminal aspect to most patients in forensic settings. Often, patients' index offences, are the reason that they are sectioned, but sometimes not. Patients sometimes become unwell in prison, and are brought to hospital for recovery, and sometimes, never leave, serve their sentence out in hospital, and get released through the mental health system. You are then, not only working with mental health patients, but also with criminals, with criminal histories, with varying degrees of illness. You de-sensitise yourself to their criminal histories; stories of child rape, paedophilia, murder for cash, hostage taking. You are then expected to park your emotions to one side and treat the "patient."

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				5.606 if this was a physical health hospital, and someone said this is my home now, they would be laughed out of it! *Researcher: we all know people like this.* *5.627 Well, ive had really frank conversations with these really stuck patients, and, they are homeless people, what I mean by that, is that they are happily homless on the street, but this is such a better option for them.*		I was threatened by a patient of mine, after I helped him purchase the wrong electric razor on Amazon. He broke into the office out of nowhere, pointed in my face, and said that he was going to have me killed. That he was going to make sure someone would meet me outside the hospital when I left my shift. I laughed it off and didn't even report it to the police! It was only many years later, when a member of the Met Police came to a team away day and was looking for experiences of staff. I shared the experience above, and the said that I should have certainly reported it to the police, for it is a very serious threat. You try to prepare these patients for realities of the outside world, but it will never be easier, in the patients' eyes, as being an inpatient. I didn't even to think to press charges. As I write this theme, I realise that I also perhaps enjoy the underlying danger and the strange enjoyment I get out of
		Aware of failings	The system has ultimately failed the patients, and the patients are aware of this. It is clearly shown through their fear and anxiety around discharge. The system has further institutionalised them.	*5.599 I'm probably the 10th OT that they have seen, they have seen it all before! and have failed it all before.* *Researcher: they need something like a complex discharge team?* *5.615 that's exactly it, I don't now why it doesn't happen!* *Researcher: He said that if I didn't take him on leave, he would asked to be discharged* *7.433 so go on then!* *Researcher: And he started to scream at me!* *7.448 It doesn't even make sense, its funny really, when you see someone*	*Staff being aware that they are failing, and rather than changing the system, they play along with it, or leave. They know that the system has failed their patients, and the staff continue along with it, for the one or two patients that they might get discnarged.*	

Staff Subsample Master Theme Tree						
Superordinate Theme	Superordinate Summary	Subordinate Theme	Subordinate Summary	Supporting Quotations	Insider Researcher – Subordinate Theme Reflections	Insider Researcher – Superordinate Theme Reflections
				making progress, you see someone making progress, you know that they are going to relapse! its not even a relapse, its a relapse in quotation marks. *Researcher: What do you do with these patients who won't stay out?* *6.405 you cant do anything with them, try a new tatic? Nothing really changes… you wont make an impact, and then they come back.* *Researcher: What do you do with these patients who won't stay out?* *6.382 6.405 i dont think i know anyone that has recovered.* *Researcher: wha'ts an example of being difficult to work with?* *8.310 - we all know they don't want to leave!* *Researcher: Is there a time when you felt affective?* *3.353 For a short while… but then again… as we always know, the community team let him down, we knew that would happen, the care coordinator wasn't good!*		the job. That challenge of getting this difficult patient discharged will be some sort of fulfilment for me as a clinician. I know of the unrealistic expectations placed upon these patients; getting jobs, getting flats, returning to university or study, these are often spoken about, but rarely are a reality. My colleagues know of these difficulties too; and as I analyse, I realise, that a discharge is almost like a trophy for me. The discharge of a potentially very dangerous patient, at high risk of relapse, to a world that will be difficult to live in. – look that I can achieve!

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				Researcher: What does that recovery look to you? *8.480 getting them back into the community and contributing, but the long stay guys, you cant even have an argument without them getting aggressive.* *8.33 if you light a fire, it is seen as very dangerous, but if you're acute and light a fire, you're there forever!* *8.499 And then we come along as staff, and say things like O don't worry, its going to be fine, moving these people on from where everything is lovey dovey! imagine starting a universal credit claim, you haven't got a job, I've worked so hard to get out of hospital to join this queue?*		

Staff Subsample Master Theme Tree						
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		The non patient	While there is a greater sense of connectedness than on other psychiatric units and wards, the goal on the part of the staff, is to move patients on. There is a fetishist view that discharge and progress is the goal for patients, as it is indeed in the interest f the staff to see movement in patient populations.	*R and then he would threaten you if you want to move him?* *5.711 if you try to move me, ill go to the PICU, lets get our resources then, and tell him that he is moving!* *Researcger: messy* *S: Yes, and a risk of him being injured, or staff being injured!* *5.734 I'm getting a little too close to discharge, so I'm going to kick a member of staff!* *5.664 Resistant to partaking in, not benefiting from the affects.* *3.485 some people are unwell, and should not be in prison, and then you have some people who don't have anywhere to go, so they go to you.* *2.493 With the "new" patients we have, we don't know how to look after them…* *2.666 I cant stop you smoking weed, but the fact that you are bringing it onto a ward, ou have no respect for any other person!* *8.590 you are discharged, but not trusted!*	*Staff know of the mechanisms that patients use to stay, but they are perpetuated by the staff themselves.* *The strange use of positive risk taking here – comes to mind. How staff take risks with the known patient risk, to test safety – bizzare!* *How patients STILL manage to smuggle psychoactive drugs into the hospital – there are no proper security mechanisms in palce.*	

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				2.232 when they no longer like their 2 bed flat, they want to be with friends, or something better they try to get admitted!		
		Every day danger	The innate danger of the job is made clear, even in the job description, but people apply to work in these roles. There is detail of having to attend restraint and breakaway skills and training, yet people still apply, and want to work in these environments, and this is for several reasons beyond that of the job	*Researcher: What is it like when this place is full of unsatisfied staff, unsatisfied patients, what does that feel like?* *Ellie: you're almost holding on for something to happen, just waiting for something to happen, then you can stop it!* *Ellie: …and within the week, he was back, at the back of my building, waving the kitchen knives that I had provided him with.* *June: One of the wayts that we are safe, is that the corect levels of staffing are maintained, and having bank staff properly induced and*	*Why would you work here? On some wards, you know you are going to get injured – and those that are injured are often injured badly!* *I felt this very difficult, and often relied on my tongue and cheek attitude in avoiding the physical. My physical health then disallowed me to partake in dangerous*	

