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Developing a CBT manual for adult inpatient secure services

by

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ABSTRACT

FACULTY OF MEDICINE

Cognitive Behaviour Therapy for Psychosis

Doctor of Philosophy

DEVELOPING A CBT MANUAL FOR ADULT INPATIENT SECURE SERVICES

By Gurmit Dhillon

Over half a century, there have been significant improvements in mental health outcomes particularly in individuals with psychosis. This is due to understanding and advances in psychological therapies e.g Cognitive Behaviour Therapy (CBT) and psychotropic medication.These studies have been based on outcomes that focus on symptoms and general functioning and the predominant nature of these studies has been quantitative. Patient movements have criticised these studies due to no effort being made to include their views. In order to get a better understanding of patients' experiences of CBT for psychosis (CBTp) in secure services, it is important to gather their views of 'supportive and non supportive work' including the views of the treating professionals. This will help to develop a qualitative foundation, rich of their experiences, which may help to form the base of a manual. This thesis is divided into three studies and used both qualitative and quantitative methods. The first study looks to explore the experiences and views of patients and professionals in secure settings. This study used sequential method of grounded theories e.g. thematic analysis, approach looking from a social constructivists view, to explore both patients' and professionals' views of what is supportive in CBTp in secure services. In total there were 33 professionals and 17 patients from two sites who were interviewed about their experiences in providing and receiving therapy. Professionals provided rich data on various aspects of therapy and patients narrated their experiences of therapy, medication and being held in secure services. Patients provided their views of what is supportive and non supportive in CBTp including other psychological therapies and factors which may effect their work with professionals.

Following the first study, the findings of the grounded theory led to the development of a model and themes that formed the basis of a CBTp manual in the second study. This intervention was based on the work on Kingdon & Turkington (2005) guidance, but adapted for delivery in a one to one work. This study adopted a pilot Randomised Controlled Trial (RCT) and eight patients received newly adapted CBT treatment and four patients were in control group who received Treatment As Usual (TAU). Patients who received the new CBT intervention achieved improvements in their psychotic, negative symptoms; social functioning, anger and insight. To further consolidate qualitative data from study one and two and gather patients' views of the new CBT intervention, study three was carried out. This study employed qualitative work and analysed patients views using thematic analysis. Patients provided their views of what works in CBTp and factors that are important to consider when working with patients in secure services, which allowed further adaptation to the new CBT guidance manual. The findings of all three studies are further discussed with the limitations and implications for clinical practice and research.

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Author's declaration

I, Gurmit Dhillon

declare that the thesis entitled

Developing a CBT manual for adult inpatient secure services: exploring patient and mental health practitioner views on CBT for psychosis in secure services

and the work presented in the thesis are both my own, and have been generated by me as the result of my own original research. I confirm that:

- this work was done wholly or mainly while in candidature for a research degree at this University;
- 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;
- where I have consulted the published work of others, this is always clearly attributed;
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- parts of this work have been presented for publication and conferences below:
    - **BABCP annual conference 2012**
    - **EABCT annual conference 2012**
    - **Exploring service users and mental health professionals' views on CBT for psychosis in adult inpatient secure services. The Journal of Forensic Psychiatry and Psychology. Submitted manuscript**

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List of definitions and abbreviations

ASPD – Antisocial Personality Disorder

ADHD – Attention Deficit Hyperactive Disorder

ACT – Assertive Community Treatment

AAM – Anger/Aggression Management

BIS – Birchwood Insight Scale

BPD – Borderline Personality Disorder

CD – Conduct Disorder

CBTp – Cognitive Behaviour Therapy for Psychosis

CBTpd – Cognitive Behaviour Therapy for Personality Disorder

CBTp- ss – Cogntive Behaviour Therapy for Psychosis in Secure Services

CNWL – Central and Northwest London Trust

CPRS – Comprehensive Psychopathological Rating Scale

CRB – Criminal Record Bureau

CBGT – Cognitive Behaviour Group Therapy

DBT- Dialectic Behaviour Therapy

CJS – Criminal Justice System

DOH – Department of Health

HCR-20 – History Clinical and Risk Management

ITT – Intention to Treat

IPA- Interpretive Phenomenological Analysis

ICP- Individualised Care Plan

IAPT- Improving Access to Psychological Therapy

MDT- Multi Disciplinary Team

MDO- Mentally Disordered Offender

MHA- Mental Health Act

MHSA – Mental Health Scotland Act

SS- Secure Services

NICE – National Institute of Clinical Excellence

NIMHE- National Institute of Mental Health in England

MoJ – Ministry of Justice

MI – Motivation Interviewing

PANNS – Positive and Negative Syndrome Scale

PBR- Payment by Results

PICASSO - Psychological Interventions for Coping with Anger and Schizophrenia

PS – Problem Solving

PSP – Personal and Social Performance

PCL-R – Psychopathy Checklist Revised

RCT – Randomised Controlled Trial

ROC – Receiver Operating Characteristics

RC – Responsible Clinician

RNR – Risk Need Responsivity

SLaM – South London and Maudsley

SANS – Scale for the Assessment of Negative Symptoms

TAU – Treatment as Usual

VRAG – Violence Risk Appraisal Guide

WAR – Ward Anger Rating Scale

Chapter One: Literature Review

1.1 Introduction

This chapter will present the background to this study by looking at historical aspects of secure services in the UK and analysing empirical studies on the efficacy of CBTp. It will discuss the prevalence of severe mental illness in the MHSS population and the risk of psychosis. Consequently it will discuss patients' and professionals' experiences in MHSS settings.

1.2 Setting the Scene: historical perspective of the mental health system in the UK

Mental health institutions in the UK have been established for generations. In Europe during the mediaeval era, a variety of settings were employed to house the small subsection of the population classed as 'mad', who were housed in institutional settings. Bethlem has been a part of London since 1247, originally as a priory for the sisters and members of the Order of the Star of Bethlehem, from which the building took its name. In 1337 it became a hospital, and it admitted mentally ill patients from 1357, but it did not become a dedicated psychiatric hospital until later. Early sixteenth century maps show Bethlem, next to Bishopsgate, as a courtyard with a few stone buildings, a church and a garden. Conditions were consistently dreadful, and the care amounted to little more than restraint. Since its inception, Bethlem has seen a wide range of changes in its name, structure and even location. In 1999, Bethlem Royal Hospital became part of South London and Maudsley NHS Foundation Trust (SLaM) (David, 1996).

1.3 Modern Mental Health Secure Services

Forensic mental health services are provided in secure and community NHS settings. Brunt and Rask (2005) described the roles of a forensic mental health service as being the facilitation of a therapeutic environment, the protection of society and the maintenance of security. A patient's level of risk determines which level of security they enter (Kennedy, 2002). The client group currently consists of people who are sectioned under the Mental Health Act (MHA) 1983, as amended in 2007, who have mental illnesses and who are deemed to be a risk to themselves or others or have offended. McCann (1999) described

people in forensic care as being a diverse group with a range of diagnoses, mental health problems and offences. Secure services operate on three levels of security – high, medium and low – and some secure care services also have specialist community teams, providing community-based care for former secure care patients or liaison for mainstream community mental health teams working with them.

1.3.1 High Secure Services

High secure services in the UK evolved from the lunatic asylum system and the first institute was named the Broadmoor Criminal Lunatic Asylum in 1863. This name was later changed to Broadmoor Psychiatric Hospital due to the government's change of attitude towards mental illness.

Currently, the NHS provides all high secure beds in England. There are three NHS high secure hospitals in England, Ashworth, Broadmoor and Rampton hospitals, and one in Scotland, called Carstairs (DOH, 2011). The admission criteria for high secure hospital are that patients must be remanded under the MHA 1983 and pose 'serious and immediate harm to the public'. The precise criteria focus on three major issues: (a) the presence or absence of recognizable mental disorder; (b) liability of detention and (c) the level of danger – patients must present a grave danger to the public that could not be managed in a less secure environment such as medium secure unit (Nottinghamshire NHS Trust, 2007).

1.3.2 Medium Secure Services

The concept of medium secure services originated in the 1960s, with passive operation until the 1970s when places in special hospitals and prisons became overcrowded with mentally ill patients, leading to the commissioning of regional secure units (Butler Committee, 1975). Medium secure beds are provided by both the NHS and the independent sector, with the latter providing around 35% of medium secure capacity (Centre for Mental Health, 2011). They are designed for patients detained under the Mental Health Act 1983 who 'pose a serious danger to the public'. Patients' average stay in medium secure units ranges from two to five years (DOH, 2007). Guidelines for admission to medium secure services are centred on age, evidence of mental illness and co-morbid problems, including personality disorder or mental impairment. Recently the DOH (2000a) proposed a specialized long-term medium secure unit

for patients with complex issues surrounding previous inappropriate detention within high secure units owing to lack of suitable placement. The admission criteria build upon the above guidelines, including previous admission to a high secure unit for at least three years, the need for further care in a lower security service and further benefit from treatment (Power et al., 2006).

1.3.3 Low secure services

The definition of low secure services in terms of treatment is ambiguous and the Department of Health (DOH) has recently issued a consultative document looking at various aspects, one of which examines the position of the low secure services in the mental health system (DOH, 2012). The DOH (2002) defines a low secure unit as one that delivers:

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

The criteria for admission to a low secure service focus on behavioural problems that cannot be managed in an open acute inpatient unit and patients who display a significant risk of aggression or absconding or are vulnerable to suicidal risk, including sexual disinhibition in the context of serious mental illness (DOH, 2002).

MHSS in the UK houses more seven thousand patients at a time and most of these patients are in medium and low secure facilities (Centre for Mental Health, 2011). Because data collection in this area is not standardised across the regions, and because the term 'low secure' in particular is poorly defined, it is hard to achieve a firm patient figure for all secure services. Secure care services cost the NHS a total of £1.2 billion in England in 2009/10 (Centre for Mental Health, 2011).

The Department of Health is currently developing guidelines on both low secure services and psychiatric intensive care and how the latter might be deployed at any tier of security.

1.3.4 Prison services

Individuals who have mental health problems make up an extremely high proportion of the prison population (Rutherford & Duggan, 2007; Green, 2010). It is assumed that at least seventy per cent of the prison population has some sort of mental illness (Singleton et al., 1998) and the numbers are growing (Rutherford & Duggan, 2007). Inmates who are sentenced to prison can develop mental illness whilst in incarceration (Offender Health Research Network, 2010) due to overcrowding, victimisation (e.g. bullying), and environment effects (Green, 2010), which also increase the risk of suicide (Offender Health Research Network, 2010).

Currently, treatment for inmates is provided by an In–Reach Mental Health Team, which offers limited services in the assessment and treatment of severe mental illness (Green, 2010). This can be limited by the contrast between the prison service's philosophy of punishment/control and the care provided by the In-Reach team, and at a wider level, by conflict between the DOH and Prison Services (Green, 2010). This distinction creates further problems for inmates who are suffering from mental health problems, who hence receive minimal care.

1.4 The 'Systems' and the patient's journey

Patients admitted in these settings generally have committed criminal offences and have serious mental illnesses. They are deemed dangerous to themselves and to the public. Generally patients admitted to secure services go though three tiers of security – high, medium and low – and the direction of progress is normally a step-down approach from high to low security. In some instances, patients are referred back to high security if they pose significant risk of aggression and absconsion. This process is determined by the severity and intensity of the risk posed to staff and the motivation to repeat absconsion, including the risk of suicide and self-harm.

Patients' journey in the forensic system involves the Criminal Justice System (CJS), the Mental Health Act, 2007 (DOH, 1983) and the Ministry of Justice (MoJ). This journey is further complicated by assessments from various parties, such as the police.

1.4.1 The role of the CJS

Once an individual commits a crime, they are detained into police custody and an initial risk assessment is completed. The risk assessment consists of two parts: a self-assessment and a custody officer assessment - a comprehensive assessment. If the latter assessment reveals current problems relating to previous substance misuse and psychiatric history, the information is passed on to the police liaison nurse, who will validate it and if appropriate will refer to the court and further to the court diversion team specialising in mental health issues (Adatia, 2010).

During the prosecution process, the Judge will decide the individual's outcome: remand to bail, hospital or custody. If a hospital order is required, an appropriate section will be sanctioned under Section 35 or 36 of the MHA 2007 (Hospital order for assessment and treatment).

The role of court diversion

The court diversion scheme originated from the Reed report, which highlighted the importance of diverting offenders with mental health problems in the right direction: for example, into hospitals (DOH, 1992). This scheme concentrates on providing appropriate services to offenders with mental health problems in the early stage of the offender pathway to ensure that the right decision is made about their treatment, taking into consideration the risk to self and public.

1.4.2 Admission following court disposal and the MHA 2007

Once the offender is assessed and deemed to have serious mental health problems, the term 'offender' changes to 'Mentally Disordered Offender' (MDO). The MHA 2007 plays an important role in the life of MDOs in that it affects their detention and its duration. To understand various Sections within the MHA 2007, one should pay attention to the third part of the Act, which is summarised below:

- Section 35: accused offender remanded to hospital for assessment of mental condition.
- Section 36: accused offender remanded to hospital for treatment.
- Section 37: convicted offender sent to hospital for treatment (called a hospital order).
- Section 38: convicted offender sent to hospital for assessment prior to sentencing (an interim hospital order).
- Section 47: offender serving a sentence transferred from prison to hospital.
- Section 48: offender not sentenced – transferred from prison (or other form of detention) to hospital.
- Section 41 and 49: Restriction orders normally applied in addition to some of the above Sections due to the risk that the offender or MDO poses to others, e.g. sexual violence.

1.4.3 MoJ

The MoJ is one of the largest government organisations and looks after criminal, civil, family justice and human rights issues. The main aim of the MoJ is to protect the public and reduce reoffending behaviours. In relation to MDOs, the MoJ is the overarching body that provides guidance to the courts working with MDOs, which includes the CJS and the MHA, 2007. Patients' leave and mental health tribunal supervision in the community are included in the guidance.

An individual's journey to secure services is complicated and often proceeds via different routes. These routes vary depending on the mental health sections, recall from the community if the patient is not adhering to the discharge conditions and the process involving the CJS.

The journey is full of challenges - from being arrested to becoming an offender and, if there is evidence of serious mental illness, labelled as an MDO. The terminology used, from being labelled an offender to becoming a mentally disordered offender, is in itself powerful enough to create significant level of stress and feeling of stigma. The latter may be more damaging to the individual's already deteriorating mental health and at times offenders may be criminalised by the police rather than directed to the 'care' pathway (Teplin, 1984).
The process of going through the CJS can be exhausting on top of facing a situation that includes loss of freedom, family and social life. Patients' journey in the 'system' may cause more damage to their mental health and needs more attention. A brief illustration of the 'system' is presented below.

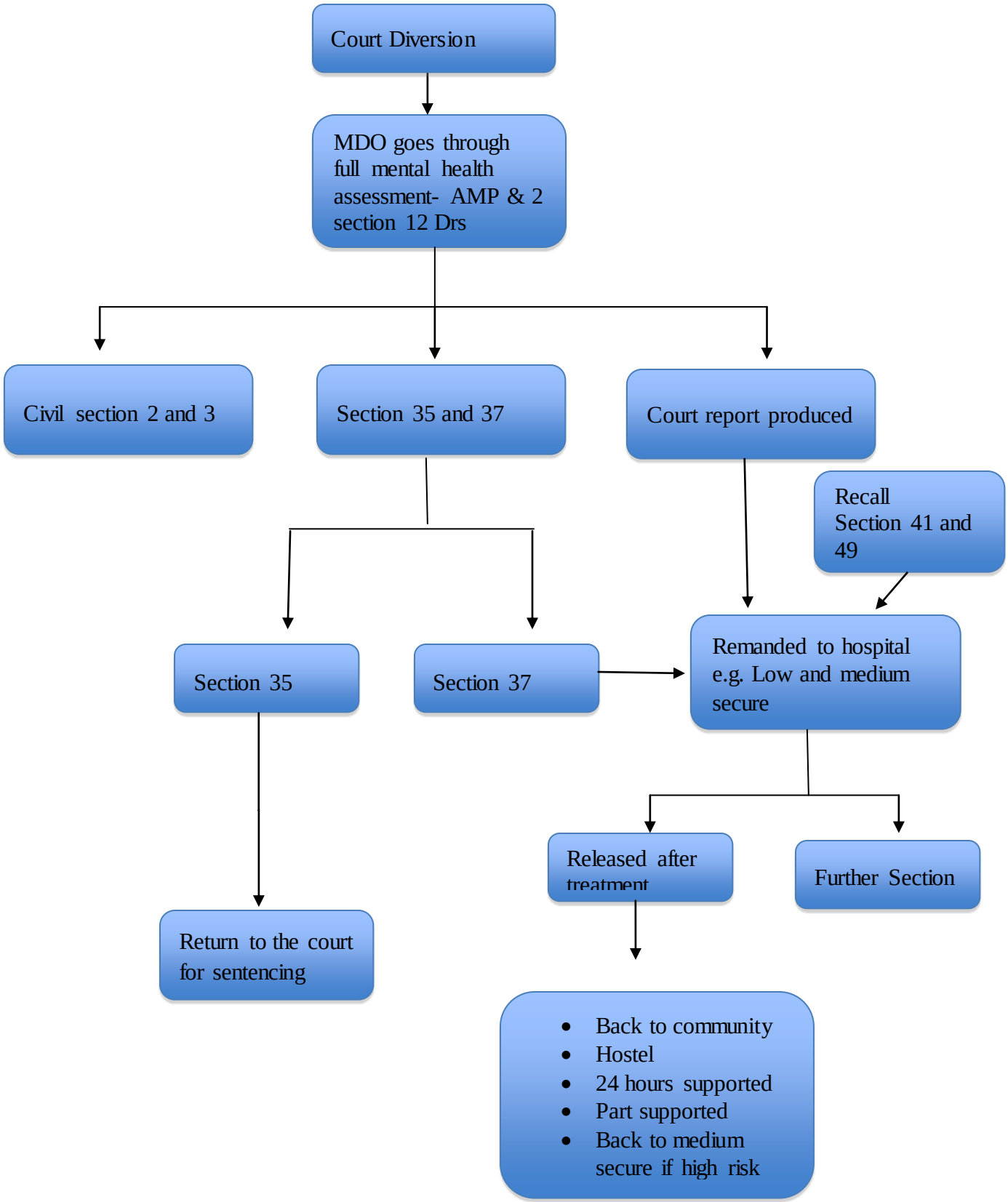

Figure 1: MDOs' pathway involving CJS

1.5 Risk Assessment: Recidivism, Reoffending and Risk Predictors

Most of the academic work on 'dangerousness' is an extrapolation from work on recidivism. Recidivism is the re-occurrence of some type of criminal behaviour, whether that behaviour has been detected by law enforcement agencies or not. Recidivism can include theft, drug possession or technical parole violations and is thus a wider concept than reoffending, which requires apprehension by law enforcement agencies, whereas recidivism in general may not. The academic literature on risk of recidivism is diverse. The problem with this taxonomic variation is that research on dangerousness or violent recidivism involves a mixture of research methodologies, research targets and a melange of crimes from sexual murder to armed robbery (Quinsey et al., 2006, p. 33).

Mental health professionals use various methods to come to decisions upon which they may advise a court or tribunal. The methods were historically divided into: (i) Clinical or professional decision-making and (ii) actuarial or statistical approaches. The merits of each are the subject of much academic debate (Hart et al., 2003; Dolan & Doyle, 2000). Clinical or professional decision-making is characterized by an idiosyncratic individual case-by-case approach to risk assessment. It has been criticized on a number of grounds, for example low inter-rater reliability, general low validity and failure to specify the decision-making process (Dolan & Doyle, 2000).

The Baxtrom studies represent a low point for the above approach. The case of Baxstrom v Herald (1966) involved the release into the community or to conditions of low security of 966 patients who were detained in hospital on the basis of dangerousness as a result of mental illness. In a four-year outcome study on these patients, Steadman and Cocoza (1974) found that 20% had been reconvicted, the majority for minor non-violent offences. This was an appreciably low reoffending rate given that they had been detained because of dangerousness and high risk of re-offending. Recent meta-analytic studies by clinicians (Mossman, 1994) of predictions of recidivism, including violent recidivism, showed an overall Receiver Operating Characteristics (ROC) curve analysis of 0.73. The ROC is a metric that was first used in the military field in the analysis of radio frequency and images in the Second World War (Westin, 2001). Generally a ROC curve informs properties of various tests by looking at a cut-off point that can determine the category of an individual with a certain score and where

this score belongs in the whole group. For example, one way of using this method is to predict violence more accurately than chance.

The Actuarial approach is underpinned by statistical statements about the co-occurrence of events, with the relationship expressed as a frequency or probability (Eldergill, 1998). The contributory events are usually static and historical (e.g. previous violence) and the outcome event is either physical or sexual violence. Actuarial risk assessment tools have been used for some time in the US and Canadian penal setting. Proponents claim that the actuarial approach adds consistency and objectivity and can direct attention to key areas (Hanson, 2004). Critics contend that the approach fails to prioritise clinically relevant variables and individual variations (Hart et al., 2003, p. 6). Other limitations include the fact that actuarial approaches tell us only what is characteristic of a group of people and not an individual in the group. Moreover, human behaviour is difficult to predict using mathematical theorems because the list of possible contributory factors is impossibly wide and many factors vary infrequently or with unquantifiable weight.

The clinical vs. actuarial debate has led to the development of risk instruments which blend both approaches. This has been termed Structured Clinical Judgment, an approach which represents the combination of empirical knowledge and clinical expertise.

Two widely used risk prediction instruments will be briefly surveyed: the Psychopathy Checklist-Revised (PCL-R) and the Violence Risk Appraisal Guide (VRAG) (Quinsey et al., 2006). The PCL-R is the most widely used instrument of prediction of reoffending in general and violent offending, and research that has looked at the accuracy of risk predictions using this instrument has given effect sizes ranging from 0.42 to 1.92 (Bodholdt et al., 2000). Other meta-analyses of published and unpublished outcome studies of the PCL-R have provided effect sizes of between 0.55 for general criminality and 0.79 for violent recidivism and overall these are characterised as being 'moderate to strong' (Dolan & Doyle, 2000, p. 308). The VRAG is an actuarial instrument and was developed on a calibration sample of 681 males charged with severe violent crimes. Use of this instrument on several populations of offenders has yielded ROC curve measures of .75, .74 and .74 for violent reoffending for 3 ½, 6 and 10 years respectively (Dolan & Doyle, 2000 p. 305).

1.5.1 Dynamic Predictors

Dynamic predictors of violent recidivism are those variables that either change with time or can be made to change with time by rehabilitative efforts. These fall into three categories: (i) Those that vary continuously in real time (e.g. intoxication); (ii) those that vary within a longer time period (e.g. the death of a parent or intimate partner or provision of therapy or a rehabilitation programme); and (iii) those that vary predictably (e.g. age). Quinsey et al. (2006) delineated various problems with the use of these variables in risk prediction strategies. These include the unpredictable variation in the presence, configuration and impact of these variables in the research time period. Another difficulty is the lack of agreement amongst researchers as to what constitutes a dynamic variable. Some, for example, put personality characteristics in the dynamic category, whilst others put them in the static category by virtue of the fact that by definition, personality should be a constant.

The History, Clinical and Risk Management–20 scale (HCR-20) is now the most widely used instrument of structured clinical judgement in use for the prediction of violence in clinical populations (Gray et al., 2007). This assessment is intended for use as a prediction tool for future violence and has been tested in forensic, correctional and civil inpatient psychiatric settings (Webster et al., 1997b). Although initially designed as an aid to be used with other risk assessments, the HCR–20 is different from other instruments in its ability to formulate risk assessment and management that is unique to the individual.

Finally, risk assessment needs to be put into context. It is not the most important component of care, although it is an essential part of it. If our focus is exclusively or unduly concentrated upon risk, engagement with the person concerned can fail to develop or be damaged, they can feel stigmatised and developing a trusting confiding relationship can be very difficult. Even where risk seems to be the presenting problem, gaining an understanding of the breadth of the person's experiences and circumstances is the most appropriate way not only to work with the person but also to assess and manage any risk issues (Kingdon & Finn, 2004).

1.6 Major mental disorders and violent/offending behaviour

The relationship between mental disorders and violent and criminal behaviour remains controversial (Lombroso, 1911; Monahan, 1981; Pilgrim, 2010). Mental disorder may be common but can be debilitating and can lead to a variety of negative consequences for individuals, their families, and society. Studies so far have observed modest associations between major mental disorders and violent crimes (Kooyman et al 2007); however, such correlations are the results of several confounding factors (Monahan & Steadman, 1983; Mullen, 1984). In recent years, considerable effort and progress have been made in understanding various distal and proximal risk factors in mental disorders involved in offending behaviour and the underlying psychological processes. Studies have been criticised for focusing on the relationship between major mental disorders and crime instead of channelling their attention into designing effective treatments (Hodgins, 2001).

In order to design effective treatment, practitioners need systematic assessments encompassing actuarial and empirically grounded risk dynamic factors, which will inform the development of a new and sophisticated case formulation. Subsequently, an evidence-based case formulation will inform effective management of the individual, hence reducing violent and offending behaviour. Current treatment strategies for mental health offenders predominantly use the CBT model to treat offence-related problems and mental health is an area that receives less attention (Moran & Hodgins, 2004).

1.6.1 Prevalence of mental illness

It is estimated that one in four adults experiences at least one mental health problem in their lifetime (Singleton et al., 2003); however, this result conflicts with other findings which suggest that 1200 in every 10,000 individuals in England will have a mental health problem (Sainsbury Centre for Mental Health, 2007).

Schizophrenia affects approximately one percent of the population in their lifetime throughout the world (Pinals & Brier, 1997). The onset of symptoms typically occurs in young adulthood (Castle et al., 1991), with approximately 0.4 to 0.6 percent of the population affected in the UK (Bhugra, 2005). Individuals with schizophrenia tend to experience a

variety of symptoms, which include certain types of hallucinations (auditory, visual, somatic and physical), delusions and thought disorder (Kingdon & Turkington, 2005).

Bipolar Disorder has a similar pattern, affecting approximately one percent of the population (Weissman et al., 1988), and it can cause major disabilities (Mitchell et al., 2004). Individuals with bipolar disorder are characterised by mood swings that can range from elation (mania) to extreme sadness (depression).

The prevalence of Major Depression has not been researched extensively. One estimation is that it affects 17 per 1,000 males and 25 per 1,000 females in the UK (NICE, 2004); however, in North America the prevalence of having a major depressive episode within a year-long period is 3–5 percent for males and 8–10 percent for females (Kessler et al., 2005; Murphy et al., 2000). Population studies have consistently shown major depression to be about twice as common in women as in men (Kuehner, 2003). The risk of major depression is increased with neurological conditions such as stroke, Parkinson's disease or multiple sclerosis and during the first year after childbirth (Rickards, 2005).

Findings on the prevalence of Personality Disorder are limited and confused by the current classification systems. The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, 2000) currently suggests a range of options, including using personality factors and dispensing with the current multi-axial system. Proposals are now being made to link conduct disorder in children with antisocial personality disorder in adults and simply use the term ‘conduct disorder’ for that continuum (Royal College of Psychiatrists, 2010). Similarly, Borderline Personality Disorder, another inherently confusing and stigmatising term, might be better placed amongst the emotional disorders alongside post-traumatic stress disorder (PTSD) and bipolar disorder rather in the separate PD category and described as ‘rapid cycling’ or ‘complex’ PTSD (Kingdon et al., 2010).

Interest in Conduct and Related Disorders has emerged recently and is receiving substantial attention among both clinical and non-clinical practitioners. Coid et al. (2006) reported that the weighted prevalence of Personality Disorder was 4.4% in the UK and was highest among unemployed and separated men. Singleton et al. (1998) conducted a survey among prisoners in England and Wales and found high prevalence of Personality Disorder specifically in the antisocial category.

1.6.2 Schizophrenia

Several prospective and retrospective studies in clinical populations, birth cohorts and community-based epidemiological studies from various regions (Brennan et al., 2000; Fazel & Grann, 2006; Link et al., 1992; Link & Stueve, 1994; Stueve & Link, 1997; Swanson et al., 1990; Wallace, 1998) have reported that the risk of committing violent offences is greater in individuals with schizophrenia compared to the general population. Other studies have also demonstrated evidence for an association between schizophrenia and non-violent offending (OR 1.2, 95% CI, .7-2.1, Lindqvist & Allebeck, 1990; OR 2.49, 95% CI, 1.49-4.16, Modestin & Ammam, 1996; OR 3.0, 95% CI, 1.4-6.3, Tiihonen et al., 1997). In a recent study, Swanson et al. (2006) reported that the six-month prevalence of any violence (minor and major) among individuals with schizophrenia was 19.1%, with 3.6% of participants reporting serious violent behaviour.

Substance abuse may act as a mediator between major mental disorder and violence. Numerous separate analyses have been conducted among individuals with schizophrenia and substance abuse. These studies demonstrated the impact of substance abuse in schizophrenia and violent offending (OR 25.2, 95% CI, 6.1-97.5, Räsänen et al., 1998; OR 18.8, 95% CI, 13.4-26.5, Wallace et al., 1998). In another study, Elbogen and Johnson (2009) looked at a data set representative of the US population to examine whether schizophrenia leads to violent behaviour. They concluded that severe mental illness in itself did not predict future violent behaviour unless accompanied by other variables such as substance misuse. Fazel et al. (2009), in their meta-analysis review, highlighted the high risk of violence in individuals with psychosis (with or without co-morbid substance misuse). They concluded that the risk of homicide is elevated in individuals with psychosis compared to the general population.

Interestingly, Swanson et al. (2006) found that the effect of substance abuse on serious violence was non-significant when controlling for age, positive symptoms and childhood conduct problems. They claimed that it may be these covariates which have played a role in mediating the effect of substance misuse.

Little research has been done on the association between negative symptoms and violent behaviour. Krakowski et al. (1999) observed that persistently violent patients in a hospital ward had significantly more negative symptoms as compared to non-violent patients and

patients with decreasing violence. On the other hand, Swanson et al. (2006) found that higher scores on five out of seven negative subscales were associated with significantly decreased risk of serious violence. Negative symptoms may be serving as a protective factor, possibly through the social avoidance that is inherent in them.

In addition, individuals with schizophrenia are often labelled or stigmatised as dangerous and unpredictable, which may have some self-perpetuating tendency, although they are more likely to be the victims than the perpetrators of crime (Wehring & Carpenter, 2011). The belief that individuals with mental illness are dangerous is a significant factor in the development of stigma and discrimination (Corrigan et al., 2002).

1.6.3 Bipolar Disorder

Although many studies have been conducted in the area of schizophrenia and violence, there are just a handful of studies showing the association between bipolar disorder and violence (Brennan et al., 2000; Modestin et al., 1997; Tiihonen et al., 1997). For example, one study indicated a higher rate of criminal behaviour in bipolar and manic patients (Modestin et al., 1997).

The association between Bipolar Disorder and violence appears to peak during manic episodes and may well relate to other contributing factors such as substance misuse and environment. Craz et al. (2009) conducted a retrospective study on the national crime register in former inpatients. This study included 1561 patients with Bipolar Disorder, Manic Disorder, and Major Depressive Episodes and Affective Disorder. The data revealed a moderate association between Affective Disorder and criminality. Criminal behaviour and violent crimes were higher in the manic group. Similarly, Dean et al. (2007) also found a higher rate of aggressive behaviour in patients with manic disorder. Thus, we can conclude that individuals with bipolar disorder commit violent behaviour during manic phase and in most cases this violence is spontaneous and not planned.

1.6.4 Personality Disorder

There is a conventional view that personality is associated with violent behaviour, either directly or indirectly (Barlett & Anderson, 2012). This issue has been discussed implicitly and is now emerging from various sources. Research so far has identified two important types of disorder – Antisocial and Borderline Personality Disorder – that have strong relationships with violence (Fountoulakis et al., 2008).

Coid et al. (2002) proposed a cognitive model explaining the functional association between Personality Disorders and antisocial behaviour. They concluded personality disorders act as predisposing factors influencing the development of motivations which subsequently facilitate the disruptive behaviour. Another study (Craig et al., 2006) examined differences in personality characteristics between violent, sex and general offenders. Violent offenders had significantly more chaotic lifestyles, displayed greater psychopathology than sex or general offenders and were most likely to reoffend, with over a quarter committing further violent offences.

Studies are emerging in recognizing that personality disorder is a common contributor to violent behaviour in patients with psychosis (Moran et al., 2003; Fazel et al., 2009). However, it is essential to acknowledge that there is an absence of a causal link and further research is needed, as this knowledge will contribute to risk management and appropriate psychological treatment, such as CBT.

Antisocial Personality Disorder (ASPD) is recognized as one of the most difficult conditions within the personality disorder spectrum that may cause individuals to engage in violent behaviour and involvement in CJS (Mueser et al., 2006; Moran et al., 2003).

Another essential area that can shed light on understanding personality and difficult behaviour is Conduct Disorder (CD). CD is an extreme form of severe disruptive behaviour that can interfere with a child's development and learning abilities (Joughin, 2006). CD may co-exist with other difficult behaviours, such as Attention Deficit Hyperactive Disorder (ADHD). Current prevalence rates are 6.9 % in boys and 2.8% in girls aged between five and ten years (Green et al., 2004). The prevalence of CD is higher in the forensic patient population than in general population (Hodgins et al., 1998).

Research is now emerging that examines the relationship between CD and ASPD (Myers et al., 1998), as understanding this relationship can provide theoretical openings into the interaction and prevalence of violence and engaging in substance misuse within individuals with schizophrenia (Mueser et al., 2006). Other studies have shown that CD is a precursor to schizophrenia (Kim-Cohen et al., 2003; Hodgins et al., 1998).

