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‘My Shared Pathway’: The experience of users of a low secure service

by

Caroline Clarke

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ABSTRACT

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‘MY SHARED PATHWAY’: THE EXPERIENCE OF USERS OF A LOW SECURE SERVICE

Caroline Clarke

Adoption of the recovery approach has proved contentious in forensic services, which has traditionally been dominated by the medical model and concepts of security and risk; nevertheless, there is currently a focus on embedding recovery principles in forensic services (Drennan & Alred, 2012). One advancement has been the development of ‘My Shared Pathway’, which was introduced to forensic services in 2011 (Esan, Pittaway, Nyamande, & Graham, 2012) with the aim of increasing transparency, promoting recovery and reducing admission times.

The first part of this thesis is a systematic review and narrative synthesis of forensic mental health patients’ perceptions of recovery. Relevant databases were searched and a total of 11 studies that fit the inclusion criteria were identified. There was significant overlap of themes across the studies, these were subsequently organised into seven categories/superordinate themes: *Connectedness, Treatment, Sense of Self, Past Experiences, Freedom, Hope* and *Health*. Two superordinate themes were particularly prevalent in 9/11 of the studies: *Connectedness* and a *Sense of Self.* It is argued that a focus on increasing opportunities for forensic mental health patients to develop a sense of self and connectedness could help improve recovery.

The second part of this thesis is an empirical paper describing a study that explored the lived experience of ‘My Shared Pathway’ for six male patients who were detained in a low secure service. Interpretive Phenomenological Analysis (IPA) was used to capture the subjective meanings that patients ascribed to this process. Five superordinate themes were identified: *It’s a Journey, We’re Vulnerable in Here, Relationships with Staff, Loss and Hope.* These findings are consistent with those seen in the forensic recovery literature and suggest that ‘My Shared Pathway’ helps promote recovery in a number of ways. Clinical implications and suggestions for further research are given.

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DECLARATION OF AUTHORSHIP

I, Caroline Clarke
declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

‘My Shared Pathway’: The experience of users of a low secure service

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. [Delete as appropriate] None of this work has been published before submission [or] Parts of this work have been published as: [please list references below]:

Signed: ....

Date:...

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Chapter 1: What does recovery mean to a forensic mental health patient? A review of the literature

1.1 Introduction

This paper is a systematic review and narrative synthesis of the literature surrounding forensic mental health patients’ perceptions of recovery. Despite literary evidence of the recovery approach that dates back to the Normalisation movement in the 1970s, services have been slow to implement recovery principles into their everyday practice, nowhere more so than in forensic services (Drennan & Alred, 2012).

Forensic services offer unique challenges to the recovery approach, which is grounded in principles of hope, empowerment and individualism (Drennan & Alred, 2012). Opportunities for engaging with these principles are likely impacted when facing the implications of sanctions, restrictions and potential indefinite detentions that are seen in secure services, which potentially makes recovery more complex for forensic mental health patients (Turton et al., 2011). Having a greater understanding of the personal meanings of recovery held by forensic mental health patients could provide an insight into how recovery principles might be better embedded in secure services. Whilst there is a paucity of research involving forensic service user perspectives (Coffey, 2006), there have recently been a number of papers published that aim to provide an insight into meanings of recovery for this client group. These will each be reviewed, with key themes being highlighted and organised into superordinate themes/categories, along with potential clinical and research implications.

There has been some debate in the literature about the best terminology for referring to individuals accessing mental health services (McLaughlin, 2009); e.g. service user versus patient. This is yet to be resolved, and therefore for the purposes of this paper, both terms shall be used interchangeably.

1.1.1 What is recovery?

The recovery approach to severe mental health problems advocates a more holistic approach than the traditional psychiatric model. Whereas previously the focus of psychiatric recovery was on symptom reduction, the recovery approach focuses on empowering individuals to overcome a range of challenges associated with mental illness; such as social isolation, loss of valued living, etc. Mental health problems are perceived as merely one feature of an individual. Efforts are made to support opportunities for increasing autonomy, reclaiming identity and engaging in meaningful activities to help overcome the stigma of mental illness and help develop self-awareness, acceptance and self-esteem (Turton et al., 2011).

Several definitions of recovery have been offered, although it is widely accepted that it is difficult to define something so personal. The most often quoted definition comes from Anthony’s 1993 paper that promoted recovery as a new vision for mental health services:

> “A deeply personal process of changing one’s attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing way of life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness.“
>
> (Anthony, 1993, p.527)

Leamy, Bird, Le Boutillier, Williams & Slade (2011) conducted a systematic review of published descriptions and models of personal recovery in mental health. They reviewed 366 papers and included 97 in their final review to develop their emerging conceptual framework. This included five processes of recovery; including: *Hope and Optimism about the Future, Connectedness, Identity, Meaning in Life* and *Empowerment*. Studies focussing on people from black and minority ethnic backgrounds identified two further themes: culturally specific facilitating factors and collectivist notions of recovery.

Drennan & Alred (2012) have proposed a four facet model of recovery that includes the principles of personal, clinical, functional and social recovery, highlighting Anthony’s definition as representative of personal recovery. They argue that the process of recovery involves a combination of factors that may hold different priorities at different stages; referring to Ridgway’s (2001) claim that recovery comes from an interaction between the characteristics of the individual (sense of meaning, hope and purpose), the environment (meaningful activities and support) and exchange (hope, choice, and empowerment). Offender recovery is proposed to be an additional facet for forensic mental health patients. These five facets shall now be considered in turn.

1.1.1.1.1 Clinical Recovery

Clinical recovery describes a reduction or cessation of clinical symptoms of illness and is thus an aspect that is more easily understood by others. Drennan & Alred (2012) highlight how clinical recovery tends to be described in outcomes defined by others and that this may detract from self-acceptance processes.

1.1.1.1.2 Functional Recovery

Functional recovery does not require a change in the experience of clinical symptoms. It refers to the restitution of functional capacity necessary for undertaking life tasks; such as engaging in relationships and employment/vocational activities. Skills training programmes promote functional recovery by focussing on building life skills, rather than symptom reduction

1.1.1.1.3 Social Recovery

Social recovery implies overcoming the social exclusion that mental health patients have suffered throughout history. The promotion of professional and non-professional relationships, integration in social networks and employment/vocational services offers increased opportunities for social recovery.

1.1.1.1.4 Personal Recovery

Personal recovery is the most difficult to define, due to the idiosyncratic nature. It involves a personal growth of what is most meaningful to the individual; what constitutes personal recovery for one, may well be meaningless to another. It has been described as the process that happens when someone ‘hits rock bottom’ and sees this as an opportunity for change and personal growth (Drennan & Alred, 2012).

1.1.1.1.5 Offender Recovery

Forensic mental health patients are individuals who have committed a criminal offence and who also experience mental health problems. Recovery in this client group is therefore more complex, as it must encompass the features of traditional recovery as well as offender recovery.

Offender recovery relates to the subjective concept of an offender coming to terms with the offence that they have committed, appreciating the need to change the personal factors that led to their offending, accepting future risk of reoffending and accepting the range of consequences of their offending behaviour (Drennan & Alred, 2012).

1.1.2 **Recovery in Forensic Mental Health Services**

Adoption of the recovery approach has proved contentious in forensic services, which has traditionally been dominated by the medical model and concepts of security and risk. Positive risk taking, trust and choice for service users have been highlighted as factors for organisational change necessary for recovery orientation (Shepherd, Boardman & Burns, 2010; Slade, 2009). The risk of serious harm to others and potential security breaches affects all areas of forensic service delivery and can thus limit opportunities for organisational change. This does not mean that recovery is not possible for this population; more that careful consideration is needed to ensure a safe balance of maintaining security and promoting recovery is achieved. Whilst empowerment and choice are hailed as key features of the recovery approach, an all or nothing approach is counterproductive. Roberts, Dorkins, Wooldridge & Hewis, (2008) highlight the limitations of choice for detained service users and point out that whilst ‘maximal choice’ is the goal for recovery orientation in mainstream services, ‘optimal choice’ is an alternative goal for forensic mental health patients. Offence related therapies typically involve confronting and challenging the individual’s behaviour and offence supportive beliefs (e.g. National Offender Management Service, 2010), which appears in contrast to the affirming and accepting principles of the recovery approach. More recent approaches, such as the Good Lives Model (Ward & Brown, 2004), have highlighted the importance of drawing a balance between challenging offence related factors whilst at the same time affirming non-offence related characteristics and encouraging a more holistic approach with a focus on developing and nurturing pro-social features.

Whilst forensic mental health services face unique challenges when trying to embed recovery principles, they are not entirely impassable. It is imperative that this marginalised client group, who are already doubly disadvantaged by their very nature of holding both offender and patient identities (Barker, 2012), are not left behind in the recovery drive. The advantages of embedding recovery principles applies to both service users and providers. Forensic mental health patients are often cited as a difficult to engage client group (Davison, 2002); however, there is evidence to suggest that implementing the recovery approach in forensic services can increase treatment engagement by two-fold (Gudjonsson, Savona, Green & Terry, 2011). Careful adaptations that work with the unique challenges these services face could help meet the balance of ensuring risk is safely managed and recovery safely promoted.

It has been argued that person centred care approaches are not suitable for ward environments and forensic personality disordered patients (Doren, 1987, Hamilton, 2010). Hamilton (2010) claims that the flexibility that recovery person centred approaches promotes can lead to inconsistent boundary management, or altogether erosion that leads to enmeshment and the abuse of both patients and staff. Hamilton (2009,2010) developed the Boundary See Saw Model as a standardised model for managing relational boundaries; highlighting that the therapeutic relationship is the key commonality in recovery and security and the need to find a safe balance between these two, at times conflicting needs. At one end of the see saw sits the focus on security, on the other sits a focus on care. Safe relational boundary management occurs in the middle, where safe balance is maintained. steps outside of this zone tip the seesaw into a risky zone of over- or under-involved care and reflect the ‘slippery slope’ into boundary crossings and violations. However, progression on the ‘slippery slope’ can be stopped by re-balancing the seesaw. Hamilton argues that the key aspect of relational boundary management is having a clear understanding of the non-negotiables for oneself, as well as the team and wider organisation, to facilitate recognition of boundary shifts and highlight the means for repair and rebalance to safe levels of recovery and security before boundary crossings and violations occur.

Hamilton claims that staff who adopt a ‘Negotiator role are able to strike a balance between security and care. Negotiators are open, respectful, contained, balanced and have clear explicit boundaries, but are also responsive to patients’ needs. They are able to hold both the ‘offender’ and ‘victim’ identity of patients, enabling them to be responsive to both risk and vulnerability factors. The ‘Negotiator’ contains risk and promotes healing through a collaborative professional relationship. There are both inflexible and flexible boundaries that are maintained by a combination of attunement with ongoing processes and application of professional judgement, taking into consideration both the immediate and long term consequences of boundary movement. The ‘Negotiator’ sets explicit limits and manages boundaries in a nurturing, respectful and negotiated way, which elicits a reciprocal role of feeling contained, nurtured and safe. The inflexible boundaries provide a sense of predictability, while the flexible boundaries provide opportunities for autonomy and empowerment.

1.2 Method

The databases psychINFO, EMBASE and MEDLINE were searched using key terms such as ‘recovery and forensic*’ or ‘recovery and secure’. There were no restrictions on publication dates. Searches revealed a total of 1456 papers. Titles and abstracts were reviewed to identify the relevant articles. Searches were conducted on 5th February 2014 and updated on 14th April 2014.

Journals of particular relevance (Journal of Forensic Psychiatry & Psychology, and the British Journal of Forensic Practice) were manually searched and did not produce any more papers.

The reference lists of relevant papers were examined to attempt to discover further relevant studies. None were found.

Given the uniquely personal nature of the process of recovery and the body of evidence that advocates service user perspectives about recovery processes be given priority (Donnelly et al.,2011), it was decided to only include qualitative service user perspective studies.

1.2.1 **Inclusion Criteria**

- Qualitative/mixed methods empirical paper where forensic mental health patients have shared their views on recovery.
- Published work (e.g. book chapter) that describes forensic mental health patients’ perceptions of recovery.

1.2.2 **Exclusion Criteria**

- Quantitative paper relying purely on measures of recovery.
- Perceptions of recovery expressed by others; e.g. staff or family members.
- Poorly described work that does not provide enough information to critically appraise its worth.

Ideally, only qualitative empirical papers specifically exploring forensic mental health service users’ perspectives on recovery would be included; however there is a significant paucity of research in this area, as evidenced by a total of seven such papers. The search was thus extended to include papers that involved an aspect of qualitative research where forensic mental health patients discuss their perspectives on recovery (e.g. a qualitative evaluation of the implementation of a recovery based service model), which revealed a further three papers. Further inclusion criteria of high quality, easily replicable, research should be used as standard; however, given the limited research available, it was decided to also include papers that had summarised their methodology to the point that it was difficult to accurately appraise/replicate. These inclusion criteria revealed a total of ten papers. Discussion with a relevant expert in the field of forensic recovery led to the discovery of two relevant book chapters; however, one did not provide sufficient description to be considered for an empirical review. All decisions to exclude studies were discussed in supervision.

1.2.3 Appraisal of studies included in the review

The debated about how to assess the quality and validity of qualitative research continues (Smith, 2011). Guidelines for assessing qualitative research have been developed (Elliott, Fischer, & Rennie, 1999; Yardley, 2000); however Smith (2011) argues for the need to have guidelines that are specific to the field being appraised. For the purpose of this review, Yardley's (2000) criteria was used as a general guideline and was enhanced by Coffey's (2006) guidelines for assessing forensic service user research. Papers included in this review have been appraised in accordance with the following principles.

The process of conducting and reporting research is integral to the quality of the study and so a clear description of the data collection and analysis is essential (Spence, Ritchie, Lewis, & Dillon, 2003). In order to maintain trustworthiness of the data, Silverman (2001) suggests that studies should negative or divergent cases (Silverman, 2001). The inclusion of contextualised extracts helps to establish credibility and plausibility of findings (Hammersley, 1992).