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			being one that is secure.	*trained. I have worked in another hospital, and I have never felt unsafe going to an emergency!* *Peter: they are all quite critical of the people who are unwell* *3.536 - the entire music system, Xbox, 57 playstation games, all thrown away and by people who were NOT unwell!*	*restraint – maybe this is why I lasted so long!* *It may also perhaps, be the reason why many nursing staff are older – as they can rely on the "younger" staff to "step up."*	
		Strange expectations	How you are expected to work within this environment? How you also expect yourself to work here? You read reports of these patients that are soon due for admission, you are shocked by the index offence, their criminal behaviour and their psychiatric history, of violence and further risk behaviours.	*5.146 – "…and then meeting the perp, which is hard enough in itself, and then you have to somehow form a bond!"* *7.180 it makes you feel safe, you know your admission way in advance, and you have their histories.* *5.140 you're going in to read emails, about rape and in intricate enough detail* *6.299 we get people who are restrained, and then they cant leave, and then there is chaos, turning the place upside down*	Expected to be professional to the people who have committed the most heneous crimes. Being professional I these cases is part of the job, nspite of the sometimes, disgusting histories that you read. With no real supervision, to address these feelings, as *you* will be	

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				4.466 It scares the life out of me, you just end up grabbing something during an incident anyway!	made out to be an awful member of staff.	
		Working with Awe	How I've managed to work and live within this strange environment, and how I've managed to work with the risk, and how I find meaning in it. You have build up these persuasively real relationships with the patients that you know and perhaps, hold a sense of resentment for, for the crimes and acts they have committed.	*5.82 you're working with 170 odd people who don't give a shit about being politically correct, and its super refreshing to be honest* *5.65 - i know i have an antisocial side, and I find myself rooting for the bad guy sometimes.* *7.396 - In A&E, and he started to shout, screaming that he has coronavirus, starting coughing on people, and they sectioned him - its frustrating, but you cant help with laugh* *3.832 - it sounds bad but it is true, apart from the days when you have good chats*	*Making the job easier, the reality of the job easier,. By adding a sense of awe.* *Through awe, you don't have t understand, but just spend some little moment, in thinking about how bizzare it all is.* *Ut get progressively easier, as you "get used to it!" You get*	

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				3.873 - I've never come home and said, O I've had a great day in work today! *5.155 - i do feel as if it is getting progressively easier.* *2.214 one guy was like - I've been arrested 20 times, and I've been brought here so may times...* *5.14 for me its very exciting - i love the criminal aspect!*	*used to how craxy every day s.*	
Firefighting rather than treating	Many of the roles in this workplace, are vocational, traditionally, a calling or way of life, and society has an strong idea of what his entails. Nursing staff and doctors enter this role to make a difference to peoples lives, but they soon learn, that is is no longer a vocation, and not the job they expect. It is a role of firefighting,	Fireflighting	I am a nurse, OT, or psychologist, but that is not what I do. I work as an admin, a police officer, prison guard, or meeting chair. My skills that I've trained for are not being used, but instead, are fuelling the autocratic machine.	*7.233 - Youre not actively helping people move into the community, your don't know when the MoJ are going to let them go, so, your basically, a prison guard* *3.273 - I'm running the ward myself some days. I'm doing the entire ward round, the entire management round, and doing leaves, and going groups all in one day. Like, NO! no! what is everyone else doing? Nothing.* *2.134 – no houses so they come to us for a house, no ASU for a drug and alcohol detox.* *2.222 – I just went up to him, and said that this is not a housing association!*	*What you are doing is freflighting, you are trying to keep a staus quo of calm all to the detriment of the patients, and their "recovery"* *How sometimes, you even damage the relationships you have with patients, when asking them for a drug screen, or telling them some bac news – i.e. leave suspension –*	For those that still think they can make people well, and help patients recover, they time is nigh. These OTs, nurses, managers, are supposed to help patients recover from their mental illness, but find themselves, acting as prison guards. In forensics, there is the dichotomy of acting as a custodian and carer, something that I always found difficult to understand, after seeing it in a video at my induction training many years ago. It was only

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	endless paperwork, and feigned teamwork.			*2.576 – I emailed my manager 2 weeks ago... can you make me and my colleague housing officers, cos that's all we do.* *7.224 - You literally do in to give people meds, open doors for them, and that's it! That's your day!* *8.112 – one minute you are their family, and the next, your asking for a drug screen* *2.134 – firefighting - we firefight through the entire day, we have very few people with mental health issues, mostly social issues.*	*you are damaging and then repairing relationships.* *Strange!*	after many years of working, did I truly understand this. When I started, I didn't know of the power that the Ministry of Justice have over the clinicians in forensic settings. Everything needs consent of the MoJ, from transferring hospitals, discharge and more, the clinicians themselves don't have total autonomy over their actions. Staff share their experiences of building up relations with patients, and the next minute, supervising a drug screen; carer and custodian. As the years progressed, staff also become their own administrative staff, and took on more and more paperwork, leaving even less time for therapeutic intervention. Above, a colleague shares their experience of how the ward had become a housing office, with patients seeking different ways to access the crippling housing system in East London. With diminishing housing stock, and little suitable housing for those who need specialised care and
		Never being good enough	You are never good enough. The hospital always wants more, needs more, and you need to be willing to give it. There is support on offer, should you ever have to tap into it, and when you do tap in, its tokenistic and facevalue.	*2.336 who's going to sit down and do a datix? There is no time for a datix!* *2.518 Then everyone gets pissed off at us, cos they are waiting for 6 to 1 weeks to even try and ge them a house.* *2.750 – Ive been able to give this man the start he needed in order to stay* *3.58 - Frustrating! You don't feel as if you are doing anything to help anybody, so therefore, what is your worth, you know. You feel worthless in a way*	*The care you deliver is never good enough and you know this. Whether this be through management saying that paperwork is not up to date, what your paperwork is not up to date or whatever. But then on the everyday, the patients will also tell you that you aren't good enough.*	