1.6.5 Psychopathy

Psychopathy shares the same concept as ASPD in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV –TR, 2000) and dissocial personality disorder in the International Classification of Disease (ICD- 10; World Health Organisation, 1992). There are overlaps in some of the items (Wallinius et al., 2012) and some researchers argue that ASPD is a consequence of psychopathy (Cooke et al., 2004), while others maintain that antisocial behaviour and personality traits are part of the formulation of psychopathy (Neuman & Hare, 2008)

Psychopathy is recognized as a major problem in that it is associated with mental disorders such as ASPD (Blackburn & Coid, 1998), substance use disorders (Tengstrom et al., 2000) and CD with childhood onset (Soderstrom et al., 2005). Studies have shown a relationship between psychopathy and violent crimes (Hare et al., 2000; Tengstrom et al., 2000), and this suggests that psychopathy may be a robust predictor of recidivism in patients with schizophrenia (Nolan et al., 1999). Interestingly, Gray et al. (2007), in their study of predicting violence and self-harm in MDOs, found the PCL-R to predict violence moderately in all forms of aggression. Similarly, Neuman & Hare (2008) continue to argue that psychopathy as measured on the PCL-R is a good predictor of violence in prison, MDOs and civil psychiatric populations.

It is of great importance to acknowledge the role of personality in violent and even criminal behaviour. This may provide professionals with answers that will enable them to understand the implications for risk assessments, management and most importantly treatment, such as medication and CBT.

Studies so far in the area of mental disorders and crime have not reached a definitive conclusion as to the relationship between offence and mental disorder. Most studies have demonstrated that the presence of schizophrenia enhances the likelihood that an individual will commit a violent offence such as homicide (Fazel et al., 2009). These generalisations are made on the basis that the presence of a mental disorder increases the risk of violence, with no account explaining what types of crime are associated with what category of mental disorders (Vinkers et al., 2011). This information is essential, as it can also provide professionals with tools to work with, assessments, formulations and goals for treatment in offence and mental illness work using CBT. Knabb et al. (2011) highlighted that CBT work with MDOs needs to address specific types of offence and related disorders, and currently there is no established research and treatment of this kind.

1.7 Co-morbidity and treatment

Co-morbidity refers to the presence of more than one diagnosis occurring at the same time. In psychiatry, this terminology is confusing, as it is unclear whether the co-morbid problems actually refer to the presence of various clinical constructs or to several indications of a single unit (Maj, 2005).

It is not uncommon for MDOs to have co-morbid problems (Blackburn et al., 2003) and generally *personality disorders, substance misuse, depression, anxiety and cognitive deficits* (Blackburn et al., 2003) can coexist. The prevalence of co-morbid psychiatric and somatic problems is receiving increasing interest, although there is a dearth of research in this area and further exploration is needed (Oreski et al., 2012). These co-morbidities can contribute to the worsening of patients' physical health, more severe psychosis, depression and lack of engagement with professionals.

There is high co-occurrence of personality disorders with other Axis I mental disorders in forensic mental health settings and there is an absence of clear guidelines for treatment (Howard & Duggan, 2010).

Comorbidity *of Personality disorders* with schizophrenia and substance misuse cause greater psychiatric impairment and hence difficulty in treatment. Esbec & Echeburua (2010) identified several factors that predict violence in patients with mental health problems. These

are previous background of aggression, substance misuse with personality disorders, psychopathic traits and environmental stressors. The presence of ASPD in incarcerated offenders, both male and female, is associated with high suicide rates and impaired quality of life (Black, 2010).

The treatment of personality disorder as a co-morbid diagnosis is difficult, as it is often masked by the symptoms of acute mental health problems and until these symptoms are addressed, opportunities to work with difficult personality traits are limited (Moran & Hodgins, 2004). It is essential that co-morbid problems are accurately identified and discussed so that effective treatment can be delivered.

Gibbon et al. (2010), in their review of 471 participants with ASPD, looked at eleven different psychological interventions. The concluded that three interventions – contingency management with standard maintenance, CBT with standard maintenance and a 'driving whilst intoxicated program' with incarceration – were effective compared to the control condition in at least one outcome. This study did not report any change in antisocial behaviour.

In contrast to the above, Davidson et al. (2010), in their exploratory RCT of CBT for personality disorder (CBTpd), found positive results in reducing antisocial behaviour and changing thinking. They concluded that CBTpd is helpful, acceptable and warrants a full RCT.

Another modality that is used with personality disorder is Dialectic Behaviour Therapy (DBT). This modality originated from Linehan (1993) in her work with patients with Borderline Personality Disorder (BPD). DBT is based on the bio-social theory of the aetiology of the affect regulation system with strategies adopted from CBT and some aspects of Zen practice (Swales & Heard, 2009). A controlled trial of the effectiveness of DBT for BPD in an inpatient setting showed significant improvement in the treatment group in both the psychopathology variables and reduction in self-injurious behaviour, with no improvement in the waiting list group (Bohus et al., 2004). Reflecting on the complexity and heterogeneous nature of MDOs, CBT in combination with principles from DBT may be effective in treating some of the constructs within ASPD, such as impulsivity and anger.

Substance misuse is not just common but causes significant problems as a co-occurring co-morbidity in patients with schizophrenia and other psychoses (Fazel et al., 2009). It is estimated that half of all patients suffering with schizophrenia also present a lifetime history of co-morbid substance misuse disorders (Volkow, 2009) and this worsens the treatment of schizophrenia by further destabilising the illness, creating problems with treatment adherence, family and social instability, getting into trouble with the law and most significantly the management of psychotic symptoms (Green et al., 2007).

Treatment of co-morbid substance misuse with schizophrenia is a major challenge for professionals working in secure services and other mental health settings. Motivation and readiness for change is complex and can often demotivate patients and professionals alike. Generally, treatment for substance misuse as an independent or co-morbid problem is underpinned by principles from Motivational Interviewing (MI) techniques and CBT. MI is primarily a counselling style that looks at the stages of change and resolves ambivalence about change.

A recent systematic review identified 19 studies of MI with offenders. The author concluded that MI could lead to improved retention, enhance motivation and reduce offending. However, due to variation among the studies in factors such as treatment populations and targets, a meta-analysis of the effects was not warranted and an overall conclusion about the effectiveness of MI could not be reached (McMurran, 2009).

In a recent study, Kelly et al. (2012) reviewed the treatment of patients with substance misuse and co-morbid psychiatric disorders. The authors reviewed 24 research reviews and 43 research trials and concluded that the most effective treatment of co-morbidity is the use of multifaceted treatments, e.g. pharmacotherapy, psychotherapy and CBT. A combination of treatments may target different components of the disorder depending on their severity.

Studies looking at the efficacy of psychosocial treatment of substance misuse with schizophrenia and other psychoses are still lacking and further research is needed to address this major problem (Kelly et al., 2012).

Depressive symptoms commonly present with schizophrenia and are associated with poorer quality of life, lower medication adherence, higher use of mental health systems and the need for specialized treatments (Buckley et al., 2009; Conley et al., 2007).

Patients in mental health systems, including prison, have higher level of depression and anxiety (Singleton, 1998). Patients' psychological appraisal of depression in schizophrenia is an important area and is often surrounded by issues, including lack of controllability of their illness, greater loss, humiliation, shame, self-blame and entrapment arising from their psychosis (Birchwood et al., 2005).

Similarly, anxiety disorders coexist with schizophrenia and require management (Kingdon & Turkington, 2005). The most common anxiety disorders studied are PTSD, panic attacks and disorder and Obsessive Compulsive Disorder (OCD) with schizophrenia (Buckley et al., 2009). Studies in the area of panic disorder as a part of a syndrome in schizophrenia are limited and other studies in this area generally focus on panic attacks as a risk factor in developing schizophrenia, biological plausibility and panic symptoms as a common factor in paranoid schizophrenia (see Buckley et al., 2009).

Trauma is common in patients with psychosis and early traumatic life experiences appear to be a risk factor in psychotic disorders and PTSD (Jankowski et al., 2009; Buckely et al., 2009). Exposure to traumatic events such as child abuse at a young age tends to increase the probability of psychosis in later life. Current evidence suggests that the three-symptom cluster that defines PTSD according to the DSM-IV has direct effects on severe mental illness (Jankowski et al., 2009). For example, the avoidance cluster of PTSD may promote social isolation and this symptom is a risk predictor of relapse or negative symptoms of schizophrenia.

Approaches to treat co-morbid problems are scarce and there is a need for further research in this area. For example, current treatment guidelines for PTSD, anxiety and depression disorders promote CBT (NICE, 2009). These guidelines are useful in directing professionals working with these groups. Adaptation is required when working with patients who have co-occurring problems with schizophrenia, particularly in secure services, where this problem is prominent. One way of working with co-morbid problems would be to consider factors that are common to these problems, such as cognitive deficits and over-sensitivity to stress.

Evidence-based psychological treatment needs to take these factors into account and adjust accordingly using a flexible approach with input from the care team. This will ensure better understanding amongst professionals working towards a common goal.

1.9 Summary

This chapter has discussed the prevalence of major mental disorders and co-morbidity concerns among patients in secure services. Patients' journeys through different formal restrictive pathways contribute to their ongoing distress, particularly when they are seen as '*bad and mad*', which inevitably might create the feeling of stigma. In addition to ongoing difficulties, such as multiple diagnoses, a sense of stigma has the potential to further exacerbate their distress and mental health problems.

Complex difficulties in the form of multiple diagnoses, difficult childhood experiences together with significant offending behaviour make treating this population challenging compared to other mental health settings. Co-morbid problems frequently remain undetected and untreated despite regular and long-term contact with mental health services. Faced with overt symptoms of psychosis in patients, many mental health professionals tend to focus upon these phenomena, often excluding other equally troubling co-morbid presentations. As such, the treating professionals are often puzzled when making decisions as to what works (Roth & Fonagy, 2006), particularly when patients do not respond to the treatment. Historically, treatment in these settings has relied heavily on medication to treat psychotic symptoms, and whilst psychological interventions have been available, they have relied on limited evidence-based practice, mostly relying on a psychodynamic theoretical orientation.

CBT principles have been used but these are limited to reducing offending behaviour and risk issues. There has been a movement targeting mental health needs but mostly these are carried out at a low level. Thus, this study will hopefully contribute further to our understanding of patients' views of what is supportive and what is non-supportive in CBT in these settings.

The following chapter will discuss evidence-based treatment in psychosis, including the limited CBT work in secure settings.

Chapter Two: Evidence based treatment for Psychosis

2.1 Evidence of CBT for psychosis

Pharmacological drug treatments for schizophrenia have been employed for decades. Although these treatments are effective in reducing positive symptoms (Tandon, 2012), patients with residual symptoms that are resistant to treatment may require further input from adjunct treatments. Antipsychotic medication produces limited improvement in motivation, social functioning and quality of life in patients with schizophrenia. This is complicated by poor adherence due to side effects and inefficacy (Lieberman et al., 2005).

Over the past decades, the evidence for psychological therapies in schizophrenia has been mixed and reported using various methods of research. Of all psychological therapies, the most consistent findings are reported in CBT, family therapy and social skills therapy (see Paterson & Leeuwenkamp, 2008 for a review). Dixon et al. (2010), in their review of psychosocial treatment, recommended other affective treatments for schizophrenia, which include assertive community treatment, supported employment, family-based services, token economy, skills training, psychosocial interventions for drug, alcohol and weight management and CBT. These authors reviewed studies from across the world and summarised the evidence for each recommended modality. They also summarized interventions for which the evidence was not judged to merit treatment recommendation, such as cognitive remediation, peer support and peer-delivered service, interventions increasing adherence to medication and psychosocial treatment for recent onset of schizophrenia.

2.1.1 CBT for Psychosis

The evidence supporting the use of CBT for psychosis is well documented. The first case study published looked at treating the delusions of a patient with schizophrenia using cognitive therapy (Beck, 1952). Later work in this area gradually emerged, with randomized controlled trials beginning to look at the efficacy of CBT for psychosis (CBTp) (Kingdon & Turkington, 2005). CBT became one of the fastest growing modalities in recent history and has been trialled in various different diagnoses with some success. Positive findings for CBT

have been reported in many areas in schizophrenia research, particularly in acute and first episode psychosis, treatment resistant groups and relapse prevention.

2.1.2 CBT for acute and first episode psychosis

The goal of CBT in this stage is to shorten the experience of psychosis and enhance functional recovery, e.g. by providing psychoeducation (Addington & Gleeson, 2005). Addington and Gleeson used a modular approach and stressed that it catered for the needs of many patients without strict exclusion criteria. This approach may provide a sense of awareness and normalize patients' experiences.

Randomised Controlled Trials (RCT) carried out in CBT for acute and first episode psychosis are scarce. Drury et al. (1996) carried out an RCT that consisted of a group of patients receiving CBT and a control group. CBT was provided to the experimental patients in individual and group format, with the control group having a therapist providing structured activities. The CBT group showed greater reduction in positive symptoms at twelve weeks, and a nine-month follow-up revealed a decline in positive symptoms for both groups, with significant results in the CBT group. The authors conducted another trial with similar results (see Drury et al., 2000).

Lewis et al. (2002), in the Study of Cognitive Alignment and Therapy in Early Schizophrenia (SoCRATES) trial, looked at a five-week CBT programme plus routine care compared with supportive counselling plus routine care and routine care alone in a multi-centre trial randomising 315 people with acute schizophrenia. The outcome suggested that the CBT group had temporary advantages over those receiving routine care and supportive counselling in accelerating remission, but these results were not maintained after four weeks for CBT versus routine care.

2.1.3 Medication treatment resistant group

Medication (antipsychotics) resistance poses a major challenge for both professionals and patients. The effects of this are extended to patients' social functioning and family life (Rathod et al., 2008).

Studies in this area have been carried out for decades, as professionals are often puzzled as to the medication management of this difficult patient group. Tarrier et al. (1993), in their controlled trial, compared the effectiveness of CBT (coping enhancement strategy) for medication-resistant psychotic symptoms with a waiting period and a cognitive intervention: problem solving. Patients in this study received ten sessions over five weeks. Although patients who received CBT showed a reduction in positive symptoms compared to those on the waiting list, the evidence for CBT was equivocal compared to those receiving the problem-solving approach. There were high drop-out rates and the authors did not use intention to treat analysis.

Sensky et al. (2000), in their RCT of CBT for medication-resistant schizophrenia, found CBT to be superior to a Befriending (BF) intervention used with a control group. The outcome at post therapy demonstrated positive outcome for both groups; however, the CBT group fared better at their nine-month post-treatment follow-up compared to the control group.

Turkington et al. (2008) reported a five-year follow-up study. They looked at CBT and BF interventions delivered by the same therapist (e.g. nurses) to control for non-specific factors. CBT was superior to BF on overall symptoms (CPRS scale) and negative symptoms (SANS) for a longer period, with its effects continuing to be evident at five-year follow-up, although the trial had limitations, such as the lack of a Treatment as Usual (TAU) group. The CBT intervention was delivered using a manual by one of the authors (Kingdon & Turkington, 2005).

2.1.4 Relapse Prevention

Gumley et al. (2003) reported an RCT on CBT for early signs of relapse in schizophrenia. This trial reported outcomes based on a twelve-month follow-up period comparing CBT to TAU. CBT treatment was based on a manual and was delivered by the first author. At twelve months, eleven patients in the CBT group had been admitted to hospital compared to nineteen patients in the TAU group. In addition, the relapse rate for TAU was higher, at twenty-five patients, compared to thirteen for the CBT group. Further outcomes on positive symptoms, negative symptoms, global psychopathology, performance on independent functions and pro-social activities showed significant improvement. As with most research, the limitations of

this study are highlighted: there were no blind assessors and the authors recommended a replication with control for attentional effects of CBT with longer duration (i.e. more than twelve months).

In contrast, Garety et al. (2008), in their recent multicentre RCT, trialled two pathways: (1) those without carers allocated to CBT plus TAU; (2) those with carers allocated to TAU, CBT plus TAU or family intervention plus TAU. These treatments were delivered for nine months with up to twenty sessions. The CBT outcome surprisingly did not reduce relapse rates at twelve or twenty-four months compared to family therapy and TAU. This was attributed to the use of a generic CBT manual rather than a specific tailored CBT for relapse prevention, hence highlighting the importance of further research into adaptation processes to fit with the context. Secondly, the trial therapists reported difficulty in maintaining focus on positive symptoms when the symptoms were absent. This was complicated by the mixed sample of acutely ill patients who had relapsed in response to ceasing medication and were thus a medication-sensitive group.

2.1.5 Meta-analyses and reviews

Several authors have carried out reviews and meta-analyses to measure the effectiveness of CBTp in schizophrenia. Gould et al. (2001), in the first empirical review of CBTp, carried out an effect size analysis of seven studies involving 340 patients. The analysis outcome concluded, with an effect size of 0.65 (residual symptoms), that cognitive interventions are useful in decreasing positive symptoms and the sustainability of this effect over a period of time is robust (ES=0.93). This finding that CBTp is beneficial to patients in reducing positive symptoms was further confirmed by other reviews looking its effectiveness in chronic and treatment resistant patients (Pilling et al., 2002; Tarrier & Wykes, 2004).

Zimmerman et al. (2005) reviewed fourteen studies to measure the efficacy of CBTp for positive symptoms. They concluded that CBTp is an effective treatment for positive symptoms and has long-term effects. The authors acknowledged the limitations of the studies reviewed, which included methodological differences and non-specific treatment in addition to psychiatric care.

In the most comprehensive meta-analysis, Wykes et al. (2008) carried out a review of thirty-four studies of CBT using a Clinical Trial Assessment Measure. This review concluded that CBTp has a modest effect on positive symptoms. The authors in this study criticized some of the existing studies, more than half of which did not use a statistical method that was satisfactory to account for drop-out rates, while only a few described the process of assessor blinding. They also suggested that future studies should include measures of treatment process that allow an estimate of the dosage of treatment rather than the number of sessions, include outcome measures that are acceptable to patients and incorporate long-term follow-up processes to assess the robustness of treatment effects.

Interestingly, the most up-to-date Cochrane review of CBT for schizophrenia and other psychosocial treatments looked at twenty trials and concluded that in the main, there were no difference in overall effectiveness between CBT and other talking therapies. Rehospitalisation and rate of relapse were not reduced and CBT was no better in improving mental state or positive and negative symptoms. This review suggests that CBT and other talking therapies may be better in retaining patients in treatment and there may be benefits in longer-term CBT for depression and distressing feelings (See Jones et al., 2012, for review). The authors of the review used strict criteria when assessing studies, and as with most studies, they found that there were inconsistencies in methods, randomisation and blinding.

Recently, CBTp has received more attention from both its proponents and opponents. The opponents have criticized recent CBTp meta-analytic studies based on methodological flaws, particularly in the inclusion and exclusion criteria, when reviewing these studies (see McKenna & Kingdon, 2014, for a debate). For example, they criticize previous CBTp studies for not using rigorous blinding procedures and argue that there is a risk that positive findings are down to chance (McKenna & Kingdon, 2014; Jauhar et al., 2014). Jauhar et al. (2014) mention that they were puzzled that NICE guidelines support CBTp for positive symptoms despite evidence against this approach. However, looking at their review, twelve out of the thirty-four studies examined were not based on therapies recommended by NICE and the studies reviewed were either group or brief CBT studies in the UK; some of the studies reviewed were in Chinese, so their relevance to NICE is suspect. In addition, the review included different populations, from acute inpatient to outpatients, first episode patients and older adults, and this does not provide much help for professionals clinically in terms of what works for whom. There was also wide heterogeneity in the studies reviewed to

obtain a meaningful estimate. There was no mention of the clinical significance of the dose or duration of CBT treatment, which might also inform outcomes.

In a more recent meta-analysis, Turner et al. (2014) reviewed forty-eight studies, comparing psychological interventions for psychosis, and found that CBT was significantly more efficacious than the other interventions pooled in reducing positive and overall symptoms (g=0.16). This finding was robust in all sensitivity analyses except for researcher allegiance, when it lost its significance. Researcher allegiance is a distortion of findings due to investigators' preferences for a particular therapy and this has been highlighted as a bias that affects outcome.

Similar results were found in another CBTp meta-analysis where effect sizes of 0.36 for delusion and 0.44 for hallucination were reported initially; however, blinded studies reduced the effect size of CBT for delusion by a third but increased the effect size of CBT for hallucination to 0.49 (see Van de Garg et al., 2014). As with all studies, both of the above reviews have been criticized by their opponents for not including relevant studies that might have affected their results, thus introducing a publication bias.

Meta-analyses have been regarded as the gold standard, as they provide useful quantitative evaluation of the efficacy of studies. Whilst they are useful, there are many caveats in performing a valid analysis, as in some cases they may not be the best method and results can be misleading. There are rules that must be followed when performing this type of review: for example, identification and selection of studies, heterogeneity of results, availability of information and data. In the process of selecting studies, some authors tend to select positive studies, usually in favour of new treatment or against well-established studies. This is selection bias, something which appears to be a concern in most CBTp meta-analyses: hence the claim that CBTp has been oversold (McKenna & Kingdon, 2014). Another concern that is important to highlight is the publication of positive studies: publication bias, which appears to be linked mostly to drug-related research. As mentioned above, heterogeneity is an important factor when completing meta-analysis, and as reported above, the Jauhar et al. (2014) study suffered from this limitation, as their review included different populations, ages and phases of diagnosis. In any case, an increase in the level of heterogeneity will inevitably make any justification of results more difficult: as such, conclusions can be only generalised with low conviction (See Walker et al., 2008).

There are guidelines for high quality systematic reviews (GRADE working group); however, if authors continue to deviate from some of the basic rules of meta-analysis, this will lead to the reliability and validity of future being questioned. Nevertheless, is it important to note the recent Cochrane Review of CBT for schizophrenia is a good example of meta-analysis that followed the GRADE system and it might be useful if this system could be adopted as a standard guideline for all future meta-analyses.

2.1.6 Evidence-based psychosocial treatment in MDOs

Psychosocial treatments for MDOs have been around for decades and empirical research on which psychological modalities work best is lacking. Individuals with mental illness share some constructs with the general population when committing criminal behaviour, e.g. committing robbery to fund and consume illicit drugs, and the risk is moderately higher than in the general population (Stuart, 2003). Martinson (1974), in his influential article, summarised that "nothing works" in prison settings with offenders, and since this article, knowledge in the area of recidivism and offending has moved forward, at least in recognising significant factors that are involved in criminal behaviour. One of the most important contributions in the forensic psychology literature is the Risk-Need-Responsivity Model (RNR). This model was proposed in the 1980s and formalised in the 1990s with the offender population in Canada (Bonta & Andrew, 2007) and is now widely used in the assessment and rehabilitation of offenders (Ward et al., 2007). As proposed, the model is divided into three constructs, described below.

Risk – This principle requires offenders to be identified according to the level of the risk that they will reoffend. For example, high-risk offenders and low-risk offenders could be separated and have different pathways within the CJS and mental health services.

Need – This principle looks at the criminogenic needs of the offender. Needs in this regard encompass personal characteristics, relationships with other individuals and contextual factors that lead the individual to commit crime. For example, an offender from a poor background, with a poor relationship with family and friends and maladaptive problems in school can engage in violent behaviour. These factors are considered as risk factors that can inform an appropriate formulation and treatment.

Responsivity – Once the above risk factors have been identified, the treatment route can be identified. This is an important junction, as evidence-based treatment may make a difference in reducing reoffending behaviour. Responsivity in this regard should be considered carefully and effort should be made to tailor treatment to the individual's risk factors, protective factors and most importantly readiness to change.

Proponents of the RNR model advocate that its principles are effective in understanding and formulating criminal behaviour and subsequent treatment (Ward et al., 2007). The RNR model could be adapted for working with MDOs. This process could start at the CJS in identifying offenders that have previous mental health history or significant other risk factors that could lead to severe mental health problems. Once filtered, MDOs can be routed to either community or secure services to receive specialised treatment according to their needs.

Current models in CJS and prison services in the UK are programmed towards care versus the punishment model and there is urgent need to balance this dichotomy (Green, 2010). Millan (2001), in his review of the Mental Health (Scotland) Act, 1984, made recommendations for the reformation of this Act (MHSA, 1984). In this review, the committee recommended the protection of MDOs and emphasised treatment (care) over detention, whether in hospital or in the community. The Millan (2001) committee proposed ten essential principles:

Non-discrimination
Equality
Respect for diversity
Reciprocity
Informal care
Participation
Respect for carers
Least restrictive alternative for care and treatment
Benefit to patients that cannot be achieved other than by intervention
The welfare of the child is paramount.

Some of these principles could be adopted as general guidelines when working with MDOs, with the ultimate goal being geared towards the recovery model (See The Clinical Model - A Framework of Principles, 2009).

2.1.7 CBT for psychosis in secure services

Literature in CBTp in secure services is sparse however, recent review (Knabb et al., 2011) revealed that out of ten psychological treatment modalities, only three had a weak to moderate evidence base, with another two having been empirically validated in MDOs. The five modalities that have been validated are Behaviour Therapy, Dialectical Behaviour Therapy (DBT), Assertive Community Treatment (ACT), Therapeutic Community and CBT (Knabb et al., 2011).

To get more information on studies in this area, the researcher carried out a search using OVID databases (MEDLINE and PsyINFO, 1987-2010) to review published research studies carried out in the field of psychological interventions for psychosis in forensic mental health settings in UK. Only three studies were found (Haddock et al., 2004, 2009 and Laithwaite et al., 2009). The first of these studies included a case series evaluating the feasibility of cognitive-behaviour therapy for the treatment of psychotic symptoms and anger in patients with a diagnosis of schizophrenia who were living in a low secure unit. The results showed benefits for the patients involved and demonstrated that the approach was feasible to implement within such a setting and there was notable reduction in positive symptoms and measures of anger (Haddock et al., 2004).

In their second study, which focused on Psychological Interventions for Coping with Anger and Schizophrenia (PICASSO), Haddock et al. (2009) conducted a randomised controlled trial to evaluate the effectiveness of CBT and Social Activity therapy for patients with schizophrenia and problems with anger and/or aggression. This was the first randomised controlled trial in the field of psychosis in this population. PICASSO recruited patients from in-patient (n=68) and outpatient mental health services (n=19), including forensic mental health establishments. The CBT intervention included motivational strategies to aid engagement, strategies to reduce the severity and distress of psychotic symptoms and strategies to reduce the severity of anger linked to aggression and violence. Patients were randomized to the above CBT intervention or a Social Activity Therapy (SAT) which aimed to help patients identify activities they enjoyed and help them to carry these out.

The interventions were manualised, with twenty-five sessions delivered by therapists trained in the protocols. There were thirty-eight patients in the CBT treatment group and thirty-nine in the SAT group. This study concluded that CBT was superior to SAT in reducing incidents

of aggression. Delusion severity reduced with decreasing risk management. It is noteworthy that there was no benefit on anger compared to the previous study and the authors recommended that a longer treatment period might be necessary to get positive results. In addition, the authors did not make any effort to measure the social functioning of the patients, an important aspect in mental health services and recovery.

Laithwaite et al. (2009) evaluated the effectiveness of a recovery group intervention based on compassionate mind training for individuals with psychosis in a high security setting. The results provide initial indications of the effectiveness of a manualised group intervention based on the principles of compassionate focused therapy for this population. The authors of this study incorporated patients' views in a separate study.

2.1.8 Group CBT in secure settings

In terms of clinical efficiency, group interventions provide greater access to evidence-based treatment than individual therapy. The NICE guidelines for schizophrenia (NICE, 2003) state that group activity in the acute phase of schizophrenia is an 'essential element' (p.38) of the care provided by mental health services. Cognitive-behavioural programs are also recommended in the post-acute, maintenance, and recovery phases, with group interventions specifically recommended for social skills training. Whilst there have been many evaluations of group programs for offenders with mental health problems, there are currently no evidence-based guidelines for the development of these groups (Hodgins, 2001).

Two literature reviews have investigated the current research base for Cognitive Behaviour Group Therapy (CBGT) with individuals with a diagnosis of schizophrenia (Lawrence et al., 2006), and with patients in a forensic setting (Duncan et al., 2006). Lawrence et al. (2006) identified five studies that met the following inclusion criteria: the intervention had to be defined as group CBT; participants had a diagnosis of schizophrenia; outcomes were assessed using standardized measures; the trials were controlled trials with outcome measures taken before and after the intervention. The five studies used different outcome measures and could not be combined into a meta-analysis. The authors found significant improvements for social anxiety and depression symptoms in several of the studies. Results for auditory hallucinations were mixed, with some studies indicating specific improvements (Wykes et

al., 1999) whilst others showed no change or difference from the control groups (Wykes et al., 2005; Bechdolf et al., 2004). Improvements were also found for measures of general psychopathology (Halperin, 2000; Kingsep et al., 2003; Wykes et al., 2005), but these improvements were only maintained at follow-up in the Wykes et al. (2005) study.

Finally, Wykes et al. (2005) also found a significant improvement in social functioning, which was maintained at follow-up. Lawrence et al. (2006) concluded that CBGT appears to be an effective treatment when compared to treatment as usual, but when an active treatment is compared, its superiority is reduced. Furthermore, the methodological limitations of the studies in the review (i.e. poor blinding procedures, non-random allocation to groups and repeated measures designs) meant that the findings could not be used for any recommendations of 'best practice'. The authors suggest that further research addressing these shortcomings should be undertaken in order to establish the efficacy of CBGT.

Duncan et al. (2006) used a broad inclusion criterion (i.e. that the studies reviewed had to evaluate a structured group intervention with offenders with mental health difficulties) and identified twenty articles for their literature review. All the interventions followed cognitive behaviour therapy principles; the majority followed a CBT manual or an amended version of a manual adapted to the needs of the service. Analysis of the different group interventions yielded four main types: 'problem-solving' (PS), 'anger/ aggression management' (AAM), 'deliberate self-harm' (DSH) and 'other' (including CBT for psychosis and social skills training). Pooled effect sizes were calculated for each of these group types. The results showed moderate to high effect sizes for all types of group, with the highest effect size found for the AAM group, which had a pooled Cohen's d of 1.30 (SD=0.74) and the lowest found in the DSH group, with a pooled Cohen's d of 0.78 (SD= 0.80). The authors concluded that "structured psychological interventions, generally based on cognitive behavioural principles, are becoming an important component of the rehabilitation process for mentally disordered offenders" (p.237). They balance this with a recognition that the quality of the methodology and design would need to improve in future studies if this area of research is to continue to develop.

Since these reviews, studies have continued to find clinical benefits associated with CBGT, including improvement in levels of hopelessness, depression, self-esteem, coping strategies and social skills (Barrowclough et al., 2006; Hornsveld & Nijiman, 2005; Laithwaite et al.,

2007). Unfortunately, the methodological limitations (e.g. small sample size and lack of a control group) outlined by Lawrence et al. (2006) remain a major problem for this research, limiting the generalisability and reliability of the conclusions. As clinical guidelines are yet to be developed regarding the use of CBGT, particularly in forensic settings, there is a need for thorough evaluation of any group program to ensure that it is benefiting attendees.

2.2 Cognitive Therapy for Schizophrenia

Cognitive therapy is not an entirely new approach, as it has been around for more than fifty years. In 1952, Beck successfully treated a patient who held delusional beliefs, and following this, cognitive therapy gained fame in the arena of psychotherapy. Since then, cognitive therapy has extended both theoretically and clinically to major mental health disorders such as personality disorder (Beck et al., 1990), substance misuse (Beck et al., 2002) and psychosis (Kingdon & Turkington, 1994; Chadwick et al., 1996; Bentall et al., 1994, 2001; Blackwood et al., 2001; Garety et al., 2001). The application of cognitive theory for psychosis has been explained using different models that predominantly look at the role of attribution, although some of the models continue to be debated for applicability with patients and the context.

2.2.1 Cognitive theories and processes of psychosis

Maher's theory of delusion states that delusions reflect rational attempts to make sense of anomalous experiences (Maher, 1998). His view is that delusions are a response to abnormal and emotionally disturbing phenomena that lead an individual to search for explanations. Maher's theory has been refuted by other theorists on the grounds that delusions can also develop in normal conditions and the model does not account for how delusional beliefs are formed and maintained (Coltheart et al., 2010). Coltheart argues that basic cognitive disturbance may link to information-gathering biases such as jumping to conclusions.

Recent studies have advanced knowledge of the psychological processes in people with persecutory delusions. Theory of Mind (ToM), attentional bias, attributional bias, and other data-gathering biases will be the main theories explored, among other contributors.

Theory of Mind (ToM)

Theory of Mind refers to the ability to infer mental states (beliefs, thoughts and intentions) of others in order to predict and explain their behaviour, and has been conceptualized as the process of "mentalising" (Frith, 1992; Harrington et al., 2005). Persecutory delusions reflect false belief about the intentions and behaviour of others that could arise from theory of mind deficits. According to this theory, when ill, paranoid patients still know that other people are guided by internal mental states but, as they are no longer able to accurately infer what others' beliefs and intentions actually are, they assume that others are hiding their intentions and, therefore, have malevolent intentions (Langdon et al., 2006; Bentall et al., 2001). Corcoran, Frith and colleagues attempted to test this theory. They investigated whether schizophrenic and non-clinical patients were able to comprehend a task requiring inferring of intentions and behaviour. They found that people with schizophrenia had impaired ToM, whereas those in remission and in the non-clinical groups showed no deficit (Frith & Corcoran, 1996). Subsequently, it was claimed by the authors that memory and IQ influenced the results and suggested that IQ might contribute to the deficit. In addition, it was also suggested that people infer others' mental states by referring to their own mental state in similar conditions, i.e. through memory (Bentall et al., 2001). Frith and Corcoran (1996) subsequently conducted a further study in which one question following each story required simple memory for the story, whereas the other required the listener to infer the mental state of one of the characters. In order to ensure that inability to infer intentions was not simply a consequence of poor comprehension or memory, the ToM was only scored if the memory question was answered correctly. The main findings were that schizophrenic patients with persecutory delusions were impaired on the ToM questions compared to normal controls and psychiatric controls. Therefore, this contributes to the idea that people with persecutory delusions have a mentalising deficit that is not attributable to general intellectual dysfunction or to logical memory impairment (Bentall et al., 2001).