Qualitative research typically involves small sample sizes and thus it is a study's ability to generate theory that establishes its usefulness (Coffey, 2006). Whilst findings from qualitative studies may not be directly generalisable; theories developed from findings may have applications in other contexts (Murphy et al., 1998).

The importance of relating data to the context of its production has been widely discussed in the literature and a reflexive approach that demonstrates an awareness of the ways in which the researcher has shaped the data collection and analysis is recommended as a key feature of qualitative research (e.g. Coffey, 2006, Mays & Pope, 2000; Smith, 2011).

In summary, qualitative research must describe the research process adequately (*transparency*), include the steps that were taken to collect and analyse the data (*credibility)*, provide contextualised extracts of data to enable scrutiny of the validity of interpretations (*verifiability*), explore both convergent and divergent cases (*trustworthiness)*, make explicit attempts to theorise from the findings (*transferability*), and present accounts even-handedly (*fair dealing*).

Research in forensic mental health services must contend with a range of ethical problems (Coffey, 2006). The majority of service users are detained under the Mental Health Act (MHA, 1983) or are living in the community and liable to recall to hospital. This raises concerns about capacity to give informed consent, the validity of any consent obtained, as well as issues pertaining to control, confidentiality and the potential for exploitation of a literally captive audience. Given these serious concerns, external scrutiny via a research ethics committee is deemed an essential safeguard for this population (Coffey, 2006).

1.2.4 **Synthesis**

Thomas & Harden’s (2008) Thematic Synthesis was used to synthesis the data from the identified studies. It draws on the principles of primary qualitative research to generate a synthesised thematic analysis of qualitative research in a systematic review by identifying recurrent themes in the primary literature and drawing generalised conclusions. It was developed to address specific literature review questions about need, appropriateness and acceptability of interventions, as well as effectiveness and has been used in multiple reviews; such as patient-doctor relationship (Ridd , Shaw, Lewis , Salisbury, 2009) and understandings of cancer risk (Lipworth, Davey, Carter, Hooker &Beliefs, 2010).

There are three overlapping steps to Thematic Synthesis (Thomas & Harden, 2008):

1. Free line-by-line coding of textual findings from primary studies.
2. Organisation of free codes into ‘descriptive’ themes.
3. Generation of ‘analytical’ themes – using the descriptive themes, reviewers produce a new interpretation which goes beyond the original studies.

1.2.5 **Figure One: Flow chart: Study selection process**

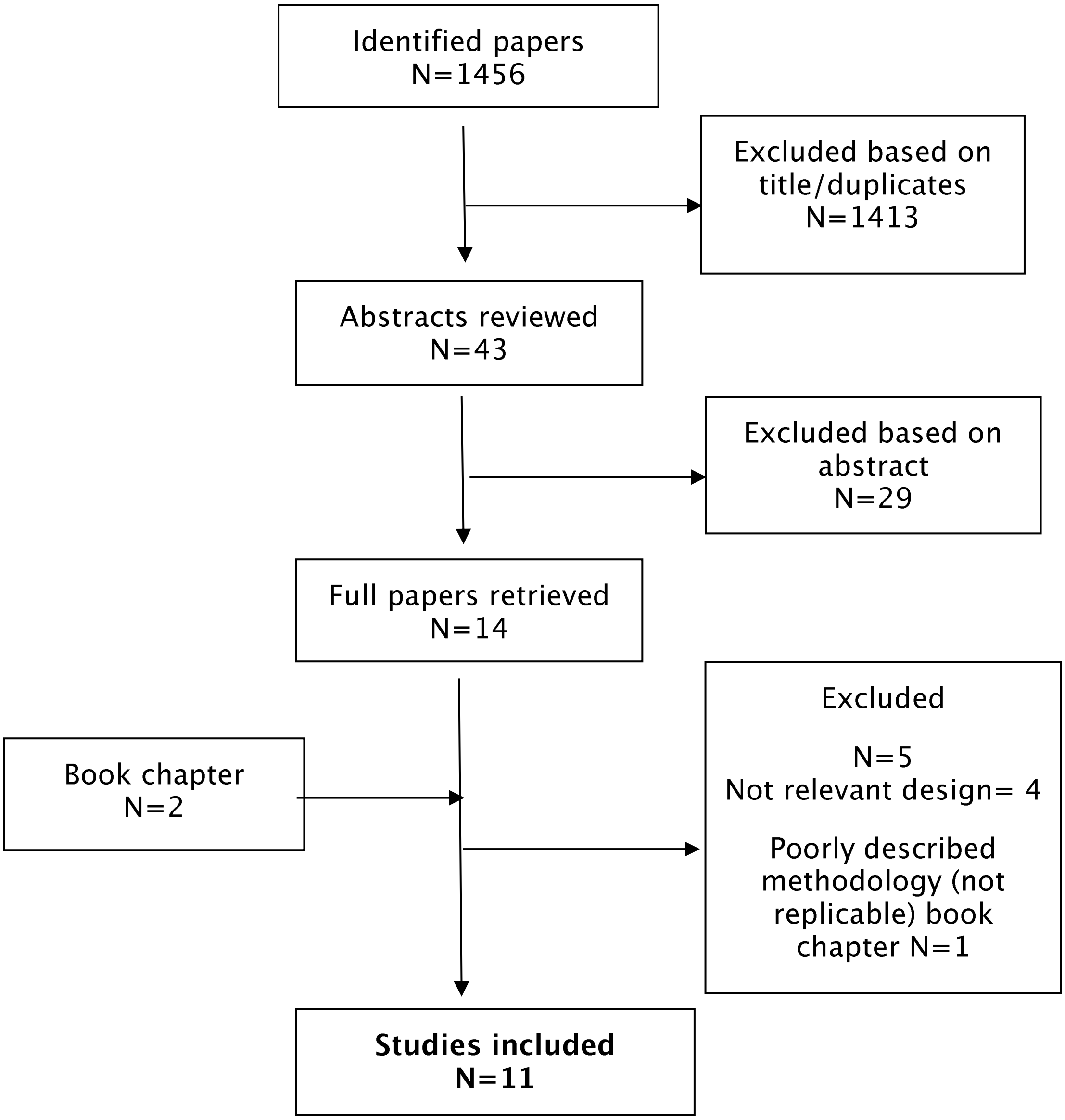


Figure One illustrates the literature search process.

1.3 Results

The reviewed studies (see appendix A) comprised of qualitative research papers (n=10) and a book chapter (n=1). The studies were conducted in three countries, including the UK (n=8), New Zealand (n=2) and Australia (n=1). The UK has been over-represented in qualitative research since the 1980s (Smith, 2011), as reflected in this particular field. Participants were recruited from a range of settings; including high secure hospitals (n=3), regional secure service (n= 6) and a population drawn from different services, including community and secure (n=1) and not specified (n=1). The majority of studies used inclusion criteria that covered any forensic mental health patient in that service whilst three targeted specific populations; these incorporated dual diagnosis mentally disordered offenders who had been recalled to a medium secure service (n=1), women who had committed maternal filicide in the context of severe mental illness (n=1) and high secure forensic mental health patients who had committed a homicide (n=1). Sample sizes ranged from 4-13, with a mean size of 7. A variety of methodologies were used, including: focus groups (n=2), semi-structured interviews (n=8), open ended interviews (n=1). Various analyses were applied, including: Interpretative Phenomenological Analysis (IPA) (n=3), Hermeneutic phenomenology (n=1), Thematic Analysis (n=2), Naturalistic Paradigm (n=1), Social Constructionist version of Grounded Theory (n=1), Grounded Theory and Directed Content Analysis (n=1), Thematic and narrative analysis (n=1), Thematic Content Analysis (n=1). All of the studies used the patients’ own perceptions of recovery.

1.3.1 **Table One: Processes of recovery**

Recovery Process	**Number (%) of 11 studies identifying the process**
Connectedness	9 (82)
Treatment	7 (64)
Sense of self	9 (82)
Past experiences	3 (27)
Freedom	8 (73)
Hope	7 (64)
Health	5 (45)

Table One identifies the seven categories of recovery that emerged.

1.3.2 **Categories of Processes of Recovery**

The systematic review revealed a total of seven categories of recovery, each will now be considered in turn.

1.3.2.1 Connectedness

Connectedness was a central theme in 9 of the 11 (82%) studies that were reviewed. Participants spoke about the importance of being able to maintain relationships with their family members (e.g. Stanton & Simpson, 2006) and how being detained in secure services can limit the opportunities for this (e.g. Barsky & West, 2007). Being able to participate in vocational and recreational activities away from psychiatric services provides opportunities for engaging with others and building new relationships (Walker, Farnworth & Lapinski, 2013). This was also important as a means to overcome the stigma and social isolation that many felt they carried as offender patients (Walker et al., 2013; Moore, Lumbard, Carthy, Ayres, 2012; Mezey, Kavuma, Turton, Demetriou & Wright, 2010; Turton et al., 2011). Relationships with staff were also highlighted as a form of connectedness (Barsky & West, 2007; Mezey, et al., 2010; Cook, Phillips & Sadler, 2005; Ferrito, Vetere, Adshead, & Moore, 2012; Walker, et al., 2013; McQueen & Turner, 2012). For some, relationships with staff were another form of social exclusion that created an ‘us and them’ divide (Barsky & West 2007). Confrontational staff relationships that were perceived as deliberately antagonistic were described as socially isolating and responsible for subsequent passivity about care (Ferrito, et al. 2012). Conversely, positive relationships with staff were highlighted as being key facilitators of recovery. Feeling respected, valued and cared for by staff was discussed as being particularly important for detained forensic mental health patients who spend most of their time with staff and have few opportunities for relationships outside of hospital (Mezey et al., 2010). Positive relationships with staff influenced how patients defined themselves and nurtured self-esteem (Laithwaite & Gumley, 2007; Turton et al., 2011). For some, relationships with staff provided them with acceptance, inclusion, companionship and a sense of belonging that they had never experienced before (Turton et al. 2011). The challenge of being accepted by others in the ‘outside world’ was highlighted as a milestone on the road to recovery. The need for forgiveness and acceptance from victims, family members and others was believed to be as important as self-acceptance (Mezey et al. 2010).

1.3.2.2 Treatment

Treatment was discussed as a key theme in 7 of the 11 (64%) studies. The opportunity to reframe events via therapeutic intervention enabled a rationalisation and understanding of their story and medication provided a relief from symptomatology which increased a sense of control in their recovery (Ferrito et al., 2012). For some, the concept of recovery was unnecessary and imposed by others, as they did not believe they had anything to recover from, except from being detained, and believed that therapy was nothing more than ‘jumping through hoops’ (Moore et al., 2012). Still others felt that they did not get as much therapeutic input as they believed necessary for their recovery; they described a lack of consistency across services that left them feeling like they were missing out on access to psychological therapies (Barsky & West, 2007).

1.3.2.3 Sense of Self

A sense of self was a key theme present in 9/11 (82%) of studies. The relationship between this theme and the other most represented theme of connectedness was also highlighted in the form of reciprocal relationships between self-discovery and nurturing relationships. The capacity to reflect on past experiences and identify potential pivotal moments where things could have been different was integral to this process. Previous relationships were typically described as characterised by feelings of loss, rejection and mistrust. Being detained in hospital led to reflections on past relationships and a subsequent desire to build relationships with staff and, in some cases, repair relationships with their families. This development of relationships was interpreted as an important feature of recovery and one that could be impeded by factors associated with being detained in a secure hospital, such as the practical implications of restrictions of opportunities for visits and correspondence to facilitate the nurturing of relationships. The development of relationships with those around them was discussed as a facilitator for self-discovery and the motivation for change (Laithwaite & Gumley (2007).

The loss of individuality was discussed as a barrier to recovery (Moore et al., 2012); having opportunities to develop a sense of self that was independent of the offender identity, such as through vocational experiences, was deemed paramount to recovery. Being able to develop new skills and demonstrate personal achievement nurtured a sense of self-worth that made the return to ‘normal’ society seem that much more possible (McQueen & Turner, 2012). The concept of a split-self was identified and how the process of life style changes could help resolve this rupture by letting go of the ‘other’ aspect of the self and allowing them to feel that they can just be themselves with a sense of normality (O’Sullivan Boulter & Black, 2013).

1.3.2.4 Past Experiences

The role of past experiences was a key theme in 3/11 (27%) of the studies. Participants’ past experiences were often characterised by unpredictable abuse and neglect and was described as a cause of difficulties in relationships and well-being in later life.

For some, the most difficult past experience was their index offence and having to live with the traumatic memories. Repressing such memories was a form of coping which could be disrupted when forced (e.g. by a chaplain) to face the memories. Shame of these memories perpetuated a state of self-loathing that kept them trapped in distress and unable to forgive themselves.

It is worth noting that 2/3 studies that identified this as a theme had a more offence specific focus; one involved patients who had committed a homicide and the other maternal filicide (Feritto et al, 2012; Stanton & Simpson, 2006), respectively. Both studies specifically addressed their offences in the interviews and so this would likely have impacted upon the findings, making the notion of offender recovery (Drennan & Alred, 2012) more salient.

1.3.2.5 Freedom

Themes around freedom were prevalent in 8/11 (73%) of the studies. Detention in a forensic mental health hospital significantly impacts upon freedom in a number of ways. In addition to the obvious factors, such as not being able to come and go when you please, there are numerous ways in which personal freedom is lost, depending on the level of security of the service in question. Patients are subjected to property and body searches, there are restrictions on what can be kept in their room and all property is recorded and monitored. There are also restrictions on who can visit them and when, and visits are as closely monitored as all other aspects of life in a forensic hospital, leaving no room for privacy.

Continuous monitoring can create tension, making it difficult for patients to relax, as they feel that they are ‘living in a gold-fish bowl’ (Moore et al., 2012). Increased freedom on the wards was highlighted as beneficial for recovery, patients who had transferred from high to medium secure services described being more trusted by staff and being able to access their rooms and tea and coffee making facilities throughout the day as a privilege that made them feel better (Barsky & West, 2007). Having time away from the wards and sight of the security wall was identified as an essential recovery process (Barsky & West, 2007). For others, detention was seen as both helpful and necessary for their recovery, with security measures being seen as factors that helped keep them safe from the hostile public. The prospect of discharge could seem a daunting process that would make them more vulnerable (Mezey et al. 2010).