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				7.265 - : patients will say stuff, like we don't have enough activities. But how many times we've booked out the social spaces, bingo etc. does anyone go, No! If there's food, they might turn up *3.25 - , it just turns into a recipe for disaster and nobody feels validated and nobody feels , em, like they are doing anything good at their job. So yea, it's been difficult.* *3.58 - Frustrating! You don't feel as if you are doing anything to help anybody, so therefore, what is your worth, you know. You feel worthless in a way* *2.20 - ... and then we burnout, and then we get told off for burning out.* *3.239 - And then you work too hard as staff members and then you burnout, and they you get a letter saying that you have been off sick.* *4.56 - Preceptorship means nothing! If I kill someone on my preceptorship, I still loose my PIN.* *3.942 - I always knew we were replaceable but, em, didn't realise it was that quick. I gave in my notice the day before yesterday, and yesterday they had replaced me.*		input, the hospital has become a way of subverting the welfare system, and the staff know this. You then, cant plan for your day's work, for one day you are a nurse, housing officer, redeployed to another ward, or supervise a patient on a community visit. It is impossible to plan your day or week, and you become a slave to the rhythm, of firefighting, and unlike firefighters, you never feel a sense of thanks nor do you think you are making any real change.

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				7.372 - He left, ... gave me a hug, and spoke to me, saying that he was so thankful that I was so kind. And he came back and thanked me. And I havnt heard of him coming back since... or have you heard a thank you... hahah nor have I heard a thank you, that is true. No one has thanked me!		
		Detrimental dedication	How this nursing/OT/psychology clinical based role is ony a job, no longer a vocation. You learn in university and not on the job. There is still an underlying sense of sistership, but this is quickly depleting. There is a sense of it being acceptable to act as the ward Sisters of yesteryear would have, managing staff with hierarchical self	*8.645 - ... going to conferences every other day, if you're a senior nurse, you are in meetings all day. What about working on the ward.* *6.22 - : it was a mixture of a few things. obvuiously i realsied i didn't want to be a clinical psych, so the experience of the NHS wasn't any longer benefiting.* *6.28 - i was frustrated, i was doing the work of everyone, i was being attacked by patients, i was not being supported, so i just turned around, and was like, thats it, im done. i would do anything but be here.*	*Its only a job – ie its not a vocation – I am here to make money and leave.* *I am getting no joy from this role, but that is fine, I am getting paid.* *I am not getting anything out of this role, other than the wage – and that is all I am getting out of it.*	

Staff Subsample Master Theme Tree

Superordinate Theme	Superordinate Summary	Subordinate Theme	Subordinate Summary	Supporting Quotations	Insider Researcher – Subordinate Theme Reflections	Insider Researcher – Superordinate Theme Reflections
			importance and feeding on lack of confidence.	*6.183 - we rarely had an OT. the psychologist we have now, is on the brink, but she's good, she went away for a month just to take some time out, but she's not going to last longer* *8.5 – its been a good experience, insightful, learned loads, you now, scary, monotonous.* *2.98 – I felt as if I let the team down, and I didn't want to leave, but I was told that by my shift coordinator that I was told to leave 3 hours ago,* *3.821 - and you've a good day, what's that like when you leave work? When the day has flown well?... nothing spectacular!*	*Seeing other senior staff, not doing any clinical work – just paperwork, which is easier on the self, but worthless for the patient.* *Knowing that you're not doing the job well enough – and not doing anything about it apart from trying to change your job title and role.*	

Staff Subsample Master Theme Tree

Superordinate Theme	Superordinate Summary	Subordinate Theme	Subordinate Summary	Supporting Quotations	Insider Researcher – Subordinate Theme Reflections	Insider Researcher – Superordinate Theme Reflections
Realisation of the challenge	There is a preconception, that staff working in specialised settings, have specialised formal training. This is far from the truth. Nurses, doctors, psychologists, occupational therapisyts amongst the other profressions, undergo general education in their progression, there is little in terms of specialised forensic education. Staff enter the workplace, unskilled, under skilled and therefore find ways to work within the environment.	Staff not able	Something that nods to how staff are not the cream of the crop. Above, there is a section on how the staff feel as if they are useless, and unskilled perhaps to compete their tasks, lack of support from management and feeling as if days at work are meaningless.	*8.139 – you are telling them something about the men, and they are telling you about boundaries etc. all the nursing staff have cop-on!* *3.429 But again, they just went for the most restrictive option. They look at him as if he is a threat.* *4.170 - I looked at the risk assessment, and it was done in 2017, She asked whether she needed to update it!* *3.243 - And then you work too hard as staff members and then you burnout, and they you get a letter saying that you have been off sick. Well of course I've been off sick! I can't fucking deal with your bullshit, you know what I mean!*	*The staff not being able, and also seeing this in your other colleagues – and pointing these issues out is normal, and necessary.* *If when pointed out, this can be construed as bullying or micromanagement , but so is the quality/lack of quality of the current cohort of people, who are no longer bound to their job, considering their job is just that – a job – no longer a meaningful career.* *You are then left with only the staff who are not able, not able for the job, not able to move on. The staff that can move up, do, and the staff that are not able to work with these people, move on. – this is a larger*	As a member of staff, you must learn how to survive within this system. After years, you learn that the whole system is simply harbouring dangerous patients, some of whom, will get discharged, and those that are, will return. Those that remain in the hospital, think it is their home, until they are moved to another hospital to offer respite for staff. You eventually learn that you are not going to change the system, and you want to continue in the role for which you have studied hard, and perhaps even still see it as a vocation. I have had peers, who have very quickly moved up through the managerial system, perhaps to survive the lack of satisfaction, and to live with the vocational decisions that they have made. Whilst those career managers will also be, there are many managers within the NHS who are first and foremost clinicians, with little managerial experience, which perhaps explains the lack of scrutiny. I always found it strange, for