Harrington et al. (2005) conducted replication studies examining ToM in relation to persecutory delusion (in schizophrenia) rather than ToM in schizophrenia more generally. Participants were divided into paranoid, non-paranoid and healthy control groups using tasks that included verbal and non-verbal, and first and second order ToM tasks. These findings concluded that ToM ability is impaired in people with schizophrenia and that there is a specific relationship between persecutory delusions and poor ToM. It was also suggested that some of the inconsistent findings in research on ToM and schizophrenia are possibly due to the diverse range of tasks used by different researchers, and also to the varied methods of grouping symptoms. Langdon et al. (2006) did not find any evidence of a link between persecutory delusion and ToM; instead, ToM was associated with poor insight.

Attributional Bias

Individuals readily infer causes of events that are salient to them (Bentall et al., 2001) Attribution (a proposition containing or implying the word "because") can be found in every few hundred words of recorded speech. Attribution theory explains a framework for understanding the causal explanation that individuals give for their own behaviour and the behaviour of others (Blackwood et al., 2001). The role of this kind of proposition has been closely observed in patients with depression and persecutory delusion (Garety and Freeman, 1999; Bentall et al., 2001). Kaney and Bentall (1989) reported the first study of abnormal attributional style in paranoid patients. Individuals consistently demonstrate the causes of events; that is, they tend to take credit for success (internal attribution for positive events: the "self-enhancing" bias) and to deny responsibility for failure (external attribution of negative events: the "self-protective" bias). The second bias may serve to enhance self-esteem (Blackwood et al., 2001). Bentall et al. (1994) suggest that this exaggerated attributional bias functions to preserve self-esteem by limiting conscious awareness of negative aspects of the self stored in the semantic memory. When such negative self-representations are primed by threatening events, other blaming attributions are elicited to prevent activation of discrepancies between how the subject views himself ("actual self") and how he would like to be viewed ("ideal self"). Ideally, the activation of these discrepancies would lead to loss of self-esteem, and attribution bias occurs at the expense of contributing to the patient's negative perception of the intentions of others.

Bentall et al. (1994) further suggested a model of persecutory delusions, in which activation of discrepancies between perceptions of the actual self and the ideal self results in externalizing attributional bias. Acting to close the discrepancy between the actual self and the ideal self and open self-other discrepancies which act to defend the individuals against feelings of low self esteem results in persecutory delusion.

This study was further developed by Kinderman and Bentall (1997), who compared causal attribution for negative events in persecutory delusion, depression and non-clinical controls. The results of their study showed that depressed individuals had internal attributions for negative events compared to their counterparts. Both non-clinical participants and those with persecutory delusions attributed positive events to internal causes more than negative ones, suggesting 'self-serving bias'.

Internal or External causes of events?

Several studies have found that people with persecutory delusion, when compared to depressed and non-clinical control groups, show a bias toward excessively external attribution for negative events (Bentall et al., 1991; Sharp et al., 1997; Kinderman and Bentall, 1997). For example, the author has observed these phenomena in one client, who has a tendency to blame "the witch lady" (perpetrator) who is constantly watching and sending "negative vibes" (harm) in the form of stomach pains, not only to her but also to her nephew on several occasion (negative event).

However, evidence for internalizing bias for positive events is less convincing (Bentall et al., 1994). Most of the above studies used the Attribution Style Questionnaire (ASQ), which has been criticised for its low reliability (Bentall et al., 2001). Kinderman and Bentall (1996) developed a measure called the Internal Personal and Situational Questionnaire (IPSAQ), which was found to have superior reliability to the ASQ. The IPSAQ was divided into three subscales, namely internal causes, external situational causes (events determined by circumstances) and external personal causes (events determined by another person). Using this questionnaire, Kinderman and Bentall (1997) found that patients with paranoid delusions were shown to have a tendency towards making external personal attributions as opposed to external situational attributions to negative events.

However, recent work has shown that the association between persecutory delusion and attributional biases is equivocal. Martin and Penn (2002) found little support for the link when participants' attributional statements were assessed by independent judges and these ratings were analysed. McKay et al. (2005) found no evidence for an association between persecutory delusion and externalizing bias and limited support for a link between persecutory delusion and personalizing bias. Carlin et al. (2005) carried out studies in forensic settings and found that external attributional style is present in individuals with psychosis, but is not specific to persecutory delusion, and that there was no special role for attributional style in persecutory delusion.

Perceptual/Attentional Bias

The adaptive behaviour of individuals relies on monitoring of salient information in the environment, particularly threatening stimuli. People with persecutory delusions preferentially attend to threat-related stimuli (Bentall et al., 1989; Fear et al., 1996) and preferentially recall threatening episodes (Blackwood et al., 2001). Bentall et al. (1989) developed a heuristic model of delusion, which shows the relevant information processing involved in acquiring and maintaining a belief.

There is a large body of evidence documenting the disruption of information processing in psychotic individuals, leading to a variety of perceptual disturbances (Peters and Garety, 2006).

- Attending to threat-related information

Kaney & Bentall (1989) administered a Stroop test to depressed, paranoid and normal participants. In this test, participants were required to name the ink colours on printed words, ignoring the meaning of the words. A strong association between reading and naming the colour indicated selective attention and paranoid participants showed slower responses for threat-related words in comparison with neutral words. This research was replicated by Fear et al. (1996) using additional anxiety-related words, but no specific effects were found.

- Threat-to-self information bias

Attention to threat-related information is biased when the threat is to the self. The evolutionary advantage of a "threat-to-self" network outweighs the deleterious effect of such hypervigilant or attentionally biased threat detection (Blackwood et al., 2001). Similar biases have been demonstrated when the content of the task is concerned with threat to the subject's self-image or self-concept. Kinderman et al. (2003) carried out research in people with and without persecutory delusions to test different types of threat relating to self-perception. They found that people with persecutory delusions showed changes in self-perception following the processing of information perceived to be threatening to the self.

- Memory bias and preferential recall in threat-related information

Explicit memory is the result of attention to retrieval of past memories and is primarily tested by free recall; in contrast, implicit tasks do not use explicit instructions, instead aiming to assess involuntary retrieval of stimuli following prior exposure (Taylor & John, 2004). Several studies have found evidence of an explicit recall bias for threat-related information for paranoia. For example, Bentall et al. (1995) have reported evidence that paranoid patients selectively recalled propositions from stories that were threat-related words.

- Time spent on attending to threat-related information

Phillips et al. (2000) found that people with persecutory delusion spent less time attending to threatening areas of social scenes than did schizophrenics, but instead spent more time viewing non-threatening areas. However, Phillips and colleagues argued that paranoid patients are quick in checking threatening stimuli and move rapidly to checking threats elsewhere.

- Estimating the frequency of negative events not only happening to self but also to others.

Kaney et al (1997) asked depressed paranoid patients, non-depressed paranoid patients, depressed patients and normal controls to estimate the frequency of selected negative, neutral and positive events in the past and future for both themselves and others. They found that people who experienced paranoia (with or without depression) gave high estimates of negative events affecting themselves and others.

Taylor and John (2004) conducted research to investigate attentional bias and both implicit and explicit memory biases for personally salient and standardised emotional stimuli in persecutory delusions and depression. Paranoia was not found to be associated with attentional bias and both groups failed to demonstrate attentional bias for personally salient information. However, attentional bias was found for standardized emotional stimuli in the depressed group.

A recent study by Garety et al. (2005) concluded that it is likely that social processes are important in belief change, such as the potential benefit of a supporting relationship for discussing ideas and experiences.

Reasoning biases

- Jumping to conclusion (JTC)

It has been suggested and regularly shown (Peters & Garety, 2006; Garety & Hemsley, 1994) that delusional patients produce a JTC reasoning bias, which is characterised by making decisions based on little or inadequate information. It is hypothesized that individuals with delusions (Blackwood et al., 2001; Garety et al., 1991; Garety and Peters, 2006) are more prone than normal individuals to draw firm conclusions based on equivocal evidence and are more likely to revise their decisions when faced with disconfirmatory evidence.

This early JTC bias may serve as a data gathering bias (Garety and Freeman, 1999) and increase the likelihood of inferring an erroneous style of information gathering, which in fact has implications for delusion formation. It has also been suggested that people with psychosis make less use of past information when forming judgments and are overly influenced by current stimuli at the expense of context or previous learning (Kapur et al., 2003).

One possibility is that both biases reflect motivational rather than information processing abnormalities. It has been suggested that individuals suffering from persecutory delusion display a disturbance in so-called Bayesian reasoning (Garety et al., 1991). Garety and colleagues used a probabilistic task with one hundred coloured beads in two separate jars with individuals with persecutory delusions and controls. They found a significant difference between these groups in the number of draws required before making decisions.

In the largest study to date, Garety et al. (2005) found that a JTC bias was present in approximately half of their sample of a hundred deluded participations, over 80% of whom suffered from delusions that were persecutory in content. The aim of their study was to elucidate the factors that contribute to the severity and persistence of delusional convictions. Their hypothesis that reasoning processes (JTC, belief inflexibility and extreme responding – dichotomous thinking) would be associated with the severity and current delusional conviction was confirmed.

- Need for Closure (NFC)

NFC is the desire for an answer – any answer – rather than confusion and ambiguity (Kruglanski, 1990). People with high NFC "may 'leap' to judgements on the basis of inconclusive evidence and exhibit rigidity of thought and reluctance to entertain views different from their own" (Kruglanski & Webster, 1996, p. 264)

There has been vast research during the last ten years in the field of psychological processes to understand the onset and maintenance of biases in thinking. If we formulate the understanding of psychosis as having different levels of explanation, from biological to psychosocial, the closest level of understanding is the psychological. Despite advances made in this area, there appears to be no concrete central theme or agreement between concerned bodies regarding a particular process or theory that can account for the formation and maintenance of overwhelming experiences.

2.2.2 The Models

To date, the Attribution-Self-Representation model developed by Bentall et al. (2001) and Freeman et al.'s (2002) multi-factorial model are the most plausible models in the field of persecutory delusion.

In general, the self-serving bias claims that we take credit for positive events (internal attribution) and tend to blame others for negative events (external attribution). It has been suggested that the implicit dimension of persecutory belief is an exaggeration of this bias,

which serves to reduce discrepancies between different self-representations which would otherwise create negative emotions (Bentall et al., 2001).

Bentall et al.'s (2001) model is grounded in earlier psychodynamic accounts insofar as it holds that persecutory delusions are constructed *defensively*. Unlike depressed patients, however, paranoid individuals are hypothesized to avoid (*defend against*) the activation of negative self beliefs, by attributing negative events to the actions of malevolent others (McKay et al., 2007). Therefore, via such externalizing, personalizing attributions, paranoid individuals project their latent negative self-representation onto others. In short, paranoid individuals will not only abrogate responsibility for negative events, but will tend to blame *other people* for those events.

Furthermore, the individual's current level of self-esteem is expected to affect the type of attribution made. Bentall et al. (2001) argue that in paranoid patients, externalizing is evoked for negative events that threaten to highlight covert discrepancies between the actual and ideal selves. This style serves the defensive function of minimizing awareness of such covert discrepancies, such that positive overt self-esteem is maintained. In their model, they suggest that attributions are indications of underlying schemas and that attributions will affect future self-representations according to the accessibility of stored knowledge about the self. In addition, they also suggest that:-

- Internal attributions will trigger matching memories and beliefs about the self and increase discrepancies between the actual and the ideal self.
- External – personal attributions for negative events are likely to affect what others think of our selves.
- External – situational attributions for negative events would not influence either the self view nor the view that one believes others have of one, as it requires more cognitive effort.

In order to describe the inter-relations in the functioning of the attribution – self – representation cycle in paranoid individuals, it is necessary to explain why individuals excessively generate external attributions that implicate the intentions of others. One of the possibilities could be the type of information that is readily available to paranoid individuals. As discussed earlier, attentional biases are more readily available in individuals with

persecutory delusions compared to normal individuals. Thus, individuals with persecutory delusions attend selectively (Bentall and Kaney, 1989; Fear et al., 1996) and remember (Bentall et al., 1995) threat-related information, and are excessively sensitive to emotional expression. A JTC information gathering style (Garety et al., 2005) and the need for closure may result in early conclusion and difficulty in understanding others' minds and may also make external – personal attributions more likely, hence contributing to the formation of persecutory delusions.

However, a weaker formulation for this model is that it predicts that people with persecutory delusions should show a discrepancy between overt and covert self-esteem (Garety and Freeman, 1999) and that delusion only partially fulfils its defensive function, such that overt self-esteem is not fully preserved.

Multi-Factorial model of psychosis

This model conceptualizes from the stress-vulnerability framework, which was originally coined by Zubin and Spring (1977). Freeman et al. (2002) proposed that the route to psychosis depends upon interaction between vulnerability (from genetic, biological, psychological and social factors) and stress (which may also be biological, psychological or social). The route to experiencing psychosis begins with a precipitating environmental and /or neurobiological event that disrupts *cognitive processes* (attribution, attentional, jumping to conclusion biases) and/or affective disturbances that lead to anomalous experiences. These anomalous experiences trigger a search for meaning/explanatory hypothesis (e.g. the experience of going outside in an unusual state prompts the initial thought "people are looking at me strangely") and this would continue until sufferers generate and adopt as a delusional belief an externalizing misattribution (e.g. "People don't like me and may harm me, I'm a *bad* person"). At this point, people with delusional belief do not make any attempt to further an alternative explanation (need for closure bias) which would be self-correcting with an internal attribution (e.g. "I'm really tired and anxious today, probably because I've not been getting enough sleep"). Langdon et al. (2006) suggested that an extreme self-serving attributional bias might contribute towards a failure of this type in persecutory-deluded individuals.

In this model, the delusional beliefs are hypothesized to arise from both emotional and psychotic processes. Anxiety has been postulated to have a central role in delusion formation and maintenance (Freeman et al., 2005). In short, this model suggests that persecutory delusions are a reflection of individuals' emotions and pre-existing beliefs rather than primarily a defence of the covert self (Freeman et al., 2002).

Similar to many other theories in this field, a weaker formulation for this model would be as follows:-

- Studies focused on non-clinical population (Freeman et al., 2005).
- The link between anxiety and persecutory delusion formation remains somewhat equivocal, as recent studies have found that it is depression rather than anxiety that is most closely related to persecutory delusion (Freeman et al., 2005).

2.2.3 Other Theories

Threat control override theory

This theory was originally developed by Link & Stueve (1994), who posit that a relationship exists between violence and psychotic symptoms because psychotic symptoms can cause an individual to feel threatened personally and overwhelming thoughts can take control of an individual. They argued that delusional beliefs are responsible for violent behaviour in people with mental disorders. Data from the MacArthur study, one of the largest multi-wave studies of violence in post-discharge patients, concluded that men were more likely to respond to threat delusions with violence with a fight-or-flight response. A recent study Fanning et al. (2011) postulated that individuals who are predisposed to psychosis are at higher risk of being aggressive, although the relationship is not trivial. Similar to other theories discussed earlier, there is paucity of research that clearly explains the causal relationship between delusion and aggressive behaviour, although this is an important theory and probably the only one to postulate this relationship.

Bandura's theory of learning

Alternative theories have focused on the importance of an individual's beliefs and experiences in the development of offending. Sutherland (1939) reported that differential association in criminality encourage individuals to learn offence supportive beliefs and criminal behaviours through their interactions with criminal others. Learning through modelling others – behaviour theory (Bandura, 1977) – continues to be at the forefront, particularly in prison settings, where its utility centres on looking at pro-social behaviour. However, the modelling of pro-social behaviour relies on the presence of pro-social models and a desire to behave in a pro-social manner.

2.2.4 Manualised approach

The National Institute of Health and Clinical Excellence (NICE), in its latest guidelines, recommended that CBT should be offered to all patients with schizophrenia, preferably by using a manual (NICE, 2009). NICE also found that the use of treatment manuals was associated with more consistent reporting across trials, with the majority of papers (24/31) making reference to either a specific treatment manual or to a manualised treatment.

Manual-based treatment has been widely criticised for undermining the clinical judgement of practitioners (Garfield, 1996). However, Wilson (1996) asserts that in clinical judgement, a vast quantity of complex information has to be processed by the therapist, who will then have to choose from a large number of relevant theories in which to frame the information and is prone to an element of cognitive bias based on personal perspective. Consequently, the validity of case formulation is suspect. Thus, it is better to rely on an empirically supported research-based treatment that works for most people than to assume that each individual is an exceptional case and would not be helped by the research-based treatment. Since clinical judgement may be inaccurate and could lead to comparatively inferior results, an actuarial approach to treatment is ethically defensible (Wilson, 1996). Application of the most effective approach known to a particular problem has a good chance of being effective, particularly in multi-component programmes, although the effectiveness of this simple decision rule requires empirical testing.

Manual-based treatment usage in clinical practice represents a new and evolving development with far-reaching implications for the field of psychotherapy (Wilson, 1998). Most studies have employed cognitive behavioural treatment manuals for psychosis that differ somewhat from one another (Rector & Beck, 2002; Tarrier & Haddock, 2002). Even though no one standard CBT protocol has been predominantly used with the secure services population, some studies have used a treatment package which describes a comprehensive CBT approach (Kingdon & Turkington, 1994; Nelson, 1997).

Roth & Fonagy (2006), in the "What Works for Whom?" review for the secure services population, suggest that interventions and therapies are most successful when they are intensive, long-term, theoretically coherent, well structured, engage the patient and take account of their hopes and aspirations, are well integrated with other services and are tied into follow-up care.

Most offending behaviour programmes are manual-based and focus on general offending behaviour (Hollin & Palmer, 2006); however, very little attention has been paid to the secure in-patient population. In the secure setting, most CBT for psychosis manuals are generated on the basis of expert opinions, as described in a previous study (Haddock et al., 2009).

One study focused on the manual, but not in the area of psychosis but rather in depression in forensic patients. Ryba (2008) used a modified version of Thase's (1996) CBT manual for inpatients to treat depression among forensic patients in the US. It was concluded that with minor modification of the manual, this approach might be useful and effective in managing symptoms of depression and hopelessness commonly seen in forensic patients. This recommendation was made cautiously until well-controlled studies could be employed to formally test the effectiveness of the treatment program. Depression is a significant co-morbid disorder in forensic patients with psychosis (Kingdon & Turkington 2005). There is a paucity of published studies regarding manualised treatment in CBT for psychosis in a forensic setting.

2.2.5 The importance of patients' and professionals' views

There is a small, yet growing amount of qualitative research into the experiences of people with psychosis (Greenwood et al., 2009). The growth of consumerism has highlighted the importance of being involved in their care and this has been reflected in satisfaction surveys (Rankin & Stallings, 1990).

Within the secure services sphere, there is a dearth of research about patients' experiences in what they think is important (see Coffey, 2006, for a review), and more studies are needed to understand patients' perspective of what works.

CBT for psychosis is a collaborative approach and the views of patients and the concept of recovery are becoming essential in the organization and delivery of mental health services (Greenwood et al., 2009; Bellack, 2006). Patients' involvement in their care, particularly in secure services, is essential, and this may help them to voice issues that are important to them, indirectly helping professionals to manage risk better and increase the ecological validity of interventions. In a recent qualitative review, Hodget and Wright (2007) collected the views of patients from different modalities (e.g. CBT, DBT, Solution Focus and Family Therapy) and the results reflected that therapeutic relationships, relational and interpersonal aspects were important and may be underlying foundations that facilitate the therapeutic bond between the therapist and client, arguably the important mechanism that may facilitate the 'change' process in patients.

Qualitative research in psychosis has helped to bring about a greater understanding of patients' experiences and the meaning they attach to these experiences (Laithwaite, 2009; Greenwood et al., 2009). On the other hand, it is equally important to understand practitioners' views and experiences of treating this patient group. Furthermore, this informs us of the processes involved in these experiences. Such knowledge and understanding is important if we are to gain a greater knowledge of the factors and processes involved in recovery from psychosis, particularly in this forensic sub-group. This information is invaluable and can be used to help patients and practitioners: for example, generating a manual from understanding their views and experiences.

Quirk & Lelliot (2002) viewed the emphasis as being very much on clinical practice and the worlds of professionals and argued that there was a real need for in-depth interview studies involving patients to understand the meaning of in-patient care to these people.

Patients' perspectives on therapy have received little attention in the psychotherapy process (Rennie, 1992). This is a reflection of the traditional positivist prototype in research with its emphasis on quantitative methods. Due to concerns about methodological rigour and the inherent problems of small and non-representative samples, qualitative research has previously lacked status in the larger scientific field.

In recognition of this, standards for regulating methodological quality, whilst respecting core values and diversity, have been developed (e.g. Elliot et al., 1999). There has also been an increase in the application of more systematic approaches, such as Grounded Theory (Glaser & Strauss, 1967) and Interpretative Phenomenological Analysis (Smith, 2003) in psychosis research (e.g. Boyd & Gumley, 2007).

2.2.6 Summary

In sum, CBTp has been shown to have a weak to moderate effect in treating different phases of psychotic disorders, although there remains a paucity of efficacy and effectiveness studies in the area of co-morbid problems in schizophrenia. Patients in secure services face complex issues of co-morbid problems alongside main diagnoses and the limited CBT studies reveal that this modality has room for improvement and needs further research to demonstrate its efficacy and effectiveness (Haddock et al., 2009; Laithwaite, 2009).

A variety of models in CBTp have been proposed with common themes relating to understanding of psychosis and other important theories that have an important role within this population. Current theories of CBT for schizophrenia are limited and do not explain clearly the link between delusions and aggressive behaviour. Extensive research in this field has demonstrated that cognitive biases (attentional, misattribution and JTC bias) contribute to the formation of persecutory delusion; nevertheless, the evidence has fluctuated from time to time. As discussed above, Bentall et al. (2001) and Freeman et al.'s (2002) multi-factorial model are the most plausible models in the field of delusion (Garety & Freeman, 1999). A systemic review to explore JTC bias is currently underway, as this may be important both in terms of further informing models of delusional thinking and in guiding treatments (Taylor et al, 2014). In addition, clinical experience shows that patients with persecutory delusions tend to externalize experiences and actively engage in a search for meaning for their experiences.

As mentioned above, individuals with schizophrenia often have co-morbid problems, and currently the theoretical foundation of CBT for schizophrenia does not account for this; there is a need to understand other models and most importantly to further develop theoretical ideas which may contribute to a better understanding.

Manualised treatment has been shown to hold an important place in guiding professionals in carrying out CBTp work; nevertheless, there is a lack of scientific publications for the application of CBT in secure services. As discussed above, the best way to work collaboratively with patients is to incorporate their views about the treatment and this is an important way to gain knowledge of what is supportive and non-supportive in CBT. In view of this, the next chapter introduces the first qualitative study to explore patients' and professionals' views of CBTp.

STUDY ONE

Chapter Three: Exploring patients' and professionals' views on CBT for psychosis in secure services.

3.1 Introduction

In the previous chapters, an overview was given of CBTp in general and forensic settings. It is acknowledged that there are limited studies looking at CBTp in forensic mental health services. Patients remanded to forensic hospitals often experience high levels of psychotic symptoms and the reality of their legal situation may worsen their condition. Individual CBTp is not often used with this population due to a generally high level of impairment and there is an absence of an approach for structured CBT for this population.

3.1.1 Aims

The overall aim of this study is to collate and analyse patients' and professionals' views of secure services and to gain an understanding of their views of what is supportive and non-supportive in CBT for psychosis.

The secondary aim involves extracting themes and issues that will inform the generation of a manual suited to the needs of patients in secure services. This manual will be piloted in the forthcoming feasibility study. In order to clarify the key components in CBTp in secure services it is

3.1.2 Objectives

The objectives below will help to achieve these aims:

- To gain meaningful understanding of patients' experiences of what is supportive and what is non-supportive in CBT for psychosis and other psychological therapies in secure settings
- To elicit from mental health professionals (Psychiatrists, Clinical, Forensic and Counselling psychologists, CBT therapists, mental health nurses, social workers, occupational therapists, art psychotherapists and other qualified mental health

workers) their experiences, awareness and interpretations of working with psychotic patients and their response to CBT, e.g. what works

- To identify those strategies which health professionals recognise as being supportive and non-supportive in CBT with patients in secure settings.

3.2 Methodology

This study adopted a qualitative method. This is quite appropriate, bearing in mind the fact that it seeks to elicit and understand both patients' and health professionals' experiences in response to what is supportive and non-supportive in CBTp. The researcher received supervision from an expert in qualitative work throughout.

In constructing the methodology for this study, the researcher looked at available qualitative approaches and this section will outline the advantages and disadvantages of some of these methods and provide a rationale for the use of the method that was selected.

First, the researcher looked at Interpersonal Phenomenological Analysis (IPA), but due to its particular focus on small sample sizes, its case-by-case style of analysis and its desire for homogenous samples (Smith & Osborn, 2008), it was deemed inappropriate, as the researcher was interested in exploring views from patients and professionals across contexts and the sample was inherently dissimilar, although IPA is an interesting method that looks at the details of lived experiences.

The second approach considered was ethnographic research, a method which looks at the values, behaviours, beliefs and language of a culture (Creswell, 2009). Whilst this is an interesting method and fits in with the researcher's enquiry, this method was discarded due to its sole aim of analysing the above constructs in a given culture.

Thirdly, the researcher considered the narrative approach, a method which predominantly looks at an individual's life story, written in a chronological manner (Creswell, 2009). This method is most suitable for case studies, but was rejected because the present study aims to approach a fairly diverse population.

Special attention was paid to the interplay between researcher and participants. The researcher currently works in one of the London research sites. Given the nature of secure services and the vulnerability of patients, it is appropriate not to rely on pre-determined topics and to infer that patients' experiences may be negative.

In order to comprehend the practicalities and dynamics of CBTp in this population, it is important to first understand the wider system and environmental factors which can promote or hinder therapy processes. We looked at the grounded theory approach, a method that allows symbolic reaction and assumes that behaviour is influenced by meanings that individuals attribute to their environment (Mead, 1934). Grounded theory aims to minimise the biases of the researcher by providing a step-by-step guide to the analysis and coding of data. A coding framework is useful, as it provides a framework for the research data, encouraging saturation. In addition, this method assumes that the individual carrying out the research does not impose pre-conceived ideas or biases on the research process (Creswell, 2009; Charmaz, 2006). Grounded theory (Strauss & Corbin, 1990) was chosen as a method for initial analysis, as it allows the observation of the social processes of patients and professionals in secure services and offers new understanding of experiences (Charmaz, 2006). This methodology is influenced by the social constructivist revision of grounded theory (Charmaz, 1990), which recognises the role of the researcher's perspective in the generation and development of a model and themes. In particular, the social constructivist approach recognises the interaction between the researcher and the patient's views as a mutual creation of knowledge (Charmaz, 2006).

Given that one of the aims of the present study is to observe supportive and non-supportive views between patients and professionals, a cross-comparison is necessary and a further synthesis was carried out using the thematic analysis approach (Braun & Clarke, 2006). Some literature differentiates these approaches as independent of one another and some considers thematic analysis to be a form of grounded theory, as the two approaches share many overlaps in their stages of analysis (Ryan & Bernard, 2000; Kurtz & Jeffcote, 2011; Floersch et al., 2010). Mixed methods are relatively new and are divided into two types: mixed model refers to mixing qualitative and quantitative approaches and mixed method refers to the inclusion of a quantitative and a qualitative phase in an overall research study (Johnson & Onwuegbuzie, 2004). In the present study, the researcher employed grounded theory to understand patients' and professionals' views and the overall dynamics in secure services that

might affect therapy processes. Thematic analysis was used as a second analysis technique to cross-check professionals' and patients' views and to identify important overlaps. Similar to grounded theory, thematic analysis is a technique which is compatible with the constructionist paradigm (Braun & Clarke, 2006). Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data and the researcher is mindful to safeguard against the 'anything goes' approach and to make sure that the analysis is rigorous (Braun & Clarke, 2006). A similar analytical approach was also employed in the third study, which will be discussed in Chapter Nine.

A recent study of CBT for patients with psychosis (Greenwood et al., 2009) used the thematic analysis approach in analyzing data. The researcher has produced a table of the overlaps in the analysis of grounded theory and thematic analysis (Appendix 1).

The researcher in this study is a Cognitive Behavioural Psychotherapist. The identity and role of the researcher in the hospital is known by some patients, and this may influence issues regarding disclosure and confidentiality. These issues were made clear to the patients at the point of meeting. The researcher was aware of the need to manage the tension between trying to create a free-flowing discourse enriched by participants' experiences and participants' concerns regarding the possible adverse consequences of disclosure. These issues were discussed in supervision with an expert, which provided the opportunity to reflect on interviews and how the questions posed could reduce such tensions.

3.2.1 Sampling

This study adopted purposive sampling when recruiting patients and professionals in secure services. Purposive sampling is an appropriate method in this case, as patients and professionals are selected based on preselected criteria that are relevant to the research objectives. Purposive sampling is a non-probability sampling technique which ensures that some individuals have a better chance than others of being included in the study (Patton, 1990). Purposive sampling is the most commonly used non-random sampling technique in which the sample group is decided according to the researcher's idea of appropriateness (Marshall & Rossman, 2006).

The researcher considered other random probability sampling methods, such as simple and stratified random sampling. These types of sampling require more effort, are time consuming and are generally employed when there is a team of researchers. The key strength of random sampling is that it permits better generalisation to the population.

In contrast, as with other sampling limitations, purposive sampling can be perceived as a form of convenience sampling as the researcher aims to recruit individuals who are easier to interview, nearer to the researcher's base or perhaps known personally.

Due to the nature of qualitative work, data saturation occurs when the researcher is no longer hearing or seeing new information. Sample size was determined pragmatically according to three considerations:

1. The likely number of informants required to gather meaningful data, typically at least four to eight per focus group (see Krueger, 1994; Stewart & Shamdasani, 1990)
2. The extent to which data is saturated and no new information is being generated.
3. The availability of patients and professionals.

Sample sizes for purposive sampling are often determined on the basis that no new data is emerging or bringing any additional knowledge (Mack et al., 2005).

3.2.2 Recruitment of patients and professionals

Gaining access involved obtaining ethical approval through the National Research Ethics System (NRES) (Appendix 2).

This study was scrutinised by the data protection agency of the trust and according to the Caldecott principles. The researcher had to obtain an honorary position with the London and Hampshire sites.

Recruitment of patients

Patients were recruited through secure services (low and medium). The researcher made efforts to obtain a balanced sample that was representative of the population, which included

female patients. The researcher recruited patients who had been referred for CBT whether or not they had completed, were receiving or had dropped out from therapy. NICE recommends at least sixteen sessions of CBT using a manual for psychosis. The researcher made note of how many sessions of CBT the patients had received.

The researcher also recruited individuals who had not been in contact with CBT therapy but had received other therapy. This enabled gathering and understanding of a number of views from patients with varying experiences of the services in order to achieve the aims of the project.

Patients were identified through discussions with the responsible clinician, e.g. the consultant psychiatrist. With the agreement of the consultant, a junior doctor, a nurse or a therapist in the MDT team informed the patient regarding the study. Information leaflets and consent forms were given at this point. The patient was invited to participate and a consent form was collected after 24 hours (Appendix 3).

The researcher assessed patients' capacity (based on the Mental Capacity Act, 2005) and sought advice from the consultant or the responsible clinician. The researcher is specifically trained to assess mental health capacity and if a patient was unable to consent on that occasion, the researcher might come back at another time, providing that the patient agreed.

Recruitment of professionals (focus groups)

Recruitment of professionals to participate in the focus groups was conducted through secure services. The researcher held presentations at the secure services as part of the recruitment process. Professionals were identified via their respective department, such as the psychology and psychotherapy department. Focus groups are an appropriate method when the aim is to clarify, explore or confirm ideas with a range of participants (Goodman and Evans, 2006).

All professionals were given full details of the study (information leaflet and informed consent form: see Appendix 4). The researcher aimed to make the focus groups representative of the different types of practitioners.

The purpose of these focus groups was to elicit information from the therapists concerning their experiences of working with patients with psychosis in a secure environment. There was particular focus on:

How the therapists engage, assess, formulate and work with various aspects of psychosis in this group. Helpful and unhelpful strategies that they have encountered

Issues other than therapy – e.g. environment, culture – that they think are essential and that require specific management from the therapist.

The sessions were tape recorded (with informed written consent) for transcription after the interviews. Session logs were maintained to record non-verbal communication and other observations that might help to inform the analysis. Participants were given the option of writing down their experiences should they be more comfortable with this.

Careful consideration was given to the identity of the researcher and the potential power imbalance in the interview setting. It was felt that making the interviews open-ended, without any set agenda, would facilitate collaboration and also enable the professionals to have control over the discussion.

3.3 Stages in the study

Stage 1 – Interviewing and understanding patients' experiences in psychosis and CBT (individual interviews).

Stage 2 – Interviewing mental health professionals concerning their experience of delivering and treating patients with psychosis (focus groups).

Stage 3 – Analysing all information.

Stage 4 – Adaptation of an existing manual from the analysis of data.

3.4 Categories of patients involved in this study

One of the major considerations throughout this study was the protection of those participating. Patients were given appropriate information to provide informed consent to engage in the study. The researcher had extensive discussions with his supervisor and a consultant psychologist in devising the criteria. The table below summarises the categories of persons who were eligible to participate in this study.