1.3.2.6 Hope

A sense of hope was identified as a key feature of recovery in 7/11 (64%) of the studies. Hope helps to counteract feelings of despair and provides a motivation for change as it offers a new way of being (Moore et al., 2012) and a belief that your life is worthwhile (Turton et al., 2011). An emphasis on personal change from services gives patients the knowledge that others still have hope for them and helps them develop hope for themselves (Cook et al., 2005). Initiatives such as community day leave provide opportunities for seeing a life after discharge as more individualised and attainable. Being able to engage in personally meaningful activities and pursue personal interests increases hope for a life not defined by illness and offending history (Walker et al., 2013).

1.3.2.7 Health

The concept of physical and psychological health was prevalent in 5 of the 11 studies (45%). The relationship between physical and psychological health was identified in one study (Turton et al., 2011) and how both needed to be nurtured in order for recovery to become reality. The traditional aspect of clinical recovery and symptom reduction was identified as a key feature in feeling ‘normal’ again (Turton et al., 2011) and being able to return to the person they were before they became ill (McQueen & Turner, 2012). Gaining an insight into their illness provided a sense of relief and facilitated self-compassion and coming to terms with their offending (Stanton & Simpson, 2006). It also created a greater understanding of how to better manage illness, and increased self-care and treatment adherence (Turton et al., 2011)

1.4 Discussion

This is a systematic review and narrative synthesis of forensic mental health patients’ perceptions of recovery. Despite Department of Health policy (DoH, 2011) that states the importance of service users’ views on recovery, there is a significant paucity of research in the area of forensic mental health. This is a sub group of service users who are particularly marginalised by being doubly stigmatised and isolated as both mental health patients and offenders (Barker, 2012) and it appears that they continue to be marginalised in the recovery literature as well. All be it limited, there is an emerging evidence base; this review identified 11 studies that fit the inclusion criteria. There was significant overlap across the studies, themes from each were organised into seven categories/superordinate themes (see Table One). Two superordinate themes were particularly prevalent in 9/11 (82%) of the studies: connectedness and a sense of self. Laithwaite & Gumley (2007) describe the apparently reciprocal relationship between these two themes. Patients typically describe a history of adverse past experiences and unstable, harmful relationships. Being detained in hospital encourages reflection on past experiences/relationships which can lead to an insight into illness and self and a desire to repair past relationships and form new ones with staff and peers. Increased connectedness can increase self-awareness, and help individuals adapt to hospital life and instil hope for the future. Detention in forensic services can create barriers to this process, such as when an ‘us and them’ atmosphere is present (Barsky & West, 2007) and/or opportunities for repairing/maintaining relationships outside of the hospital are restricted (Moore et al., 2012). Initiatives such as community day leave and vocational activities can help overcome some of the barriers that detention results in (Walker et al. 2013; McQueen & Turner, 2013).

These themes are consistent with the processes of recovery identified in the generic mental health literature (Leamy, 2011). Freedom was the other most prevalent (8/11, 73%) superordinate theme; which is perhaps expected, given that the vast majority of the participants in this review were detained under the Mental Health Act. The ‘Past experiences’ category identified here is not found in the generic literature. However, it was only identified in 3/11 studies reviewed, and two of these had an offence specific focus, which likely increased the saliency of ‘offender recovery’ (Drennan & Alred, 2012) and thus increased the likelihood that participants would discuss this. It may be that if other studies had adopted more of a focus on aspects of offender recovery, they would also have found this facet of recovery more prevalent.

1.4.1 **Critical Review**

1.4.1.1 Methodological quality of the review

1.4.1.1.1 Strengths

A key strength of this review is that it provides a synthesis of forensic service users’ perspectives of recovery, which is very topical and relevant. Focussing on the service user perspectives, excluding those by staff, friends and relatives meant that a picture of the lived experience has been developed. Using an established model (Thematic Synthesis, Thomas & Harden, 2008) provided an opportunity to develop a replicable synthesis. Applying guidelines for appraising qualitative research enhanced the quality of the review.

1.4.1.1.2 Limitations

This review was restricted to qualitative published research, a paradigm that has a history of being criticised and dismissed as unbiased, anecdotal and lacking in rigour (Anderson, 2010) and so there may be a publication bias that has prevented a collection of studies with different findings being available for review. Excluding quantitative studies restricted the number of studies that were available for review; however it was felt that qualitative research was the most appropriate means for exploring spontaneous perceptions of recovery, in line with the recommendations from the literature on investigating recovery (e.g. Donnelly et al., 2011). Only one coder was used in the analysis and so there is the potential for researcher bias, a second independent coder is recommended to counteract such potential extraneous variables (Centre for Reviews and Dissemination, 2008) .

1.4.1.2 Methodological quality of included studies

Ideally, sound methodological quality would be applied as part of the inclusion criteria; however, given the very limited number of studies that are available, it was decided that all of the relevant published studies would be included. Nevertheless, the majority of the studies had a clearly described methodology that included steps to enhance the quality of their research.

1.4.1.3 Strengths of included studies

Mezey et al. (2010) adopted various stages of analysis/methodologies and employed multiple coders. Another strength of this study is the attempt to reduce bias, as evidenced by the efforts made in devising the interview and employing both clinical and service user researchers who were not clinically involved with the participants’ care. Three studies used both service users and service providers as part of the research team (Turton et al. 2011, Mezey et al. 2010 and McQueen & Turner, 2012). Patients commented that they felt freer to speak without fear of judgment, thanks to having a service user researcher (Turton et al., 2011). The findings of all of the studies supported Leamy et al.’s (2011) review of what recovery means to generic mental health patients, differences that arose were mainly related to the additional facet of offender recovery (e.g. forgiving themselves, Stanton & Simpson, 2006) and being detained under the Mental Health Act (1983) (e.g. freedom on the ward, Barsky & West, 2007).

1.4.1.4 Limitations of included studies

Laithwaite & Gumley’s (2007) whole research team were chartered psychologists working in the hospital where the research took place. The research design and analysis was thus all undertaken from a psychological view point, which may well have influenced the focus and explained why this relied heavily on relationships and yet there was no mention about engagement in meaningful activities, which has been central to other recovery focussed work (e.g. McQueen & Turner, 2012, Walker et al., 2013). In addition, disclosure is likely to have been impacted due to fear of subsequent consequences. Psychologists are associated with risk assessments and decisions about readiness for transfer to less secure facilities; whilst the authors acknowledge this factor and highlight their use of reflexive processes, it is unlikely that this fear of reprisals associated with disclosure could be controlled for and may have impacted upon what participants felt safe to discuss. The latter limitation applies to all of the studies in this review. Whilst some studies made attempts to reduce bias by using researchers that were not connected to the team at all (Barsky & West, 2007), others used clinicians that were employed by the service where the research was based (Feritto et al., 2012). In one study (Mezey et al, 2010) participants were paid £20 for an hour of their time; whilst paying participants is not uncommon, this is a significant sum, and it is possible that this made participants feel obliged to provide favourable comments. Methodology was not always clearly explained, some studies involved extensions of previous research (e.g. Turton et al., 2011; Stanton & Simpson, 2006) and pointed readers to the earlier studies for further clarification of methodology, yet the previous studies did not provide sufficient detail either (Stanton & Simpson, 2006; Stanton & Simpson, 2001). Some studies used combined or adapted methodologies and further clarification of the final ‘product’ would have been beneficial (e.g. Mezey et al, 2010; Turton et al,, 2011)

1.4.2 **Implications**

1.4.2.1 Clinical

The findings of this review indicate that connectedness and a sense of self are two key facilitators of recovery. Whilst the nature of being a forensic mental health patient limits opportunities for these, adaptations to services can help overcome/reduce these barriers. Non-confrontational staff who make patients feel valued, respected and cared for nurture relationships with patients and increase their self-esteem (Laithwaite & Gumley, 2007). Staff-training programmes have been shown to increase recovery oriented practice (Gudjonsson, Webster & Green, 2010) and having staff who have skills and knowledge of recovery principles has been identified as a key theme in recovery-oriented practice in mainstream psychiatric services (Shepherd, Boardman & Slade, 2008). Increasing opportunities for building/maintaining relationships outside of hospital can help increase a sense of connectedness (Stanton & Simpson, 2006). Increasing opportunities for day leave and vocational activities offers opportunities for increasing connectedness and a sense of self. Such adaptations could help streamline services and reduce admission times (Gudjonsson et al., 2011).

1.4.2.2 Research

More research putting forensic service users at the forefront is necessary to reduce the gap between forensic and generic mental health services. In times of public service frugality, such as these, finding the resources for research can be difficult and mean that this is a field that is neglected. However, research of high rigour could help argue the case for an increased focus on embedding recovery principles to help streamline services, if it clearly demonstrated the value of recovery principles in terms of increasing recovery and reducing admission times.

‘Offender recovery’ (Drennan & Alred, 2012) is a recently proposed aspect of recovery; research that attempts to access this facet specifically is recommended to ensure that unique aspects of recovery that are specific to forensic mental health patients are not being missed.

‘My Shared Pathway’ is a recovery oriented initiative that was introduced to promote measurable outcomes and patient choice, with the aim of increasing transparency across forensic services, standardising care and streamlining care pathways. It offers a collaborative way of planning, following and managing a patient’s stay in secure services and aims to bridge the gap between a focus on security and recovery, so that each is awarded equal priority. Patients are encouraged to be more responsible for their care and work in partnership with their multi-disciplinary care team to identify and meet the outcomes that will help them be discharged from secure care. A number of resources are used to help in this process; workbooks are used to identify recovery journeys and care pathways by exploring how patients got to be in secure services and what they can do to help them move on. This is hoped to increase communication and collaboration between staff as well as increasing transparency about what needs to be done for a patient to progress along their care pathway. The workbooks also provide a concrete tool for monitoring progress measuring outcomes.

‘My Shared Pathway’ offers an opportunity to research a new initiative that aims to promote recovery in forensic services. As it is designed for forensic mental health patients, it also offers an opportunity for a piece of research that specifically taps into ‘offender recovery’. Whilst service-user feedback has been provided in quantitative questionnaire format (Esan, Pittaway, Nyamande & Graham, 2012), to date there has not been any published research on the patient experience of ‘My Shared Pathway’.

Chapter 2: Empirical paper: ‘My Shared Pathway’: the experience of users of a low secure service

2.1 Introduction

2.1.1 Offender care pathways

Forensic mental health services typically provide secure care for individuals who will have committed a criminal offence and whose mental health problems pose a risk to themselves and/or others. Extensive assessment, treatment and rehabilitation is delivered by multi-disciplinary teams across a range of settings; including prison, hospital and the community.

Hospital treatment is provided across low to high levels of security, with perceived level of risk determining the level of security they are placed in (Kennedy, 2002); the goals of secure services are to reduce risk and enable mental health recovery within the least restrictive environment (Department of Health and Home Office, 1992). Evidence-based interventions (NHS management executive, 1991) are provided in line with the principles of the recovery approach (e.g. Slade, 2009) and social inclusion (e.g. National Social Inclusion Programme, 2009). Patients may be admitted from the community, other secure services or transferred from prison. Once discharged into the community, continuing care is either provided by the discharging team or a specialist community forensic mental health team if they transfer out of area. This process represents a care pathway for the individual.

The Pathways to Unlocking Secure Mental Health Care report (Durcan, Hoare & Cumming, 2011) investigated pathways in forensic mental health services and made recommendations for ensuring a better flow through secure services. Low and medium secure services were criticised for a lack of clear standards, poor definitions of eligibility, and a lack of transparency in treatment provision, outcomes and discharge criteria. Further to this, poor continuity of care and communication across services (Duggan, 2008) have been highlighted as detrimental to care pathway progression (Glorney, et al., 2010).

2.1.2 The Recovery Approach

Evidence of the recovery approach can be seen in the literature dating back to the Normalisation movement in the 1970s (Drennan & Alred, 2012); although it received a greater level of attention following Patricia Deegan’s (1988) paper that drew upon the empowerment discourse and called for a recognition that attempts to treat health were fruitless without a focus on progressing a personal recovery journey. Several definitions have since been offered, although there is recognition that it can be difficult to define something so personal. Themes of: *Hope, Empowerment* and *Individualism* are generally understood to be the core features of recovery (Drennan & Alred, 2012). Drennan & Alred (2012) proposed a four facet model that included the principles of personal, clinical, functional and social recovery, arguing that the process of recovery involves a combination of factors that may hold different priorities at different stages. They claim that an additional facet of offender recovery is needed for forensic mental health patients. Ridgway (2001) claims that recovery comes from an interaction between the characteristics of the individual (sense of meaning, hope and purpose), the environment (meaningful activities, support) and exchange (hope, choice, empowerment).

The implementation of the recovery approach has proved contentious in forensic services. Promoting concepts of choice and empowerment is particularly challenging in a field that has traditionally been dominated by the medical model and concepts of security and risk. Recent years have seen a shift away from this position, and there is evidence of recovery principles beginning to become embedded in forensic services (Drennan & Alred, 2012). An example of this has been the development of ‘My Shared Pathway’ which was introduced to forensic services in 2011 (Esan et al., 2012).

2.1.3 ‘My Shared Pathway’

‘My Shared Pathway’ promotes collaboration between services and service users. This collaboration is grounded in recovery principles of choice and empowerment and aims to change the pattern of the ‘expert delivering care to the patient’ to a collaborative effort. They provide a holistic approach to health care that is a break from the traditional medical model focus on symptoms and risk.

‘My Shared Pathway’ was developed following DOH (2011, 2012) policy guidance advocating person centred care and various initiatives that promote the use of standardised outcome measures and payment by results (e.g. DOH 2008, 2010 and

2011). The North of England Specialist Commissioning Group, Yorkshire and Humber Office developed it in partnership with service users, commissioners and clinicians. It is based on promoting measurable outcomes and patient choice and has three main aims:

1. Meet individualised need
2. Demonstrate efficiency
3. Reduce cost without reducing quality

‘My Shared Pathway’ offers a collaborative framework for planning, following and managing a patient’s stay in secure services and aims to increase the focus on recovery in order for it to achieve parity with security. Patients are encouraged to be more responsible for their care by working in partnership with their multi-disciplinary care team to identify and meet the outcomes that will help them be discharged. A number of workbooks are used to identify recovery journeys and care pathways by exploring what led patients to secure services and what they can do to help them move on. This is hoped to increase communication and collaboration between staff and patients, as well as increasing transparency about what needs to be done for a patient to progress along their care pathway.