Staff Subsample Master Theme Tree						
Superordinate Theme	Superordinate Summary	Subordinate Theme	Subordinate Summary	Supporting Quotations	Insider Researcher – Subordinate Theme Reflections	Insider Researcher – Superordinate Theme Reflections
					issue, of making this degree free and funded, and hiring ANYONE for the degree, to fill government policy – which is ill thought out.	young staff to climb the managerial ladder, when they have studied to become clinical staff. As I examine and reflect on my experience, it was so that they could make their job work for them. Perhaps they were seeking a more meaningful role, or perhaps, it was because they simply hated their clinical role. The staff with good skills and abilities are quick to climb, which leaves inexperienced and disengaged staff to do the clinical work.
		Feigning teamwork	The team will always be disjointed; not everyone wil see eye to eye, and not everyone will be on the same playing field. People have their own vested interests for being in the job, and those will only have care about their roles.	*3.251 - So yes, they will say that if you have a good relationship with your managing team, they'll owe it to formality, you know how it goes. O I have to have this meeting blah blah blah, which you do, yes I understand* *3.563 Its' like a power thing, its very much a power thing. The power has gone to their head. They used to be good nurses, and I knew then as nurses, and I had just started* *5.266 - no one tells me, nursing management sometimes tell OTs to sit in day areas.* *3.83 - and the man is screaming and shouting and banging and kicking...and they haven't*	*How people are just out for themselves – and how there is no real teamwork – only something that is called teamwork – which is actually just a few people on shift, interacting interdependently.* *This feigned interdependent way of work, leads to those being unable or less skilled, becoming less*	

Staff Subsample Master Theme Tree						
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				been giving him the space like I had said, to give him space. They hadn't been following what I had said to follow when he gets himself in that state and instead, they were encouraging him to act out,. *3.196 - There is no input, no empathy, there is no wanting to get to know that person and to help that individual person they want to just follow the protocol of just giving meds doing a housing form.* *2.79 – They said that to see (me) break down, shows how far the team has fallen, how were not having the right support.* *3.691 Em, it can be quite lonely. In that you only have one or two other people you are working wanting to help people*	*skilled. Everyone does their little but, with little in the way of helping each other.*	

Staff Subsample Master Theme Tree						
Superordinate Theme	Superordinate Summary	Subordinate Theme	Subordinate Summary	Supporting Quotations	Insider Researcher – Subordinate Theme Reflections	Insider Researcher – Superordinate Theme Reflections
		Silo Working	The lack of support does not only some from your own team, but from other agencies, that ar either unwilling, unable or they, themselves, so not care either. The lack of support here, is referring to the support not received by the front line staff, those with the most contact with patients and those who spend the most time, and know the patients the most.	*4.40 I had it passed as in everything was signed off, but had not finished the year. So I was made start it again! So I'd been qualified for 9 months, and then it took we another 2 months before I could do meds there! Because no one had the time!* *2.951 The problem is its really difficult, they have this false sense of entitlement, they have this false idea of how things are.* *6.177 – I was on a ward where the OTs were on rotation... the psychologist we have now, is on the brink... the prior psychologist input was shit* *6.330 there was no social worker, they were shit* *7.246 - They'll make decisions that go against what the nursing staff have already said, and that hugely undermines the nursing staff. And the patients learn that, and they just say, ah, Ill just talk to the doctor.* *3.517 - We don't have the greatest support from the police system, the police say that they are unwell, even though you are telling them otherwise.* *2.317 – you have to tell them you have a hostage situation before they will send someone*	*The silo working, everyone out for themselves, your being given extra work to do, to re-skill or up-skill, but this is only to the advantage of the person who has asked you do to it.* *You own projects are changed by management, to better and further advance their career, and I have personal experience of this, and can see why people so the least they can, or the most they can for their own career gains.*	

Staff Subsample Master Theme Tree						
Superordinate Theme	Superordinate Summary	Subordinate Theme	Subordinate Summary	Supporting Quotations	Insider Researcher – Subordinate Theme Reflections	Insider Researcher – Superordinate Theme Reflections
Acting as a means of self preservation	There is also a preconception, that staff will be hard working and dedicated, for they are proudly NHS staff. Bright eyed and bushy tailed, new staff enter the workplace, and learn from their elders, not to e chance their skills or abilities, but rather ways of deep acting, in order to survive the chaos.	Playing with Responsiblity	To survive and working with the workplace, you need to adapt your methods of working. You must gain the skills and abilities t work within such an eicironment, where there is always an alternative motive for doing something. To make sense of the career they have choosen, there are skills learned to continue with their	*6.101 - id go in and not want to do that, cos sometimes i didn't just want to be in charge, and those would be the days that things wouldn't get done. i didn't want to stand up and take control then, cos in the end it isn't my job.* *3.380 - O, quote on quote from the manager of the PICU, he's been a very naughty man, and he can't get away with what he's done. Bearing in mind the man is sick!* *3.792 you don't have all of these personal issues that they bring to work, like what all the crap teams do. Do you know what I mean. They don't all bring their personal shite with them*	*Dysfunctional and unbalanced, the work environment is not one where you will learn best pracrice- there will be a few staff members who actually know how to do everything, but many simply do the bare minimum, for there is too much.* *Learning from those who are there a long time – means that you*	Staff start to act in strange adaptative ways to work with the colleagues, who are also acting with the same sense of inauthenticity. Staff become so disenfranchised by their job, that they simply no onger know how to be a clinician. They seem unable to engage with risk assessments in a meaningful way, perhaps knowing they are useless and outdated, – and seem unable to engage in any critical conversation on care planning.