3.4.1 Inclusion and Exclusion

Category 1 - Patients in secure services who have received psychological therapy e.g. CBT for psychosis	
Inclusion	Exclusion
Patients admitted to secure mental health services	Mild to moderate learning disability measured by cognitive battery assessments (if this prevents them from participating in the discussions)
Held under the mental health act 2007	Severe illness which may affect capacity or markedly affect their ability to participate in the interview, e.g. very thought disordered or distressed by symptoms.
Willingness to participate in the study, be interviewed and have notes made and/or be tape recorded.	Lacks capacity or does not provide consent. Those patients who, in the opinion of the responsible clinician, would be expected to be distressed by the interview, e.g. those with low insight into their illness
Have capacity to consent and understand the interview. If capacity present, decision-making process around psychotherapy may be recorded	

Category 2 - Patients in secure services who have not received CBT therapy for psychosis but have received other psychological related therapy	
Inclusion	Exclusion
Patients admitted to secure mental health services	Mild to moderate learning disability measured by cognitive battery assessments (if this prevents them from participating in the discussions)
Held under the mental health act 2007	Severe illness which may affect capacity or markedly affect their ability to participate in the interview, e.g. very thought disordered or distressed by symptoms.
Willingness to participate in the study, be interviewed and have notes made and/or be tape recorded.	Those patients who, in the opinion of the responsible clinician, would be expected to be distressed by the interview, e.g. due to low insight.
Have capacity to consent and understand the interview. If capacity present, decision-making process around psychotherapy may be recorded	

Category 3 - Mental Health Practitioners who are skilled in CBT use with patients from secure services also (known as 'Therapists')	
Inclusion	Exclusion
Practitioners who have postgraduate certificate level training in CBT therapy and experience in treating patients with a diagnosis of schizophrenia using ICD-10 and DSM-IV criteria	
Willingness to participate in the focus group and have notes made and/or be tape recorded	

Category 4 - Qualified Mental health practitioners who work with patients in community and secure services (e.g. substance misuse workers, criminal justice system workers, psychiatrists, art psychotherapists, forensic clinical psychologists, counselling psychologists and occupational therapists)	
Inclusion	Exclusion
Practitioners working with mental health offenders. No extensive experience delivering CBT	
Willingness to participate in the focus groups and have notes made and/or tape recorded.	
Practitioners who have psychological therapy training in other modalities in treating patients with a diagnosis of schizophrenia using ICD-10 and DSM-IV	

Chapter Four: Data collection and analysis

4.1 Introduction

This chapter aims to discuss the data collection methods and analysis, which will be examined in section 5. This discussion will highlight important issues in choosing data collection methods in light of the context of this study and its theoretical background.

4.2 Data collection

In constructing this study, several methods from the literature on qualitative studies were considered. It is essential to consider the position of the researcher and the context in which this research took place.

4.2.1 Method for data collection

Patients

Several data collection methods were considered, including patient observations, focus groups and in-depth interviews. Considering the context of the patients (who were long-stay hospital inpatients), the observational method was not considered appropriate, as it would not provide necessary descriptive data. The survey method would not provide a thorough data description and patients' motivation to complete long surveys might be limited.

One-to-one interviews were the most appropriate method, given the nature and context of the patients. One-to-one interviews allow patients to talk about personal experiences, feelings and sensitive issues (Mack et al., 2005).

Focus groups, which are a form of group interview that depend on the generation of discussion among participants (Kitzinger, 1995), were not considered appropriate given the complexity of patients' mental health issues, e.g. low insight and anxiety.

Professionals

Professionals working in these settings have limited time and are often involved in clinical, administrative and managerial work. In light of this, one-to-one interviews were thus considered too time-consuming and a focus group approach was more appropriate. Focus group discussion in this context was the best mechanism by which to explore issues from the perspectives of various professionals working in the same setting. Participants in focus groups influence each other through reaction, which creates rich data within a short time (Mack et al., 2005). Focus groups are an appropriate method when the aim is to "clarify, explore or confirm ideas with a range of participants" (Goodman & Evans, 2006:354). The researcher in this study followed the following guidelines (Mack et al., 2005) in preparing for the focus groups:

Making arrangements and becoming familiar with participants.
Informed consent and introductions.
Preparing ground rules and answering questions.
Discussions from general to specific and handling any uncertainties.
Closure – thanking all participants.
Debriefing the co-facilitator and discussing notes after the focus group.

4.2.2 Process of data collection and analysis

This research gathered data through one-to-one semi-structured interviews and focus group interviews. A total of twenty-six interviews were conducted, of which seventeen were with patients, three were individual interviews with professionals and five were focus groups with professionals. The individual interviews with professionals were conducted by the researcher, separately due to time and availability issues

All interviews were conducted in secure settings and were audio-taped and transcribed. Memos and field notes (writing and audio recording) formed an important part of this research.

4.2.3 Interviewing and analysing data

Patients

Each participant was interviewed for approximately 45 to 60 minutes using a semi-structured interview (Appendix 5). After each interview, transcripts were coded on a line-by-line basis to elicit implicit and explicit statements. At this stage, the researcher remained open to the data and flexible. During the coding process, it was necessary to constantly compare and contrast the analysis of codes in order to establish analytic distinctions (Charmaz, 2006). All data analysis was facilitated using the qualitative computer software NVivo 9. The researcher attended two specific training modules that provided guidance on the effective use of this software, which is designed to manage and aid the in-depth exploration of qualitative data. It also provides a platform for consistency and a trail for analysis and linking ideas to data (Lewins and Silver, 2007). For example, it allows the user to code data line by line and store these codes in a database for retrieval and comparison with other interviews' codes. Subsequently these codes provide a saturation pattern of emerging codes (from different sources of interviews and frequency). This process leads to transparency of emerging themes, which is also called focused coding (Charmaz 2006). (See Appendix 6).

Further interviews were conducted to explore emerging themes with the aim of achieving theoretical saturation (Strauss and Corbin, 1990). As the interviews, continued a pattern of emerging themes became more transparent, which allowed the process of axial coding e.g. identifying relationship between themes, to be undertaken (Strauss & Corbin, 1990; Charmaz, 2006).

Professionals

Focus groups for professionals followed a similar process of analysis. The researcher made contact with the head of services of both London and Southampton sites. The researcher was invited to join in their weekly meetings to carry out focus group discussion. Three focus groups were conducted with professionals who had CBT experience in London and Hampshire sites using a semi-structured interview Format (Appendix 7). The number of professionals who attended the focus groups varied, such that one of the groups only

contained four professionals, which is the minimum number required (Kitzinger, 1995). The biggest group contained nine professionals. Professionals with no CBT experience were interviewed using a semi-structured interview (Appendix 8) at London sites, with one focus group being held at London (site 1) and the other group at site 2. The latter session involved only three professionals, as one of the therapists failed to attend the meeting. The Hampshire site did not employ other therapists such as art therapists. Each focus group lasted approximately sixty to ninety minutes.

4.2.4 Data credibility

Triangulation in qualitative research is an essential concept which addresses the reliability and validity of the data (Creswell, 2009). This study produced rich and detailed descriptions of data, thus ensuring some level of internal validity (Creswell, 2009). For example, the researcher acknowledged bias in interviewing patients in his work setting. The reliability of the data was assessed by comparing and contrasting data from different patients and professionals. An ex-patient from a different site independently reviewed a random sample of patients' transcripts. These transcripts were checked for the coding and interpretation of themes and any uncertainty was clarified. For example, one of the obstacles that arose was the interpretation of meaning behind patients' emotional expressions. A similar process of reliability ensued for the professionals' transcripts. Focus group transcripts were analysed by one of the focus group members. These transcripts were checked for coding and interpretation and any changes were highlighted.

Themes were explored within and between patients and professionals to map out 'making sense' models of views and experiences. The data were analysed to generate themes and models, which were subsequently validated with a qualitative study expert to get a better view of the whole process. The following chapter will reveal the findings of this study.

Chapter Five: Results

5.1 Introduction

This chapter discusses the findings from the qualitative interviews with the verbatim quotes from patients and professionals, together with the author's commentaries. For purposes of clarity, the patients' and professionals' quotes are in italics (e.g. I'm fine).

5.2 Final sample

Interviews were conducted with patients and professionals. In total, the data set comprised fifty-two participants, as outlined below according to their categories:

Patients

Seventeen face-to-face interviews were conducted at the London and Hampshire sites. Ten patients were recruited from the London sites and seven from Hampshire.

Focus Groups with professionals with and without CBT experience.

Three focus groups were conducted with professionals who had experience in delivering CBTp (n =23). Sixteen participants were recruited from the London sites and the remaining seven from Hampshire. Two focus groups were conducted with professionals who had no experience in delivering CBTp (n=10), all of whom were from the London sites.

Final study data is summarised in the following graphs according to participants' respective groups and constructs. It important to note that there was one female and the rest were male patients in this study.

5.2.1 Professionals interviewed

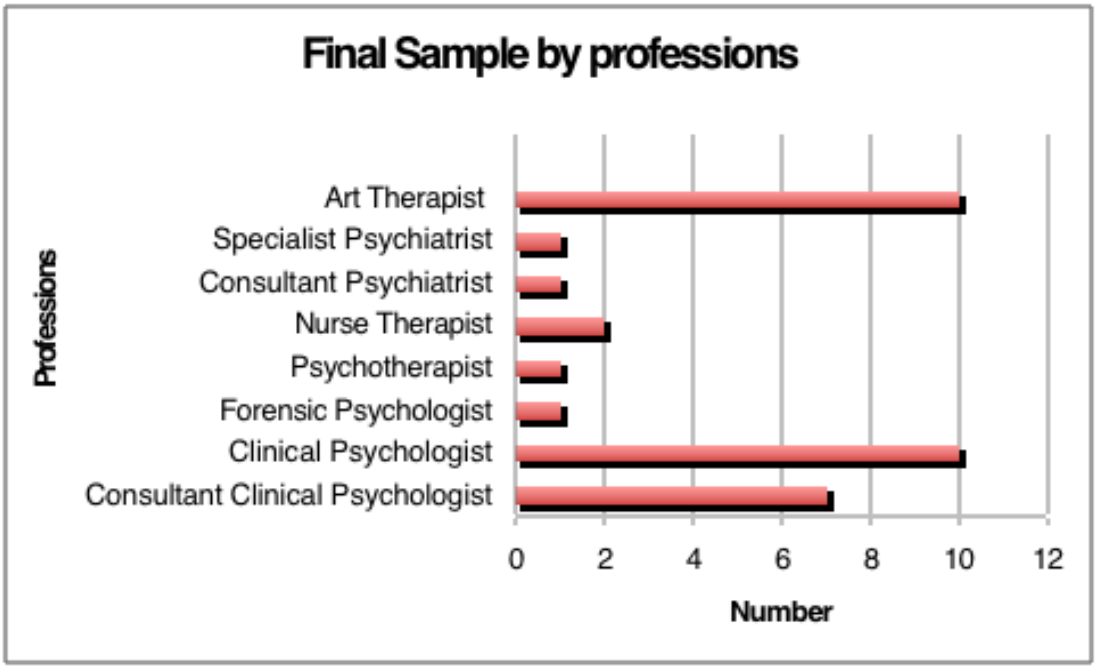

Figure 2: Final sample of professionals by their professions

Figure 3: Professionals by experience and research sites

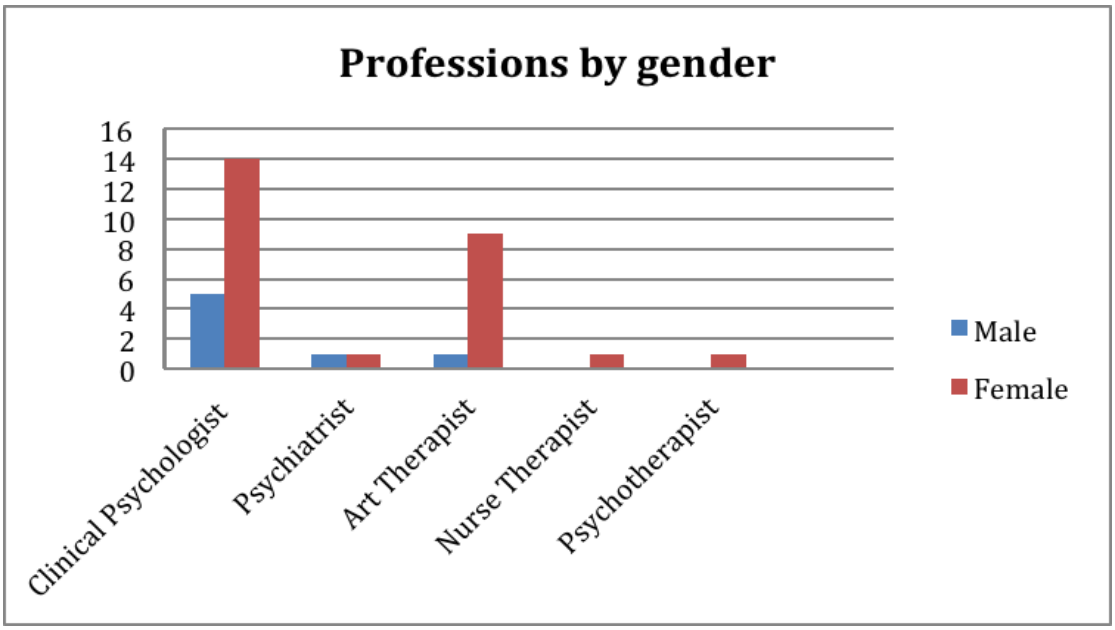

Figure 4: Professions by gender

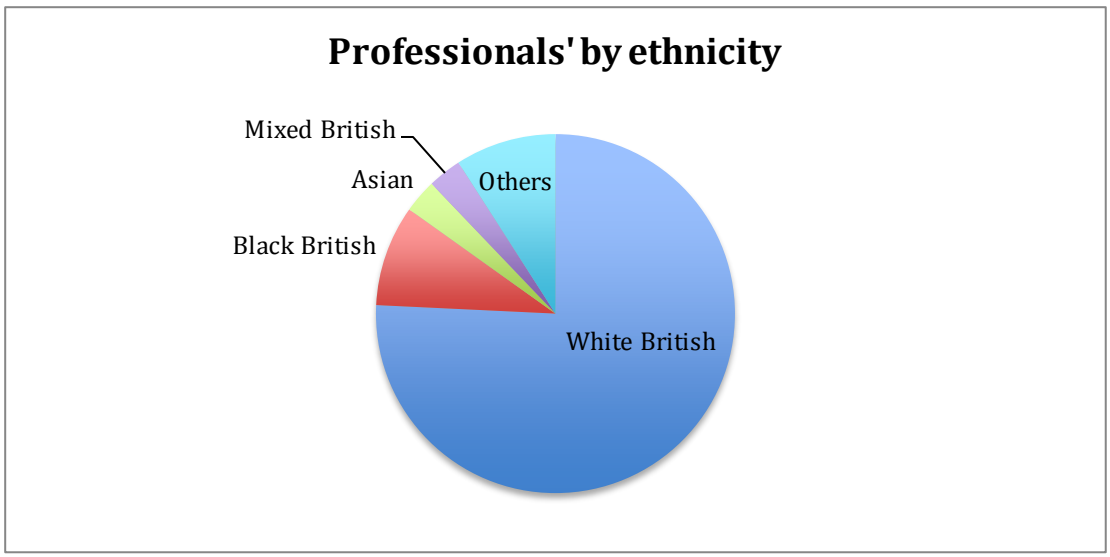

Figure 5: Professionals by ethnicity

5.2.2 Patients' interviews

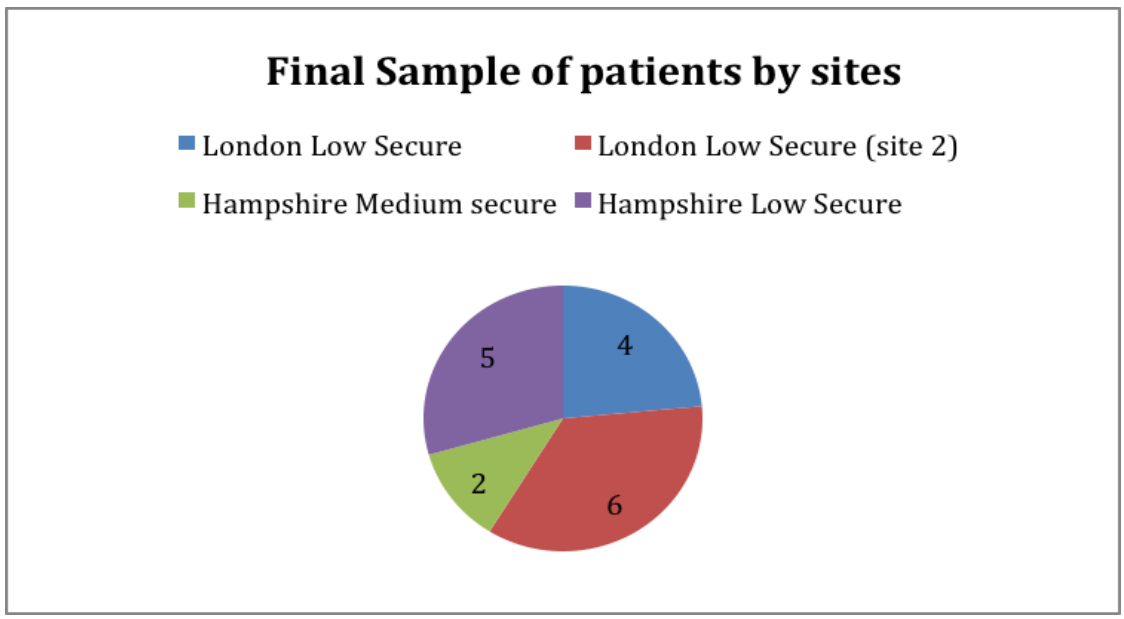

Figure 6: Final sample of patients by research sites

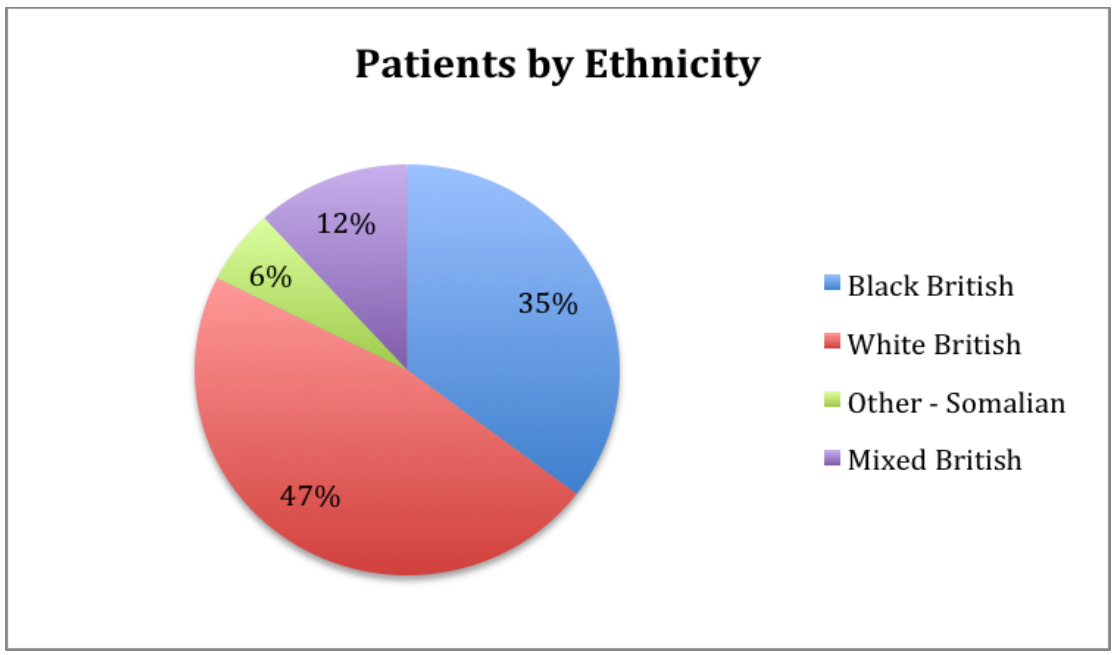

Figure 7: Patients by ethnicity

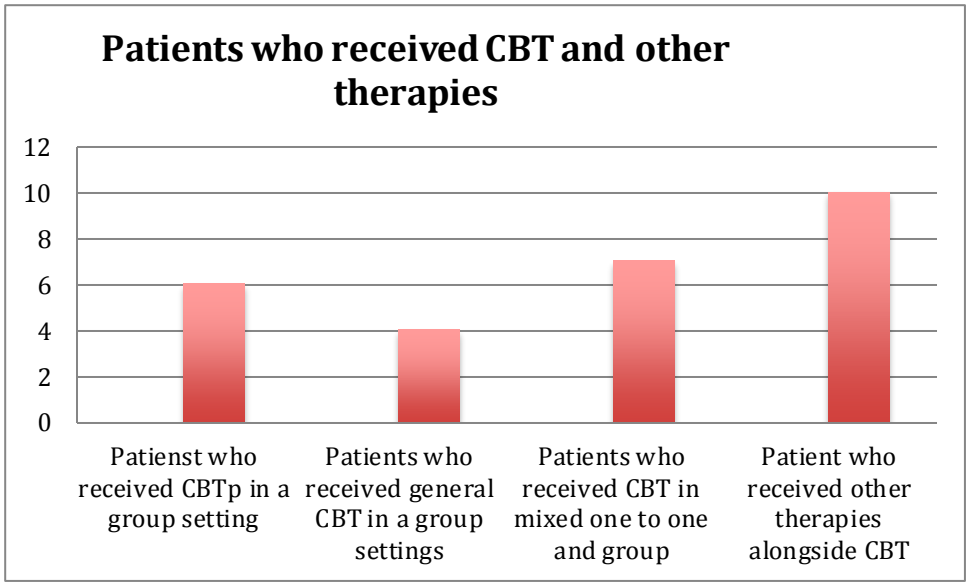

Figure 8: Patients who received CBT and other therapies.

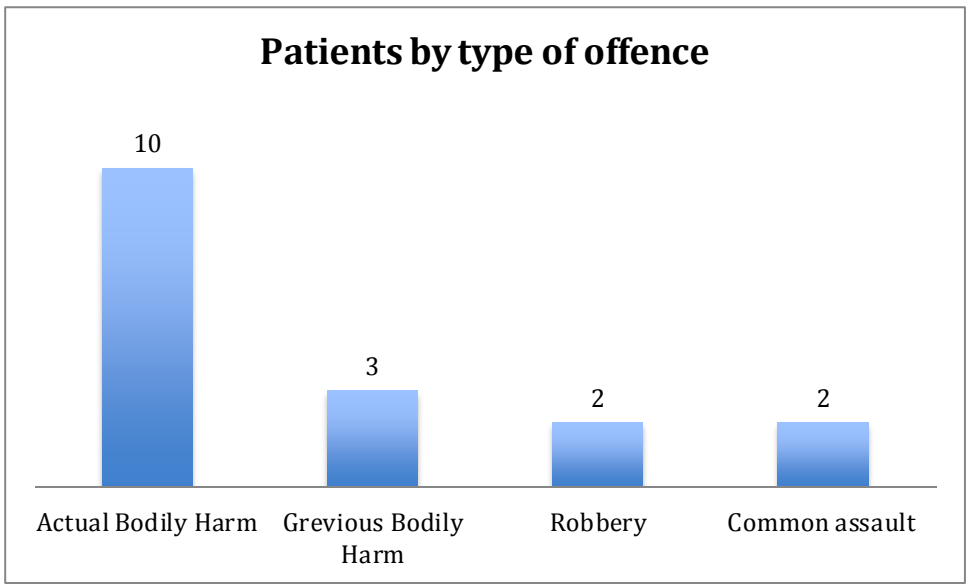

Figure 9: Patients by type of offence

5.3 Patients' themes

The initial section will review the emergent themes in relation to patients' views on their stay in secure services and treatment. In the second section, the themes emerging from the professionals' focus groups will be reviewed. All themes are illustrated within their overarching themes. It is important to note that the main themes are organised according to the frequency of patients' verbatim quotes, and will be discussed accordingly.

The themes from the perspective of the patients' are:

Overarching themes

Place of healing – patients described their care in hospital as a positive experience
Confinement – Patients talked about restricted lifestyle and limited contribution of decision making about their care

Main themes

Place of confinement vs. place for consolidation
Stigma feelings
Regular meeting as a platform to understand self better
CBT model as a practical framework to keep mind in check and solve problems
CBT as a psychoeducational process to understand and provide insight into my problem
CBT therapy as equals
Medication helps to get better

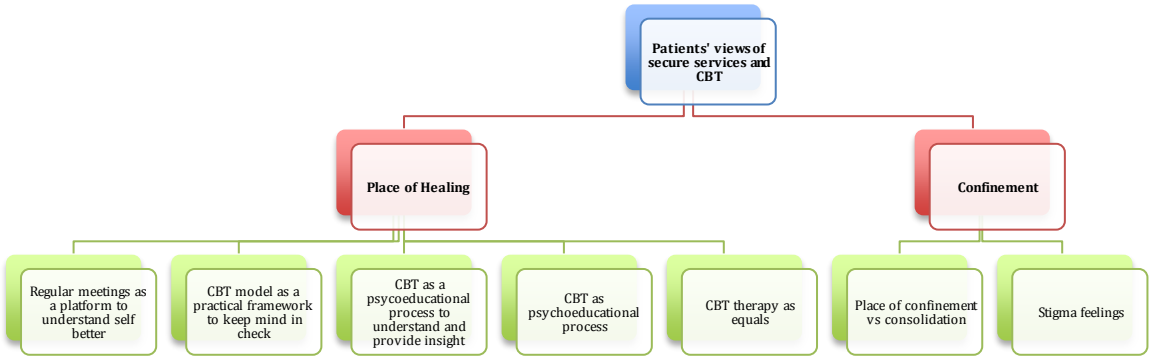

Figure 10: Patients' views of secure services and CBT

5.3.1 Place of confinement vs. consolidation

Patients viewed their stay in secure services on a spectrum from a place of confinement to a place of consolidation. The description of their care as a place of confinement incorporated limitations to their freedom, a struggle to understand the system, an imbalance of control and feelings of coercion. The patients expressed their confinement as making them feel depressed.

As P6 and P7 describe, they considered that their confinement is not understood by medical staff and, in their view, they did not need to be contained.

I think that the doctors, with all their experience, the one thing they don't know about is what it's like to actually be detained, you know, um, that's something they will never be able to understand, you know, so sometimes it can get to you.

P6, page 2

I don't like it. I don't think I need to be here.

P7, page 1

Several patients described having limited freedom. P12 described his experiences related to not being able to have much freedom. He also mentioned feeling anxious about getting on with other patients and his lifestyle being affected.

I want my freedom back, if you know what I mean. Like you can't have a girlfriend. Um, you can't just go wherever you want. Sometimes it gets boring with not a lot to do and sometimes you got to get on with the other patients, which is not always easy, stuff like that.

P12, page 1

Similarly, P9 and P14 framed their experiences as being in secure services for a long time and described frustration over losing control of many life activities in which they used to engage. They associated this with a sense of losing freedom.

I don't like it.
Um, I worked outside all of my life and coming here being locked up did not go down too well with me, I didn't like it at all, um, I suppose I've got more used to it now and as of the length of time I have been in here. I have been granted more leave to go outside and that has lifted my spirits somewhat. But um it's very strict in here and it's just sometimes difficult for me.

P9, page 4

Well I don't suppose any of us do; none of us want to be here. I'd prefer to get out. I've done seven years this time, so. Well, I think about all the things I should be doing, you know? All the things I could be doing when I'm out.

P14, page 1

Another theme that arose was not understanding the system and not knowing about their future plans. P3 expressed this through a metaphor.

I still view it as an outsider. Because I went to a drama therapy class and the lady taking the class viewed me as a sailor in my boat on the horizon looking for land, and she was just saying in a way, describing to me that although I am always on my own, like a loner, kind of thing, yes and I am setting sail and drifting away on the water and no one knows where I am going to come to land or what I am going to do when I get there. It's like me coming into contact with the real world and people around me: no one knows what I am going to be like, they are scared of me, things going wrong, they don't like certain things, I don't like them, but I mean I just drift.

P3, Page 2

Imbalance of control and coercion was also expressed by some patients. They reported difficulty in communicating with professionals due to the fear that the doctors would lengthen their stay in the unit. The doctor is seen as a powerful person who normally contributes significantly to the decision-making process, which is often against the patient's wishes. P4's narrative illustrates this:

Did I find it hard? I found it hard to speak to them because he (the doctor) was the one who controlled what was going on in hospital and I had a bit of a, not a problem talking to him, it was just I could not get my thoughts clear, I could not get my thoughts out to him properly, because he was in control of my care and I thought he could take advantage and could do anything in his hands to - you know - make my care. He can decide when I was going to be discharged, he can decide what medication I must take, he can decide how long I must stay in hospital for, and so on. He is the main person in charge of my care in hospital.
It made me feel, I was feeling upset because I did not want to be in hospital, I wanted to be in the community, but there was a reason why I was in hospital, because I was unwell, so I have to accept it and move on.

P4, page 2

Similarly, some patients mentioned not having a choice and being controlled by doctors. P6 describes this experience as jumping through hoops to fulfil the doctor's wishes.

Sometimes it can feel like you are jumping through a lot of hoops for the doctor, doing this and doing that – ugh.

P6, page 2

P3 and P8 both felt that there was no choice in the decision-making process and that the doctors had control over their lives. P3's account portrays a picture of punishment.

I have tried explaining to them but they said if I don't they will take me to a secure unit so they give me no choice. It's forced on me: take it or get locked away. Yes, leave me no choice.

P3, page 3

Which is strange really because doctors, they are more into the clinical side of things, just see you twice a week sit down with your team. The nurses, they see more of you than the doctors. The doctor just comes in twice a week, or he might come in on the off chance, sit down with you and see how things are, and um, that's about it really. You have two ward rounds a month and that's your whole life really, it evolves around these two ward rounds, so it's very serious really when you think about it. It's a serious thing because these people have got control of your life and no man should have control over another man's life.

P8, Page 2

In response to the above, some patients expressed a sense of feeling submissive. P6 and P12 described the care as affecting their mood and making them feel depressed.

I go through a lot of mood swings here, being detained, you know, and some days I wake up feeling very claustrophobic and other days I wake up and I feel good. Something is going to happen today, you know, I'm meeting somebody out in town or something like that.

P6, page 2

Um, it's alright. It's a bit depressing at time.

P12, page 1

The majority of patients viewed living in secure services as a negative experience. However, there were a few patients who expressed positive views, including seeing the experience as a time for consolidation.

I feel as if I am coming to the end of my stay, my therapy has just finished. I am having time for consolidation

P15, page 2

P10 attributed his experiences as being looked after to get him well and saying that the care was more than medication and talking. It is important to note that P10 came from a different country and this might affect his views[1].

I think it's like you are in hospital or rehab - we have somebody to take care of you, they take care of you, they give you medication, they are talking to you as well, and they are giving you something.

P10, page 1

P11, P15 and P16 mentioned being in secure services for a reason, and in addition, P16 acknowledged his index offence and trust from professionals, which helped him to move on. They valued the treatment that they received and felt that their stay in secure services had contributed to their wellbeing.

[1] Individuals who come to the UK under various migration routes, particularly asylum seekers, generally come from poor countries where the systems of mental health care are either not fully established or disorganised.

[2] Integration is described as a process whereby continuity is recognized between thoughts, feeling and behaviour during

It's where I need to be. I have got a problem, I am controlled by medication and therapy, um, I have just been granted a conditional discharge pending my parole hearing. If I get parole, I move into the community, into a 24 hour care home, and if I don't get parole, depending on how much of a knock back or review for the next parole hearing, and if I do go back to prison, my consultant will rescind my conditional discharge and I will stay in hospital. Yes. I was in maximum secure to start with and I have worked through the grades and um, this is good.

P 11, page 1

I have learnt so much that I did not know before. It's just awfully tragic for my victims and it's also very tragic what I had gone through and I did not realise just how damaged I really was, you know, behavioural wise. Mentally. So I've come a very long way. I'm quite articulate now, if you had met me a few years ago, I would not have been able to sit here and have this conversation with you: it would have been totally different sort of conversation.

P15, page 2

I don't mind where I am now on an open locked ward and could come and go as I please within reason, and they trust me enough now to be released soon. If they did not trust me, I would be on a locked unit. I like it, I like it.

P16, page 1

5.3.2 Stigma feelings

As a major mediator in helping patients to get well, this section will discuss the patients' perceptions of feeling stigmatised. An apparent theme was that some patients with psychosis internalise public and sometimes carers' stigma, and as a consequence, experience shame and fear, which can result in delayed help-seeking or relapse.

P5 felt that he was labelled for his problem. Expressions of frustration were evident in his account. He perceived that the therapists had a hierarchy, in which he was at the bottom rather than being on equal terms:

I don't hold it against them but it makes me feel stigmatised and institutionalised because I feel when I get out I'm going to still pick this up this environment and it's not very veracious or eloquent to pick up what you pick up in places like this but um, they affect your behaviour and moral, especially when you have been what I've been through.

P5, page 5

Similarly, P13 provided a picture of someone who was feeling shame and had low self-esteem. He also felt that his carer had a different attitude towards him, which made him feel low.

No. I was trying to get away from all that. Yes, my father was irascible, and belittled me. Um, and it kind of started from there. So I had to get out of there and concentrate on finding myself.

P13, Page 2

5.3.3 Regular meetings as a platform to understand the self better

In this section, regular meetings with professionals were perceived as an important aspect of care that contributed to patients' wellbeing. Participants expressed that meetings helped them to move into the community, understand their illness, understand the system and help other

patients, and also to build their confidence. It is interesting to note that out of the seventeen patients interviewed, sixteen stated that they observed meetings with professionals – for example, everyday interaction with staff – as a positive experience to help them get better and move out. These narratives are exhibited by the following patients.

P1 framed these experiences in the context of staying in the hospital for a long period. He associated going through several meetings and sessions with professionals with an aim to get well mentally and occupationally and be able to move back to the community.

I don't mind it. Suppose that's how to keep you on the straight and narrow if you do get out, you do eventually get out. Well, it reminds me to check, reminds me to do things what I am told to do. So I can get a good job out there and I could make progress with my life and move on and back yeah.

P1, Page 1

This view was echoed by P2, who expressed that meetings with professionals were a good experience, as he gained a better understanding of the illness and of himself as a whole person. P2 acknowledged the stages from unwellness to recovery in the context of being able to reflect on his negative experiences and associated his meetings with progress.

I didn't mind them, but I thought they were just a waste of time, but I was just being ignorant: my thoughts were quite ignorant back then, when I was on the previous ward, because I was quite unwell. Well now I've seen that the, the groups and the one-to-one sessions can help me to understand my illness and how I could better my life.

P 2, page 1

A similar narrative was observed to be reported by other patients in that meetings were seen as a platform where they felt comfortable and could get help. P16 viewed meeting with staff as a platform for recovery and understanding the system.