Evidence based outcome measures are used to monitor the progress of ‘My Shared Pathway’ with the aim of standardising care and increasing transparency. It aims to streamline care pathways so that admission times will be reduced as efficiency is increased and was introduced nationally as a Commissioning for Quality and Innovation (CQUIN) target in March 2013 (NHS England, 2012).

2.1.4 **Study Rationale**

Forensic services have been criticised for a lack of clear standards and transparency in care provision (Durcan et al., 2011). The recovery focussed ‘My Shared Pathway’ provides a framework for standardising treatment and outcomes in secure mental health services whilst maintaining person centred care. If successful, patients will progress along their care pathway requiring less time in secure services and they will be able to safely reintegrate into the community, reducing the number of readmissions. It has been predicted that this streamlining of services has the potential to reduce the £1 billion + of government spending on secure services (Esan et al., 2011; Mental Health Strategies, 2010).

Forensic mental health service users are a particularly marginalised subgroup of individuals who are doubly stigmatised and isolated as both mental health patients and offenders (Barker, 2012). They represent a subgroup of society who experience widespread stigmatised narratives that dehumanise them with terms such as ‘evil’ and ‘monster’. With such an embedded, and socially accepted, history of prejudice they risk being forgotten in the recovery drive. Champions of the recovery approach have been working to tackle the challenges of balancing recovery and risk in forensic services and there have been CQUIN targets and NHS policies developed that require the implementation of the recovery principles and Shared Care Pathways in forensic services (NHS England, 2012). In line with the principles of evidence based practice, it is important that these initiatives are evaluated and reviewed; in particular as it remains unclear how this approach is being received by patients.

Service user perspectives are integral to the recovery approach and there is evidence that treatment receivers who feel without a voice in the responsiveness of their care are at risk of disengaging (Grady & Brodersen, 2008). Whilst recent years have seen an increased representation in the literature, forensic service users continue to reflect an under-researched population, and there is a paucity of forensic service user perspectives in comparison to other fields (Coffey, 2006). A report commissioned by the Bamford Implementation Rapid Review Scheme stated that service user perspectives on the recovery orientation of services should be a priority, in order to maintain the integrity of the central premise of personal experience that underpins recovery (Donnelly et al., 2011).

To date, there has only been one peer-reviewed paper that has included service user perspectives on ‘My Shared Pathway’ (Esan et al., 2013) and this only included one paragraph summary of questionnaire informed feedback about the associated resource books. A deeper qualitative exploration is needed to develop a greater understanding of the patient experience of ‘My Shared Pathway’.

2.1.5 **Research aims**

The aim of this study is to explore the lived experience of the ‘My Shared Pathway’ initiative for male patients who were detained under the Mental Health Act (MHA, 1983) in a low secure service. A qualitative design was used to capture the subjective meanings that patients ascribed to this process. Having a greater understanding of the lived experience of ‘My Shared Pathway’ could help provide an insight into this process that could help add meaning and improve other services.

2.2 Method Methodological Approach : Interpretative Phenomenological Analysis (IPA; Smith, Flowers, & Larkin, 2009).

IPA is one of the most commonly used qualitative methodologies in psychology (Smith, 2011). It was chosen for this study because of its phenomenological focus on hermeneutic empathy that allows for the exploration between what people say in their interviews and the way that they think about their experiences. It has an idiographic focus that places the individual and their experience at the centre of the research as the unit of the analysis. One cannot directly access another individual’s experience; instead the purpose of IPA is to become ‘experience close’ (Smith, 2011) in order to illuminate the links between thoughts, talk and experience, ensuring a holistic focus on the individual’s experience. The researcher must engage in a hermeneutic process of engagement and interpretation; however, the participant is also engaged in making sense of their own experience, creating a double hermeneutic for the researcher who is trying to make sense of the participant trying to make sense of their experience.

2.2.1 **Ethical considerations**

Ethical approval to conduct the research was granted by The University of Southampton Psychology Department’s Ethics Committee, the Southern Health NHS Trust Audit and Development department and the Southfield’s Interventions Team (See appendices B-D).

2.2.2 **Recruitment of participants**

The service involved in this study is a 26 bed low secure service for men and women where ‘My Shared Pathway’ was formally introduced in 2012.

Participants were selected using ‘purposive sampling’, which is the typical form of sampling in IPA, as it allows selection of participants who are most relevant to the research question (Willig, 2001).

The decision to exclude female participants was made on the premise that the experience may be qualitatively different for females than it is for males. As the male population is larger, male patients were chosen over their female counterparts to maximise potential participation.

Permission to contact patients was received from respective clinical teams. The researcher, who was completely independent of the service, attended ward community meetings to outline the research and invite patients to take part. Information sheets and consent forms were provided (see appendices E and F) and emerging queries were discussed in the meetings. All of the patients consented to receiving formal invitations to participate by post, which included another copy of the information sheet. Patients were assured that their choice to participate, or not, would not have any impact on their current or future treatment. Following the written invitations, a total of eight patients volunteered to participate, two of whom were excluded as they were new admissions who did not have sufficient opportunity for the experience of ‘My Shared Pathway’ at this service. Six participants were included in the final analysis, see Table Two for demographic information. IPA studies typically involve small samples, due to the in-depth nature of the analysis (Smith et al, 2009; Smith, 2011), a sample of 4-10 participants is recommended for professional doctorate studies (Smith et al. 2009). Participants were paid £10 for their time.

2.2.3 **Confidentiality**

In order to protect the confidentiality of the participants and their associations, pseudonyms have been used throughout, including in quotes, as identified by [ ]. All identifying information has been removed

2.2.4 Table Two: Participants’ demographic information

Pseudonym	Age	Ethnicity	Diagnosis	Admission length
Bob	45	White British	Schizophrenia	4 years, 2 months
Richard	59	White British	ASD/Paranoid schizotypal	2 years, 8 months
Philip	40	Black British	Schizophrenia	7 years, 7 months
Gavin	32	White British	Schizophrenia	1 year, 1 month
John	36	White British	Schizophrenia	3 years, 4 months
Rupert	54	White British	Bipolar Disorder/Antisocial personality disorder	8 months

2.2.5 Data generation

Participants were interviewed using a semi-structured interview schedule (see appendix G) that was designed to encourage spontaneous and unrestricted speech through non-leading open-ended questions. Interviews were audio-recorded and transcribed verbatim. A pilot interview was conducted with a patient in the current service who subsequently provided feedback on their experience of being interviewed. Their feedback led to the ordering of the questions being changed and the addition of an explicit request immediately prior to the interview commencing that, if possible, participants give long descriptive answers.

2.2.6 Data analysis

Interpretive Phenomenological Analysis examines raw data to explore values, beliefs and cognitions in order to adopt an ‘insider’s perspective’ and develop a rich descriptive account of participants’ experience (Smith et al., 2009). Transcripts were manually analysed for recurrent themes using IPA (Smith et al., 2009). The open and non-leading interview questions enabled participants to generate a rich narrative that would provide an insight into the participants’ construction of their experience, and thus themes that were important to them.

Each transcript was individually read numerous times in order for the researcher to become ‘immersed’ in the data. Notes were made on initial coding, highlighting connections, associations and preliminary interpretations of the text. Emerging themes were identified and classified as recurrent when they were present in at least half of the other transcripts, enabling a balance between holding an idiographic perspective and identifying generic accounts across transcripts to promote rigour (Smith, 2011). This process relied on the researcher’s interpretive engagement with the text, adopting a phenomenological approach to make sense of the experiences that the participants are sharing whilst engaging in a naturalistic paradigm (Smith et al., 2009).

2.2.7 **Validity**

The traditional validity methods used in quantitative and qualitative methodologies cannot be applied to IPA (Vignoles, Chryssochoou & Breakwell, 2004). One of the central premises of IPA is that inevitable biases and interpretations of the experience of others prevents establishing a true and full understanding that can be unequivocally verified (Willig, 2001). ‘Member checking’ is a validation strategy adopted in some qualitative designs; however, the interpretive nature of IPA, makes it less appropriate for this design as “The combined effects of amalgamation of accounts, interpretation by the researcher, and the passage of time can make member checking counter-productive” (Larkin & Thompson, 2012, p112). Member checking is further complicated by asking participants, who are engaging in the naturalistic paradigm, to provide interpretations on the researcher’s phenomenological paradigm interpretations of their experience and thus this practice is discouraged for IPA, whilst a focus on other validity measures; such as independent audits are encouraged (Gil-Rodriguez, Heffernon & Smith, 2014). The findings were fed back to participants by letter (see appendix J) with an invitation to discuss these in person if desired and other validity measures were adopted.

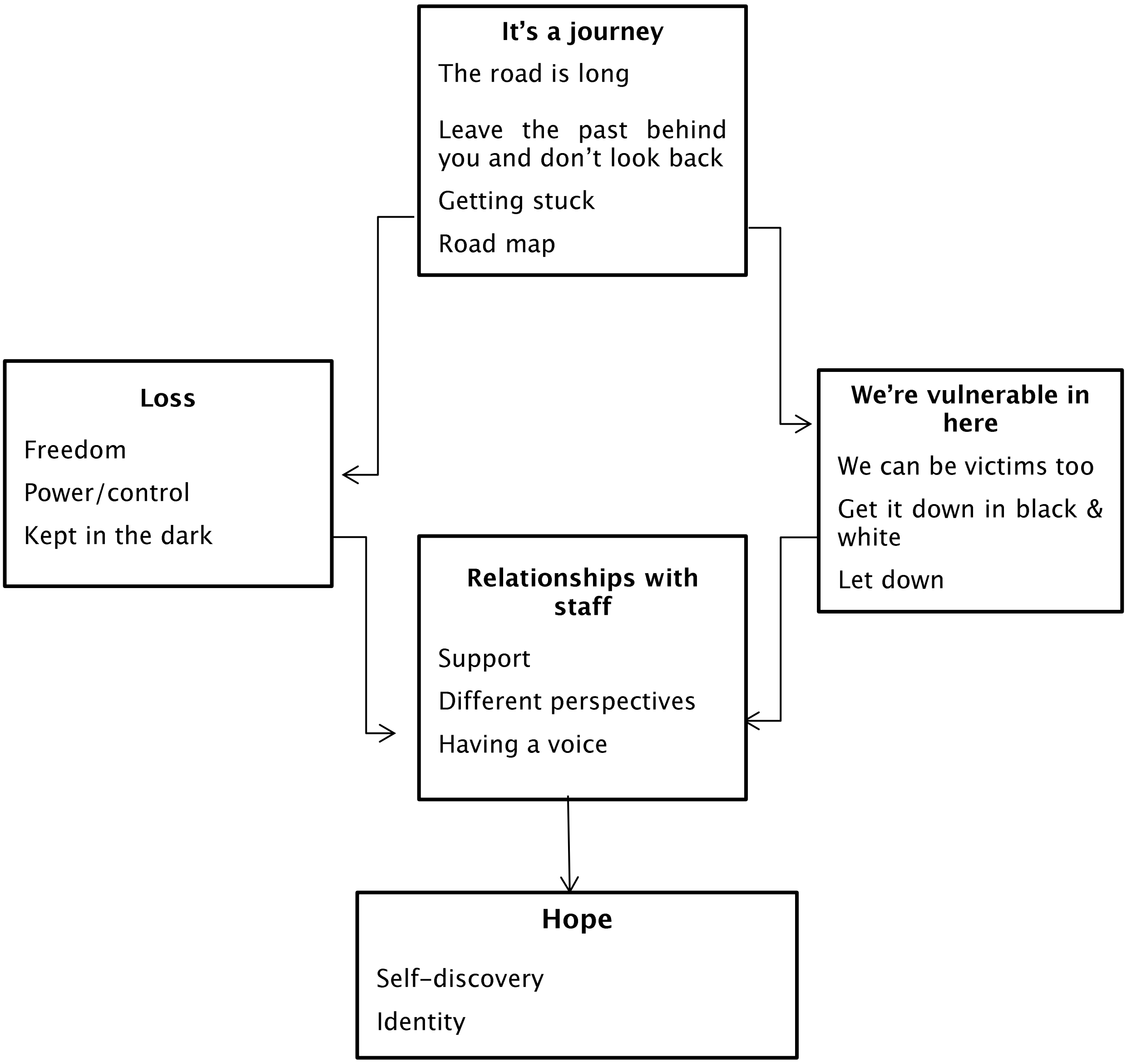
Milton (2004) claims that validity is established through developing themes that are grounded in the data and made transparent for inspections of interpretations of the data. In order to promote validity in this study, the researcher attended an IPA data analysis clinic and participated in group exercises designed to ensure that identified themes were grounded in the data. For example, individual quotes from two themes were spread out on a table and group members were invited to discuss their interpretations and generate theme titles. The ‘Road map’ theme was quickly identified verbatim with full support from the group. The ‘We can be victims too’ theme was identified as ‘We’re vulnerable’ which is conceptually identical to the superordinate theme of ‘We’re vulnerable in here’ that it falls under. Group discussion led to an agreement that this was a good representation of the themes being grounded in the data. An independent audit (Smith et al. 2009; Gil-Rodriguez, Heffernon & Smith, 2014) was conducted by a forensic psychologist with substantial experience of ‘My Shared Pathway’ and a post graduate researcher experienced in qualitative psychological research. They participated in data exercises that involved matching themes to quotes to provide a conventional triangulation of the results (Heffernon & Ollis, 2006; Gil-Rodriguez et al., 2014). Overall there was general agreement about themes; where opinions differed it tended to be across themes where there was significant overlap. Discussion led to further collapsing of themes and minor changes in theme allocation (see appendix H for further details). Further validity is promoted by the examples that are presented here for inspection of interpretations (Heffernon & Ollis, 2006).