Staff Subsample Master Theme Tree

Superordinate Theme	Superordinate Summary	Subordinate Theme	Subordinate Summary	Supporting Quotations	Insider Researcher – Subordinate Theme Reflections	Insider Researcher – Superordinate Theme Reflections
			choice of job, and this makes the workplace even stranger.	*5.297 - But I wont be told, em, I wond have my timetable done for me by someone who is not my manager, if that makes sense. Ill help out, and ive done leave, and anyone that knows me, you know,* *5.306 - With OT, its way more of a grey area. We are in and out of sports, physical health, leave, in and out of education, employment team. There is a huge cross over. I find that new OT's find it difficult to establish themselves on the wards.* *4.296 - I want you to have my back, and that is why he accused her of bullying because, she saw something that she didn't like.* *7.80 and they say things like, you cant talk to me like this, you are younger than me, you cant tell me what to do, I know how to do my job, well, fucking do it then!* *3.262 And you tell them the reasons why without trying to obliterate the entire ward in the process you know, you have to keep some things quiet*	*will learn how to survive there – which means, doing the least amount possible.* *If you try to do too much, your martyrdom wont be appreciated.*	I have had arguments with management over how safe it would be for a patient to have a brush in their room to clean the floor. A patient with no risk behaviours nor assaults on staff in years, was not permitted to have his own brush in his room, for it was deemed risky. Another patient who was in the community every day for 5 days, for 6 hours each time, was not permitted to be outside for 6 or 7 days. A patient who was mandated by the MoJ to be in handcuffs when leaving the hospital, and who was mandated to be in a secure vehicle with a prison cell, was brought to hospital in a taxi with no cuffs, and the staff member hid behind the mantra of least restrictive practice. Staff hide behind risk assessments that have been conducted and have not updated. Refusing patients

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		Lack of skills	But the reasons you act this like this, is because your work colleagues simply lack the skills and abilities to do their job effectively,a nd some simply don't care.	*3.171 Because people don't, it feels as if people don't care. Right now, with all of the difficulties we have with our shortage of staff and the different patients that we are getting, it's just like people don't care anymore* *3.120 - , if someone had just come in and sat down with him and talked with him, for 5 minutes, quietly, away from everything, he wouldn't have needed to go to seclusion, the whole thing could have been managed better,* *3.194 They know that person is going to do to the psychiatric intensive care ward, its just a matter of time they think so they just let it happen.* *4.507 don't you remember when we discussed getting the speaker out whenever we could, even things like that, it was only once a week. What can't we do this whenever!* *4.222 - . I said to her, this is how I would do it. Bearing in mind I have only been qualified for a year. I'm not the most experienced nurse not he world. But it's common fucking sense! I said what I would do, is this that and the other.* *4.205 - And you know why I think they are shocking, they've come out with this false sense of I know what im doing...*	*The general lack of skills needed to perform the job is shocking. There is very little in terms of interpersonal relationships.* *There is no interview process to train to become a nurse, OT, only for psychologists and for medics* *The academic-lization of these careers which were never taught in universitiies until recently, have led to people not having the skills, but a degree paper that says they have the skills.*	access to things like pornography as a care plan has not been conducted nor risk assessed for. Staff say that the shortage of staff is the reason for everything, from paperwork not being completed, to simple tasks not getting completed, to delays in treatment and care. Changes in governance and the ever growing mound of paperwork and audits, to ensure that you are doing your job properly, actually is counterintuitive, and hinders progression. Shortage of staff is no longer believed as an excuse, and people will say that "everywhere is short," and this then starts to become normal. Nurses don't believe each other, shortage of staff is normal, paperwork is never compelted. This constant stress leads to further firefighting, and nothing is done with real quality, and staff find ways to continue work with their colleagues.

Staff Subsample Master Theme Tree						
Superordinate Theme	Superordinate Summary	Subordinate Theme	Subordinate Summary	Supporting Quotations	Insider Researcher – Subordinate Theme Reflections	Insider Researcher – Superordinate Theme Reflections
				7.90 - no, I say that respect needs to be earned, and if your dumb and lazy, im not going to respect you! *"missing quotation – check Keep and transcripts. "consultant knowing of incompetent nurses.""* *7.164 - …, you are counting down the minutes until you can go home. Or you find yourself leaving the office, and letting them stay in their doing the paperwork, at least you can have time with the patients, and someone sane to talk to!* *7.57 The long stay staff are institutionalised more so than the patients. They'll do something, and you might question why, and they'll just say, that's how its done* *7.317 - I think the power gets to some peoples heads! O, im the nurse in charge! O, Im suspending your leave, you need to wait for 30 mins before leave. O don't speak to me like that! Even though they are asking something reasonable, like why has my leave been suspended*		

Staff Subsample Master Theme Tree						
Superordinate Theme	Superordinate Summary	Subordinate Theme	Subordinate Summary	Supporting Quotations	Insider Researcher – Subordinate Theme Reflections	Insider Researcher – Superordinate Theme Reflections
		Surviving the Job	The only way to survive this workplace is to make the job as easy as possible, and this sometimes entails making the decision to take on extra work, and sometimes, to take on less.	*8.270 but they don't build the trust do they – you'd be in the job for a while, and just don't move around, or get to the next band.* *3.718 - Sit in the office on their phone, the band 6s will sit in the doctors office and book flights or sit on the phone and talk to people about their other business. Ehhh, then you'll have s staff member who will sit down the back of the ward and will say that they are checking up on people when they are not* *4.400 - : Band 5s make the shift, and you get so many of them that just don't want to do anything, apart from meds, and even at that, they say that they can't do two lots of meds in a shift, and you even get that with new people.* *7.190 no, they wouldn't! no one knows how to admit, how to scrutinise section papers, no one even knows how to use the computer systems!*	*This is similar to the one two above – how making the job as easy as possible is the only way to survive – you are unskilled, nobody can teach you, and the workplace is archaic and you don't even like your job. But you have spent 4, 5, 6 years becoming a clinician, and now you have debt to pay off, and only really, one job you can apply for, so you stay, and you must!*	

E Forensic Mental Health Contextualisation

These vignettes serve to only further offer insights into the types of clinical presentation of patients, their forensic and criminal justice histories. Staff vignettes and aim to offer an insight offer into the workday, and an applied referenced vignette, aims to offer an insight into a relationship between a patient and a staff member in forensic mental health care.“.

Patient Contextualisation Vignettes

Albert.