I don't mind.
Well with the aid in my recovery and the system in which I live in this place I am in the habit to co-operate.

P16, page 1

This was also reflected in P11's narrative about attending meetings after being in the system for fourteen years. He described his experience as a learning curve which helped him to better his communication skills.

I've been trained to do it now. When I first went into prison I never talked to anybody. I had what they classed back then as learning difficulties with Dyslexia 'cause I did not learn to read until I was twenty-two, um, so my communication skills and abilities to talk were very low. But as I say that over the past sixteen years, um, I've learnt how to communicate with people, understand people – empathy, if you want to call it. I had a job for fourteen years as a patient representative and originally it was done because they said it was unhealthy to not talk to people.

P11, page 1

P4 provided a narrative with similar tone and but unable to elaborate. It was noticed that he might be going through a transition phase between resistance and acknowledgement of his current situation.

I don't mind, if it's going to help me I will do it.
Yes, it has helped me yes.

P4, page 1

Some patients reflected attending meetings as a training ground to boost confidence and self-esteem. P13 and P15 reflected on their experiences of attending many groups, including formal meetings with other professionals. Their experiences reflected building self-esteem and confidence. P15 was able to identify and learn positive skills from others.

I don't mind. I'm compliant with meds, I go to groups. I don't mind interviews or tribunals or ward rounds. I am willing to participate. I feel quite comfortable in those.

P13, page 1

Um, appointments and meetings, I don't mind. I'm fine, it does not scare me or anything. I'm quite confident you know, I don't mind meeting new people, I'm quite open. Obviously, I can be selective in who I talk to, but I think because different people have different skills and you can pick up on what skills you might need from a certain person. You know.

P15, page 1

In the process of reflecting on these experiences, those who became better were in a position to help others by participating in external research-related meetings. P9 clearly reflected that he perceived this meeting as a place in helping other patients in the future.

I don't mind if it's helpful. It's giving back, you know? The hospital have given everything to me so I am returning that by co-operating with the hope that it might be able to help.

P 9, page 1

This was also reflected by P8.

I haven't got a problem with that. If it helps other people then it is all good.

P8, page 1

The majority of patients expressed positive views about meetings. Nevertheless, during these interviews, one patient depicted meetings as a repetitive process of answering the same questions. He conveyed this as a potentially distressing experience.

This was apparent in the following narrative.

Unfortunately some of the questions that are asked are very repetitive. You know I had quite a few interviews with the psychologist and I found myself repeating when I went to CBT and ETS so that was the only thing. But no, it was most helpful.

P9, page 1

5.3.4 CBT model as a practical framework to keep mind in check and solve problems

In this section, most patients talked about attending several sessions and employing a CBT framework to keep their minds in check and solve problems. All patients received CBT in general and some had CBT for psychosis. CBT for psychosis was mostly conducted in a group format followed by individual sessions. All patients reported attending a variable number of sessions during their stay in the hospital, as below:

I had about a good 15 lessons, sessions.

P1, page 4

Nine sessions

P10, page 3

Oh, loads. Twenty.

P2, page 6

CBT: six, I think.

P13, page 2

About twenty-two sessions

P17, page 2

All patients acknowledged having between six and twenty-two group session of CBT and CBT for psychosis (CBTp). The researcher made attempts to differentiate general CBT and CBTp.

Three patients acknowledged the CBT framework as a helpful technique to keep their minds in check. They related this to their general and specific experiences. P1 elaborated on the use of the framework by acknowledging the consequences of his behaviour that could jeopardise his future.

I suppose it is good in a way, it helps to keep my mind in check, you don't want to be out there where you've got an illness and you don't know how to go about getting better, um, don't want to be outside doing the wrong things or getting yourself into a lot of foolishness where you could be in a place that could keep your mind in check and you are more aware of the things you are doing. I suppose it does help you, yes.

P1, page 2

P2 attended individual sessions of CBT and also attended CBTp group sessions. He was able to reflect on the connection of his stressful events to his breaking down.

Well I can recall we were talking about a lot of things for the last couple of years for some behaviour and the way you thoughts can make you behave and also delusions.

P2, page 4

P15 added that she used a technique of 'old self' and 'new self' as a useful way to control her anger.

Regression, imagery, um, diagrams, behaviour cycles, mood cycles, and how I felt about myself. Just things like that really.

Um, I think the diagrams to show, you know, thoughts, behaviour, that was my first thing that I grasped. So that sticks out the most for me. So what I started doing was doing diagrams myself. So that I could give myself that half second chance in either behaving in old way or finding an alternative, so that was quite helpful. And that stands out more than anything. Because that was my behavioural change. Regression has helped me accept, also to find compassion for myself.

P15, page 2

Some patients perceived the model as a problem-solving approach. They used this approach as a tool to identify the problem, triggers and solutions. This also helped them to create new coping skills and build on existing ones. P9 reflected on his CBT for psychosis group sessions, which he perceived as problem-solving approach.

It was not anything in particular: I just found it all very useful and I came away from CBT feeling that I had done something worthwhile by identifying these problems and what to do to remedy the situation and um, you know, the help groups that were available to you so that you can get immediate help if you feel that you have got a problem that's coming on.

P9, page 3

Other patients mentioned using this framework to address problematic behaviours stemming from the powerful emotion of anger. They described looking at the initial thoughts that lead to anger and making a functional analysis of their behaviour. Patients' responses were positive with regard to the acceptability of integrating this model into their routine.

P11 conveyed his experience using the timeline and problem-solving approach to address anger issues.

We did a lot of time line. We discussed ways of alleviating the symptoms of my voices. Um, I did a lot of work: one part of it was WRAP, wellness recovery action plan, that was another one. Um, I have a lot of problems outside as well as inside so we also talked about how to behave and how to work around that. Um, that's about it.

It stopped me from doing it. It did not stop me, I still self harm, I still punch things but I don't know I am doing it. It's like bang, bang, bang, oh bloody hell, my hands are all broken up again, I can't smoke because I've hurt my hand. So that was one good way of stopping doing it.

P11, page 3

P7 and P8 narrated a similar experience of anger and worked with the model to generate solutions to their problems.

They just sort of like looked at my behaviours from how I have reacted to stuff and what I think and what my thoughts are about things.

P7, page 4

It was quite good really because we talked about many subjects about behavioural problems or looking at how you would approach certain situations like your anger or um, how you would deal with other people, many things, I can't think off the top of my head.

P8, page 5

P4 reported being able to relate to the basic model and understanding his problems. He was able to make the connection between understanding negative thoughts and their consequences on beliefs.

I found it very helpful because it gave me more understanding about cognitive behavioural thought? What's it called again – Cognitive Behavioural Therapy – and it gave me an insight about what goes on in your mind, how you can change it, how it gives us more understanding about our mental state and what goes on.

P4, page 4

Similarly, P7 framed his experience in using thought diaries to identify his negative thoughts. He found it difficult to remember his thoughts when discussing with his therapist, and thus found writing useful.

Yes, it's just thought diaries, yeah. It is quite useful but it's hard to kind of like try to identify your thoughts, you know what they are and that, and what they are looking for and stuff like that.

P7, page 2

P8 had a similar experience but was able to provide information on identifying thoughts in a situation.

Yeah, going on about how you would deal with thoughts, talking about being in a situation where um, I can't remember, I wish I looked for it now, and um, because we had files on it as well.

P8, page 5

5.3.5 CBT as a psycho-educational process

Psychoeducation has been a vital part of CBTp and informs patients on the basic tenets of their disorder. The majority of patients expressed that psychoeducation was an essential element in therapy which helped them to have better awareness. Patients' narratives were divided into understanding their illness, learning through video sessions and making sense of their experiences.

P1 and P2 mentioned receiving psychoeducation on different types of mental illness and symptoms. They perceived this as a platform to learn about their diagnosis and other factors that have an effect on their mental state. P1 talked about the effects of illicit drugs on mental state and knowledge of the symptoms of mental illness.

They acknowledged that psychoeducation of mental illness is an overt process of creating an awareness of symptoms which can provide them with some insight into their problems.

It makes me know what schizophrenia is about, and if I'm diagnosed with it, um, it makes me know more about what drugs are about, what sort of drugs is, like ecstasy, LSD, speed, what sort of drugs is about, what it is, if it's a stimulant.

P1, page 3

Sigh--- Well, Well it has help me realise that that is a part of psychosis, which is, could be one of a few illnesses, mainly schizophrenia.

P2, page 6

P16 and P17 had a similar experience of learning about the symptoms and relating to their own experience.

Well, knowing the symptoms when they happen to me.

P16, page 3

Um, we went through what are the symptoms, what happens if you experience a symptom.

P17, page 2

P6 reported that having education on delusions and getting an independent view from a professional resolved uncertainties regarding patients' diagnosis and treatment.

Um, we would go in and they would they would teach us stuff about delusions and things like that – mental illness – and there would be questions and answers and we had a guest speaker come in once which was an independent doctor to answer questions, just to get an

independent perspective on any queries, you know, and ugh, yeah, it was ok. It was actually one of the better groups I have done.

We looked at the three different types of delusions that there are, the categories, and ugh, it was only then from the CBT group that I knew what I had been suffering from, before that I did not know. That's what the groups are there for – to teach you. And um, yes, I was very keen for finding out, you know, what was going on with myself, and yeah, that's about it.

P6, page 4

P2 benefitted from knowing that he was not the only one going through a particular problem.

The facilitator showed us different backgrounds of people and what they were going through, so that, that just helped me to know that I was not just the only one in that position.

P2, page 6

Some patients expressed benefiting from receiving psychoeducation video sessions. They perceived this as coming from an independent individual, which helped them to normalise their feelings. This was narrated by P3 and P2.

The 'Voices' video is useful because it can happen to anyone. It just helps you understand where people are coming from: when people are saying crazy things it helps to understand where they are coming from. You don't just view them as crazy and out of their heads: you view them as ok, well he's saying this and that now and I've seen this and that on the TV and video so I can see where they are coming from a bit better, making it clearer. Just to clarify things, you know what I mean.

P3, page 5

Well, well it has helped me realise that that is a part of psychosis.

P2, page 6

Some patients mentioned making sense of their problems when discussing them with their therapists. P12 and P9 mentioned understanding what had they learned from the psychoeducation and one-to-one sessions. P9 found the structure of the psychoeducational modules easy to follow and comprehensible. He reported completing most of his work and was able to apply the knowledge gained to his current experiences.

Um, making sense of everything.

Well I was able to talk about my mental illness, I was able to talk about the past, and um, we were able to understand how things had happened and able to talk about my different symptoms. Um, trying to make sense of everything.

P12, page 4

Well it was almost like being broken down into modules which I found easy to follow and also I found that the balance was right between the different subjects that we spoke about. It all made common sense; we also had videos as well, which were helpful. I just felt comfortable with CBT, not like ETS. I felt benefit from it: we identified things to trigger you off, what to look for, how to remedy situations, so it was quite thorough.

P9, page 2

5.3.6 CBT therapy as equals

In this section, most patients discussed their relationships with their therapists. Most of the patients interviewed expressed views that they got along with their therapists due to the therapists' interpersonal skills, professionals skills, confidence and the fact that they were treated as equals. All patients felt that they had been attended and listened to by their therapists, allowing them to freely discuss issues.

Four patients described their satisfaction with the therapists' skills in helping to facilitate their understanding of their problems. P12's, P4's and P17's narratives provided the impression that they genuinely felt that their therapists were very helpful in solving their problems.

Um, I'm seeing the psychologist; I've only just started seeing her. And she seems pretty good, helpful. We did drugs and alcohol work today and that's quite good and um, yeah, I think the therapist is quite good here.

P12, page 1

Yeah, he was good: he understood a lot about the group and parts of the mental state and parts of the yeah. It was a good group. The guy was very helpful, he helped me in a lot of ways because I did not know about the mental state, I was just, was confused: I thought most of the cause of my problem it gave me more understanding about it, about what was going on.

P4, page 4

There were a few people.
They were ok yes. Yeah, they are quite helpful. Understand that you are ill, and help you.

P17, page 3

P15 provided positive comments in relation to the interpersonal skills of being genuine.

Um, ----- is a very genuine person: she tells it as it is, which is great. She's not scared to confront you, which is really good and positive, and you know, it's been a bumpy journey. I can't say she is a bad therapist: she has worked for me, whereas I was in another place before here and that never worked for me.

P15, page 3

Similarly, P9 appreciated his therapist's help and thought highly of him.

Psychology-wise has been brilliant; I could not ask for anything better, I did forty-two sessions with my psychologist. Individual ones yes, we have only recently just finished that. It was very comprehensive, it was structured, it was helpful, so yes, in fact, the psychology sessions were the best treatment that I have had since I have been in here. Because he was so relaxed and understanding and helping to unravel things from my past and helping me to let go of negative things that had happened to me and to be able to look forward in a positive light.

P9, page 4

Some patients felt that professionals' skills were important, as they could trust that they were being treated by someone who was qualified and knew what they were doing. P11 and P1 narrated their experiences in this respect and could relate to a professional who knew about their job.

Which one------. Very professional – she has done this obviously dozens and dozens of times, um, I tend to wander off the subject and she brings me back and that is one of my problems but she was quite patient and she would sit there and listen to me, and pull me back to what we were doing, and as I said we have done it over one or two years.

P11, page 4

Any person. Any person that's trained, not just any old person who know what they are talking about but any person that's trained and understands what they are talking about. Yeah.

P1, page 7

Another variable perceived to be important is the therapist's confidence. P6 and P3 preferred having a therapist who was confident in carrying out their work and able to come to their level.

Oh right, definitely somebody who knows what to do and is in control. Somebody who is very confident, you know, and somebody who is friendly and down to earth along with it.

P6, page 6

Um, someone who knows what they are doing, knows what they are talking about, got confidence in themselves.

P3, page 7

A number of patients were able to explore and share their feelings more openly with their therapist, as if they were a friend or someone close, and were treated as equals. Experiences of interactions of this form were conveyed as bringing a sense of belonging and acceptance. Patients P7, P8 and P9 expressed that their therapists were people they could trust and be flexible with. P7 mentioned having moments of humour, which suggests that he was seeing his therapist on an equal footing.

Yes, I like him. We get on well. He's my nurse on the ward we go out together and stuff. Yes, we get on well, we have a joke, but were serious when we talk about it like but it, we can make it light hearted sometimes but there are lots, I can trust him.

P7, page 4

P8 reported that his therapist disclosed some of her personal matters, which created a sense of equality.

Um, we talked about many things, umm, mainly my anger really, and how I look at life, my childhood, growing up as a kid, just going back through what brought me into this environment. No she is very good, she's very good, you can have a good conversation with her. She opens up. Well she opens me up a bit, I can speak about anything really, really anything that is on my mind.

P8, page 7

In contrast, one patient that felt his engagement with his therapist was not as expected. He described having difficulty in engaging with professionals and attending groups. His attendance was tied in with his discharge plan.

There were two doctors, one psychology and one psychiatrist, and a nurse. They were helpful to a certain extent, but even then my heart was looking to the end of the program. What they said to me was, the psychiatrist on my ward said, 'It would help in the tribunal, help ease the result that you do get it', so I went, that was part of the reason that I, went you know.

P16, page 4

5.3.7 Medication helps to get better

Although there were negative perceptions amongst patients, on the whole medication was viewed as something that helped them to get better. There was considerable consistency in the themes that emerged from the responses of most patients.

The majority of patients talked about their experiences of taking medication, suggesting that this was an integral process, and for a small number it was felt to be essential, with a sense of finding the 'right' medication to address their problems. Nevertheless, some patients' views were reserved in that they were not sure if medication was the ultimate means to get them better, and to some extent, it exacerbated their situation.

Below are four patients' views on receiving medication. P11 acknowledged that medication did not completely eliminate his overwhelming perceptions: hence, he needed intervention such as therapy to achieve recovery.

Very good. Everywhere, but in here has been very good.
Medication-wise I think I am on the correct medication. It does not totally eradicate the voices but it takes it down to a level where I can function.

P11, page 2

P16 reported experiencing difficulty in the early years but acknowledged being on the right medication.

Initially it was tough. But it changed about two or three years ago to a new method, and I like it. It's a good one.
Clozapine. Yes.

P16, page 2

This view was echoed by P17 and P12.

Yes, the treatment has gone well here.
Yes, well, it's good that they are trying to help me: they put me on the right medication, so.

P17, page 2

I feel my treatment here is pretty good. I'm on the right medication. The doctors listen to me about what I want from my medication, stuff like that.

P12, page 1

Some patients expressed opinions that indicated the presence of high ambivalence. They were unsure whether medication was the only answer to their problems. The varying responses reflected the range of experiences and values held by patients relating to their recovery. Some patients also expressed that the management of their medication could be better. They discussed tapering off the medication gradually, as they were on the road to recovery.
P14 expressed his experience of being on medication and therapy with a great level of uncertainty. P8 talked about having a system of weaning which could gradually hand over personal responsibility.

The treatment is alright; it's just sort of the medication and therapy really.

P14, page 2

Well, as far as I look at treatment, I feel that medication helps to a certain degree; then comes a time when you need to be weaned off it. My personal opinion, me, I personally think I need to be weaned off it slowly whilst I am out in the community. And then um, just get on with my normal life really.

P8, page 3

Some patients felt that medication was meddling with their minds and that they were being forced into taking it. The increased dosage of medication contributed to the belief that they had severe mental illness and impeded some of their functioning.

P1 provided a narrative of experiencing a degree of mental illness on a spectrum and was not a proponent of taking medication. For example, taking medication was making him believe he had more mental illness, which can be construed as having additional co-morbid problems, such as medication paranoia, as a result of this belief. Similarly, P3 felt that his personal space and choice were being invaded. He mentioned being coerced into taking injections.

I'm not too happy with me, myself being on medication. I don't think I have more mental illness but it is still imposing me with the drugs, I feel as though its making me think that I have got a mental illness. Making me really think that I have got a mental illness.

P1, page 2

Treatment. I don't like the injections and I try to tell them that but every time I stop trying to take it they force a needle into me so if I try to tell them 'no I'm not taking the injections' they will manhandle me and force it into me, then they raft me up and I run the risk of me being injured.

P3, page 2

5.4 Patients' themes - other therapies

In this section, patients provided their views about other therapies (art, occupational, family therapy and gym) offered on the ward to complement the treatment regime. Most patients reported that these other therapies were a useful adjunct to their treatment.

Some patients perceived art therapy as a medium of time and mind occupancy and a place to reflect emotions. Other patients perceived engaging in occupational activities as a way of learning to be independent and maintaining healthy experience. The majority of patients perceived some therapies to be more useful than others and expressed their views according to their preferences and personal benefit. Nevertheless, some patients viewed therapy as something that they needed to do in order to get leave.

5.4.1 Place of time and mind occupancy

P17, P10 and P9 narrated their experiences of engaging in art therapies groups which gave them a structure for their week and engaging in domestic activities. P17 provided his narrative below.

To do some work some physical work and keep your mind occupied.
Yes it was all helpful. It gave me a good structure for the week, so.

P17, page 4

P10 mentioned engaging in drawing and his therapist providing feedback to the responsible clinician.

How I draw in it, I draw a cougar, she tells the doctor is doing good. Good, for attention, good for someone in this.....

P10, page 6

Similarly, P9 engaged in this activity to occupy his time in addition to providing a structure for the week.

I'm starting drama therapy and I also go to work rehab twice a week and I'm also learning how to use a computer. So those things take up a fair amount of my time in the week.

P9, page 4

Some patients perceived attending groups as a means of distraction from their problems and being able to relax. This view was narrated in the context of listening to music to take their minds off overwhelming perceptions. P8 had a similar view of attending groups to stimulate his mind and relating with the music-making process, whereas P2 perceived art therapy as a means of engaging in a non-verbal way which helped him to concentrate on a skill.

It keeps your mind stimulated. Being in a band is quite good: it's something different.

P8, page 7

Well, as I said before, they help you come together as a group and you can actually relax and take your mind off of things, and, and with the drama group you had to talk.

P2, page 9

5.4.2 Place to reflect and to express emotions (art therapies)

The notion of expressing emotion was mentioned by some patients, together with reflections. Patients acknowledged that it was important to have a reflection of their situation and to express emotions in a non-verbal way. This process was seen as an alternative way to engage with their therapists. P14 mentioned benefitting from art therapy and being able to express feelings and reflect on a drawing. Reflecting emotions in this way enabled him to express them in a non-verbal and non-threatening way.

Just being able to express your emotions and things like that thought art.
Well, could be anything really, any sort of emotional thought or anything like that. But then expressing it on some paper.

P14, page 5

P3 provided a similar account of reflecting his personal qualities after engaging with the drama therapist. He mentioned working on metaphors which made sense to him.

Basically a lot of my strengths and weakness, how I feel about myself.
Um, give me insight into things.

P3, page 7

Despite some patients mentioned benefitting from art therapies, others saw the merely as drawing lessons and associated them with leave status.

I don't really find it useful. I don't think it is useful, but it probably is useful to some people; to me it's not really useful. You just draw in it, you don't do anything else. All you do is just draw, draw, draw, and draw a person or whatever you want to draw.

P1, page 7

Well really it's just to fill out time because otherwise you lose your leave.
Um, yes I would have not gone, really. I have to do something, but, um…

P5, page 7

5.4.3 Learning new skills and to be independent (occupational therapy)

In this section, patients provided their views on engaging with something practical: meaningful activities that they engaged in whilst they were out in the community. Four patients mentioned gaining occupational skills which gave them confidence and a feeling of

working towards independence and community integration. It gave them the ability to practise practical skills that they would use when discharged.

P11 and P9 mentioned learning how to be independent and gaining new skills for future employment.

Basically it was to show people I can handle myself, I can look after myself, um, things I would need to use within the community.

P11, page 5

P9 also described gaining confidence and enjoying different activities.

And that's the same as working on Cafe on the Hill, where I go twice a week for work rehab. One of the things that has helped me is that the fact that I have been married for 35 years and my wife has helped me and I can't cook, so I have been having some cooking lessons off the OT and working at the Cafe on the Hill has given me the confidence to try different things, helping out in the kitchen, so I have really enjoyed that.

P9, page 4

On the other hand, P15 and P12 described being ward representatives. This unique experience provided them with the confidence to help run other activities and helped them to develop leadership skills.

P15 reported attending a course that is normally offered to professionals and felt that this was promoting equality.

I am ward rep so I um, I'm involved in OT at the moment in trying to promote shared pathway, which people get rolled on from April. I'm going to a training course on Friday in ----------, which involves patients and providers, and so it's on an equal basis, I am also hopefully going to a WRAP training course.

P15, page 4

Yes. Stuff like music. Newsletter group. I work as a unit rep. And yeah, I engage quite a lot really.

P12, page 4

In summary, patients viewed CBT treatment as a medium which helped them to understand their mental health and risk issues. The therapeutic relationship, e.g. characteristics of professionals, is seen as an arbitrator that facilitates a smooth relationship throughout the therapy for both CBT and other groups.

5.5 Professionals' themes: what is supportive in CBTp?

This section outlines professionals' views on CBTp and its usage in secure services. All professionals in the focus groups presented vast experiences in dealing with complex patients. Not all professionals advocated CBTp as a sole therapy for all problems: most preferred mixed methods from different modalities. Themes are outlined according to the questions asked in the focus groups. Similar to patients, the main themes were described using the frequency of the professionals' quotes.

The themes from the perspective of the professionals are:

Overarching themes
Solution-focused
Multimodal approach

Main themes
Assessment style and psychometrics
CBT for conduct/personality disorder in secure settings: an integrative approach
CBTp manualised treatment in secure services settings: picking out bits that suit
CBT for comorbid problems – a multi-model problem solving approach
Forensic pathway and case formulation approach
Therapeutic mutuality and motivational styles
Working with overwhelming beliefs, perceptions and risk factors

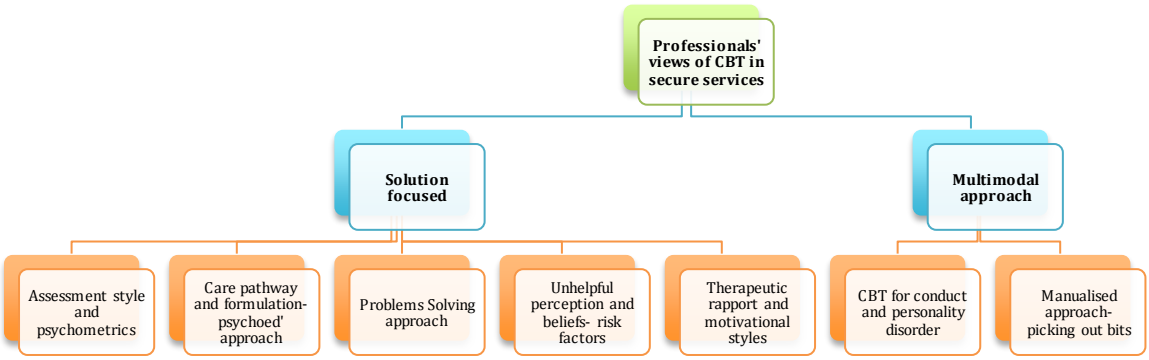

Figure 11: Professionals' views of CBT in secure service

5.5.1 Assessment style and psychometrics

All professionals acknowledged assessments as an important aspect when interviewing patients using a CBTp framework. Most professionals agreed on the importance of employing validated psychometrics to elicit patients' insight, recovery style, perceptions of illness, self-esteem, psychotic symptoms and the level of anxiety and depression.

A number of professionals emphasised the style in which the therapist engages and influence the patients, with motivation aspects forming a central part of this process. Three professionals shared their experiences, emphasising motivational styles. Professionals agreed that given the nature of psychometrics, which can be long, it is the style which makes the difference. An example was provided by FG1:

Well, I think every therapist brings a slightly different style, while you have the psychometrics there and they are pretty much given how you administer them, how you approach the patient to engage them into even co-operating, or even sometimes how you break up, how you deliver

the pack in a way, um, yeah, yeah, it's more that type of approach, I guess it's the motivational side of it, of how you deliver, because I mean people sit down and do a whole lot of questionnaires, they don't like them much – I mean mostly they are co-operative, but I mean it's a fairly awful task and I think there is a degree of motivational work that goes on. I mean you try to do what you can but it's a bit of a luxury in many ways, um, and so people I think develop a nice quick style but which still engages the person, which is a skill in itself actually.

FG1, WL6

A similar approach was adopted by other professionals in identifying barriers that may demotivate patients and hinder engagement. SF1 elaborated on the importance of incorporating motivational barriers and goals which will help to plan a pathway towards discharge.

I think one of the issues in assessment is always about motivation and being able to bring in motivational approaches to, when you are talking to people when you are trying to get them involved. Um, to overcome some of the passivity within the system. So for me, um, yeah, being able to introduce CBT is probably too much at assessments – it is more general, it's about what will help and what will get in the way and all those sorts of things and bringing in motivational assessments.

FG4, SF1

RV7 echoed a similar experience in conducting semi-structured interviews at the pace of the patient, which may be useful to gradually explain the intentions and process of the assessment.

I think that the standard psychometric measures that we use are helpful but in addition semi-structured interviews help because it gives you the flexibility to pace the interview at the person's understanding.

FG2, RV 7

The use of psychometrics forms an integral part of the assessment process. Most professionals acknowledged the use of a mixed battery of psychometrics in assessing patients. These consist of personality, cognitive, executive functioning and various forensic assessments.

From the outset, some professionals acknowledged employing CBTp-related assessments, building on the core pack with some modifications. Most professionals indicated that they used some of the renowned psychotic symptoms assessments to work with their patients.

RF5 mentioned the use of general psychometrics to screen all patients. Specific measures were used to gauge outcomes for patients who engaged in groups.

We have a standard set of measures that look at issues covering self-esteem, emotional control, coping skills, we have a measure of alexithymia, a measure of mood, locus of control. So a kind of broad sweep so that kind of core pack is augmented with, I think, someone may have a neuro-psych assessment because there were concerns about their cognitive functioning, and other people may complete specific anger measures. Also if there are individuals who are going into groups and they may complete specific measures that work as pre- and post-group measures so there is a range of things; we also include an assessment of personality in our standard set up measures.

FG3, RV 5

WL5 reported using specific examples of psychometrics, which they used prior to and at the end of the CBT for psychosis group programme.

I suppose for the, just thinking about measures that are used for the CBT for psychosis group, you've got a standard battery that we use for the group, the pre-group and post-group, so the main measure that we use in terms of assessing people's symptoms is, um, PANNS, Person Based Illness Model, um, so that provides a useful overview of the symptoms that the person is experiencing, um, and there is also an interview based one, um, other measures that

are used are the Calgary Scale for depression, um, the Recovery Style Question which number seven mentioned earlier on, Birchwood Insight Scale, that's the official insight scale

FG1, WL5

Similarly, CN1 and RV5 reported using a specific motivational and symptoms questionnaire.

For CBT. I think that set of tools that came out of, I'm not sure if it was Gudjohnsson's scale, we had a look at the conjunction ones which were about motivation and insight. I think those are very good psychometrics for looking at the reason for a person's level of motivation and how likely they are to be motivated to engage with your therapy. I think those are very good psychometrics.

FG3, CN1

I would say some of the models particularly Belief about Voices framework. I find quite useful in terms of informing assessment and the sort of things in terms of things that we should be looking at in the CBT framework.

FG2, RV5

However, the use of some medical words in some psychometrics was seen as a barrier. This was due to the implicit messages conveyed to the patients through the wordings, which could jeopardise their engagement, particularly with regard to their diagnosis. The professional below narrated this:

I've just signed off some of the psychosis measures because they mention the word psychosis, voices, delusions and things like that. A lot of the people we work with don't agree with the diagnosis and don't like to call them those kind of words and I think that can put people off using those kind of measures and we have to creatively try to assess what their problems are without that kind of standard measure for people who would just not fill it out.

FG2, RV6

5.5.2 CBT for conduct/personality disorder in secure settings: an integrative approach

Although all interviews were completed with professionals working with the adult population, some professionals had experience of working with adolescents with conduct disorder. Some adolescents' units are attached to secure services and patients who meet the criteria are normally transferred across. In describing their experiences, most professionals agreed that they were not able to use a single psychological framework to address conduct disorder. All professionals had difficulty in providing the precise framework to work with these problems. They adapted a mix of CBT-oriented frameworks which were useful in containing challenging behaviours. This was described by some of the professionals.

RV3 and RV1 provided narratives of employing mixed methods in addressing conduct disorder.

Possibly not CBT in its purest form, I know number one hates the expression, so that you can use other aspects or different types of models for CBT that you perhaps integrate and this probably echoes number four's previous statement using an integrated approach because looking at conduct disorder there is usually going to be a development of personality disorder so you need to work within a slightly different way.

FG2, RV3

CN 4 also presented the view that there is no specific CBT approach for personality disorder and suggested mixed methods of other therapies.

Um, well the answer is no in a sense that we do not do any specific interventions for personality disorder so you are hoping to catch those elements of abnormal personality in a generic way by dealing as we do, in a package way, with broadly speaking attitudes and beliefs and behaviours in relation when you talk about people relating to others and how they get here to be in a forensic unit, but no I haven't. No, there is no specific CBT approach.

Well if you were to do it clearly you would be looking at DBT approaches, schema focus approaches, which we do not do here.

FG3 CN4

Dialectical Behaviour Therapy (DBT) was mentioned as an important approach to tackle challenging behaviour. This view was conveyed with recognition of its limitation, that it may not necessarily address patients with a mixed diagnosis, as explained by the professional below.

Um, probably the guys with emerging personality or previous conduct disorder would go through other kinds of cognitive behavioural approaches, like we have a dialectic behavioural therapy team, and skills group, so a lot of it would be around trying to develop emotional regulation skills and trying to input control indirectly, well directly relevant to their conduct problems but not necessarily addressing them to conduct disorder and psychosis.

FG2, RV1

All professionals felt that the complexity of personality disordered offenders, including co-morbid problems, is difficult to treat without a relevant framework. Most professionals agreed on using at least the fundamentals of CBT. The excerpts below highlighted this point.

CBT can be used anywhere. I don't think there is something which stops people from using CBT for any disorder. There is no need for a manual-based therapy for each disorder, so long as we use the principles. DBT is nothing but a more enhanced interpretation of CBT, just a different name; the principles have been derived from CBT and PTSD for anxiety, for any disorder, it's about the principles of CBT – as Beck said, it's the principle, which can be used to suit any particular situation, diagnosis or illness.

FG3, CN1

I can't see why not. Again, it depends on that person's personality, I guess, how they respond. That is also what we did as part of the assessment: that is to do a personality assessment as well. Because it might be something in their personality that would not respond very well to this type of programme, so I cannot see why it would not work with conduct disorder.

II2, CN2

Meanwhile, SF1 adopted a branch of the CBT framework which was useful in looking into working with schemas.

Yes. Using the CBT approach and interestingly and usefully I got some feedback yesterday looking at schemas, a more schema approach for that, where they have come from, how they play out, how they cope with those, and that has been the focus for that kind of work.

II3, SF1

However, in contrast, other therapists mentioned being able to work model-free in the context of looking at developmental issues, which is a core process in understanding personality disorders. RV3 and RV4 concurred that it was a complex issue which needed more understanding of relationship and attachments issues.

I think to work model-free, I think to work with pure CBT model, um, it doesn't help because it doesn't enable that understanding relationship or bonding. And I think that is quite important when you are working with complex issue connected to conduct disorder.

FG2, RV3

I would echo that. I certainly as a therapist would not ever choose CBT as a model choice simply because I consider the attachment basis in therapy might be more useful, as it's a developmental issue anyway.

FG2, RV4

The majority of the professionals felt that there was a lack of guidelines. Some professionals felt that there were insufficient treatment programs to address this problem, which led to a

discussion of other severe personality disorder units. This was reflected by the professionals below.