2.2.8 **Quality Assurance**

The interpretative nature of IPA requires a constant process of reflexivity in order to offer quality assurance (Brocki & Wearden, 2006). Reflexivity entails being aware of “the ways in which the researcher and the research process have shaped the collected data” (Mays & Pope, 2000, p.51).

A reflexive journal was used throughout this project to record thoughts and observations at various points in order to document a transparent account of the data collection and analysis process and highlight the ways in which the data was shaped by the researcher and research process (Mays & Pope, 2000). This process was discussed within the research team (main researcher, supervisor and independent auditors). An example of extracts from various stages is provided in appendix K. Combined, the researcher triangulation and the reflective journal provide quality assurances of the data.

2.3 Findings



2.3.1 **Figure Two: Representation of superordinate and sub-themes arising via IPA**

Participants were able to give a clear account of their experience; central to this was their description of ‘My Shared Pathway’ as a journey *(‘It’s a journey’*), one that was long and challenging as it forced them to address their past transgressions, which was a difficult but important process. During this journey, they described feeling vulnerable (‘*We’re vulnerable in here*’) to abuse and exploitation as well as being let down by their care teams. On this journey, they suffered much loss *(‘Loss’)* as their freedom and opportunities for autonomy were taken from them. The pivotal feature of ‘My Shared Pathway’ lies in therapeutic relationships (‘*Relationships with staff*’). Staff have the ability to provide support and give patients a voice in their care, which helps the process of self-discovery and developing new identities that are not centred around those of illness and offending which creates a sense of hope for the future (‘Hope’) and helps people move along their recovery journey.

2.3.2 Table Three: Frequency table

Superordinate themes **and** subthemes	**Prevalence (No. of participants represented in theme)**	**Participants providing support of theme**
It’s a journey	6	Bob, Gavin, John, Richard, Rupert, Philip,
Leave the past behind you and don’t look back	4	Bob, Gavin, Philip, Richard
The road is long	3	Bob, Gavin, Richard
Getting stuck	5	Bob, Gavin, Richard, Rupert, Philip
Road map/journey planner	5	Bob, Gavin, John, Rupert, Philip
We’re vulnerable in here	6	Bob, Gavin, John, Richard, Rupert, Philip,
Get it down in writing	4	Bob, Gavin, John, Philip
Let down	3	Bob, Richard, Rupert,
We can be victims too	3	Bob, Richard, Philip,
Loss	6	Bob, Gavin, John, Richard, Rupert, Philip,
Freedom	5	Bob, Gavin, Richard, Rupert, Philip,

Control/power	4	Bob, Richard, Rupert, Philip,
Kept in the dark	4	Bob, John, Richard, Rupert
Relationships with staff	6	Bob, Gavin, John, Richard, Rupert, Philip,
Support	5	Bob, Gavin, Philip, Richard, Rupert
Different perspectives	5	Bob, Gavin, Philip, Richard, Rupert
Having a voice	4	John, Philip, Richard, Rupert
Hope	6	Bob, Gavin, John, Richard, Rupert, Philip
Self-discovery	4	Bob, Gavin, John, Rupert
Identity	5	Bob, Gavin, John, Rupert, Philip

Table Three provides information on the prevalence of participants represented in themes in order to ‘situate the sample’ (Elliott, Fischer & Rennie, 1999).

2.3.3 **Superordinate theme: It’s a journey**

‘My Shared Pathway’ was described by all as if it were a physical pathway, a journey towards recovery and freedom. Participants spoke about the need to move forward and how looking back can be detrimental and cause them to get stuck along the way. ‘My Shared Pathway’ was described as a road map that can help patients navigate their way along their journey. Temporal references were used as markers for progression and metaphors of physical journeys were prevalent.

2.3.3.1 Subtheme: Leave the past behind you and don't look back

Participants spoke about the process of reflection on past experiences to build a better understanding about what led them to secure services and what changes they need to make to be discharged. The need for therapeutic interventions to provide a rationalisation and understanding of the individual's life story has been highlighted as a key feature in recovery (Ferrito et al., 2012). Participants in the present study discussed this both in terms of being a helpful process for recovery and also a distressing process that could act as barrier to recovery.

> **Bob:** You've got these forms, with all these different questions and stuff like that. I'd argue, at the end of the day, yeah, the Shared Pathway could be a sense of understanding and talking and not getting confused or upset over things in the past and stuff like that. It's a new thing coming up that can help you. So I reckon the shared pathway is that little bit in a hospital situation [pause] and the questions come up with stuff, if you can answer 'em in a good way, you can work towards it, so it's not all beginning to the end. Once you've answered questions, it's all what's it's cracked up to be, and that's better for you, hmm, yeah, that's what I mean. (P1, 9-15)

Here Bob speaks about what it's like to complete the workbooks; how this is a new process that can help patients talk about their past experiences and develop a greater understanding of these. It appears that Bob finds hope in this process, in the way that he describes it as a new thing that is better and helpful. Bob appears to indicate that answering questions is an essential milestone. Beginning the sentence with the word "once" suggests that this is something that must occur first; before you can get the benefit of 'My Shared Pathway', you must first answer questions. The phrase "it's all what's it's cracked up to be" suggests that Bob has been told about the benefits of 'My Shared Pathway' and wants these, but in order to access these benefits, you must also give what is asked of you. Bob goes on to reflect on how this process is challenging and can feel counterproductive, having to reflect on difficult past experiences, when you want to be looking towards the future:

> **Bob:** Then you've got to put all the pain, all the trauma behind you and build up this whole new person [pause], but you're still you, you've still got all the hurt, so you can't look back, just got to keep moving forward. (P3, 87-89)

Bob describes an adverse history of pain and trauma and uses physical descriptors of how you can cope with this, e.g. putting the pain behind you, and building up a new person. The first part of this sentence appears to be describing what is expected, as if this is perhaps what Bob has been told he must do. The pause mid-sentence appears to act as a divide between this and the reality that the trauma is not a physical object that you can leave by the side of the road on your journey and you are still the same person who lived the trauma and must carry the scars. This was a sentiment that was shared by other participants who also described difficult past experiences that they did not want to have to face:

> **Gavin:** I don't want to go back there, I want to look forward to the future and see how life turns out for me (P8, 370-371).

Gavin’s choice of words appears to suggest that having to reflect on these past experiences is not merely a painful retelling, but perhaps an act of re-traumatisation. “I don’t want to go back there” indicates that he feels talking about the past is equivalent to reliving it. This iatrogenic effect of re-traumatisation has been discussed in the literature (e.g. Read, Rudegeair & Farrelly, 2006); the distinction between retelling and processing trauma is important in ensuring that opportunities for re-traumatisation are minimal (Herman, 1997). It is possible that patients are feeling pressured to retell their trauma in their workbooks without having sufficient space/support to process this, which can lead to a sense of reliving the trauma.

The role of past experiences has been highlighted as a central theme in the forensic recovery literature (Feritto et al., 2012; Laithwaite & Gumley, 2007; Stanton & Simpson, 2006). Forensic patient’s past experiences are often characterised by unpredictable abuse and neglect, patients thus have to come to terms with the trauma that has been inflicted on themselves, as well as that which they have inflicted onto others (Feritto et al., 2012; Laithwaite & Gumley, 2007; Stanton & Simpson, 2006). These findings suggest that more support is needed to help forensic service users come to terms with their past experiences, and thus promote ‘offender recovery’ (Drennan & Alred, 2012).

2.3.3.2 Subtheme: Getting stuck

Participants described facing obstacles on ‘My Shared Pathway’ and how these could create a sense of ‘stuckness’.

> **Phillip:** They [pause] they want to freeze you in your mistakes, to think of you as your mistakes. You can’t move past that...they tell you you can’t [pause] you have

> to keep thinking about your mistakes or else you repeat your mistakes. (P8, 377-379)

Phillip describes feeling that the process of retelling past mistakes creates a sense of becoming stuck in those mistakes. The first sentence is a powerful reflection on Phillip’s experience of this process that portrays the power dynamics of the relationships between staff and patients. Phillip describes staff ‘freezing’ patients in their mistakes and deindividualising them to the point that they are seen merely as their mistakes. Acceptance and inclusion from staff has been highlighted as important in helping forensic mental health patients develop connectedness and a sense of self (Laithwaite & Gumley, 2007). When this does not happen, an ‘us and them’ divide can occur, creating social isolation and passivity about care (Barksy & West, 2007; Ferrito et al., 2012).

For some, the obstacles that they faced seemed impassable:

> **Bob:** Sometimes it feels like I’m piggy in the middle. All the goodies on one side and all the enemies on the other, and I’ve got to try and get out, but there’s this ring of fire, trying to get out, but you can’t get out. (P4, 120-122)

Bob uses metaphorical language here to create a picture of his perception of being stuck and helpless. Bob has adapted the typical ‘goodies’ and ‘baddies’ terms to “goodies” and “enemies” which creates a greater divide and also adds a personal quality. It is not merely that they are ‘baddies’ and therefore a general threat to others; referring to them as “enemies” makes it seem that they are particularly threatening to Bob. The latter part of this quote is a powerful portrayal of the feeling of being stuck. Bob speaks of the need to try and get out; the repetition of this adds a sense of urgency, yet the metaphorical fire blocks this and leads to the sense of finality described at the end: “but you can’t get out.”

In contrast, ‘My Shared Pathway’ was seen as a means for counteracting this sense of becoming stuck:

> **Rupert:** Yeah, yeah it would do. I mean they’d be geared up to get you out of the place as opposed to geared to keeping you here and hopefully their assessment will be such that it will be more, as I said, positive and the reason it would be more positive is that they’re putting their time into help it move on and motivate and encourage, yeah. (P7, 338-341)

Rupert suggests that ‘My Shared Pathway’ offers a framework for staff to facilitate discussions with patients that help them move along their care pathway. He describes this as a change from being “geared to keeping you here” to “geared up to get you out”.

2.3.3.3 Subtheme: Road map

Participants described ‘My Shared Pathway’ as if it were a road map that identified their past experiences and guided them along their care pathway towards a return to life in the community.

> **Bob:** It’s all there in black and white really. I could get the whole book out and look at all the past things. I’ve writ all about destroying my brain, everything in that book is about destroying my brain. I can’t do that no more. I didn’t know what I was thinking. I was always losing the plot, do you know what I mean? There’s so much violence, and the mates I’ve seen killed…I just can’t go back to that, I just have to look in the book and see I am lucky to be alive basically. I’ve got to move forward, I can progress, but I can look back and see where I went wrong. I can’t go that way again. (P3-4, 113-118)

Bob describes the workbooks as a concrete tool that can be used as an aid to identify past experiences that need to be avoided and provide direction towards a better future. In contrast, this was not always experienced as a positive process:

> **Phillip:** From the idea of the Shared Care Pathway you should be getting ideas about why you’re here, or what you needed to do to get out, what the staff here are trying to do for you; what, what the doctor’s planning for you and how you’re going to get out of it. What you need to do to get out of it. But from my, my [pause] f-f-from [long pause] my access from a psychiatry point of view is that ... or a psychology point of view is, is that it’s manipulative, it’s assumptive and detrimental....It looks down on a person. That you’re trying to say, ‘you do this, this and this. We think this about you.’ Not so much think this about you, but ‘we feel this is what, what, what your traits are. We feel this is where you’re coming from’ and then, then they’ll start telling you what you need to do about it. But to actually do that they’re-they’re-they’re trying to be, trying-trying to command you in one, one sense or another. Not, not immediately, but c-command you in a sense of [pause] command you in a sense of um [pause] an overlord factor. They say they want to know about you, your thoughts, opinions. But they don’t. (P2, 54-68)

Phillip appears to see value in the aims of ‘My Shared Pathway’ in identifying these markers for past mistakes and direction for progress in the future; however, he feels that this fails to be delivered. He goes on to describe how he has not experienced this as a collaborative process and felt that it was more about staff instructing direction, rather than helping to collaboratively discover it. Phillip was ultimately left feeling that his viewpoint was unvalued and likely contributed to his subsequent decision to disengage from ‘My Shared Pathway’, as there is evidence that the risk of disengaging from therapeutic processes increases when treatment receivers feel that they do not have a voice that treatment providers deem worthy of listening to (Grady & Brodersen, 2008).

2.3.3.4 Subtheme: The road is long

Participants described the lengthy process of their care pathway.

> **Bob:** It is clearer, clearer than what it was, but it all just takes such a long time. (P2, 70-71)

Bob experiences ‘My Shared Pathway’ as more transparent, in line with its main aims; however, he does not appear to experience the process as any less lengthy.

> **Richard:** I wanted to go there and the doctors agreed to it and the process was then very, very slow because, as I said, I think the doctors needed to be reminded of it more often. I think it’s very clear that for instance Doctor [Ricardo]was quite well meaning in agreeing right away that I should move there as soon as possible but then, erm, because I, myself, didn’t actually remind her of it she seemed to just forget about it completely every now and then and that made it very, very slow to get progress and I think that, erm, if I had simply reminded the doctors about it more often, let’s say once a month or so, progress would have been much faster.(P9, 296-302)

Richard: Now, erm, doctors very, very … doctors are quite helpful in this place when they do talk to you but they very, very rarely actually ask to talk to you and a meeting with the doctors, other than the ward round, which is once every three weeks, happens usually maybe about once every six months or so and in fact they ought to be more often than that. Yeah. (P8, 262-266)

Richard describes the impact of not having regular discussions with doctors and how this contributes to the experience of slow progression. The language that Richard uses helps to emphasise this as a drawn out process, as he draws out the process of explaining through the repetition of words and pointing out the different time frames for meetings.

The aim of shorter admission times was remembered and cited as a motivator for engaging in ‘My Shared Pathway’:

> **Rupert:** Are you interested in getting out as soon as possible? Oh yes, absolutely. Therefore that’s the carrot that’s dangled isn’t it? But I want to get out as soon as possible, what do I have to do? I’ll sign up now please. You know, that’s the big old taster and yeah. That is the incentive, which is the premise really. (P8, 391-394)

2.3.3.5 Superordinate theme: We’re vulnerable in here

Participants described a variety of ways in which they feel vulnerable whilst being detained in secure services.