I was in prison, serving a two year sentence for robbery. When I was in prison, I became very withdrawn, and depressed. I would stay in my cell for days on end, not speaking to anyone, not even to my cell mate. All I could think about was my family, and how I was missing out on my kids growing up. After about 6 months, the staff became concerned, and they would ask me questions about my mental health. I kept quiet, but I knew they suspected something was wrong. I started to become paranoid about the staff injecting me with medication for my depression; I had heard similar stories from other prisoners. I started to avoid all contact with staff, and became more withdrawn.

One night, I could hear a team of guards come to my cell, I knew they were going to inject me, so I armed myself with a metal bar I’d broken off the bed. When the door opened, I went for them, hitting one screw across the head. There was only one guard, and they were conducting their usual nightly checks. I was placed in an isolation cell for attacking the guard, and whilst there, I became more paranoid about the staffs’ intention., they were out to get me, they wanted me to feel less of a man. Each time the door opened, I was so terrified about getting in injected, that I would jump from my mattress, and swing at anyone who came into the room. I was then removed to the hospital wing of the prison. I became worse for a time, and was refusing all medication they would offer. After speaking with some doctors and nurses, they

believed I was suffering from a psychotic depression, so I attacked the doctor too. All they wanted to do was inject me.

After about a week, I was moved to a regional secure unit. I was told that it was like a hospital and prison combined, where they could force me to have the medications. I ended up in a seclusion room after my first night, terrified of the staff, I managed to jump on a nurse who was conducting night checks.

The next morning, the seclusion room door opened, and about 10 nurses entered, they restrained me on the floor, and gave me the medication that I feared to have for so long. I was also told that I was going to be sectioned under the mental health act for treatment, I was going to be placed on a section 37/41, that allowed them to give me treatment against my will.

After about a week, I started to feel normal again. I didn't know what happened. I could remember hitting people, but didn't know what got into me. I was starting to realise that the staff wanted to help me. I started to work with my nursing team, I got out of hospital about a year later.

Bernice

I came into the hospital system after I attempted to kill my 5 year old daughter. I believed she was the devil incarnate, and that she was going to grow up to take over the world and bring about the apocalypse. One night, I went into her room, and tried to smother her, but luckily my partner was able to stop me before hand. I had just lost my job, and my relationship was hitting rock bottom, I was really stressed. I was arrested and brought to a hospital, where I was placed on a section for treatment, section 2 and then a section 3. I was in and out of seclusion for weeks, I thought that everyone was the devil, and that my daughter had finally began to take over the world. I was arming myself in my room with weapons, and was making weapons out of anything I would in order to defend myself. I kept attacking staff and my fellow patients, so I was moved to a secure unit. It was intense, people were unwell, and this made we worse at

first. I continued to try to attack staff, but there were many more of them, and the ward had a seclusion room. All the furniture was bolted down, and there were loads of staff.

My medication was changed many times, and nothing seemed to work. I was offered clozapine, a type of antipsychotic, and soon after I started to take it, my paranoid thoughts started to disappear. I was no longer attacking staff, and started to realise that they were actually there to help me. I became more well, and started to go into the community with the nurses again. Now I have to work with social workers and with family therapy in order rebuild my relations with my immediate family. My partner was terrified at the time, but has come round to the idea that I was unwell. I hope my daughter grows up to understand that too. It's going to be very difficult to move back into the family home know, all my neighbours know what happened.

Carly

I was put on a 47/49 when I attacked my cellmate. He was telling everyone I was a batty boy, and he cant be going around telling people lies about me, so I beat him up bad. The staff thought I was paranoid about people, and I said he was chatting shit! I was placed on the hospital wing of the prison, and they were offering me medications, I did not think I was unwell, they just wanted to give me this medication to make me sleep so they could rape me when I was knocked out – no way.

I was taken to a medium secure unit, where they forced this medication on me. I refused to take it, and thought that all the staff were trying to rape me. I was so confused and didn't know what to do. I started to believe that the observing staff was going to rape me, so I tried to break out of seclusion and managed to break through the lock, but by the time the door gave way, there was a team of nurses who injected me. I woke up worse than before, paranoid about the staff and about everyone wanting to rape me.

I started to feel better, but every so often, I felt as if people were taking behind my back and this made me so angry, so I destroyed my room a few times.

I was eventually moved to a rehab ward, where I still would have paranoid thoughts every once in a while, and they felt real. I started to work with a psychologist for a couple of months, and they tried to give me some coping skills, but I don't think she was much help. I've finished my sentence now, but am still under a section, so I'm not allowed leave. My MDT say that if I continue to engage with the psychologist, they would write off to the Ministry of Justice for community leave. That would be the first step to getting out of hospital, hope I can keep it together until then.

Daniel

A few mates and I were having a BBQ and there were a few people smoking spliffs. I had taken cannabis before, but this time it didn't agree with me. After my first spliff, I started to talk rubbish, I cant remember, but my mates tell me I was cursing everyone, and not making much sense, then I started to rip my clothes off and started to attack my mates. They called the police, and I was brought to a 136 suite in a hospital not far from me. I was placed on a section 2 for assessment, and then a section 3 for treatment, where they gave me antipsychotic medication. It took me ages to come round, I was so unwell. The medication made me very stiff, and I found it difficult to walk, and I was dribbling everywhere. I can remember one time when my folks visited, they started to cry, I was in such a mess, I was drooling everywhere, I couldn't even talk properly.

The team wanted me to do some drug addiction work before offering me community leave. I did a few sessions and started to use community leave, before I knew it, I was discharged.

I've always smoked weed, so wont stop. I don't think I was unwell, so I'll stop taking my meds as soon as I'm discharged. , it must have been a dodgy spliff or something.

Esther

I've been in care for years now, almost 20 years. I was in Rampton high secure hospital for attacking a nurse, before moving to a medium secure hospital. I was nearly discharged before, but the stress of living my myself again made me relapse, so I had to go through the whole cycle again, from high dependency wards to a rehab ward where I am now. I've been on this ward 3 times before, and the staff are great. In hostels, there aren't any staff to talk to. I need the support of the nurses here, they look after me. Every time the team talk about moving me on, I get really anxious and become unwell. I start getting paranoid, and start relapsing. The last time I was moved on, I lit my flat on fire, I was brought back to the hospital – I wasn't ready to leave.