I was just going to add a little bit. We have had a care pathway for some patients, relatively young, from medium secure adolescent forensic service into our service. My view is that they have not fared particularly well in the clinical area, and fairly poor, and that might say something about the fact that we don't have sufficient treatment programs for models to address their needs but it might say something else about the service, I don't know what other people think about that but I think we have struggled with the younger guys with conduct disorder that we have admitted. One of the disappointing things is that not very much came down from DSPD in relation to public disorder there and they had hopes that they would start to kind of research and address that a little bit more but not very much came out of that.

FG2, RV1

The above view was echoed by CN4, who agreed that the research on personality disorder was limited and may be creating further doubt. CN4 further mentioned the integrative approach of different therapies which may be useful for different components of the symptoms.

I do have knowledge of what goes on in DSPD Units and they do have a schema focus: they offer DBT and all packaged within a kind of I guess you would call it a milieu therapy, in which people are encouraged to discuss in certain forums for this to discuss their relationships with fellow peers and with staff and those become the subject of therapeutic intervention; I think that's what's being done at the moment. I think that is the best way to go about it and none of these DSPD units have actually come out with any definitive evaluation studies of the methodology to date, have they? That's all work in progress so we don't quite know if these approaches work.

FG3, CN 4

Due to the richness of co-morbid problems attached to the personality of patients, some professionals felt that it might be appropriate to treat certain parts of the personality that

emerge and exhibit problematic thoughts and behaviour. For some professionals, it was more important to treat the co-morbid problems, which are causing the difficulty, rather than the personality. This was evident in the professionals' descriptions of the component which was causing emotional and behavioural problems. For example, RV7 reported looking at certain components that are causing problems rather than treating personality *per se*.

I was just thinking rather than treating the personality you might just treat an aspect of it, like anger, which obviously you would use CBT for, but to say you are treating an antisocial personality disorder, I don't think there is any model that really would cover everything, but CBT, I mean the model is part of emotional regulation skills in DBT, so you know you can work on aspects of the antisocial personality using CBT but it would just be a small part of it. I would say that CBT does focus on attachment and that is the integral part of it. I don't think you can treat or cure a personality disorder but you can look at the relationship and help it and use is adaptively

FG2, RV7

WL5 provided a similar view.

I guess all of our, well, probably a lot of our group programs and a lot of the individual work are in various different ways addressing aspects of antisocial behaviour or things that might be antecedent to antisocial behaviour so I guess it is something that is related to an awful lot of ideas within the CBT approach.

FG1, WL5

Another consistent theme across most professionals was developing a strategy based on problem-solving to manage difficult behaviour. Some professionals went on to describe a strategy to work with patients with these problems. Most professionals had the same view of having boundaries and structures in place which can have a positive mirror effect on patients' personalities.

In the quote below, WL 6 emphasised that creating boundaries and consistency are important aspects when working with challenging behaviours.

I think with that because most of our people have PD of some form and within the antisocial spectrum the way we develop our programs with very clear boundaries and structures and the sort of things which work for people with PD, we very much put in place with the modelling and the consistency of therapists, we do a lot of modelling ourselves within the groups, and the confinement, so the whole thing is geared to, I mean I treat all my patients – whether I should or I shouldn't is beside the point – as PD and work on that structure in that setting because that's basically how they respond best in terms of being then able to hear any therapeutic approaches as well, so that consistency, clear boundaries and confinement is incredibly important.

FG1, WL6

The above view was echoed by WL1.

And I mean, bearing in mind some of our groups, I'm thinking of the sex offenders' group, which last for fourteen months, is quite a significant piece of work. I mean having twice-weekly therapy sessions with more or less the same team, the same rules, the same boundaries, the same confinement, does have an effect on the personality traits.

FG1, WL1

Other strategies included understanding patients' overcompensating strategies and using simple explanations to educate patients. This style was adopted by the professional below.

I commonly use Beck's book on personality disorders and I think it is in the current volume sets out the idea that people with personality disorders, they have developed, or over-developed or overused strategies for self and with relationships with other people and strategies that they don't use enough but could benefit from using a great deal more and that's just really useful in explaining in plain words to people with antisocial personality disorder how much of their current situation and their current way of behaving and relating looks to us, and where we might see problems and opportunities, so it's a good way to get from the negative to the positive in a very difficult area to get without stigmatising.

FG 1 WL 7

Some of the professionals acknowledged inappropriate usage of terminologies and concepts of the diagnosis. They found it difficult to justify and explain concepts such as personality disorders to patients when treating them and often were not sure of what they were treating. Three professionals agreed on the above view and concurred that the concept and language usage in this problem creates barriers and doubts in the treating professional and the patient.

We get very preoccupied with and we get tools to be preoccupied with empathy deficits and lack of empathy and if I got a pound for every time somebody said 'Can you work with this guy on empathy?' Um, so it kind of goes back to the previous point about what exactly are you treating – I mean is there a disability type of approach you are working with in the same way that I would a learning disability in a compensatory approach rather than a mental health related treatment approach, and I think we have got the wrong kind of concepts for that emerging in personality disorder.

FG2, RV1

The wrong concepts and wrong language. I think we use very negative language which is not helpful to our clients or our colleagues. I'm not sure that the treatment that you want to work on to treat, why should you treat a personality?

FG2, RV4

I think there is something fundamentally offensive about describing someone whose personality is disordered, and that you know what does that mean to the person who is on the receiving end of that to be told that their personality is disordered, so I kind of go along with the other comments about finding areas of work that you can collaboratively work on to make that person's life a bit better because I think what you can say is commonality across aspects of what we might call personality disorders the psychological distress that goes with that and actually look at alleviating that if we can.

FG2, RV5

5.5.3 Manualised approach: picking out bits

A majority of the professionals participating in this study agreed that there was little guidance in the area of CBTp in secure services. Of the three focus groups, one had devised their own CBTp group manual and another service offered generic one-to-one CBT. Most professionals reported going through the process of adapting and 'picking out bits' from published resources that suited their patients' needs. A number of professionals adopted the stance of using theoretical models according to the presentation of the patients. RV7 reported adapting an approach from different sources with specific topics and acknowledged the difficulty of not having any guidelines, particularly for this setting.

I have used a manualised approach before for anxiety and depression, but myself and the other CBT therapists tend to pull bits from a manualised approach to adapt. We have not found a manualised approach for psychosis that suits this setting. I think a recovery-based manualised approach when working with voices was helpful. I find that you could pull bits from, and picking out bits that suit, so that's, yeah it been more about parts from that, like identifying what stressful events are like and what the coping strategies are and those sorts of things that are common in a manualised approach.

FG2, RV7

SF 1 presented a similar view of not using a specific manual but evidence-based practice.

Gosh yes, ok, we might not use a manual approach but we use an evidence-based approach, so you know, we are both probably guided by the model.

II3, SF 1

Nevertheless, some professionals combined their experience and attended specialised CBTp training, which helped them to devise their own CBT manual. They agreed that a structured approached provided a balance in working with patients and the manual could be modified to fit with the patients' needs. This was narrated by WL2 and WL1.

I guess the manual was developed with the patient in mind anyway so it's kind of open to that, um, and it works fairly well in terms of containing the group and the facilitators to have a structure to work through during the group, but generally it's an ongoing process and the manual is adapted pretty much after every session almost, you know, ideas are jotted down that might be worth doing next time or maybe keep it the same but it was just the group this time, you know the dynamics in the group didn't make something work as well as before, or so it's about keeping an open mind to tweaking it really.

FG1, WL2

I suppose we have taken a kind of reflective approach as we have a session, as number two said: we then review what has gone well and what has not gone too well and then we make suggestions for the manual, so the manual is not set in stone and it remains flexible and open, and gives a basic structure, but I think there is a freeway to add or remove things; I mean still respecting the program integrity, but it gives the flexibility to customise it to what we've got.

FG1, WL1

The above view was echoed by CN4, with additional comments about having a one-to-one approach as a follow-up to the group programme.

It depends on your definition of manualised approach, I think. In a way it maximises is if you have a structured approach that is tied to the manual and then you can follow it up individually; you can slightly adapt it to individual needs – that is what we have been trying to do here. Um, I think the times when I've taught the more highly functioning individuals when you say "Here – do this worksheet", people are not usually motivated to do it or they do it slightly differently to the way you would think they would do it, and so, very difficult, I think you need the one-to-one approach to follow up the manual and the results get varied to the structured approach.

FG3, CN 4

All professionals reported adopting a manualised approach which could be tailored to patients' individual needs.

On the other hand, some professionals acknowledged that running these programmes repeatedly with the same patients can be seen as a 'boring' and as a repetition of the learning process, which may hinder patients' progress. This was expressed by WL2.

Having had experience of running the program time after time, it's really helpful in terms of, I've seen exercises that one group will respond really well to and the next group you run, the same exercise, patients will give you "that's rubbish", "why do you make us do that?" and it's trying to work out whether you need to take it out, or how responsive you are, cause which clients might be responding to the first group or the second group. It's about using your knowledge and experience to make those decisions as well.

FG1, WL2

In response to the former point, one professional acknowledged therapist factors as an important contributor to counter 'boredom' and the outcome of the group. WL6 mentioned that the presence of the therapist's energy and commitment can make a difference with the same patient group.

I completely agree with you but I also think there is another element of therapists because I also think you're wonderful in the group so it's not a question of you in this, I do notice that sometimes, different therapists, the way they present exactly the same exercise and the amount of energy they put into it, or their own enthusiasm, is probably what is making it work because I've seen some people deliver stuff and I think "Oh my God" you know, whilst at other times you'll get somebody else who is very comfortable with it….

FG1, WL 6

Nearly all professionals adapted their work to fit with their patient population from experts who have published work in their specialised areas. As there was no specific manual for this setting, some professionals used general CBT frameworks to treat individual patients.

A number of professionals mentioned adapting renowned authors' work in CBTp and these are highlighted below. Some professionals found all series of Paul Chadwick's work useful. His approach emphasises working with psychotic symptoms and his new work, which looks at a 'person-based model'.

I think also work by Chadwick and looking at mindfulness and his application for psychosis is helpful.

FG2, RV 7

I think with individual work I have referred to the Wiley Series, CBT for Psychosis, which is probably using the manual as well.

FG1, WL2

I agree with number five; also, I am a fan of belief about voices and probably by framework of reference.

FG2, RV5

I suppose probably all of us who do the group programs would use a manual, so I guess we are all in a position of using a manual.

FG1, WL5

WL 6 mentioned Hazel Nelson's work, particularly on practical guidance, and Young's work on schema, which is essential to understand patients' schematic beliefs.

Yes, we stole from everywhere, Um, we did, um, I mean people use the tried and tested Paul Chadwick stuff, Hazel Nelson's contributed a bit and certainly people are using a lot of Young's sort of work.

FG1, WL 6

RV1 and SF1 mentioned that Andrew Gumley's work was useful in this setting. They referred to attachment issues with this population as an important moderator to understand the development and adaptation to psychosis.

In terms of psychosis, my personal gurus would be people like Andrew Gumley, Paul Chadwick's work are the two, I kind of follow their models. So yes, we certainly keep up to date with all the literature, I think. Some of the ACT stuff is really interesting, um, and the ACT for psychosis protocol has been very successful.

II3, SF1

I think I'm a fan of Andrew Gumley and Anthony Morrison with things like attachment and emotional resilience and that sort of thing, which is very relevant for here: that seems to work well.

FG2, RV1

WL5 favoured Anthony Morrison's work: he reported benefiting from the formulation and cultural understanding of intrusion work at cognitive and behavioural level.

In addition to being mentioned, not so much for the degree program but for the individual work, I personally find the manual by Anthony Morrison quite useful: that's in addition to the other names. Um, I think just the particular model he uses of psychotic experiences I think is just quite useful in terms of just thinking about both voices and delusions and the central bit of the model is sort of the interpretation of intrusion into awareness um and the central part of the model is, I find, quite a helpful model in terms of formulation of people and I guess also I suppose another aspect of it which I think is also useful is that in terms of the behavioural aspects of the work, um, the framework is very much in thinking about what the cognitive implications of, you know, whether it was a coded strategy or a behavioural experiment and making it much more to a cognitive change than some of the other authors.

FG1, WL5

CN2 and WL2 reported using the work of two different authors, namely David Kingdon on the normalisation process and Daniel Freeman on understanding paranoia.

I mean, I think that Morrison has done a great deal of summarising a standard approach but I don't really get this meta cognitive thing, I'm not really a fan of that particularly. I think Turkington and Kingdon are fantastic presenters, um, but, and I like the normalisation,

II2, CN2

Freeman's, for paranoia.

FG1 WL2

All professionals reported using a mix of CBTp models in addressing patients' problems.

5.5.4 Problem-solving approach

A number of professionals working in these settings described difficulties in working with patients who present with severe mental illness and other co-morbid problems. From the outset, it appeared that they had difficulties in prioritising the problem when these conditions overlap. Most professionals acknowledged using a multi-model approach according to patients' immediate problems, stage and ability to understand the therapy work. This approach was highlighted by WL5.

It depends how the person is presenting: if you have someone who has a real history of psychosis, he becomes depressed and you probably then focus on treating the depression aspect of it with usually a combination of medication and therapy; but you would at that point do more traditional, if you like, with some flexibility, um, work on the depression, because that component would be sort of flaring up at that point, um, and it's the same with trauma.

FG1 WL5

WL5 went on to provide an example below:

…for instance, we have just finished a sex offender program with one person in the group and he's been very sexually abused as a child and has had some heavy duty trauma of other sorts of abuse in his life, so the next piece of work with him is going to be individual work specifically on the trauma.

Similarly, other professionals provided a mixed view on this subject. Due to the complexity of patients, some professionals felt that a combination of models is helpful in treating the problem. The professional below narrated this.

Yes, because not everybody works in the CBT model and sometimes it's more of an attachment model or a combination: I find I end up using a combination model really. And it makes more sense often.

FG1, WL6

RV 3 echoed this view in the context of addressing simple psychological symptoms.

I think it's on a case-by-case basis, really: it does depend on what the trauma is and what the predominant symptom is as to what someone needs to work with. Psychosis might be, certainly, working with beliefs about voices might be the last thing you would work with; perhaps you would be working on much more simple things such as anxiety, and self-esteem work, before you can touch anything more complicated.

FG2, RV3

WL1 adopted a flexible approach depending on the patient's presentation.

Yes absolutely, you need the flexibility because not everyone responds to the CBT model, as not everybody responds to a schema or a short-term transference type therapy. So it varies on the individual.

FG1, WL1

WL7 provided a case example of how a professional worked with a patient.

I think I will just echo that, that you need to use the attachment model, for example, understanding somebody who has murdered their parent in the middle of an apparent psychotic episode, you need to formulate their long term experience of psychosis and whether this is someone who is not so much depressed but they are experiencing loss, humiliation and entrapment in a psychosis which keeps on coming back and that their best efforts of coping are failing all the time and the loss refers particularly to the loss of milestones of achievement in adult life that they are terribly aware that they are falling further and further behind their peer group from school who are doing better in income and relationships and housing and so on.

FG1, WL7

RV6 raised an interesting point about directing patients to move on if they were well enough to work on trauma. This was conveyed with institutional goals in mind, as patients who become better are normally moved to a lower security.

I will just say a lot of the time when someone is well enough to work on trauma is the time when people are starting to consider moving on from medium security to low security, or the community, so you might be able to start some work with some people but it might take years of work to do schema therapy, often to when they are well enough to do that work, and we can't really keep them here all of that time.

FG2, RV6

In addition to the development trauma issues, patients might have complex trauma resulting from their index offence, or experiences that they have had in the judicial prison system which may exacerbate their symptoms. RV 7 felt that this was an important factor that needed attention.

There's almost always an element of trauma. Most of our patients have had very traumatic backgrounds and quite often in terms of the developmental process, in prison and what you will see is, as well as recovering from psychosis, when the psychosis is receding, you see emerging personality disorders and so kind of working with those underlying personalities.

FG2, RV 7

5.5.5 Care pathway and formulation – psychoeducation approach

Care pathways and case formulation emerged as important aspects that were highlighted by most of the professionals who participated in the study. In this section, professionals acknowledged that patients' lifetime path in the mental health and forensic systems is seen as a journey full of systemic, organisational and personal issues which requires them to have an understanding and plan their way out. Professionals conveyed their narratives, which underlined the importance of understanding clinical formulation and the forensic care pathway in informing patients' outcome. WL 1 argued that having a clinical case formulation is essential in informing and understanding patients' current complex clinical presentation.

It's also a matter of having a good formulation and care pathway in mind so you can address really what is going to make a difference in the treatment.

FG1, WL1

The above view was echoed by W7, with additional comments on reformulation in understanding several psychological constructs.

So that needs formulating and the attachment to the original relationship and why the feelings of bitterness, resentment, murderousness, would become focused on a parent. And shame, as well, so there is all of that and other things beside. Yes, a comprehensive formulation and certainly not the simplistic view that circulates is that almost that the things that we do in the middle of psychotic breakdown are random, and our formulation is that they are not random: there are very, very definite reasons that can be accounted for in a proper formulation looking at the particular forms of depression, hopelessness, and rage that is there which people experience after a long experience of psychosis.

FG1, WL7

RV7 provided a similar view about the need for a clinical formulation to comprehend the complexities of patients.

I agree with what's been said so far by number one and three and I'm number seven, and in addition I would say that some aspects of CBT are easier than others to use; formulation, for example, is very helpful; clinical formulation is very useful in understanding someone in the forensic setting, which can be difficult because of the complexities already mentioned can be hard to do, and um, also adapting, I think, the model, as number six said, is necessary sometimes. That would be useful in this setting.

FG2, RV 7

Some professionals felt that the care pathway forms an important part of the clinical case formulation, which enables better goal planning within the forensic system. This was explained by looking at stages within the care pathway and planning goals.

Three professionals shared their experiences looking at good clinical pathway.

Sorry – can I just go back a little bit? It might be useful for other people to know as well and discuss it further on as well. The part of my job, I feel, is to present to people this idea of a care pathway and part of that would be to go onwards to gain a better understanding of how their experiences come to cause them distress and damage: as number six is saying, it is very important too, and risk.

FG1, WL7

SF1 mentioned that this strategy is important in motivating patients to engage and look forward to plan a gradual understanding of the self in the forensic mental health system.

------has done that, looking at really good pathways, and this is a pathway and this is where on it and how do you get to the next stage, and so we have used that as a kind of way to help people to be motivated and to engage.

II3, SF1

WL6 provided an additional view of setting appropriate goals in conjunction with a care pathway.

So the goals are in a way pre-set along that care pathway model of what they need to achieve. In the individual treatment, you do the standard therapy in that you try to look at agreement to goals between the therapist and the patient.
FG1, WL6

Coming from a different perspective, the patient's objectives within the system may not necessarily match with the institution's. Depending on the stage of mental health, the patient's goals may not necessarily agree with those of the service and this might create difficulties in engaging. WL 5 elaborated this point below.

Well, I guess it's something that is probably relevant across lots of different settings but that is something that we need to be working on in this specific service, yes, particularly where there are, as one of the others was saying earlier on, certainly to start with, the institution's goals for the person might not necessarily match up with what the person's own goals might be, because of lack of insight or denial or all sorts of factors.

FG1, WL 5

5.5.6 Therapeutic rapport and motivational styles

All professionals agreed that the therapeutic relationship is an important mediator in CBTp. Within the therapeutic relationship sphere, there are many clusters (respect, genuineness, patient's language, being flexible and the therapist's personality and humour) which contribute to a good relationship, and this was expressed by all of the professionals.

Motivational styles in therapy played an important role in maintaining patients' engagement and progress. This view was expressed to facilitate better shared understanding with patients and agreement on a common goal.

Many of the professionals felt that therapeutic relationship was important in starting, maintaining and ending therapy. They professionals recounted their experiences in facilitating engagement using different methods. WL 7 emphasised respecting and accepting patients' narratives at a given time and gradually building trust to accept and provide insight.

The curiosity and also I think what is very important is to be very, very willing to accept that for the person's own experience, that their experiences are absolute reality at the moment, certainly at the time when they have no doubt about it. It's to accept that is their reality: my reality may be different but that is your reality, and to communicate that you take it seriously and that you respect it as well.

FG1, WL7

The above view was echoed by WL1:

I would echo some of what number seven said, um, something very simple, but when you have formed a good therapeutic relationship with somebody with whom you are doing CBT for psychosis it's much easier to challenge psychotic delusions if the person actually trusts you and feels that you are on their side and I think that is quite obvious but I think it makes a huge difference.

FG1, WL 1

Whereas RV 4 and RV 5 looked at working with patients' language in which they make sense of their difficult experiences. They explained that being genuine and not using symptom-related language and diagnosis can shift patients' perspective of their problems.

Really the basis of all my work is about engagement, but using neutral language: I don't use any illness terminology ever and even words like 'psychosis'. I talk more in terms of experiences or what has happened to you, what's happening to you, so they describe that to me, so that the illness aspect does not form part of the therapeutic work that I do, so it's just bringing another way of working with that person, and the difficulties they are having. The engagement is the same: it's about mutuality, really, and I am actually genuinely interested in the patient and what the patient is saying. Using their term of reference, not mine.

FG2, RV4

I think picking up from what number six has just said, actually finding out what people's language is for their experiences is very helpful and actually in picking up on their language and using that.

FG2, RV 5

Being flexible was identified as an important moderator in starting and maintaining relationships. Some professionals found that being flexible with patients is a strategy to instil engagement and motivation. This can be carried out on the basis of a shared understanding.

Some professionals described their experiences with introducing flexibility. This was mentioned in relation to patients residing in a restrictive environment with low levels of freedom. RV 7 talked about having the flexibility to be in a dual role and helping patients to facilitate their leave, which can serve as personal motivation and a platform for better engagement.

I agree with number one: I think in addition with the CBT, the collaboration, reaching a shared goal in the initial sort of getting people on board, is helpful. I think if you are nurse trained and CBT trained, it would be having the flexibility of having to use ground leave or other ways to help the personal motivation and sometimes people do not progress past the very practical sort of ways of engaging for a long time, and, um, the flexibility, as number one said, sometimes of being in a group sometimes people see that as being a coping chat helpful

FG2, RV 7

CN 2 had a similar view:

Well I think maximal flexibility.

II2, CN 2

In addition, WL 6 raised an interesting point, elaborating on the dual role of the professionals. The role is seen as part of using a coercive mechanism paralleling institutional requirements and the therapist model. WL 6 conveyed this view, reflecting on the process whereby the professional tries to channel patients' expectations by relating and educating the organisational aims and objectives with the help of the multi-disciplinary team.

I think there is, I mean, while we have wonderful skills, and I'm not minimising any of those, I think the reality of being in a forensic setting is a degree that the patients realises an expectation that they will co-operate to get through their clear pathway and out the door again, so you have got that dual role of sort of slight coercive model, along with trying to be a therapist model, in any of these processes, and I think it is unrealistic to think that that is not there as part of the engagement as well because the team give a, by and large, I think the multi-disciplinary teams are quite supportive with what we are trying to do so, they encourage the co-operation as well. But I do think it is a dual process that goes on.

FG1, WL6

Therapists' personality and humour were identified as important components in the therapeutic relationship. Professionals narrated this as being able to conduct themselves in their own habitual way without having any anxieties and matching with patients' expectations.

CN 1 mentioned bringing her own personality and humour into the process of trying to relate to patients.

Well I guess this is a matter of therapeutic style and that for me is quite a personal thing. I usually try to be quite relaxed, low key, and you know, my own personality comes through in the sessions quite a lot I think. And I think that is very important; and I think the groups can feel you are comfortable just being yourself in the group. Um! I usually bring humour into the group as well, and that I find usually works quite well and just easy going light tone, not just having a flip chart and you try to lecture people, because that I don't find useful and does not work well, so yes, but that's my own therapeutic approach or style when trying to teach or deliver something or teach something.

II1, CN1

CN3 reported the nature of the relationship as an important moderator for engagement in which the patient expects to work towards a discharge.

My experience is really just about reading for CBT for psychosis, I've never been trained in it so it's really just a kind of theoretical knowledge, and from what I have read, the book it says on a collaborative approach and I think part of it is with the relationship with the therapist. Maybe that's where the patients get something out of it: it's the nature and quality of that relationship and expectations.

FG3, CN 3

The motivation approach is perceived as an important component when dealing with issues surrounding uncertainties in behaviour. Most professionals agreed about using this approach in resolving ambiguities and planning discharge. Professionals reflected their experiences in employing this strategy due to its ease and natural style in engaging patients. Three professionals shared their experiences of employing this approach. CN2 and SF1 mentioned using this technique to plan patients' progress in relation to discharge.

One thing I find useful is motivational interview and addressing ambivalence around engaging and being ready to change. I have been using that quite a lot recently, and find that

very useful, so just looking at the pros and cons of making changes in behaviour, what their future might be like when making changes, I find that quite useful.

FG3, CN 2

Well, again, motivational interviewing, I suppose those approaches you get from that are the best we kind of use those helping people think of pros and cons and helping people to think of goal setting. You know, I think that's really the key: what you would like to attain, ugh, having an end point which you can keep in mind, which is obviously usually discharge obviously, but helping them to kind of think back to what would help you get to discharge.

II3, SF1

The above view was echoed by CN1:

...but I know other people who have tried to use the evidence as a motivation tool and in combination with motivational interviewing, could be considered useful.

FG3, CN1

Similarly, CN 4 conveyed his experience in using a motivational strategy in a natural way. He reflected that the nature of the patient's story of their life and admission can be expressed by using a verbal timeline, which is essentially a natural way of telling a story. CN4 conveyed his view, reflecting that the process allows patients to express their narratives in a free-flowing, natural form and can provide the same outcome as motivational interviews.

I find most useful, um, a narrative approach. I have found that, perhaps it's the way I use it, that motivational techniques are not that useful in that people may be or may not be able to identify but even thought they do cognitively think "I should be doing this" or "I should be doing that", it doesn't then persuade them to do therapy and not to do the things that lead them to dangerous behaviour; so I have personally found motivation not that useful for me and I find more what I call a narrative approach, which is about the story of their life, and how they came to be in hospital, I find people can understand the narrative approach more

easily and I tend to say "Just tell me the story of your life and what other things then got you in here in the first place". I find people can understand that easily and can identify those things that might come up in motivational interviewing – you know, I was taking some drugs, I was homeless, I had fallen out with my mother – and they do then come up in a story form of the things you might then think, yep, these are the things that you might need to look at.

FG3, CN4

Nonetheless, a professional narrated her experience in dealing with patients who present themselves as socially desirable. Once the patient has better insight and goes through few cycles of this process, they become immune to the system. This may create a personality of positive impression/social desirability, whereby they learn to engage in a superficial state without genuine motivation and engagement, as described below.

Certainly in my experience and ------ and ------ presented, I think there are lots of things that can make an impact on what is normally perceived in a therapeutic environment as genuine engagement because as number three said, there is either a section that people feel that they have had to engage and sometimes they have experienced other systems where engagement is expected, so they will have to perhaps go through a process, but the actual engagement and motivation for change is absent, so they learn to be socially desirable so they respond in the socially desirable manner.

FG2, RV2

5.5.7 Unhelpful perceptions and beliefs - risk factors

Working with overwhelming beliefs and perceptions was perceived to be a difficult but manageable experience. Professionals' views on this theme were mixed and incorporated overlapping properties from various techniques.

All professionals acknowledged working with overwhelming beliefs in psychosis using a CBTp framework. Some professionals recognised validating such beliefs at a given time in the patient's life.

A number of professionals stressed the importance of sharing experiences and views, a gradual approach, identifying risk factors and coping skills as essentials aspects when working with overwhelming beliefs and perceptions. Professionals felt that sharing experiences is a vigorous mode of normalising whereby most patients, when comfortable, are able to share their thoughts with professionals.

Five professionals agreed that the idea of sharing experiences among staff and patients and between patients could have a powerful effect in reducing the intensity of overwhelming beliefs. Listening and validating patients' experiences was seen as a powerful skill to facilitate engagement and working with overwhelming beliefs. This view was expressed by RV5.

I think part of it is about listening to their entire story, actually kind of trying to make sense of what the origins of what the delusional belief is, and how they have come to believe.

FG2, RV 5

RV 6 shared a valuable strategy of sharing written reports with patients, which can be helpful in reducing the intensity of the overwhelming beliefs and promoting trust.

I would say that to help with some of the paranoid beliefs now that we are nationally starting to share reports with patients and let them have access to notes and things: they can actually check it out, and check the evidence themselves. It helps, I think, when before it was, you know, people were not automatically given reports, but I think that can certainly help challenge that belief if you are kind of going through your notes from the last sessions so that you are clear.

FG2, RV6

CBT groups were a choice of treatment adopted by most professionals, as they provided a better platform to work with patients having similar problems. Some professionals who worked with patients in a group setting found challenging patients' overwhelming beliefs

productive. They proposed the idea of getting other patients who have similar problems to share their stories in order to create a sense of similarity and belonging, albeit normalising symptoms.

CN1 narrated her experience within these lines.

I think it worked quite well to have the other group members to challenge that particular individual's delusional beliefs; um, I think it worked because they all shared. They had very different delusional beliefs, but I think they realised that it was almost like a sense of belonging they all had this problem, not that the individual person believed that they had a problem, because the beliefs are real for them.

II1, CN 1

This view was echoed by SF2.

Yes, it is giving that message that it's ok to talk about delusions; um, I think it can sometimes be helpful if it is a shared experience with other people that also experience similar things, I think it can be helpful for some people, so again, within that kind of group environment, that can kind of support that idea that it is ok to talk about things, and it is not just me.

II3, SF 2

Similarly, WL5 added his views, which looked at sharing perspectives to get patients to shift their beliefs about overwhelming perceptions.

...but I certainly think one of the most useful things about the CBT for psychosis group is that, um, sharing experiences with others within the group can be extremely powerful, in terms of the development of insight and shifting people's perspective from the experiences that come through. Um, and that's often an area that you might see some of the dramatic

changes within these group-based measures, so I think that is something that is particularly valuable in that group.

FG1, WL5

RV3 provided a useful technique for reducing patients' paranoia with a consistent approach when reporting to the MDT.

I would echo that, and sometimes, you know, all of our work is done jointly and the records are kept at the sessions. Um, I did work with one person who, when they were particularly paranoid, I used to have her sit in on the feedback sessions to staff, and so then again there was no scope for there, you know, "You're going into the office and saying one thing when you told me a different thing".

FG2, RV 3

Some professionals advocated using a gradual approach when working with overwhelming beliefs. This view was conveyed to reflect that professionals need to have an awareness of the importance of not jumping in too early, as this may shut down their already difficult-to-engage 'trusting' platform. RV6 supported the idea that early intervention can have the opposite effect:

I agree that sometimes if you challenge too soon, the beliefs can become stronger, because they will take it as a criticism of them or that there is something wrong with them.

FG2, RV 6

The above view was echoed by SV5:

One of the things that is quite difficult at times is if the delusional beliefs are very central to what the person believes: I have a sense at times that if you question them too much too soon, that actually that they develop their delusional system to incorporate the challenges, so I think that you have to be careful with that.

FG2, SV5

In addition to the above point, some professionals felt that a gradual approach is an essential skill which needs to be used carefully, particularly in secure services. They reflected on the

patients' problems that being open about their overwhelming beliefs could jeopardise their treatment, as reported in the quote below.

I think, certainly the first steps here are getting people to talk about their delusions, because actually that is quite a big thing and in a forensic setting where there is a lot of distrust and a lot of "if I talk about my delusions they will stop my leave", um, you know that the culture is not to talk about them openly, so you have to build a level of trust and so it matters about being believed and people taking it really seriously.

II3, SF 1

This view was echoed by CN2.

I think it is very gradual, and it metamorphoses over time, so my approach is very much to maybe plant a few questions, and I think I took this attitude more from a solution focus: what's not, what does not fit.
II2, CN2

Professionals reported that risk assessment and management was an important moderator in overwhelming beliefs, particularly paranoid thoughts. RV1 mentioned the importance of acknowledging risk factors that are tied in with overwhelming beliefs and finding avenues to manage them.

Just a couple of things: one is that a lot of the work we have to do around risk and defence elated issues probably would lead to some discussion if it is relevant to that individual about delusional ideas; you kind of can't do one without the other almost, which can be a bit problematic.

FG2, RV1

Similarly, CN 1 mentioned the integration of relapse prevention work, which looks at identifying risk factors not just for overwhelming beliefs, but also including relevant

offending behaviour.

I disagree with ------ on that. It depends on what is the aim of relapse prevention. For lots of patients within the British system within the secure setting, relapse prevention could mean learning strategies to avoid a return to hospital, not necessarily preventing a relapse of illness: for example, working with sex offenders and setting very clear approaches on what is allowed and what is not allowed when you they are given a discharge.

FG3, CN1

All professionals recognised that overwhelming perceptions are one of the most commonly experienced phenomena associated with psychosis. Most professionals viewed coping with psychosis in a locked environment as an important issue and provided opinions which predominantly employed the 'coping' theme in different ways. Coping in this context was conveyed using behavioural and cognitive approaches to distract and alleviate overwhelming perceptions.

RV 1 acknowledged the use of short-term strategies for coping with voices, such as listening to music.

You know someone who's needing a bit of respite from the voices has things to do like music playing in headphones or a computed dialogue playing on headphones – this kind of approaches. Distraction techniques would be something which is probably commonly used in a setting like this because it quite easy to remember to prompt people to use.

FG2 RV1

The above view was echoed by CN1 with additional skills of breathing and relaxation techniques.

I don't know, maybe, maybe listening to music and wearing headphones in combination with certain breathing techniques, relaxation techniques. I know a lot of patients who attended the group, they use those two in order to relieve the distress from the voices.

II1, CN1

CN 1 reported using relaxation techniques to relate to voices.

Yes, we run through different relaxation techniques and things that they could physically be doing to drown the voices out and identify exactly who you could identify to talk to about your voices, all those sort of things that we do here as well.

II1, CN1

One professional preferred to use compassion-related work with voices and other types of hallucination. CN2 acknowledged his experience in working with patients on this approach and provided an example.

I'm experimenting now with this guy with the smell I have because I have done so much imagery work these days because I'm using a bit of that as well, so imagining the smell coming off you, you know, being kind to yourself, looking after yourself, um, voices are multitudinous things with many and different types, and there are often positive ones in there, yes.