2.3.3.6 Subtheme: Down in black & white

The power of the written word was prevalent. Participants spoke about feeling vulnerable to issues pertaining to power and trust. The need for written evidence of achievements and queries was discussed, as was the risk of having written ‘evidence’ used against them.

> **Bob:** Erm [pause], erm, well, it’s supposed to be that it’s all there in black and white, you know, it’s on paper. So, like, they shouldn’t be able to just point out the bad, they’ve got to also show the good, you know, like your goals and what you’ve done. So [pause] everyone knows, everyone can see, it’s there in black and white, you ARE [emphasis] trying. It’s hard work you know, all of this. People think it’s easy, but it’s not. (P2, 59-63).

> **John:** Um, yeah, it kind of gives you confidence filling out the pamphlets. Because, um, you’ve got it in black and white as to what your views are. They get read by the staff. So they’ve got to do something that, or at least listen to them. (P16, 792-801).

Having opinions documented appears to generate confidence that they will be considered and potentially acted upon. They both referred to the importance of having it “in black and white” which helps ground this concept in forms of accountability. This confidence was not felt by all of the participants; such as in the case of Phillip, who did not trust what was being written about him, to the point that he felt staff may actually be falsifying notes.

> **Phillip:** If my notes, my notes were looked into then my notes couldn’t be accredited as proof, proof of treatment, because they can falsify, mis-documented and pre-written, so it could never be seen that what ... why I should be on treatment, from my notes. I’ve never seen why I should be on treatment, from my notes. So from that point of view it would be difficult for me. (P9, 412-415)

2.3.3.7 Subtheme: Let down

Participants spoke about feeling vulnerable to disappointments and being let down. Many had heard about ‘My Shared Pathway’ and felt that it sounded like a good initiative; however, they were left feeling let down that it had not been rolled out as expected.

> **Richard:** I’ve … they’ve told me about the Shared Pathway two or three times but they haven’t actually done anything with it and erm I’ve not had … I’ve hardly any say in my treatment so I haven’t erm … I don’t think the Shared Pathway is really operated much. (P1, 10-13)

> **Rupert:** Seems to be yeah because generally staff aren’t geared up to do this; there should be training for every member of staff, including support workers, on how to…this is the be all and end all of everything to get a person out of incarceration and everybody should be qualified in a way to actually deal with that. (P3, 121-124)

This experience was not true for everyone; such as in the case for John, who felt that My Shared Pathway had delivered on its promises.

> **John:** Um, yeah, I wanted to get ground leave, and they...when I first got here...They didn’t really give me reasons why I couldn’t have it or anything; it was just like, ‘no, you can’t have it at the moment’. Then when my community leave with the Shared Pathway came in, I got to have my say more. They’d said at ward round,told us it was coming that we’d get our say, and I did, and things happened more how I wanted them to happen. (P4, 197-201)

2.3.3.8 Subtheme: We can be victims too

Participants spoke about their vulnerability to being victims of intimidation and violence.

> **Bob:** Yeah, I don't want to go deep into it, but you know people hear about you moving on, and they don't like that they're not, next thing you know, you're in a fight and you aint going nowhere. It's all the violence, it's everywhere. You can't get away from it. (P2, 54-56)

Bob describes the risk of violence from other patients; such as when they hear that someone is moving on, which leaves patients vulnerable to being targeted by others and having their move sabotaged if they end up in a fight. The final two sentences create a sense of helplessness and finality. This was personally very salient for Bob, as he was waiting to hear if his team had decided that he was ready to move on to less secure facilities and he was fearful that should he get the news he anxiously hoped for, he would be vulnerable and unable to protect himself from assault without jeopardising his move.

Staff were also described as potential threats who could make patients feel vulnerable in that they had no control over when staff turnover may occur and who would be left responsible for their care. The power dynamics between staff and patients means that staff hold the power to intimidate and cause fear.

> **Richard:** The doctors here have sometimes gone after a while, suddenly, to a different hospital and they've sometimes suddenly been replaced by a different doctor. When that's happened the new doctor once suddenly was a bad doctor which, erm, didn't like me at all and that frightened me quite a lot. (P6, 165-169).

For some, the victimisation did not come from violence or intimidation, rather it was grounded in the more global effect of being detained and the personal impact that this entails.

> **Philip:** It's taking away my rights, my liberties, my freedoms, my strength, my world, my reason for being, my character, my general wishes in life, my aims, my objectives [pause] and generally closing me down. (P7, 340-342)

Philip describes the personal violations he has experienced; he lists his losses one by one, creating the sense that they are being stripped away from him like the layers of an onion, leaving him with feelings of isolation.

2.3.3.9 Superordinate theme: Loss

Participants described experiencing great losses and the significant toll this takes on their wellbeing.

2.3.3.10 Subtheme: Freedom

Loss of freedom was a prevalent theme, which is in keeping with the literature on forensic mental health patients’ perceptions of recovery (e.g. Barsky & West, 2007; Laithwaite & Gumley, 2007; Mezey et al., 2010; Moore et al., 2012; O’Sullivan et al., 2013). For some, the sentiment that freedom was a core issue to them was conveyed through short simple sentences that emphasised freedom as the essence of recovery:

> **Rupert:** This is the be all and end all of everything to get a person out of incarceration. (P3, 122-123)
>
> **Bob:** Medication, wellness**,** getting out and breathing the air – that’s wellness. (P5, 170-171)
>
> **Richard:** I need to recover by being moved out of the hospital. (P4, 109)

The importance of community leave was cited as an essential opportunity for having a taste of freedom and engaging in ‘normal’ activities, a finding that is prevalent in the literature on recovery in forensic mental health. (e.g. Walker et al., 2013)

> **Gavin:** Um, [pause] well, the first time I felt better was when, um, they took me to go to a bar in... in, er, where is it? Um, [Town]. Um, I was playing pool there and getting drinks and stuff and there was lots of people about and it was really therapeutic. I mean it was good to get out in the open again and do normal things and see normal people and stuff. (P1, 22-34)

2.3.3.11 Subtheme: Kept in the dark

Participants described feeling a loss of the right to be aware of their own treatment. This phenomenon is not restricted to forensic mental health patients and has been documented as a problem in both physical and mental health care (e.g. Webb, 2007).

The need for an understanding of ‘My Shared Pathway’ and its aims was cited as essential in motivating people to take part in it:

> **John:** Yeah. Some people haven’t had their Shared Care Pathway explained very well to them. Some of the patients who are a bit negative about it don’t really know what it’s all about. (P17, 835-839)

Being kept in the dark was described as detrimental in more generic terms to the point where patients thought that staff were making dismissive comments about their progress to reassure them; however, the less comforting truth is later revealed at key points like Care Programme Approach (CPA) meetings where patients feel unable to influence this.

> **Bob**: I think they’re hiding something from me though, you’d be surprised. I’ve got a CPA next week, Wednesday, they’ll all be going ‘you’re ready to go, you’re ready to go’. If I get the go ahead, that’ll be 15 years I’ve done....It’s like, sometimes, everyone is just telling you what you want to hear, do you know what I mean? It’s like, ‘You’re doing great [Bob], you’re doing great, keep it up.’ Then you get to your CPA and you don’t hear that no more. You hear things like ‘[Bob] refused to go to his drugs and alcohol group’. (P1-2, 36-43)

Some participants experienced ‘My Shared Pathway’ as a pivotal initiative that had helped take them ‘from the dark into the light’. The ethos of collaborative working and transparency helped them feel that they were involved in their care and had a good understanding of what was expected from them and the next steps on their care pathway.

> **John:** Because you get involved in your care, you’re not in the dark, you’re um, in the light, what’s going to happen to you, um and um, your goals set for you, and um, you get some direction, um, you get to have your say. (P7, 345-347)

2.3.3.12 Subtheme: Power/Control

The loss of power/control was a key theme discussed by participants and has also been identified as a key theme in the general literature on recovery in forensic mental health (e.g. Cook et al.,2005; Ferrito, et al., 2012).

> **Philip:** That’s what their idea of ‘care’ [emphasis] is. It’s the same here as...as it was in the children’s home..as..as it is everywhere. They tell you what’s wrong with you, they take away your liberty, your voice, your rights, your choice, your soul, and they lock you up [pause] and leave you [sigh]. (P8, 357-359)

Philip describes his experience of loss of power in secure services and equates this to his time in a children’s home which conveys a global perception of services as controlling and detrimental. His conclusion about being left and the sigh that follows it portrays a picture of someone who feels exploited and dehumanised.

A sense of powerlessness was felt in a range of areas, such as in the nature of Mental Health Act (MHA, 1983) detentions and how these create a culture of uncertainty and powerlessness as to their placement. This is in contrast to prison where prisoners can rely on their earliest release date (ERD) as a marker for when they will be released. Mental health detentions are much more flexible and depend on a number of subjective factors, such as your clinical team deciding that you are ready to move on.

> **Bob:** That shit is really black and white, there’s no grey area in prison, you do your time, you know your time, you’ve got your ERD from the moment you go in, so they can’t argue that. You know what I mean? No one can say, yeah, he’s done his sentence, but he missed his therapy one day, so we’ll keep him for another five years. That just doesn’t happen. (P2, 64-68)

For some participants, ‘My Shared Pathway’ helped them feel that they had a greater sense of control and power in their care.

> **John:** Because, um, yeah, you get choice in what you get… you know, in what happens in your care. Rather than just being told this is what happens. (P4, 171-172)

2.3.3.13 Superordinate theme: Relationships with staff

Relationships with staff was a key theme highlighted by all of the participants who felt that staff support was needed in order for ‘My Shared Pathway’ to be successful. This finding is supported in recovery in forensic mental health literature, as detained forensic patients spend most of their time with staff and have few opportunities for relationships outside of hospital (Mezey et al., 2010). The importance of positive relationships with staff has been well documented (e.g. Barsky & West, 2007; Cook, et al. 2005; Mezey et al., 2010).

2.3.3.14 Subtheme: Support

Supportive relationships with staff was described as a positive factor that helped patients progress along their care pathway with the provision of clinical support and a positive affirming relationship helping boost self-esteem and promoting recovery. Positive relationships with staff that make patients feel valued, respected and cared for has been shown to influence how patients define themselves and nurture self-esteem (Mezey et al., 2010; Laithwaite & Gumley, 2007; Turton et al., 2011).

> **Rupert:** Other people have got to give you the tools and also the direction that is necessary for you to remain as well as you possibly can. (P4, 175-176)
>
> **Gavin:** They said that they...I’m a kindly natured bloke and I don’t get wound up very easily and stuff and um, that’s helped a bit, you know what I mean? (P13, 635-636)

Some felt that staff did not provide enough practical support in completing the workbooks. This was framed within the context of a belief that other less able patients needed support with the literacy aspect, rather than any particular participant saying that they themselves needed more of this support.

> **Rupert**: So much reading and obviously there are a lot of patients that have a little bit of problems understanding and they may be a bit, I don’t know, less than intelligent and…not less than intelligent but had demands that are may be…find it very difficult to actually complete a booklet themselves by sort of answering the questions so…so therefore I think that’s kind of unfair. (P1, 21-25)

A general perceived lack of support was discussed; Philip felt that staff were not available to provide sufficient support and described their role in more punitive terms typically associated with prison guards. This type of relationship has been highlighted in the literature as a potential barrier to recovery (Ferrito et al.,2012).

> **Philip:** Um. With the amount of time the staff spend in the office it’s quite ridiculous on how they can actually provide care. They’re just here to tell you no, you can’t do this and no, you can’t do that. We’re locking doors behind you. That’s all they’re here for and that’s all they see that they’re here for, when it comes down to it. (P9, 403-406)

Feedback from clinicians in other services has highlighted ‘innovation fatigue’ and insufficient time and resources to support patients with ‘My Shared Pathway’ (Ayub, Callaghan, Haque & McCann, 2013) as detrimental to the roll out of this initiative.

2.3.3.15 Subtheme: Different perspectives

Difficulties could occur in relationships when patients felt that staff held perspectives of their needs that differed from their own. In line with Moore et al.’s (2012) findings, some participants described the challenge of having discussions around recovery and illness when they do not believe they have anything to ‘recover from’. At the more extreme end of this, patients felt that staff pathologised their thoughts and behaviours and in some cases this created a reluctance to engage with staff.

> **Philip:** There is no recovery. I shouldn’t be here. There won’t be recovery until I come off treatment and that’s going to be a long time, because the doctor don’t see to it that I need to come off. (P3, 147-148)
>
> **Rupert:** I’ve decided that it appears that we think more of ourselves and our achievements than perhaps the staff do so…I think they’re geared up here in this microscopic analysis that they do pick holes in everything you do, every bit of discourse that goes on between the staff, they think there might be a hidden agenda here and because it’s their jobs they tend to look like it, do you know what I mean? (P2, 85-88)
>
> **Richard:** There have been some patients that have done some strange things that they have been trying to bully me. When once, two or three times I have complained about that, simply describing what the other patient was doing and how they were trying to harm me. There have been some nasty doctors who said right away that I have some sort of delusion about the patient and that wasn’t true at all. And this has meant that there are times when patients are trying to harm me that I cannot tell any of the staff about it for fear of them saying it is paranoia or a delusion and that wasn’t true at all.
> (P14, 433-436)

2.3.3.16 Subtheme: Having a voice

Participants spoke about the concept of ‘having a voice’ and feeling listened to. Where participants felt they had a voice they felt empowered to speak up and take a collaborative role in their care. The literature supports this finding as a key feature in maintaining engagement (e.g. Grady & Broderson, 2008). ‘My Shared Pathway’ was described as helpful in providing a format for patients to share their views and be heard and feel that they were receiving a responsive service when their views were actioned.

> **John:** Um (pause) yeah, it gives you more confidence at ward rounds. Because when we go in you know they've got to listen to what you're saying. Whereas before when you went in, you just thought I'll hope for the best sort of thing. (P15-16, 759-767)

> **Richard:** Erm, erm, I think now that I'm here there is a difference in that I can now talk to the doctors and tell them what I think about the medication and, erm, they will often change it if I complain about something or if I ask for something else. So, when I'm here I get listened to, to some extent. Erm, before I came here I was in a place where I was, erm, hadn't … I think I had no choice at all and I think it's very important that I should have had a choice in my medication and didn't get any. (P, 135-140)

Not all of the participants felt that they had a voice. Philip spoke about the allure of 'My Shared Pathway' being the promise that they would have a voice, only he described this as not really happening and him subsequently not feeling heard.