I hope to be discharged one day, but I am not ready yet.

Staff Contextualisation Vignettes

Activities Coordinator

Hi my name is Rose, I am an activities coordinator, on an a male acute ward in London. No two days are the same for me. Every day is different. Some days I'll go shopping in the morning, some days, I'll go in early for a risk handover. I have a lot of autonomy over what I do, and what groups I run which is good, but most of the time I don't get to do them. I am always pulled into the numbers by the nursing team, or asked to do three to four other jobs at the same time, so I find running activities difficult, but rewarding when I am actually able to run these groups. I get to work really closely with the service users, and you can really make a difference in getting them back into the community. On an acute ward, they will only stay a while before heading home. We probably have the closest relationship with the service users amongst the MDT team, and that is what makes it easier for me to make a difference to patients' lives, but it is a challenge to make decisions in an MDT team, as I am considered a non-registered nurse.

RMN - Registered Mental Health Nurse

I work on a rehab ward. I spend my days in the ward office, coordinating the shift, ordering medications, and dispensing medications during meds round. I work with another nurse, and two healthcare assistants. I find my workload very tedious, there are many jobs that need to be done, many handovers to be delivered and audits to be completed. I also work shifts, so I can do most of my patients' paperwork during the night, but during the day, it is a very busy environment.

This is not the reason I became a nurse. I spend more time in the office completing paperwork, that spending time with patients. PAtients complain that I do not have the time for them, and that is true, I don't. I became a nurse to make a different in vulnerable peoples' lives, and completing care plans that no one reads or cares about, is not my idea of helping people. I just wish I could spend more time on the practical aspects of my job, rather than ensuring that we are audit compliant.

Healthcare Assistant

I work on a ward with patients. Usually, I work with one other HCA, and with two nurses. THe nurses are busy with their paperwork, or appear to be busy with their paperwork in the office, so this leaves me and my colleague in the day areas for the majority of the day. I am expected to escort patients on their prescribed community leave, response to psychiatric emergencies, have one to one meetings with patients, and help the nurses with their paperwork.

It is often so busy, that I am unable to take a break during my long day shifts, and the day can very busy and made difficult if we are short of staff, which seems to be the case more and more these days.

OT - Occupational Therapist.

As an occupational therapist, it is my job to encourage patients that are often hindered by their negative symptoms, to regain confidence in activities of daily living. I work within the MDT in delivering practical therapies and activities focusing on cooking, cleaning, washing and encouragement around physical health - diet and exercise. This is important to me specifically, as many of the patients on these wards are morbidly obese, chronically physically unwell, and many have badly managed diabetes.

I work with a team of occupational therapist assistants, and together we deliver these interventions as a team.

Clinical Psychologist / Forensic Psychologist

I work with patients on a one to one and on a group basis in addressing their symptoms and work understanding index offences. Index offences are what often results in patients behind held on restriction orders by the home office, sections 41 and 47. In order to discharge these patients, the Home Office requires that patients work on their offending behaviours, these can range from fire-setting, arson, rape and murder, to drug taking. I run psychotherapeutic interventions in helping patients understand their behaviours.

I also work with patients diagnosed with personality disorder, in order to help them understand unhelpful patterns of behaviours. Like most of my team, I am employed on a part time basis, so it is difficult to find the time to see all patients.

Consultant Psychiatrist

I am the overarching responsible clinician for the patients under my care. While I can discharge patients, when it comes to forensic patients, I have to seek permission from the Home Office in order to prescribe community leave, and discharge itself.

I attend ward rounds weekly, and see my patients perhaps once a week for ward round where we discuss progress and plan for care. I spend my time writing reports to the Home Office on

patient progress, but I am also a section 12 doctor, which means I am often called to other sites within London in order to perform second opinion assessments before someone is admitted to hospital, or to decide whether someone needs to be admitted at all.

I also have one to two students at any one time, and perform some teaching with them during their placements. I also receive referrals from other hospitals, and assess patients for suitability for transfer to be cared for in the hospital where I work.

Medical Doctor

I work as part of the medical team on the ward, there is often a senior house officer, a SpR, junior doctor and consultant at any one time. I help the consultant their report writing, and also prescribe and change medications on behalf of the consultant. I also am responsible for the physical health of patients which is important, as many of the patients in my care are very physically unwell, and some antipsychotic medications that we prescribe and administer can have some physical health side effects, I monitor patients to ensure that medications are given safely.

I am also on-call doctor from time to time, and have to run between hospitals, attend reviews, seclusion reviews and new admission physical health checks, so my day can be very busy indeed.

Psychotherapy (Art, Drama, family)

As an arts therapist, I work with patients who can find it difficult to communicate their feelings and experiences with usual psychology sessions. I work with art, paints, drawings, modelling, in order to help patients that are not well able to describe their feelings, emotions, symptoms and experiences. I work with service users, usually on a weekly basis, but as I am the only art therapist in the hospital, I have a long waiting list, and itis nigh on impossible for me to see all referred patients, which is a shame.

As a drama therapist, I work with patients who are also unable to express emotions, explore experiences, and discuss symptoms in a verbal way, and so try to help them express this in the form of bodily movements and acting. Some patients find this approach helpful, while many shy away as soon as the word drama is mentioned. It's not all charades, it can be quite a useful intervention for those who find it difficult to speak about symptoms.

I work with service users and their families. Many of the forensic patients I work with those who have had difficult histories with their families, whether this be abuse or rejection for a number of reasons. When it comes to discharge, or moving on, we work with service users and their families. Sometimes, the index offence involves family members, and there are cases where patients have killed or injured someone in their family, so this intervention is very important.