IIL, CN2

In summary, most professionals felt that CBT treatment is effective in treating some of the complex problems in this population, although there is lack of guidance in this area.

Chapter Six: Second phase of the findings

This section discusses the main findings from Chapter Five and uses thematic analysis to compare overlapping themes and differences between the perspectives of the patients and professionals. The finding will be elaborated as a discussion that looks at the current evidence base available in the literature and relevant theories. Section 6.5 will discuss the overarching higher order theme and subsequent discussions will look at limitations and implications for clinical and future research, including feasibility study.

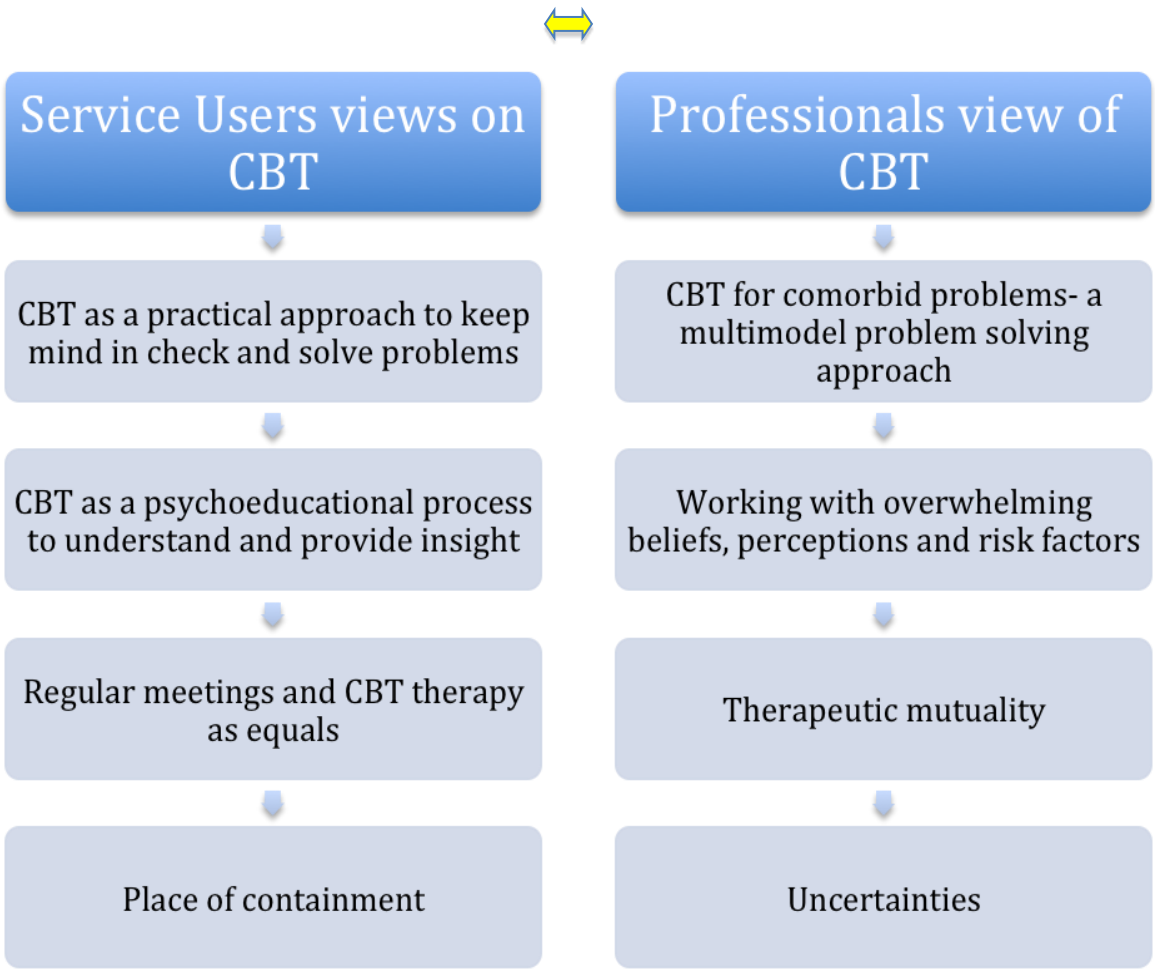

Figure 12: Overlapping themes of professionals and patients in CBT

6.1 CBT as a practical approach and a multimodal problem-solving approach

In order to get rich and meaningful data on 'what works' for CBTp, it is essential to reach the often neglected voice of the patients (Greenwood, 2009). This is an important addition to the professionals' opinions of what they think is important, which may not necessarily match the patients' expectations.

The primary aim of a problem-solving approach in psychosis is to identify a range of potential target problems and maximise a comprehensive list of possible solutions with strategies and tactics to increase the idea of positive production (Nezu et al., 2004). Studies employing a problem-solving approach to psychiatric inpatients have demonstrated some effectiveness (Coche et al., 1975, 1984) but only a few such studies have looked at severe mental illness (Huband et al., 2007).

Most professionals and patients highlighted the use of a problem-solving method. The manner in which patients spoke about their narratives revealed a consistent theme of problem-solving, as it was an easy option to adopt. For example, many patients described their experiences of using this approach to identify triggers and solutions. These narratives were conveyed by looking at feelings stemming not just from psychosis but from anger and anxiety. Some patients added seeing these problems in the context of a behavioural disturbance which caused physical damage.

I have a lot of problems outside as well as inside so we also talked about how to behave and how to work around that.

P11, Page 3

Patients' accounts reflected a search for a comprehensible tool to recognise the problem in the context of being in hospital and planning for discharge. Such narratives generate a sense of 'integration'[2] to understand some of their experiences.

[2] Integration is described as a process whereby continuity is recognized between thoughts, feeling and behaviour during psychosis, including pre-morbid beliefs. The goal is to understand and to change these beliefs and behaviour.

Professionals' views concurred in that given the complexities of the patients' problems, a strict standalone CBT method did not necessarily suffice to address multiple problems. For example, professionals suggested that there may be other theoretical models that can be employed to understand the patients, such as the schema and the attachment approach. This led some professionals to perceive that patients' wellbeing can only be understood in the context of a holistic approach rather than a single framework. Bernstein et al. (2007) highlighted the use of a Schema Focus Model, which incorporates several modalities when working with forensic patients. Although the model does not propose a strict problem-solving approach, it can be further refined to fit the purpose.

Within this sphere, professionals identified patients' complexities as a co-occurring difficulty which needs to be addressed. Professionals described prioritising patients' difficult experiences by identifying the immediate risk-related problems and working down to less severe problems. In contrast, some patients argued that this approach is only addressing the immediate problems without looking at more deeply ingrained emotional states influenced by past negative events and environmental factors on the ward. The latter was reported by a few patients relating to their safety on the wards, inhibiting their trust and the process of recovery (Halsall, 2006).

6.2 Psychoeducation and working with overwhelming beliefs and perceptions

6.2.1 Working with overwhelming beliefs and perceptions – normalising and alternative explanations.

As the data in section 5.5.7 demonstrate, the normalising approach in an inpatient unit is perceived to be a major challenge to all professionals. As part of the daily interaction with patients, professionals employ this technique to normalise the experiences of overwhelming perceptions and beliefs.

In understanding the normalising approach, the central tenet is that there are others experiencing a similar problem with differing intensity. For example, professionals reported that one of the common phenomena to occur when patients first arrive is that they believe they are the only person in the world who is going through this bizarre and distressing

experience. The normalisation process for this belief works to gradually channel patients' perceptions that there are other people in the ward going through similar experiences. A similar standpoint is reported in a case study (Morrison, 2005). This strategy could reduce the distress associated with intrusive thoughts and feelings of alienation (Kingdon & Turkington, 2005; Garett et al., 2006).

Other professionals extend this discussion to the normalising of the experience of hearing voices to perceptual disturbance. This explanation is conveyed in the context of physical problems which can cause temporary perceptual disturbance, such as pneumonia.

Most of the professionals in this study described facilitating CBTp in a group setting and perceived the group environment as a sharing platform for patients. Normalising in this aspect is perceived to be more powerful, as the process is continuous and the interaction between patients creates less of a power struggle and more acceptance of others experiencing similar problems.

This view is highlighted to be useful for some patients. The usability of this approach is reflected in their accounts: most felt that sharing in the group provided a platform to compare and contrast notes and experiences, which reduced feelings of isolation and stress. For example, one patient said that the group setting was useful to share stories and beliefs and compare notes with other members and described feeling a sense of acceptance within the group.

Similarly, some patients reported seeing video sessions of former patients and perceived this experience as an independent source that provides a sense of normalisation of their respective problems. This contributes to their view that there are others who face the same problems and are able to cope. The normalisation view may lend itself to the traditional 'cognitive triad' perspective in that the views of the self, others and the world may change.

Studies have demonstrated the applicability of the normalising strategy in the clinical population as a useful tool to reduce distress associated with overwhelming perceptions and beliefs (Ng et al., 2003; Azhar, 2000). The former case study was conducted in Hong Kong with Chinese oriented patients and the use of this strategy was found to be feasible, particularly in the initial sessions of the treatment.

On the other hand, it is important to note that the normalising approach needs careful attention, particularly when it is applied to patients with chronic and severe mental health problems. Professionals need to be careful not to over-normalise, as they may run the risk of trivialization; however, the central tenet is to provide patients with the idea of a continuum of experiences in the context of biological and psychological vulnerabilities interacting with external circumstances such as stresses in life, e.g. bereavement.

Alternative explanations for psychosis and related disorders were observed as an important part of treatment by patients and professionals. This approach was reported to have considerable potential to reduce the distress associated with psychotic symptoms and related problems. Patients acknowledged this as a helpful strategy, as it enables them to 'be their own detective' and to find alternatives to the overwhelming beliefs in a safe and contained way. For example, patients mentioned employing this strategy when they experience a paranoid thought. They recognise the nature of the thought and subsequently look at an alternative view of the paranoid thought. This approach has the potential to unlock the vicious cycle of overwhelming belief in which patients normally operate. This process can be challenging in that when addressing the origins of overwhelming belief, one needs to consider the level of conviction, the stage and the network of the belief itself: whether the belief has just one origin or is part of a web of beliefs.

The network of the belief system can be influenced by both internal and external experience, which can affect the generation of alternative descriptions (Freeman et al., 2004; Garety et al., 2007). Morrison and Barrett (2010), in their study, stressed the use of both normalizing and alternative explanations as specific factors in CBTp that may inform good outcomes.

Nonetheless, some professionals argued that having awareness of psychosis may not be in the best interest of the patients. This view was conveyed for patients who have chronic mental health problems, in that they can perceive this as a big loss and that such awareness can contribute to risk-related problems. For example, professionals described that a patient with a twenty-year of history of psychosis may perceive such insight as a shock and loss of a belonging which has been part of his life.

Reflecting on the above discussion, it is inevitable that a combination of approaches is found to be useful in this context. The normalising and alternative explanation approaches are useful in the treatment of psychosis if used within a context that is appropriate to the process of therapy. Studies have shown the effectiveness of these techniques in the clinical population and research settings (Rollison et al., 2007; Kingdon and Turkington, 2002). An interesting study by Dudley et al. (2007) demonstrated the effectiveness of the normalizing approach and its use with other techniques such as 'alternative explanations' can produce a good clinical outcome.

6.2.2 Working with overwhelming perceptions - coping strategies

Coping strategies are an important construct in CBTp and are described by professionals as an important moderator in helping patients with psychosis, who often face difficulties in their daily lives. Coping mechanisms serve as an essential function in human adaptation and careful balance is required between the right and the erroneous strategies.

Most professionals indicated that coping skills for psychosis, particularly behavioural techniques, are important to manage patients' difficulties on the ward. For example, learning to cope with voices using a diary when the voices are not so strong can provide respite and a reflection of the situation. Another medium which was discussed looked at practical strategies to use at the peak of the hearing voices experience, such as relaxation strategies and physical aids such as MP3 players. This process could be reinforced in group and-one to-one sessions to enable the strengthening of coping skills in a problem solving style.

Some patients concurred with the above view. They perceive behavioural techniques as practical skills available at times of need: for example, keeping an MP3 player in the pocket at all times and using it when the voices are distressing. In addition, other patients described using existing coping skills to live with their problems, albeit with acceptance of these problems as part of their lives (Romme & Escher, 1989, 1996; Romme et al., 1992).

6.2.3 Working with overwhelming beliefs: evidence for and against

The work surrounding overwhelming beliefs is acknowledged to be challenging for both patients and professionals. The manner in which some professionals expressed their experiences reveals a consistent theme of 'not jumping in to early' when discussing the content of the overwhelming beliefs. For example, professionals described their experiences of using this technique as a first step after building a rapport with the patients and not colluding, at least in the early phase of the relationship. This strategy is useful in the early stages, as it allows professionals to observe confirmatory biases and devise a shared understanding and a clinical formulation (Wright et al., 2009). Subsequently the information provided in these discussions will pave a path of goal settings.

In contrast, some professionals argued that this technique was difficult to execute depending on the stage of the patient's mental health. For example, if a patient has an egocentric delusion that he is Jesus and is given a task of how many people are spontaneously going to recognize him as a deity, he might report back that nobody recognised him as Jesus because he commanded them not to. Similarly, the environment on the ward can create an atmosphere of paranoia, particularly when staff are carrying out their routine checks. In this case, the 'evidence against' approach may not work, as the reality of the situation may confirm patients' beliefs (Wright et al., 2009; Kingdon & Turkington, 2002).

Nonetheless, some patients find this technique useful, as it helps them to gain better insight into their problems. For example, one patient had the belief that he played for a professional football club and over the course of the therapy acknowledged that this might not be the case, as there was no record of evidence of his name. This approach was useful in this case, as the overwhelming belief was disconfirmed by an external agent and the patient had partial insight. On the other hand, this approach can be difficult depending on the stage of the mental illness and the personality (e.g. sensitivity) of the patient. These will count towards the success of this approach; however, they may pose a significant challenge for some professionals working in this setting.

6.2.4 Working with overwhelming beliefs – the ABC approach

Themes were reported around analysing the triggers and subsequent behaviours of overwhelming beliefs. Both patients and professionals described their experiences of working with this particular approach, which looks at the meaning attached to the belief as opposed to gaining evidence. Professionals found this approach useful, as it looks at the antecedent/ trigger of a particular event and goes on to comprehend the belief/behaviour which is attached to the trigger. For example, one professional reported that it is essential not just to look at behaviour but to analyse the meaning of the belief which lies underneath the behaviour, as this will help to understand the pathology of the overwhelming beliefs and perceptions.

On the other hand, patients are frequently in a state of confusion when they first arrive and after the initial stage of orientation, professionals can help them to understand their emotions and their meanings which lead to problematic behaviour. This strategy can provide a framework for patients to organise their often muddled thinking pattern and may contribute to at least a sense of awareness of the generation of these emotions and an understanding of their meaning. Studies have shown that understanding overwhelming belief/perception itself can help individuals to reduce distress and have some control (Chadwick et al., 1996; Lakeman, 2001).

Some patients confirmed the applicability of this approach. They reflect by identifying the trigger and then being able to analyse the thought processes behind it. For example, reflecting on the triggers and thoughts that initiated the undesirable event can be helpful in understanding the whole situation. Some patients found this approach easy to understand and use as a tool for reflection and prevention of further problems.

6.3 Therapeutic rapport, space and equals

All professionals in this study agreed that a therapeutic rapport with patients, whether direct or indirect, is an important element in therapy. They shared their experiences in that there is a considerable overlap in theory and practice (e.g. good therapeutic relationship) with a common goal (Morrison & Barrett, 2010).

In secure services, some professionals employ direct approaches that address patients' psychotic symptoms: for example, "Have you heard any voices today?" Indirect approaches such as the Socratic style were conveyed as non-confrontational, and may include non-verbalising in therapy.

Professionals working in secure services come from diverse backgrounds and training orientations. Psychologists' training normally focuses on developmental psychopathology and integrative models followed by specialising in an area such as CBT or psychodynamics. Art therapists' training involves a basic theoretical framework informed by psychodynamic therapy. Most approaches have considerable overlap in theory and practice. All professionals considered that therapeutic rapport is an important factor in the journey of working with patients. For example, a significant number of psychologists mentioned that success in therapy was related to the engagement level, particularly reflecting the nature of patients' long stay, and this in itself can be extremely therapeutic in its own right. This view was shared by a number of art psychotherapists who stated that the fundamental importance of therapy is to establish a relationship. It is about how the patient can relate and engage at different levels – not necessarily talking. These views carry an important message of collaboration with patients on an emotional and relational basis – to motivate patients to engage at a genuine level and move on in their lives.

Similarly, some patients agreed that the difference that makes them feel valued is the characteristic of the professionals, such as empathy and openness towards them. Patients stated that their experience of being valued, respected and seen as equal served as a platform for engagement and taking the relationship further.

6.4 Place of confinement and uncertainty

As highlighted in Chapter Five, most patients view secure services as a place of restrictions and somewhat like prison. This view is shared by some of the professionals, who felt that some patients witness untoward incidents that can have a negative impact on their mental health.

For example, sudden incidents such as aggressive episodes can have negative consequences for other patients witnessing the event. This can create a non-safe environment, which can lead to patients feeling anxious and re-trigger some of their traumatic experiences (Benson et al., 2003). Additionally, although it is sometimes necessary for staff to carry out Control and Restrain (C &R) procedures, the staff involved may be perceived as aggressive individuals, particularly when they apply restraint techniques, which may affect patients' therapeutic rapport and interpersonal trust in them (Haney, 2001).

Security-related activities, such as searching a room, can have an impact in intruding on the patient's privacy and can create an unsettled environment. For example, professionals reported that a ward search can affect therapeutic activities, as patients find it very intrusive and offensive and this can affect the process of individual and group activities.
Similarly, professionals narrated that if a patient collapses on the ward, other patients witnessing it may believe that medication overdose may be responsible and hence feel upset and distressed, which can create uncertainty.

On a different note, professionals reported that patients' experiences of going through multiple layers of systems, such as prison and court, was perceived to have some impact on their mental state. This view was expressed in the context of patients witnessing professionals observing them twenty-four hours a day (part of nurses' work), which may feed into patients' overwhelming beliefs. For example, patients with paranoid delusions are normally hypervigilant and tend to notice this phenomenon, which confirms their beliefs. Professionals acknowledged this as a problem for patients created by the system in which they inhabit. It is difficult to discount this reality, as staff working on the wards constantly observe and write important observations, which can feed into patients' overwhelming beliefs.

Some professionals explained that patients may be working with a level of threat that is perceived as malicious and that the belief and the consequences might create difficulties for professionals: they may not be able to move that belief, but only its salience and intensity.
Most patients expressed similar concerns to the professionals that the secure services environment can be unsettling. They perceived the environment as being in a prison with restricted freedom, e.g. no time out. This experience fed into their existing problems and exacerbated anxiety. These narratives are similar to those reported by inmates in prison settings (Green, 2010).

6.5 Higher Order themes of professionals and patients

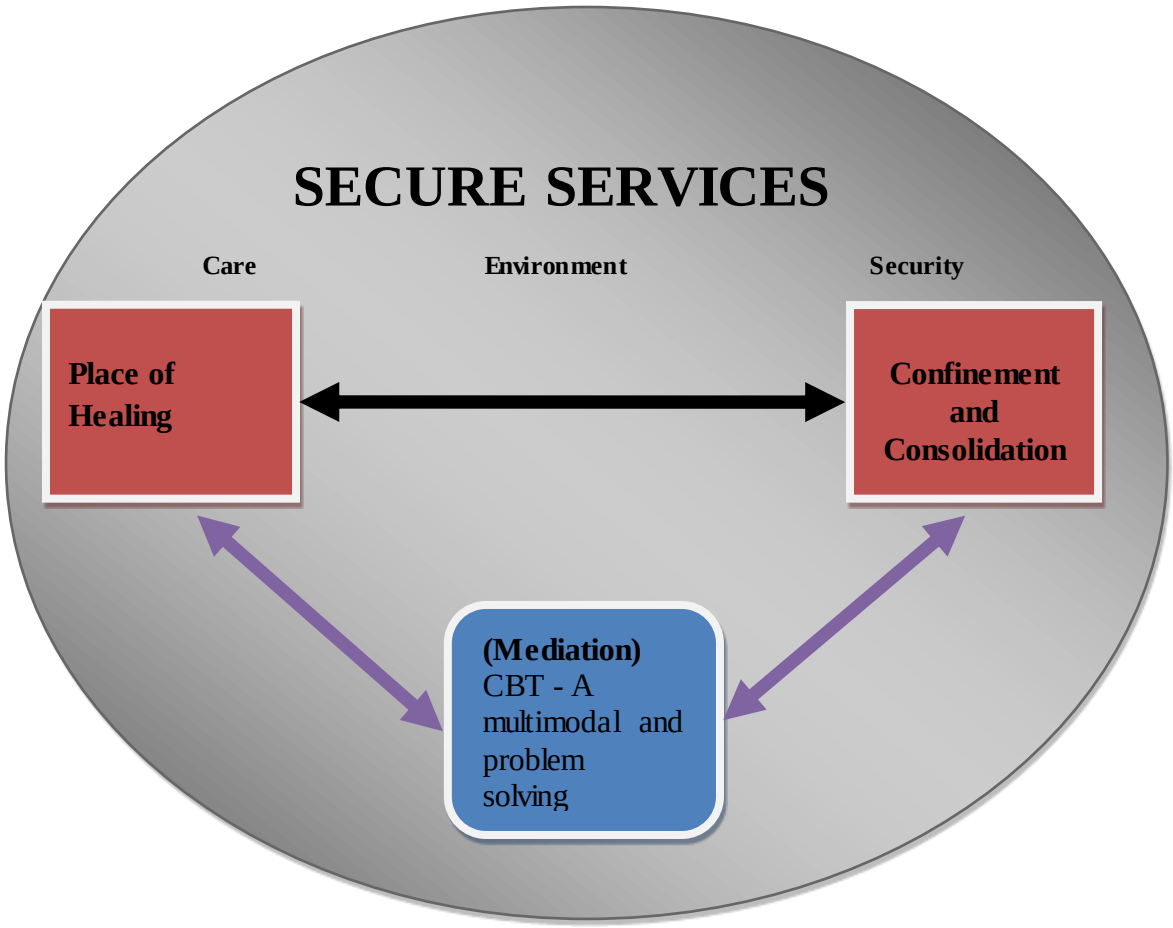

Figure 13: Higher order themes of professionals and patients

6.5.1 Place of healing

Reflecting on the discussion so far, a number of patients described their care in hospital as a positive experience. This is following the discussions on the themes in section 5.3. Patients made references to therapy as '*a place to learn practical skills', 'regular meetings to express problems', 'psychoeducation'* and perceived therapy as *'equals between professionals*.' These themes, taken together, convey a sense of a healing process.

Messari & Hallam (2003) reported a similar theme in their research. Therapists were perceived to be healers who reduced distress and improved patients' wellbeing. They also reported psychoeducation as a way to learn about their problems. The patients in this study were predominantly from acute mental health inpatient units, with one from secure services.

In the present study patients perceived therapy as a framework to *learn practical skills* to solve behavioural problems. Clinical experience shows that patients with overwhelming beliefs and perceptions have difficulty in structuring their thoughts and planning for the future. The CBT framework in this context provided them with a structure within which to place their thinking and subsequent behaviour.

Patients value *regular meetings with staff* to keep track of their ongoing situation. This theme is essential in that it provides time for patients to express their problems: for example, to understand their illness and the stage they are at within the mental health system. Patients in secure services often anticipate anxiety surrounding their future, as the decision about their discharge sometimes concerns the Ministry of Justice. The MOJ has a direct role in discharging patients who are under s37/41 of the Mental Health Act 2007. Regular meetings with staff in this regard serve as a platform for checking their current legal status, which can provide some reassurance. For example, they help patients to evaluate their current position within the system. This information is vital, as it can make patients respond differently and has a direct affect on their mental state.

Patient contact with staff members can enhance the quality of the therapeutic relationship and provide a sense of understanding and feeling secured and supported (Halsall, 2006), which in itself may contribute to the recovery process. A majority of patients in this study benefitted from meeting with staff and described their experiences as a learning curve to understand

themselves better. This process can be seen as self empowerment with help from staff to gradually build on motivation to understand the care pathway and interventions based on a shared understanding (Mancini, 2007).

6.5.2 Confinement

The majority of patients viewed secure services as a place of *confinement*. This view of a restricted lifestyle is similar to that attributed by prison inmates, and most importantly their contribution to decision-making about their care is limited (Langan & Lindow, 2004). Experiencing a sense of being cut off from social life, the outside world and their sense of belonging is a difficult experience. These factors can create a sense of hopelessness and uncertainty as to what the future holds. Although this is not a novel finding, the implications on the patient's life can be dreadful in that the recovery process can be thwarted (Mancini, 2007). Patients' individual lifestyle preferences should be respected and incorporated in their care, as these can help them to adjust to their climate (Hamrin et al., 2009). For example, professionals can strive to understand the social skills of patients and utilize this understanding as part of the protective factors and motivate them to gradually work from one stage to another (Thomas & Hersen, 2010). By considering this, the risk of 'shutting down' to professionals can be avoided.

Understanding the secure service system (e.g. the MHA 2007 and the MoJ) can be confusing, even for some professionals. Some patients struggle to understand the system they inhabit and feel that they are drifting away from their life goals. Patients' interviews discussed their difficulty in comprehending the law surrounding their detention. For example, some patients acknowledged having difficulty in concentrating and maintaining their attention when first admitted – during which time nurses read patients their rights, e.g. Section 132 of the MHA 2007.

Cognitive deficits and severe psychopathology may inhibit patients' comprehending abilities at this stage, and as they gets better over the course of treatment, they become eager to know the particular law surrounding their detention. It is at this stage that patients may seek information from nurses or other professionals and their over-enthusiasm may be perceived as suspicious and threatening. This is an essential junction of 'care versus risk' and the

professional's decision-making may either create a further gap or contribute to the recovery process. If the decision is unfavourable, this may further exacerbate the patient's paranoia, and most importantly, the patient's belief about self and others may be affected (Kingdon and Turkington, 2005).

In other instances, patients' legal status determined by the CJS plays an important role in creating a sense of hopelessness. For example, patients admitted under the s35 (assessment of mental disorder) who have a history of offending may be recommended by the psychiatrist for an s41 restriction order. This recommendation, although necessary, may be in part responsible for creating a feeling of hopelessness, as this would be the start of an indefinite long-stay process. In addition, sometimes the objective manner in which information about the patient's legal status is imparted by the professional (e.g. psychiatrist or nurse) may feed into their already deteriorating mental health. Patients in this study reported that it is 'not knowing of discharge date' that creates a sense of hopelessness (Geiger & Fisher, 2005) – at least in prison services, they are more hopeful about their release.

Sharing of this knowledge has to be carried out carefully and requires the professionals to have some understanding of the potentially damaging impact that the patient's legal status can have on his or her sense of self, beliefs, quality of life and maintaining relationships with professionals. A study by Pitt et al. (2009) demonstrated that imparting a diagnosis could have a detrimental effect on the patient's mental health, such as lack of information and finding out from a second-hand source.

Similarly, imparting information on such sensitive and important knowledge can contribute to depression, and hence has to be carried out with a view of promoting recovery. For example, the professional could provide estimates on the average length of stay of someone on a similar Section, with a view of working towards this as part of their goals. This information can be placed on the care pathway – a process of direction within the system and with estimates of a time frame.

Patients described that the framework of their care was heavily influenced by the medical model (the doctor), which limited their understanding of the problems. For example, some patients felt that their diagnosis was related to biological problems and inhibited openings to other explanations. This view is an important precept for professionals working in this

environment to adapt their treatment style to a bio-psychosocial model, which may produce a better understanding and prognosis.

The predominance of a medical model that indirectly influences patients to rely on medication as a sole treatment may impact on patients' motivation to engage, disempower them and to some extent exacerbate paranoia (Pitt et al., 2009; Gudjonssen et al., 2007). Similar findings were reported by Kilianan et al. (2003), who found that 51% of patients who perceived treatment as medication reported feeling helplessness and hence had low motivation to actively engage in their treatment.

Messari & Hallam (2003) reported a similar finding of patients complying with the medical model as part of a powerful system in order to get a discharge. Other studies asserted that such behaviour from patients is unhealthy due to the nature of their compliance, which was driven purely by social desirability (Skelly, 1994).

Patients' tendency to comply superficially to get a fast-track discharge is not surprising, given the context and situation, and this behaviour may contribute to their recovery pathway. It is possible that at this level, patients have better insight into their illness and are able to at least plan their pathway, although it is seen as superficial. Professionals should observe the keenness of patients and utilize this as a strength, gradually educating them about the advantages and disadvantages of such behaviour. Professionals should be careful not to penalize patients who disclose the truth along the pathway as long as safety is not jeopardized at a significant level. It is feasible that some patients may learn that professionals are balancing their decisions and not merely looking from a risk point of view, hence maintaining their trust. Professionals in this study acknowledged this shortcoming, with little knowledge of remediation between nurses and allied professionals.

Stigma is another prominent theme in this study. Patients felt that professionals had different attitudes towards them, which made them feel disadvantaged. Stigma in this context refers to a process of being labelled by an authority or a system. Kohlenberg et al. (2008) called this 'enacted stigma', which can have an effect on self stigma (internalised stigma). The repercussions of the professional's attitude are far-reaching and can contribute to a negative or positive recovery of patients' mental health. For example, professionals' view of patients, e.g. rebuking, may feed into their already distressing life.

The effect of stigma in practicality is more complex, as it involves various stages, particularly in forensic patients. Patients may have to go through three stages: (1) receiving different attitudes from caregivers and the police when arrested (Teplin 1984); (2) receiving different attitudes from mental health professionals, including the criminal justice system, at various stages before entering the mental health system; (3) professionals' attitude in secure services. Stigmatisation of mental health offenders in this regard can be viewed as having a double or even triple nature: the 'bad' due to the offending behaviour and the 'mad' due to mental illness (see Hartwell, 2004).

After going through a journey of stigma, the patient's level of distress can be high, and considering the above explanation of the stages of stigma, it is inevitable that patients may hold a similar view of professionals in secure services. Professionals' attitude should seek to understand the patient's perspective (the stigma journey), as this would aid in positive recovery. Professionals' interaction, showing empathy and respect towards patients, may produce positive effects and further strengthen patients' sense of self-esteem, which may enhance compliance with the care plan. A recent study by Sibitz et al. (2011) reported that mental health inpatients have low 'stigma resistance' compared to outpatients, and this was attributed to patients' feelings of being cut off from social life, loss of autonomy, motivation and acute symptomatology.

Interventions may be tailored around working with beliefs attached to the stigma, such as psychoeducation and mindfulness techniques, looking at understanding life in a secure services hospital and learning meaningful activities within the secure services, such as engaging in occupational therapies. This will aid patients' understanding of the context and help them to work towards achieving previous life goals: for example, keeping in touch with family and friends.

Overall, the patient's perception of secure services as a place of healing versus confinement can be viewed as a continuum between healthy and non-healthy mental wellbeing. One theory that explains this notion is Antonovsky's (1987) Sense of Coherence (SOC) model.
This model explains how individuals manage stress and stay well. For example, in their lifetime, forensic patients will move back and forth on the continuum of health and disease. The central tenet of this model encompasses the relationship between health, stress and coping: the salutogenic model. The SOC model is based on three components: (a)

Comprehensibility – a belief that stimuli derive from internal sources, e.g. feelings of understanding, making sense and predictability; (b) Manageability – the extent to which an individual believes that he has skills, ability and coping mechanisms in a given environment; and (c) Meaningfulness – the belief and feeling that some things in life are worthy of engagement, commitment and most importantly provide satisfaction.

The SOC model in this study may fit into the patient's model of 'place of healing versus confinement and stigma' – in other words, the 'health' and 'disease' continuum. The compatibility can be used for understanding and devising approaches that are appropriate for this patient population. For example, the psychoeducation approach, based on the mental health system and the stress vulnerability model, can provide a better understanding of the system and provide some level of insight. In knowing this, patients may be able to understand and control their internal stimuli and have some predictability of the prognosis, hence achieving the comprehensibility construct. With regard to the manageability construct, treatment could be targeted to increase the usage of existing and new mechanisms for coping with overwhelming beliefs, perceptions and other challenging aspects in the secure services environment. Gradual exposure to increase the involvement in activities on the ward could be used as a tool which may provide a sense of mastery. The patient's ability to comprehend, manage and control may lend itself to a sense of achievement and satisfaction: hence the manageability construct. Bergstein et al. (2008), in their study, employed SOC to understand delusional patients and recommended the use of the integrative biopsychosocial model, aimed at enhancing SOC, particularly during periods of remission.

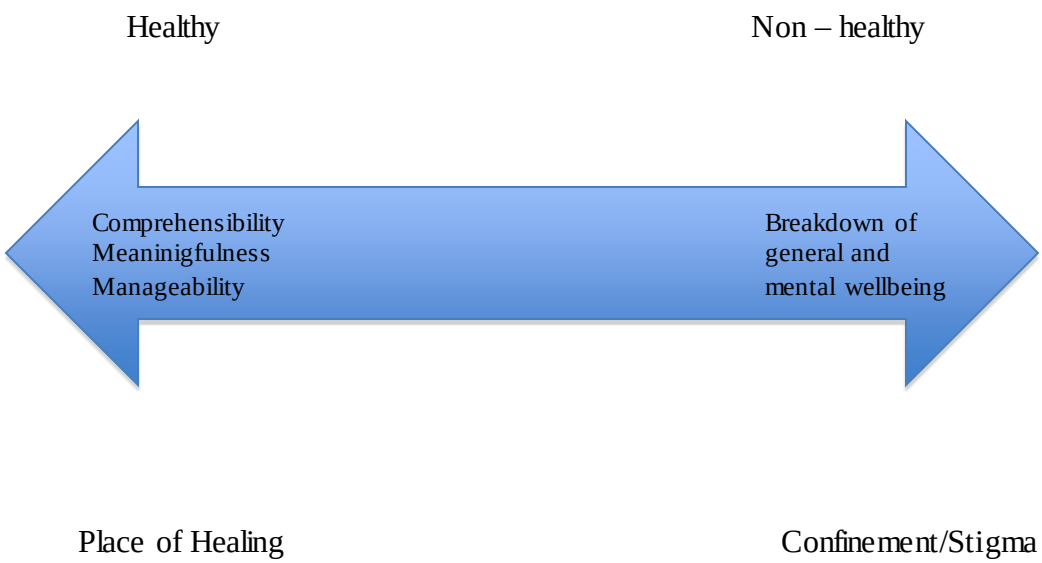

Figure 14: Antonovsky's SOC model: adaptation to patients' views

6.5.3 The multimodal and problem-solving approach

Reflecting on the discussion so far, professionals characterised CBT as a multimodal and problem-solving approach. They made references to CBT being conveyed with particular *assessment style and psychometrics* and using an *integrative approach, picking out bits that suit*, as a *case formulation* approach and as having an emphasis on *therapeutic mutuality* when working with overwhelming beliefs. A majority of the professionals stated that all therapeutic work should encompass risk as a prominent feature when working with patients. From the outset, these themes convey a connotation of a multimodal problem-solving approach.