> **Philip:** They manipulated us by offering the...the...Shared Pathway. It was...it was the carrot that promised choice ...er...er...promised to give us a voice. [Pause] Only no one was listening. (P3, 113-115)

Philip uses metaphorical language to describe his feelings of being manipulated into believing that 'My Shared Pathway' would provide an opportunity to give patients a voice and choice in their care. He delivers the first two sentences in a qualitatively different manner than the third; he takes longer to get his words out and stutters as he attempts to convey this message that they were in fact promised they would have a voice. In contrast, the final sentence, where he shares his experience that this promise has failed to be delivered, is very concise and makes the message seem more powerful as it appears to close off opportunity for discussion, perhaps reflective of his experience of this disappointment.

2.3.3.17 Superordinate theme: Hope

Participants spoke about the ways in which 'My Shared Pathway' was helping them develop a sense of hope through a process of self-discovery and developing an identity that they felt fitted in with the new life that they were building for themselves. Themes of hope are prevalent throughout the literature on recovery, both in generic and forensic mental health (e.g. Leamy et al. 2011; Cook et al., 2005; McQueen & Turner, 2012; Mezey et al., 2010; Moore et al. 2012; Walker et al. 2013). Developing a sense of self through identity exploration and self-discovery has been highlighted as a means for hope and promoting recovery (McQueen & Turner, 2012; Moore, et al, 2012; Laithwaite & Gumley, 2007; Mezey et al., 2010. Walker, et al 2013).

2.3.3.18 Subtheme: Self-discovery

Participants spoke about ‘My Shared Pathway’ facilitating the process of self-discovery by encouraging reflection on their past experiences, developing an understanding of how these contributed to their current admission, and what changes need to be made so that they may move on from secure services and not be readmitted.

> **John:** Being independent, ready to move on, um, any problems you’ve had, you’ve learnt from and recovered from. You’re like a new person with a second chance. Um, that’s about it really. (P3 141-142)

> **Gavin:** Um [pause], well it's helped me to get my past in, um, another perspective and that's cool. I mean, like to help getting... to help to understand what my life's been like and stuff. (P13, 635-636)

For some, this process brought unique challenges; it raised questions about whether or not recovery was ever possible and also forced patients to see things in themselves that they were not proud of:

> **Rupert:** We’re all…we all come from a real bad place in this establishment and throughout psychiatric units, you’ve got to evaluate yourself erm, and decide that it’s about time that something has to be done to achieve, hopefully…I mean recovery is – do any of us actually recover from anything? (P4, 169-172)

> **Bob:** You’ve got to look at the things you’ve done, and you have go to, so you don’t do ‘em again, but, um, you know, you’ve also got to look at yourself in the mirror again and that can be really hard. Yeah, really hard. (P3, 133-135)

Drennan & Alred (2012) have highlighted a longing to understand as a significant element of recovery in forensic mental health patients. It appears that the participants in this study have found ‘My Shared Pathway’ helpful in facilitating this understanding.

2.3.3.19 Subtheme: Identity

Identity was a prevalent theme; participants spoke about how it affected their recovery and the role that ‘My Shared Pathway’ plays in helping them develop new identities that incorporate the things they have learned and traits of the person they want to be. Having a new identity that was not defined by offender or patient roles offered hope for a better future, as highlighted in the recovery in forensic mental health literature (e.g. Cook et al. 2005; Laithwaite & Gumley, 2007; McQueen & Turner 2012; Mezey et al, 2010; O’Sullivan et al. 2013; Walker et al., 2013). This was a challenging process that forced patients to confront the parts of their identity that they wanted to leave behind, but also encouraging as it helped build on the parts that they wanted to take forward. At times this appeared to create a sense of re-birth as new identities began to emerge.

> **Gavin:** Well, it asks you about your past, so you do have to think about the past, you have to get it all down on paper, so it’s all there in black and white. But it also asks you about what you want for the future, who you want to be and how you’re going to be, how you’re going to do that. So you get to leave all the bad behind you and be someone new. That’s something to look forward to. (P8, 376- 378)

> **Bob:** It’s like you want to look at who you are now, who you’re gonna be, um, you know, a good dad, a good son, but instead you look in the mirror and you see that broken man looking back at you. The one that done them things and you just don’t want to look anymore **...**Yeah, but you’ve just got to do it, you know, and the thing is, yeah, the shared pathway also lets you think up the person you want to be. The one you want to see looking back from the mirror. (P4 136-141)

Not all of the participants shared in this experience. Philip described feeling held back by his identity as a black individual and how this made him feel that he was not able to access the full benefits of ‘My Shared Pathway’.

> **Philip:** Definitely, because I’m black I don’t have that much power. If I had a lot of power and I was, and I was [pause] and I was, as, as I am, then they would leave me alone. They wouldn’t approach me…approach me in the manner in which they do. But because they can get abusive with their ways, they’re abusive in many ways, verbally and sexually. Mentally. They have all the power. (P6, 290-293)

2.4 Conclusion

The aim of this study was to explore the lived experience of the process of ‘My Shared Pathway’ for six male patients who were detained under the Mental Health Act (MHA, 1983) in a low secure service. IPA was used to capture the subjective meanings that patients ascribed to this process. Five superordinate themes were identified: ‘*It’s a Journey’, ‘We’re Vulnerable in Here’, ‘Relationships with Staff’, ‘Loss’* and *‘Hope’*. These findings are consistent with those seen in the forensic recovery literature and suggest that ‘My Shared Pathway’ helps promote recovery in a number of ways.

Participants experienced ‘My Shared Pathway’ as a lengthy and challenging journey. They found the act of reflecting on past experiences difficult; for some it was even traumatic, though they ultimately found it a useful process in helping them progress on their recovery journey. Being detained brought significant loss of power, freedom and inclusion and left participants feeling vulnerable. ‘My Shared Pathway’ was experienced as helpful in providing corroboration and validation of their experiences, as it meant they had things ‘down in black and white’. Many felt let down that ‘My Shared Pathway’ was not being operated as they had expected and some felt that they had not experienced it at all. It is worth noting that at the point of interview, ‘My Shared Pathway’ was no longer a CQUIN target and staff were anecdotally reporting that they did not have the time to engage patients in this process, as they were busy trying to roll out the new CQUIN targets. Similarly, clinician feedback from other services has highlighted ‘innovation fatigue’ amongst staff trying to roll out ‘My Shared Pathway’ along with other new initiatives (Ayub et al., 2013). Relationships with staff were of central importance; supportive relationships were experienced as affirming and helped provide a sense of self that increased hope for the future. Where staff perspectives of their presentation/progress differed from the patients, they felt unheard and pathologised, and in one case (Philip), led to the point of disengaging from the process completely. ‘My Shared Pathway’ helped patients feel that they had a voice, that their perspective was always on the agenda and that they were receiving a more responsive service. Workbooks were perceived as useful tools that patients could use to help them navigate their care pathway, increasing transparency and providing a concrete tool for them to refer back to when they felt they needed a reminder about where they went wrong in the past.

Participants described themes that are prevalent in the recovery literature for both generic and forensic mental health (see discussion of themes for further details).

2.4.1 Strengths and limitations of the study

The key strength of this study is that it provides a narrative of how forensic mental health patients are experiencing ‘My Shared Pathway’ and adds to the dearth of literature on patient perspectives on offender recovery. It also offers support for the use of qualitative methods in forensic mental health research. The use of IPA methodology enabled the capturing of rich descriptions of the individual’s experience as well as consideration of the wider sample. The reflexive aspect of IPA allowed for the consideration of researcher influence on the findings. The number of steps taken to ensure that themes were grounded in the data increased the validity of the findings. Participants were describing their experience as they lived it and so potential recall biases associated with retrospective studies were limited (Dickson, Knussen & Flowers, 2008).

One of the main limitations of this study is that it relied on a small sample of patients who volunteered to share their experiences. Whilst this sample size is within the recommended guidelines for IPA (Smith, 2011), and generalisation is not the aim of an IPA methodology, it does limit how much the findings can be considered representative of the general patient experience of ‘My Shared Pathway’. It is possible that there is a larger group of patients who have become passive about their care and generally disengaged with service providers and so would then be unlikely to volunteer to share their views (Grady & Broderson, 2007); this would imply that there may be service users who are experiencing ‘My Shared Pathway’ in a completely different manner than the participants of this study. Nevertheless, the demonstration of convergence and divergence in themes evidences not only the unique experience of the individuals, but also patterns across the sample (Smith, 2011), and emerging themes were largely consistent with those seen in forensic recovery literature, indicating that the findings here may be relevant for other services. Larger scale research is needed to determine generalisability.

2.4.2 Clinical implications

The participants of this study found ‘My Shared Pathway’ a helpful process that promotes recovery and increases transparency. The service appears to have scaled back on its engagement with ‘My Shared Pathway’ since it ceased being a CQUIN target. As this appears to be a meaningful process that promotes recovery, increasing resources to ensure that it is rolled out in its entirety may help the initiative meet its original key aims of greater transparency and focus on recovery, as well as shorter admission times. A longing for understanding has been highlighted as a key feature in forensic mental health recovery (Drennan & Alred, 2012) and the findings of this study suggest that ‘My Shared Pathway’ can be a useful tool in facilitating this understanding. However, participants found the process of reflecting on past experiences very difficult and the need for more support when completing workbooks was highlighted. Increased support in this area may reduce the negative impact of retelling trauma and increase engagement whilst promoting recovery. The role of past experiences has been highlighted as a key theme in forensic recovery literature, with high levels of trauma being reported in this client group (e.g. Ferrito et al., 2012) and an additional need to come to terms with their offence histories in order to achieve ‘offender recovery’ (Drennan & Alred, 2012), indicating that high levels of support may be required to help patients process this. The importance of relationships with staff was a key theme, in keeping with the wider literature on recovery in forensic services (e.g. Barsky & West, 2007; Mezey, et al., 2010; Cook et al., 2005; Ferrito et al., 2012; Walker, et al., 2013; McQueen & Turner, 2012), staff support was described as essential for ‘My Shared Pathway’ to be successful. Not all of the participants felt supported by all of the staff. A lack of support and understanding from staff created a sense of punitive relationships, which has been highlighted as a barrier to recovery (Feritto, et al., 2012). These findings suggest that a focus on ensuring consistency in recovery orientation and continuity of care may help improve engagement with ‘My Shared Pathway’ and also promote recovery. Staff-training programmes may prove helpful in facilitating this, as such initiatives in forensic services have demonstrated increases in recovery oriented practice (Gudjonsson, et al., 2010), similarly to mainstream psychiatric services, where having staff with skills and knowledge of recovery principles has been identified as a key theme in recovery-oriented practice (Shepherd et al., 2008). Given the anecdotal feedback highlighting ‘innovation fatigue’ from clinicians in this service, and those reported by Ayub et al. (2013), consideration should be given to how staff can be better supported in this process to help boost resilience to fatigue and potential burn out.

2.4.3 **Future research**

Further qualitative research that involves a longitudinal exploration of the experience of ‘My Shared Pathway’ is needed to provide a greater understanding of the experience over time. There was only one participant in this study who had disengaged from the process of ‘My Shared Pathway’; accessing a wider population of patients who have disengaged may help provide an insight into why this is so and offer potential strategies for re-engaging the disengaged.

Appendices

A. Table One: Studies included in the literature review
B. Ethics –University of Southampton confirmation
C. Ethics – Southern Health Research and Development department approval
D. Ethics – [redacted] Intervention Group confirmation
E. Participant Information Sheet
F. Consent form
G. Semi-structured interview schedule
H. Independent audit summary
I. Debrief letter
J. Thank you and feedback letter for participants
K. Reflexive journal example extracts

Appendix A : Studies identified for literature review

Study	**Participants**	**Methodology**	**Themes**
Barsky & West (2007)	6 male participants in long stay MSU	Focus groups Thematic content analysis	Activities, freedom on the ward, access off the ward and the security wall, atmosphere on the wards, staff and access to psychological therapies.
Turton et al. (2011)	6 (4 male, 2 female) participants in MSU	Semi-structured interviews Thematic and narrative analysis	Future, process, social inclusion and treatment, self, clinical recovery and physical health
Mezey, Kavuma, Turton, Demetriou & Wright, (2010).	10 (8 male, 2 female) participants in MSU	Semi-structured interviews Grounded theory and directed content analysis	Autonomy, hope, social inclusion, self-esteem, understanding one’s illness, overcoming stigma, being valued as a person, staff attitudes and treatment setting
Cook, Phillips & Sadler (2005)	4 participants in a regional secure service	Semi-structured interviews Hermeneutic phenomenology	Hope, levelling (a shift in power that enhanced connectedness and a sense of self), relationships, working together and (adding a) human face (to an objectifying forensic setting).

Laithwaite & Gumley (2007)	13 (1 female, 12 male) participants in high secure hospital	Unstructured interview social constructionist version of grounded theory	Past experiences of adversity, recovery in the context of being in hospital, relationships and a changing sense of self
Stanton & Simpson (2006)	6 female participants who had committed maternal filicide	Semi-structured interviews Naturalistic paradigm	Managing the horror of the memories, forgiving themselves, role as mother, support and managing illness.
Ferrito, Vetere, Adshead, & Moore (2012)	7 male participants in high secure hospital	Semi-structured interviews Interpretative Phenomenological Analysis (IPA)	The role of past experiences, impact on personal development, periods of ‘loss of grip on reality’, reframing:events via therapeutic intervention, internal integration and roadblocks to the process of recovery (stigmatisation and communication breakdowns)
O’Sullivan, Boulter & Black (2013)	5 male participants with dual diagnosis recalled to MSU	Semi-structured interviews IPA	I can be me rather than some crazy whatever: self as other, I wasn’t really an addict: transition of the self as substance user, I have got no choice: disempowerment, you can’t be forced into doing something: self-determinism, and I can do nothing sober or I can do nothing high: recovery.
Walker, Farnworth &	9 participants from a secure	Semi-structured interviews	Developing a sense of self, connectedness and hope

Lapinksi, (2013)	mental health service	Thematic analysis	
McQueen & Turner (2012)	10 participants (7 male, 3 female) from a range of forensic services	Semi-structured interviews IPA	Opportunities for developing connectedness with others, nurturing a sense of self, and increasing hope
Moore, Lumbard, Carthy, Ayers (2012)	6 male participants in a high secure hospital	Focus Group Thematic analysis	Living behind two 30 feet high perimeter fences, readiness and honesty, the role of hope: the only way is up, what works? Whose job is it to recover my life? Stigma, loss of individuality, treatment resistance: You can’t recover from something you don’t think you have and when recovery is taken away or told that it is hopeless, the risks increase.