Example Applied Vignette

Kirsty, An Applied Vignette

Kirsty is a 30-year-old woman who suffered regular physical, sexual and emotional abuse from her husband. After being assaulted by her husband and whilst under the influence of drugs and alcohol, which they both abused regularly, Kirsty killed her husband by stabbing him with a knife. She was sentenced to prison. However, after becoming depressed and suicidal, Kirsty was transferred to a secure mental health hospital for assessment.

Once admitted to hospital Kirsty spent considerable periods of time being nursed on one-to-one observations, during which nurses engaged Kirsty in conversation, day-to-day living tasks and other therapeutic activities. Kirsty found one-to-one observations very intrusive apart from when Pauline, her primary nurse, undertook them. As a result, whenever Pauline was on duty she undertook Kirsty's one-to-one observations for several hours during her span of duty. This was also encouraged by most of Pauline's nursing colleagues, who found it difficult to be with Kirsty.

Kirsty would talk to Pauline about her traumatic experiences with her husband and go over and over the details of her index offence. She began to express that only Pauline understood her and she refused to engage with other members of the nursing and clinical team. Kirsty became very explosive and argumentative with the other nurses on the ward. All Kirsty's requests began to be channelled through Pauline, who was becoming increasing exhausted and overwhelmed in trying to meet Kirsty's needs. Pauline began buying food and gifts for Kirsty, which was not permitted under the hospital's policies. When challenged by her peers, Pauline became angry and told Kirsty that she was no longer able to buy things for her because her colleagues were complaining. In turn, Kirsty became angry and upset and began assaulting the other nurses for stopping Pauline bringing her food and gifts. The nurses and wider clinical team became angry and frustrated with Pauline and blamed her for their difficulties with Kirsty. Ostracised from her peers, Pauline began to confide more and more in Kirsty, sharing personal information with her about her own relationship difficulties both at work and at home.

Several weeks later, during a one-to-one session, Kirsty attempted to strangle

Pauline, causing her serious injuries. When the clinical team asked Kirsty why she tried to strangle Pauline, Kirsty reported that she was overwhelmed and felt trapped in a relationship with Pauline, who she felt was offloading her own problems onto her just like her husband used to do. Pauline, who made a full recovery from her physical injuries, was subject to a formal investigation and issued with a final written warning for her inappropriate conduct. She was moved to an alternative ward. She was also referred to occupational health and offered staff support. However, she was left feeling unsupported and angry. Subsequently, Kirsty was allocated a new primary nurse who also became

quite overwhelmed by her and a similar scenario emerged, which again led to Kirsty's primary nurse being moved to another ward

Kirsty's in-depth case vignette can be found in Kelly & Wadey's piece which explores boundaries in forensic mental health nursing. (Kelly & Wadey, 2017, p. 118)

13. Care Programme Approach (CPA) Position Statement

- In July NHSE issued a statement about CPA, however Spec Comm were not asked to contribute to this statement and so it has caused some confusion across adult secure.
- had asked for a statement to be circulated to make clear that the statement does not cover adult secure and CYP spec comm services.
- Noted that the CRG will need to develop a statement that is right for the services. Agreed to review the previous work completed in relation to CPAs and standards for them. Agreed to bring to next meeting to discuss in more detail.

ACTION:

- is working with the MH Policy team to develop a clarification in relation to the CPA statement to make clear it does not cover adult secure services. (
  - CRG to consider what further work is required in relation to CPA, including a review of previous work completed in relation to standards, and to consider the need for a Task and Finish group. (All)

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NHS

Item 9- Care Programme Approach Statement

- An amendment has been made to specify that Adult Secure has been excluded from the CPA statement
- The CRG will look at the CPA standards and consider how it applies to the AS CRG

Action: The data sub-group to think about data to be included in the CPA statement
- A task and finish group to help progress the CPA standards for AS

Annex A

Concerns raised by various stakeholders since NHS England and NHS Improvement began work on the development of the Community Mental Health Framework in 2017 include the following:

- **Variation:** in terms of the extent to which the CPA is applied, and how it is applied, by staff working within the same and in different providers, as identified by the CQC[4]. Variation in implementation of the CPA also arises within *An independent review of the Independent Investigations for Mental Health Homicides in England (published and unpublished) from 2013 to the present day* (2018), commissioned by the NHS England Independent Investigation Governance Committee;

- **Creation of a crude, de-personalised two-tier system:** a person is either "on" or "off" CPA (or previously on 'enhanced' or 'standard' CPA), which has by its nature created an inequity for service users, distorting clinical practice and impinging on clinical judgement, with little consistency or transparency in how these decisions are reached by teams or psychiatrists;

- **Significant bureaucratic burden:** the paperwork generated by CPA processes within provider organisations leads to staff spending a disproportionately large amount of their time filling in forms and entering process data onto clinical systems, rather than on direct, productive and meaningful patient-facing care – as identified by the Lord Carter review into operational productivity within mental health services;

- **Misuse of the CPA as a form of risk management tool:** service users are often treated as 'risk entities' rather than people with needs that services should be seeking to address in order to keep them and others safe. This is closely related to the more recent sense that the CPA in fact represents a barrier to safe and effective care, as professionals tend to rely on an overly standardised process rather than responding to the needs of a particular individual and the circumstances at hand;

- **Static, poor quality care planning:** professional efforts are directed too heavily towards fulfilling a process that encourages inaction, rather than using time available more effectively to co-produce live personalised care plans with service users, their carers and families, and review them dynamically and regularly as needed;

- **Lack of co-production and irregular information sharing:** it is reported that some CPA meetings take place without involvement of the service user, carer and family member, the outputs of which may or may not be communicated to them, or to a service user's GP in a timely manner;

- **Lack of integration:** an overemphasis on the clinical aspects of care that is not in line with a balanced biopsychosocial model, and does not allow for integrated, Care Act-compliant planning with other agencies relevant to the care and life of someone with a severe mental health problem, such as social care and housing;

- **Generic care coordination too often viewed as an end goal:** for too many service users, having their care coordinated is perceived by services as a satisfactory primary goal of their mental health care, rather than a complementary by-product within a system of care that is focussed on meaningful and therapeutic interventions.

[4] See CQC's 2016 *Community Mental Health Survey: Statistical release* and the same release for 2017