Appendix B Ethics –University of Southampton confirmation

Date	Activity	Comments	Attached Documents
26/07/2013 2:33 pm	**Reviewed and approved** by the ethics committee		
17/07/2013 11:24 am	**Approved by supervisor** and sent to ethics committee		
16/07/2013 9:45 pm	**Submitted** to supervisor George Johnson (gj1t07)		

Appendix C : Southern Health Research and Development Approval

To:

Clarke C.M.E.

Inbox

30 October 2013 13:53

You replied on 30/10/2013 14:09.

Hello [redacted]

This is to confirm that we have discussed your service evaluation titled: 'Shared Care Pathway: the experience of a low secure service', and in accordance with Trust policy on service evaluations, you may proceed without further action.

[redacted]

[redacted]
Clinical Governance Facilitator
Southern Health NHS Foundation Trust

Appendix D : Interventions group approval

Southern Health NHS
NHS Foundation Trust

To whom it may concern

Study title: ‘Shared Care Pathway’: the experience of a low secure forensic service

Researcher: [redacted]

This is to confirm that [redacted] presented her study proposal at the Interventions Meeting at [redacted] on the 12th August.

This meeting has the overview and governance of all interventions, audits, research activity and training within the unit.

The outcome from the meeting was that this was a very helpful evaluation of a mandated intervention which had been in place for a little over a year. Feedback from the results would enable the service to ensure ongoing service improvement in this area.

This study was accepted as a service evaluation project and hence not requiring further ethical approval as stated in the NRES guidance document ‘Defining Research’ (National Research Ethics Service, 2009).

Provision of information and recruitment of service users was discussed and felt to be appropriate and in line with all service evaluation methods within the unit.

[redacted]

Chair of the Intervention Group

Trust Headquarters, Sterne 7, Sterne Road, Tatchbury Mount, Calmore, Southampton
SO40 2RZ

Appendix E : Participant Information Sheet

Study Title: ‘Shared Care Pathway’: the experience of a low secure service

Researcher: Caroline Clarke **Ethics number**: 6243

Please read this information carefully before deciding to take part in this research. If you are happy to participate you will be asked to sign a consent form.

What is the service evaluation about?

This project aims to gather service user perspectives on the implementation of the shared care pathway at [redacted] It is being completed as part of a joint venture between Southern Health Research and Development department and the University of Southampton, as part of my doctorate in clinical psychology thesis.

Why have I been chosen?

All residents at [redacted] are being contacted to see if they would be willing to share their views on the Shared Care Pathway.

What will happen to me if I take part?

Should you agree to take part, we will make an appointment to discuss how you have found the Shared Care Pathway, what your experience of this process has been like. The length of time will depend on how much you would like to share. The maximum expected time is likely to be 60-90 minutes.

Are there any benefits in my taking part?

It is hoped that your views will help improve the Shared Care Pathway at [redacted]. You will be paid £10 for your time.

Are there any risks involved?

There are no risks involved. Whether you take part or not will not affect your current, or future, treatment. Should you agree to take part, nothing you say will affect your treatment.

Will my participation be confidential?

All of the views provided by service users will be anonymised when typed up, your clinical team will not be told any of your specific opinions. A password protected computer will be used to store anonymised transcripts of all service users’ perspectives.

What happens if I change my mind?

You have the right to change your mind at any time. You may withdraw from this service evaluation at any time. Should you do so, any information collected will be destroyed. Your treatment will not be affected in any way.

What happens if something goes wrong?

In the unlikely case of concern or complaint, you are entitled to contact Dr Martina Prude, Head of Research Governance (02380 595058, mad4@soton.ac.uk) to discuss this.

Where can I get more information?

You may ask a member of your clinical team to contact myself or [redacted] in the psychology department.

Appendix F Consent form

CONSENT FORM (*Version 2*)

Study title: ‘Shared Care Pathway’: the experience of a low secure service

Researcher name: Caroline Clarke

Ethics reference: 6243

Please initial the box(es) if you agree with the statement(s):

I have read and understood the information sheet (September, 2013, Version 2). of participant information sheet) and have had the opportunity to ask questions about the study. ☐

I agree to take part in this research project and agree for my data to be used for the purpose of this study ☐

I understand my participation is voluntary and I may withdraw at any time without my legal rights being affected ☐

I am happy to be contacted regarding other unspecified research projects. I therefore consent to the University retaining my personal details on a database, kept separately from the research data detailed above. The ‘validity’ of my consent is conditional upon the University complying with the Data Protection Act and I ☐

Data Protection

I understand that information collected about me during my participation in this study will be stored on a password protected computer and that this information will only be used for the purpose of this study. All files containing any personal data will be made anonymous.

Name of participant (print name)……………………………………………………

Signature of participant……………………………………………………………..

Date………………………………………………………………………………

Appendix G : Semi-Structured Interview Schedule

‘My Shared Pathway’: the experience of a low secure service

1. Could you describe what My Shared Pathway means, in your own words?
2. Could you please tell me about your experience of My Shared Care Pathway?
3. In what way, if at all, has My Shared Pathway affected your care?
4. Can you describe what Recovery means to you?
5. Can you tell me how My Shared Care Pathway is related to your Recovery, if at all?
6. Can you tell me how My Shared pathway is related to your care here, if at all?
7. Can you tell me how My Shared pathway is related to your future care/placement, if at all?
8. We discussed this earlier, but I’d like you to tell me again what the shared pathway means to you, this can be different to what we discussed earlier.

Appendix H Independent auditors' (IA) comments and outcome

Original theme	IA 1 comments	IA 2 comments	Final theme
Leave the past behind you and don't look back	Clear	Clear	Leave the past behind you and don't look back
Moving on	Collapse into Leave the past behind you..	Overlaps with Leave the past behind you and don't look back	Collapsed into leave the past behind you and don't look back
Getting stuck	Clear	Clear	Getting stuck
Road map	Clear	Clear	Road map
The road is long	Clear	Clear	The road is long
Self-discovery	Clear	Clear	Self-discovery
Identity	Clear	Clear	Identity
Get it down in black and white	Clear	Clear	Get it down in black and white
Let down	Clear	Not happening?	Let down

We can be victims too	Clear	Clear	We can be victims too
Freedom	Clear	Clear	Freedom
Control/Power	Clear	Clear	Control/Power
Kept in the dark	Clear	Clear	Kept in the dark
Supportive/collaborative	Very similar to we can’t do this alone	Collapse into we can’t do this alone	Collapsed into ‘Support’
We can’t do this alone	Support	Working together/supportive	Support
Pathologising	Collapse into different perspectives	Clear	Collapsed into different perspectives theme
Different perspectives	Clear	Clear	Different perspectives

Appendix I Debrief sheet

UNIVERSITY OF
Southampton

Debrief Sheet

'My Shared Care Pathway': the experience of a low secure service

Thank you for providing your perspective on My Shared Care Pathway at [redacted] Service user perspectives are essential to service development and we hope that the views that we collect from will help improve the process for other service users.

Your views will be considered with those of other service users who have taken part, all of these will be considered together in an anonymous format, no one else will know what you have personally shared about My Shared Pathway. Common themes will be drawn out and presented to the staff and service users of [redacted]. They will also be used for my dissertation as part of my doctorate in clinical psychology. Unless you choose not to (you can do this through a member of your clinical team at any time), you will receive a thank you letter and a summary of themes once the analysis has been completed.

Whilst your clinical team is aware of your participation, they will not be informed of your individual views. Should you wish to withdraw from this study, you may do so at any point, either by contacting me through the psychology department, or through your clinical team. Your treatment will not be affected in any way. Should you wish to discuss this further, please ask a member of your clinical team to contact me.

Once again, I would like to take this opportunity to thank you for taking part, your views are very important to the service.

[redacted]

Trainee Clinical Psychologist

September, 2013 [Version 2]

Appendix J Thank you and feedback letter

My Shared Pathway': the experience of users of a low secure service

Dear Mr

I would like to once again thank you for sharing your experiences of 'My Shared Pathway' at [redacted]. Your views are very important and will hopefully help improve the process for other service users.

As previously discussed, I am writing to share the findings with you. Please find attached a summary. If you have any questions or would like to discuss these findings further, please ask a member of staff to contact [redacted] [redacted] in psychology and she will arrange an appointment for me to meet with you.

Once again, I would like to take this opportunity to thank you for taking part, your views are very important to the service.

[redacted],

Trainee Clinical Psychologist

My Shared Pathway: Summary of findings

Participants experienced My Shared Pathway as a lengthy and challenging journey. They found talking about past experiences difficult; but also useful in helping them progress on their recovery journey.

Being detained in hospital brought loss of power and freedom and left some participants feeling vulnerable.

Some participants felt let down that ‘My Shared Pathway’ was not being operated as they had expected and some felt that they had not experienced it at all.

Relationships with staff were described as very important. Supportive relationships helped increase self-esteem and hope for the future. Where staff perspectives differed from theirs, patients felt unheard.

My Shared Pathway helped patients feel that they had a voice, as their perspective was always on the agenda.

Participants described the workbooks as useful tools for documenting experiences that can be referred back to when they feel the need for a reminder about where they went wrong in the past. They were also described as helpful in providing evidence of their successes, as it meant they had these ‘down in black and white’.

Appendix K Extracts from reflexive journal

Initial reading

I find myself noticing comments that draw parallels between nursing staff and prison staff I have noticed that I have been expecting more of these than are being presented. Previous conversations with patients from when I worked at xxxx keep coming to mind, particularly how they referred to nurses as ‘screws’. This is making me realise the influence this has had on me and how I parallel these beliefs myself and expect nursing staff to be perceived in this way. I wonder if this was evident in interviews. Perhaps I appeared more sympathetic when people were talking about their experience of this, though this might suggest I would be more likely to see more evidence of this theme. I think people generally find me difficult to read; from what they’ve said, so I am hopeful that I haven’t influenced the interviews in this way.

Interview with Rupert

I noticed myself making the judgment that Rupert was displaying signs of psychopathy. I wonder if it made me feel like I had to be more ‘on my toes’, expecting him to be studying me carefully and making me anxious he would be judging me negatively with his grandiose traits. This may have made me less warm than in other interviews, which may have impacted upon Rupert feeling comfortable to make himself appear vulnerable and may be why he chose to speak about other patients difficulties, rather than his own.

Cross case analysis

I found myself paying more attention to one emergent theme of ‘staff training’. This was only discussed by two participants (which is below the threshold I have chosen for recurrent theme categorisation; e.g 3). I think this comes from the time I worked in a high secure hospital at the point that they were trying to introduce recovery principles. It made me think of how negatively this was received and the focus upon staff training to build on acceptance and engagement. Even though only two people spoke about this, and one was Philip, who overall had a different presentation than the others, I was still reluctant to give this up.

Independent audit

I've found myself feeling quite anxious as I wait to hear back from the independent auditors. After working on the analysis alone for so long, the thought of someone examining my work feels exposing. I think it has probably been helpful to hold this in mind during the analysis; always anticipating my process of being scrutinised will likely have kept my interpretations true to the data.

Write up

I find myself quite surprised by how positive the findings are being shaped up. I think it's my time at XXXX and how negatively patients spoke about staff there. I also find myself being drawn to the let-down theme. I remember when WRAPs were introduced as a CQUIN target and how it became like a tick box exercise that lacked all meaning. I feel sad that again something that could be really helpful has again become less meaningful because of the pressure to meet targets.

Choosing example quotes during write up

I have clearly favoured some voices over others in my decisions about whose quotes to include for which themes. I have felt guilty about some of the voices that have been neglected; such as John and Gavin who feel particularly absent in the examples. I do not want to leave anyone out, I feel a responsibility for everyone to be heard and wonder how they would feel if they knew about this bias in the selection. My feelings of guilt and responsibility sent me back to the quotes I selected as themes to try to build up their representation, but I do not feel that their quotes provide as rich a picture of the themes than the other participants do, particularly Bob and Philip. I have experienced a conflict between wanting to have everyone heard and wanting what people hear to be meaningful and remembered and I am not sure this would be so true with John and Gavin's responses. John presented with a flat affect and used technical language, whereas Gavin presented quite childlike and was not as descriptive in his responses. Their quotes do not convey the same pain as Philip's strong passionate words or Bob's powerful metaphorical language and I have worried that some of the meaning would be lost when they are just words on a page.

Rupert is very articulate and skilled at sharing his experiences. He speaks with a confidence and appears to provide constructive perspectives that are balanced between his positive and negative experiences of ‘My Shared Pathway’.

Philip has had an experience that is very different from the others, he has chosen to disengage from ‘My Shared Pathway’, and I am aware of how difficult it can be to access the experience/perspective of service-users who have disengaged and so I feel a particular motivation to include his quotes where relevant.

When choosing the quotes, I was surprised that I was not choosing as many of Richard’s. I think back to our interview and how impressed I was by the experiences that he shared. He was the last person I interviewed and he appeared very quiet and withdrawn when I met him on the ward, he had his face down and spoke very few words, at the time I worried that it would be difficult for him to take the lead in the interview, yet I was very surprised at the change in him during the interview, how he sat up and gave long spontaneous descriptions of his experiences. Whilst he has a lot of great quotes that provide evidence of the themes, I do not feel that the language is as rich as some of the others and choose those instead.

Overall, I have tried to guide my choice of quotes by Smith’s (2011) ‘We could be diving for pearls’ paper to look for the ‘gems’ that would bring the participants’ experiences to life, so that they are not just words on a page.

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