Professionals perceive assessment style as an important aspect of therapy. Style in this context refers to the professional's ability to engage and motivate patients to complete psychometric assessments and therapy. Given the complexity of this patient population, professionals need to pay attention to issues that can hinder engagement, such as cultural and service issues, before embarking on the assessment (Wright et al., 2009; Rathod et al., 2010). Special attention needs to be given to the creation of a sphere of warmth, with motivational aspects tied in with goal planning, such as planning for leave, to provide some degree of

hope. Assessment is the first step towards the recovery process and the professional's 'style' in delivering psychometrics and therapy may be an important factor in contributing to the prognosis of therapy. Marshall (2005), in his review of sexual offender treatments, stipulated that the therapist's empathy, along with the provision of rewards for progress and some degree of directiveness, can maximise treatment benefits. Rewards in this context refer to being granted escorted hospital leave and working towards unescorted leave.

Rice et al. (1974) rated self-report questionnaires of in-therapy behaviours and theoretical ascriptions of 86 therapists and found significant style differences: female therapists were less anonymous and more judgemental, whereas experienced therapists showed more variety in therapeutic behaviour, used more historical material and placed considerable emphasis on feelings compared to inexperienced therapists.

Professionals reported using an *integrative model,* such as DBT and Schema Therapy, for personality and conduct disorder problems. Although both modalities stem from the CBT framework, there are notable differences between them (Linehan, 1993). Professionals in this study emphasised the complex nature of personality disordered offenders' problems, including co-morbid problems that are difficult to treat without any concrete framework and guidelines. Due to the nature and complexity of these problems, employing a single psychological modality can prove difficult and there is a need for the integration of other modalities (Sperry, 2006).

Challenging behaviour is a prominent feature in individuals with personality related disorders and treating this behaviour can be difficult for professionals. Other features of personality disorder include emotional, interpersonal, cognitive, behavioural and self dysregulation (Linehan, 1993). Treatment of personality disorder as a co-morbid or stand-alone diagnosis in the institutional context needs to consider several factors, such as environmental effects, readiness for change and motivation, level of functioning, past success and compliance with care plan. These indicators are essential in determining the process and success of therapy (Sperry 2006).

Schema therapy is another modality which is often used with patients having these concerns. Individuals with personality-related problems often come from a deprived socioeconomic background (Grant et al., 2004) and psychosocial influences shapes an individual's character,

which influences personality (Sperry, 2006). Schema is another component of personality and refers to the basic views of self, world and others, including views on the future (Young et al., 2003). The central tenet of schema therapy is that modifications of an individual's negative schema (self and world) and overcompensating strategies may aid in adopting a new style of thinking.

Nearly all professionals reported not having a structured treatment approach for CBTp for this setting and most indicated that they would *pick bits that suit* from renowned authors and books. This included not having a framework for addressing co-morbid problems. Professionals mentioned borrowing ideas on different topics from assessment and incorporating formulation into the relapse prevention models. The issue of heterogeneity of diagnosis, e.g. substance misuse and trauma, and related problems are of concern and require the attention of professionals who work with these issues, who are often left confused and unsure about which treatments are appropriate at what stage, as this too will determine the outcome (Rice & Harris, 1997). Knabb et al. (2011) in their review, reported that some professionals often borrow evidence-based ideas tested in other populations in the hope that they may work, such as the problem-solving approach. As robust clinical trials are limited in this setting, particularly in psychosis and offending behaviour (Hodgins, 2004), research addressing this shortcoming is needed.

The *care pathway* emerged as an important aspect of patient care. Most professionals highlighted this as an important feature for patients to acknowledge and have an understanding of in order to pave their way towards discharge. Allen et al. (2009), in their systematic review, concluded that an integrated care pathway is the most effective component in the context of predictable patient care trajectories and bringing about behavioural change where multidisciplinary working is established as less certain. The reviews in this study were taken from physical health care, as there were no systemic reviews specifically in mental health care.

Case formulation is essential, reflecting professionals' understanding about patients' clinical presentations, such as their psychiatric history, impulsivity and psychotic symptoms. Case formulation by definition involves extrapolation of predisposing vulnerabilities incorporating genetic, biological, psychosocial and cultural issues, which inform current working models, compensatory strategies and beliefs about self, others and the future (Eells & Lomart, 2011).

Most professionals reflected that the case formulation approach is central in understanding patients' complexities and choosing the right treatment. The case formulation approach is like organizing a puzzle. It allows professionals to structure and in some cases observe the origin of patients' problems and its relationship in the here and now. It provides a holistic approach underpinned by a theory or theories which may provide a valid explanation of the patient's problems and thereafter enable individualized treatment planning (Hart et al., 2011).

Notwithstanding, the process of creating a care pathway and case formulation will inevitably enhance *therapeutic mutuality* between the patient and professional in a less restrictive way.

6.6 Is there a need for a manualised treatment of CBT for psychosis in secure services?

The purpose of this question was to gain an understanding of whether CBTp-ss can be accepted as a structured individualized treatment modality in secure services. A majority of professionals in this study agreed that CBTp is an evidence-based modality that is often in use in this population. Most professionals in their interviews agreed that a manualised approach was useful with this patient population; nevertheless, there was little guidance and research in this area.

It works fairly well in terms of containing the group and the facilitators to have a structure to work through during the group.

FG1, WL 2

Patients, on the other hand, acknowledged that the brief and problem solving nature of this modality works well in providing awareness and managing symptoms and behaviour.

Symptoms - how to tackle symptoms and what to do if you experience symptoms (voices and images).

P1, page 3

This was further evident in patients' narratives, as they mentioned that the nature of the CBT framework was easy to understand, reflecting on past, current and future issues, and provided

insight into their mental illness and difficult behaviour. Patients also mentioned benefitting from psychoeducation and from individualized and group sessions that provided a structure and raised expectations for the future. Patients residing in secure services often have a long history of mental health disorder, offence and institutionalization, which adds to the difficulty in engaging (Beck & Morrison 2002; Castro et al., 2002). Reflecting on the patients' narratives of having little or no control over their treatment process and progress through the hospital environment, a majority of patients emphasized that the collaborative approach in CBT made them feel that they were being treated respectfully.

In contrast, it is noteworthy that the professionals' (e.g. nurses') attitudes towards patients, seeing them as offenders, can hamper the efforts made by other professionals working in the unit (Lilja, et al., 2004; Lilja & Hellzen, 2008). The absence of reciprocity in relationships and the presence of a dominant figure, such as a parent, can hinder therapeutic processes and evoke estrange childhood and similar negative experiences (Lilja & Hellzen, 2007). This experience may have a reminiscent effect on traumatic experiences that can hinder patients' progress.

To date, few studies have been carried out in this population (Haddock et al., 2004; Haddock et al., 2009; Laithwaite 2009) and the focus of these studies was on having a pre-determined outcome, based on individual and group settings, in which there was minimal input from patients.

Haddock et al. (2004), in their case series, reported on the feasibility of CBTp in this population and this was followed by a first randomized controlled trial of CBT for psychosis. The results of this trial were promising in that the CBTp intervention included motivational strategies and reduced violence, delusions and distress. There were no notable benefits on anger and the authors suggested that further studies should include personality factors and that the outcome might be a good predictor of violence. Although the study employed a manualised approach, it did not demonstrate obtaining any input from the patients themselves**,** as this might have influenced the outcome.

Laithwaite et al. (2009) carried out a within-subject study of eighteen participants in a recovery group in a high secure service. Results were promising: improvements were observed in depression, self-esteem and general psychopathology.

Shortcomings of this study were identified, however: the sample group was small, without any matched control group, outcome measures had no published norms and there was no mention of input from patients in the manual.

In a study conducted in America, Garret & Lerman (2007) employed CBTp for eight forensic mental health patients and the results were encouraging. Although this study was a brief case report, the results were nonetheless promising.

Literature from other studies (America and Europe) reported using DBT in inpatients and outpatients with personality disorders and found positive results: there was overall improvement in depression, anxiety and suicidal acts and improved functioning (Bohus et al., 2004; Clarkin et al., 2007). The latter studies were carried out with outpatients and had limited generalizability. So far, to the author's knowledge, there are only three studies in the UK that have attempted to use CBTp and CBT-related interventions with this population.

Currently there are several published CBTp manuals (Kingdon & Turkington, 1994; 2005; Morrison et al., 2004; Hagen et al., 2010; Wright et al., 2009; Chadwick et al., 1996; Chadwick, 2006) written by renowned authors. Most manuals are written from clinical experiences and research, with minimal input directly from a specific patient group, and the external validity of these manuals is suspect, as not all have been tested in real clinical settings. However, current CBT manuals are trending towards specific services, such as CBT for inpatients (Clarke & Wilson, 2008), hence providing a more detailed and specialised service.

Professionals' views are paramount in providing structure and direction and patients' views are equally important, as they can highlight issues that are working in regard to therapy and other sensitive concerns (Greenwood, 2009; Hodgetts & Wright, 2007). For a majority of patients in this study, the theme of stigma, particularly double stigma, played a crucial role in help-seeking behaviour. As discussed above, the professionals' attitude plays a major role in understanding and empowering patients (Brohan et al., 2010) to combat such a difficult problem, which may in itself create severe distress on top of the symptoms of mental illness. The stereotyping attitude is further amplified by the media, which tend to give misleading information about mental health patients as being unpredictable and dangerous (Beresford, 2005).

These issues have been identified as barriers to the use of cognitive therapy in previous research (Beck & Morrison, 2002). Professionals working in this service have to be mindful of their attitude, as this can determine how patients react and behave and most importantly can change the direction of positive patient recovery.

From a different viewpoint, the attitudes of professionals, such as nurses and pharmacist, can undermine CBT and other psychological modalities relative to the medical and pharmacological model, which may create an unstable environment for patients – they may feel demotivated to engage in a meaningless activity. Research has identified that medication alone is not sufficient in maintaining remission (Kane, 1996) and patients do value therapy as an important human contact (Lilja & Hellzen, 2008). A shift in professionals' attitudes may change patients' perception and motivation to engage in therapy.

A large number of patients in this study report being coerced and controlled by staff, such as psychiatrists. Patients in this situation often learn to either give in and follow the instruction of the professionals or adopt socially desirable behaviour. In the latter, adaptation to the role of a 'patient' is strongly associated with a false sense of self (Lilja & Henzen, 2008), which may promote the manipulative trait (risk factor) seen in personality disorders, and hence can impede the journey to recovery. Professionals need to be cautious in dealing with patients, particularly those with strong personality traits, and avoid getting into a risk escalation process (Heyman et al., 2004). Management of patients in this regard can be carried out by discussing the risk issues in therapy on a shared understanding rather than allowing patients to remain misinformed (Heyman et al., 2004).

Some of the findings of this study endorse previous work on patients and on professionals' work on CBTp (McGowan et al., 2005). McGowan and colleagues emphasize a central theme of *understanding, holding and engaging with the therapist's model of reality, albeit* the patient's progression, which is related to the ability to process distressing thoughts, guided by the therapy and sharing the same goal, underpinned by a solid therapeutic alliance.

Patients in this study reported that the understanding of their situation is of paramount importance, particularly in a locked environment, as is being treated equally by all professionals. A similar theme was also emphasized by Messari and Hallam (2003), who

suggest that being treated as an equal should not be regarded as a 'non-specific' secondary aspect. Ingredients in the therapeutic relationship, such as warmth and trust, could be incorporated as a topic/skill in future studies as part of the communication skills module (Taylor & Sambrook, 2012).

6.7 Clinical implications

Patients in secure services have complex problems and working with this population calls for specialized treatments. So far, research in the area of CBTp in secure services is scarce and there is limited guidance on CBTp treatment. To the author's knowledge, this is probably the first study in the UK looking at both patients' and professionals' views on CBT for psychosis in secure services. Based on the results of this study and relevant literature, it appears that CBTp is an acceptable modality and current CBTp practice in this setting is either modified from existing manuals or borrowed from other populations (Knabb et al., 2011), and that there is a need for a specialized structured approach in this setting (Blackburn, 2004). Findings from this study will add to the existing CBTp manual and literature; care pathways and forensic case formulations can be embedded into CBTp and into the therapy processes and outcome (Blackburn, 2004; Sturmey & McMurran, 2011).

6.7.1 Care pathway

As highlighted in section 5.5.5, forensic care pathways are an essential part of the mental health system. For example, services should have a clear individualised care pathway package which outlines the access pathway, such as referral from prison, courts and other secure units according to their MHA sections; stepped care interventions detailing admission and assessment criteria, including specified treatment according to diagnosis, with an average stay and time specified; a process of reviewing and detailing multidisciplinary team input to the Individualised Care Plan (IPA) and pre-discharge planning with exit pathways detailing patients' discharge to the community forensic team, supported accommodation, step-down facilities and independent housing. Care pathways could also include the help-seeking behaviour of patients, according to their culture (Rathod et al., 2010; Bhui & Bhugra, 2002).

The above pathway needs to be discussed and planned based on a shared understanding by placing the patient at the centre of the approach. Patients should be encouraged to discuss their concerns and treatment planning with short- and long-term goals. This will enable professionals to monitor the patients' progress against their pre-determined set of standards and anticipate patients' transition into a step-down facility, hence having a positive effect on their stay. At a macro level, care pathways could be informed by the Mental Health Clustering tool (MHCT) from the national initiative of Payment by Results (PBR), in this case dedicated to secure services.

6.7.2 Forensic case formulation

In addition, case formulation is an essential element that reflects professionals' understanding about the patient's clinical presentations, such as psychiatric history, impulsivity and psychotic symptoms.

Most professionals reflected that the case formulation approach is central in understanding patients' complexities. Case formulation usage in secure services emphasizes various problems encountered by the patients. These problems vary according to the diagnosis, offences, cultural, psychological, personality and developmental issues and the conceptualisation of these issues provides a structure that informs the treatment care plan. On a spectrum from general to specific, CBT formulations could range from mini (such as the ABC formulation or the Beckian formulation) to specific formulations (such as Morrison's idiosyncratic formulation). Taking into account the patient's mental state, mini formulations, such as the ABC formulation, can sometimes be better understood in the context of the here-and-now and should be advocated as a regular medium of sense-making.

Complex case formulation encompasses various multifaceted issues, e.g. forensic and co-morbid, and can be discussed with the patients according to their ability to comprehend. Formulations of patients (mini or complex) should be carried out on a shared understanding, as this would enhance patients' trust and relationship with the professionals (Kuyken et al., 2009). Information on case formulations should be tested by observing patients' responses and behaviour on the ward and on trial leave, as this would provide evidence of the predictability and reliability of the formulation (Eells & Lombart, 2011) and provide better

ecological values. If the case formulation is suspect, professionals could revisit it and discuss it with the patients to maximise the benefit and maintain therapeutic rapport. This will provide professionals with a tool to examine patients' expectations and progress.

In addition, case formulation should be revised with information on actuarial or structured clinical risk assessment such as the HCR-20 and personality assessment such as the Hare Psychopathy Checklist (short version). For example, professionals could share information from the HCR-20 with the patients and discuss the risk accordingly, considering anxiety, stress and overwhelming beliefs or perceptions. Personality assessment may provide important information, such as lack of remorse, which can be integrated into the formulation and will provide a better understanding of the patient, hence enabling the planning of appropriate treatment.

Secure services traditionally have always considered working within the Risk, Need and Responsivity Model (Andrew & Bonta, 2007). Professionals should try to incorporate this model into therapy. For example, in terms of the 'risk' principle, the professional needs to consider the risk attached with regard to deficits associated with mental illness and offending behaviour. The 'need' principle refers to the complex issues in this population, such as anger and substance misuse, and to respond according to their problems – in this case, providing CBTp for positive symptoms and awareness of high risk situations. Meanwhile, the 'response' principle looks into factors that consider that some patients may not respond to treatment and considers the underlying reasons: negative symptoms and personality problems.

These principles could be incorporated into the foundations of CBTp in secure services. In some ways, there are overlaps between case formulations and the RNR model – they both formulate risk – however, professionals should employ the RNR model as a basic foundation when conducting CBT assessment and treatment, hence building on existing resources.

6.7.3 Psychoeducation

A majority of patients in this study expressed benefitting from having psychoeducation about mental illness.

Most professionals expressed a similar view and stressed the importance of providing psychoeducation.

Psychoeducation is an important part of an intervention that can aid patients to have better awareness of symptoms and insight (Cross & Kirkby, 2001; Walker, 2006). The goal of psychoeducation in forensic settings should focus on providing information on mental illness, the legal system and coping skills. Information on mental illness should incorporate co-morbid complex issues, such as PTSD, drugs and alcohol, and anger issues, as this will provide a better understanding of these problems *per se*, their interaction and their impact on the mental state and on general and social functioning. Due to the high levels of BMEs in these settings, it is vital that cultural information on help-seeking behaviour and attributions of mental illness are included (Rathod et al., 2010).

Information on the legal system, such as the MHA 2007 and the MoJ, is important, as it can have an impact on patients' care, particularly for long-stay patients (Walker, 2012). Information should be provided on the respective MHA 2007 sections, the appeal process, manager's hearing and tribunal, and on factors that are considered by the MoJ when providing leave and the discharge processes.

Coping skills information is vital in the sense that patients may build on existing skills and learn new methods to alleviate distressing overwhelming beliefs, perceptions, interpersonal issues and anger within this environment. The underlying strategy is to provide patients with important information that they can use to understand their problems: for example, understanding what causes psychosis (facts versus myths), understanding s37/41 and tribunal processes, and learning how to cope with psychosis whilst in the hospital. The central tenet is for patients to take an active role in their care, based on a shared understanding with professionals, whilst planning for a way out of the hospital. This strategy may reduce patients' feelings of shame and stigma and encourage an active process of self-healing, including better self-esteem and confidence.

6.7.4 Working with co-morbid problems

Some professionals described the difficulty in working with co-morbid problems, including the lack of guidance and appropriate treatment approaches.

Research in this area is scarce and there is a need for further studies looking at the feasibility of integration (Barrowclough et al., 2010). Co-morbidity is now accepted as a rule rather than an exception with psychiatric disorders and the decision to address these issues lies with the professional. Patients in secure services often have co-morbid problems and professionals treating these problems may find it difficult to decide which aspect within the co-morbidity is posing or even maintaining the problem. CBT principles are predominantly useful to address issues related to psychosis, with weak evidence for reducing anger, self-harm and harmful drinking and social functioning (Davidson et al., 2009).

A comprehensive assessment can enlighten and provide a thorough formulation, which in turn may provide a holistic view of the patient's symptoms instead of focusing on the clinical diagnosis. A symptom-based model may provide a better understanding of the overlaps of symptoms and hence allow professionals to tailor the treatments according to the severity and intensity of the symptoms (Kingdon & Turkington, 2005).

Some professionals in this study reported using Dialectic Behaviour Therapy (DBT) to look at issues on anger and self-harm. DBT was first used with Borderline Personality Disorder (BPD) patients and the results in recent RCT were promising in reducing suicidal behaviour (Linehan et al., 2006). Other studies have demonstrated that DBT reduced intentional self-harm in BPD patients (Linehan et al., 2002; Koons et al., 2001). Specifically to forensic settings, Evershed et al. (2003) carried out an eighteen-month DBT for patients with anger and violence: the results were encouraging in that DBT impacted positively, with lasting effects on violent behaviour and components of anger.

DBT was developed out of CBT for BPD patients (Norling & Kim, 2010) and it is possible that professionals can adapt these principles into treating co-morbid issues such as anger and suicidal ideation and behaviour in patients within secure services.

These principles look at (1) issues relating to the acceptance and validation of behaviour, (2) behaviours that interfere with therapy, (3) the therapeutic relationship as a moderator of change, and (4) the focus on dialectical processes. These principles could be adapted as an adjunct to CBTp in treating problematic behaviours.

6.7.5 Care versus risk and security: the dual role

As highlighted earlier, professionals need to be aware of the dynamics of the dual role: care versus risk and security. There needs to be a balance between care (e.g. expressing empathy) and risk issues: often it may be the case that the professional is drawn into the caring mode whilst facilitating the therapy and forgets to exercise issues attached to risk and security. The maintenance process is highly challenging and while enacting care, professionals need to be aware of risk issues (Dale & Storey, 2004). Gilberg et al. (2012), in their research, strongly emphasised that the caring mode of the professional should be built on a foundation of 'behaviour and corrective perception', as this would enable better support and educate patients about an acceptable normalised behaviour that will protect them from having a view of being punished.

The dichotomy of care versus security is well documented in the nursing profession literature (Fisher, 2007), and other professionals, such as therapists, are also affected by this dilemma. Organisational philosophies on 'care versus risk' are an important paradigm that can aid professionals struggling with this impasse and clinical supervision may be helpful in balancing these processes.

6.7.6 Integrative model

Another important element in this study is the integrated care model highlighted by professionals. Professionals reported that due to the complexity of patient problems, an integrative model would be appropriate in understanding and addressing patients' issues.

An integrated approach to treatment allows multiple agencies working within the secure setting to communicate and work towards one goal: care for the patient. The integrative model in this sense involves having a centralized system where professionals from different modalities and professions – such as psychologists, psychiatrists and nurses – assess the patients' needs, deficits, strengths, risks and motivations in a collaborative environment.

Based on this information, the team will decide on a treatment plan that involves case formulations, with a shared treatment conceptualization that will contribute to the individual

care plan. For example, a patient with psychosis and co-morbid personality disorder can be assessed using multiple professions' assessments, leading to a comprehensive treatment plan, and this information could be shared with the patient, contributing to their individual care plan. Employing the integrated model could ensure that all professionals will gain a clearer shared formulation of the patient's needs in therapy, risks and strengths. In some ways, this will be the overall blueprint, including the patient's case formulations, individual care pathways, risk assessment and discharge planning.

6.8 Barriers to accessing CBT

6.8.1 Minimum awareness

Professionals in the focus group (those with no CBTp experience and individual interviews), predominantly in the London sites, reported having minimal awareness of the workability and understanding of CBTp. They mentioned having no awareness and principles of CBTp's effectiveness for patients in this setting.

I don't know enough and I think we spoke about this yesterday and in that finding ways to talk because we work with the same people, yeah.

FGAT, CN 3

I don't know enough in practice about it. Theoretically yes I know certain therapies work for certain people and certain presentations but I can't comment in practice how much it helps.

FGAT, CN2

Another concern was that there was no suitable information-sharing platform on each modality. This was mentioned in the light of a professionals-only meeting for the purpose of contributing to patients' care and there were no further arrangements and understanding of individuals' professional modalities.

6.8.2 Referrers' perceptions

Due to their limited knowledge, professionals were not able to refer patients to CBTp. Professionals in the no-CBTp focus group expressed reservations about referring patients if they did not know enough about it.

Is, um, I'm not sure how CBT works with addressing psychosis. Is there any evidence that it [works]? And psychosis is such a unconscious process and I don't know how CBT works; I don't know any approaches in CBT and psychosis.

FGAT, CN 5

The referrer's perception about another modality is essential, as this contributes to the decision-making in referring patients (Rathod et al., 2010).

The referral process and understanding within the therapies department is an important aspect which needs further attention. These inconsistencies need to be explored and addressed to provide a better service for patients.

I think there is an importance in having a dialogue. I think that's really important, I think being experts in each other's roles I think kind of weakens both, you know different professions, I think that having a dialogue is really important, but I also think it is really important not to have one fit, one shoe fits all, so when governmental papers talk about that being the same for everyone, it's you know, CBT does not suit everyone, arts therapy does not suit everyone, you know, but different people find different psychological treatments suit them, and help them better, and to try and help and input one on everyone else so I think is; I mean we have all worked with people, some people want things which is more structured, others who want things less structured. FGAT, CN 7

6.9 Implications for services

In order to promote a balanced and healthy environment, it is necessary to create awareness amongst professionals through training and the wider system (Kingdon and Turkington, 2005). Professionals working in secure services need to be exposed to the principles of working in an environment full of complexities of both patients and staff. The goals may be to promote an understanding in recognizing patients' views of what they think is important for their care, and in particular, looking at issues surrounding the 'confinement theme', environmental effects and philosophy of care.

Considering the views from patients will ensure better quality of care, with reduced distress, and will enhance patient engagement, particularly in understanding illness, the role of medication and the prevention of reoccurrence of symptoms. CBTp will offer the choice of an evidence-based alternative or adjunct to psychotropic medication. In summary, it would mean better care for patients, which is less restrictive and in accord with the choice agenda.

The social climate in secure services is an important factor in looking at the attitudes, beliefs and behaviours of patients and professionals (Morrison et al., 1997). Professionals may need to consider the impact of these constructs on themselves and most importantly on how they are perceived by patients, as they would also have some impact on patients' perceptions of professionals.

Secure services' philosophy of care can determine and influence the social climate: hence the balance between care and risk needs. Secure services need to work on a framework that focuses on various issues at an organizational and clinical level. The Milan principles (Milan, 2001) could be adopted when planning patients' care pathways with an overarching philosophy from NICE guidelines on secure services (DOH, 2007).

In terms of clinical training, services should allocate training for staff and dissemination of Cognitive Behaviour Therapy for Psychosis in Secure Services (CBTp-ss). The training should emphasise specific skills, such as building and maintaining therapeutic rapport and motivation in a locked unit, including DBT and schema therapy principles (Taylor & Sambrook, 2012); understanding and employing forensic case formulation (Sturmey & McMurran, 2011); care pathways (The Clinical Model, 2009) and working with obstacles in therapy within this setting, such as issues related to change. In addition, specific time should

be allocated to professionals who have completed specialised training (Jolley et al., 2012). Supervision and reflective practice could be integrated as part of the training programme and time allocation for supervision should be integrated into professionals' routine hours rather than being in addition to normal working hours. Although difficult, services should allocate extra time for specialist professionals to assess, formulate and manage complex cases, as they are invariably linked to offending risk.

6.9.1 Limitations

As in all research, there are some obstacles which limit the scope of the study to reach its full potential. One of the important shortcomings of this study was the recruitment of patients. For example, the route to reach patients was a complicated journey. There were difficulties in reaching the Responsible Clinicians (RC) to obtain approval. Once approved, the communication between the RC and the wards were poor, and at times, patients had left the ward for leave.

Some patients at the London site who had been identified as suitable declined the offer to take part. The researcher attempted to ask why and staff identified the reason as being due to the fear of not knowing the nature of the research, despite getting all the information from the leaflets provided. In addition, engagement was hampered by feelings of mistrust regarding the impact of disclosure on patients' care and discharge.

Given the sensitive nature of this research and the current economic climate, some professionals felt that their disclosure, e.g. modality, profession and site, might have an impact on their job, and hence refused to give these details. Art therapists were not employed in any Hampshire sites.

Whilst a substantial number of interviews with patients were carried out, many patients from both the London and Hampshire sites were based in low secure services compared to medium secure services.

6.9.2 Researcher's appraisal

Through the journey of this study, from drafting the proposal to the literature review and exploring concepts and theories which provide an insight into the depth of the storyline of patients residing in these settings, I have developed a better understanding of issues pertinent to risk versus care, patients' feelings of confinement and uncertainties regarding the future that create a sense of hopelessness. As a therapist, it can often be difficult to educate other professionals about therapeutic methods and most importantly about working with an integrative model.

In my role as a researcher working in secure services in one of the London sites, I have been influenced by my previous interactions with the patients. On reflection, I have worked with some of the patients as a therapist and interviewing them as a researcher was a difficult task, and not switching to therapist mode was one of the biggest challenges. I was aware of this bias and effort was made to minimise this by having supervision with a qualitative expert (Giorgi, 1995). The difficulties in maintaining the flow of the data and themes were overcome by a validation process whereby individuals from the patients' and professionals' groups reconfirmed the coding, hence reducing interpreter bias (Elliot, 1999; Creswell, 2009)

In addition, working with this patient group for nearly a decade and researching in this area has shed light onto some of the core issues faced by patients: for example shifting between confinement and healing. This has provided a platform to work on in identifying the ingredients within the grey area, such as lack of trust and information, which can be incorporated into the foundation of CBT for secure services, hence leaning towards the ethos that 'one size does not fit all' (Rathod et al., 2010).

Chapter Seven: STUDY TWO - Feasibility study of Cognitive Behaviour Therapy for Psychosis – secure service (CBTp-ss)

7.1 Introduction

There are an estimated seven-thousand inpatient beds in mental health secure services in England and Wales (NHS Commissioning Board, 2013). Out of these, there are approximately 680 beds in high secure, 2800 in medium secure and 2500 in low secure services and this indicates a population prevalence of 1.3, 5.3, and 4.6 per 100,000. Most mental health offenders have a major mental disorder, such as schizophrenia, with other co-morbid problems, and pose significant risk of harm to others and to themselves.

Research suggests that there is an association between mental illness and aggression, which is especially prevalent within those people residing in inpatient psychiatric settings (Daffern & Howells, 2002). This is unsurprising, as patients have often been sectioned due to violent behaviours which require detainment for public and self protection. Anger is believed to co-occur with a number of psychiatric disorders, including personality and mood disorders, and is believed to be especially prevalent in those diagnosed with paranoid schizophrenia (Novaco, 2010).

Studies in schizophrenia have shown CBT to be of benefit in the treatment of positive symptoms (Tarrier et al., 1998) and negative symptoms (Sensky et al., 2000; Williams et al., 2014). Medication adherence has been improved by a brief CBT intervention in patients with schizophrenia (Kemp et al., 1996) and the intervention may be cost effective (Van de Gaag et al., 2011). Recent studies have shown that CBTp is an acceptable modality and can produce improvements in positive symptoms in clinical settings (Williams et al., 2014).

Schizophrenia and related psychotic disorders are among the most disabling illnesses worldwide and pose a considerable economic burden to current healthcare systems (Mangalore & Knapp, 2007).

As well as being a major cause of distress for individuals and families, they cost the public approximately £105 billion every year though lost productivity and avoidable costs for the criminal justice system as well as the costs of care and support (Department of Health, 2011).

Information on the cost-effectiveness of alternative treatment approaches for psychosis is therefore highly relevant for decision-makers in the field of healthcare. Spending on secure services amounted to £1.2 billion in 2009/10, corresponding to 18.9% of all public expenditure on adult mental health care (Mental Health Strategies, 2010). Growth in spending on these services has been particularly rapid in recent years, having increased by 141% in real terms (i.e. after taking account of general inflation) between 2002/03 and 2009/10. This is equivalent to a growth rate of no less than 13.4% a year in real terms. In contrast, expenditure on all adult mental health services increased at the slower rate of 5.9% a year, with the consequence that the share of secure services rose sharply, from 12.3% of the total in 2002/03 to 18.9% in 2009/10. Of all the additional money made available for adult mental health care over this period, more than 30% went on secure services (Centre for Mental Health, 2011). Evidence on cost-effectiveness is important to make well-informed decisions regarding care delivery, particularly in this economic climate.

7.2 Cognitive Behaviour Therapy for Psychosis in secure services

Research on individual CBTp in secure services is less established and most patients do not receive the treatment due lack of resources and trained staff (Walker, 2004). Empirical data on the efficacy of CBTp is mainly based on generic populations, predominantly from the community, and some inpatient populations, with limited patient samples from secure services. To date, only one large RCT, namely Haddock et al. (2009), has been carried out, with limited outcome: hence, more research is needed in this area. In light of this, the development of CBTp in secure services is justified in order to bridge the gap and improve treatment outcomes, including making well-informed decisions about cost effectiveness.

The qualitative study discussed in the previous two chapters highlights important information regarding patients' perspectives when receiving CBT for psychosis in secure services. Views from professionals highlight important issues regarding psychological therapy and obstacles to complement patients' views. These views (from patients and professionals) were analysed

and CBTp was adapted accordingly to produce guidelines for use in secure services (CBTp-ss).

The present study is designed to test feasibility of the new CBTp-ss intervention and the hypothesis is that CBTp-ss is acceptable and will reduce patients' psychotic symptoms compared to TAU, reduce anger and shorten the overall inpatient stay on the ward.
The trial aimed to:

- Assess the feasibility of Cognitive Behaviour Therapy for Psychosis based on the secure services manual (CBTp-ss) within the secure services environment.
- Assess and analyse cost of using CBTp–ss.
- Assess processes to ensure fidelity to the new CBTp–ss manual.
- Further modify CBTp–ss in accordance with findings of the pilot.

7.3 Methodology

7.3.1 Study design

The researcher employed both quantitative and qualitative methods. This design allows a clear role for each component in terms of timing, weighting and mixing and is thus beneficial to enable an understanding of patients' views in addition to psychometric measurements (Creswell & Clark, 2007). This study adopted an embedded design in which one data set provides a complementary and supportive role to the other.

The quantitative study was a single blind multi-site, randomised trial of CBTp-ss for patients in secure service compared to TAU. This was followed by a qualitative study to complement the quantitative study to elicit and understand patients' experiences and expectations of therapy after the intervention. In constructing the methodology for the latter, special attention was paid to the interplay between therapist and patients. Therefore, this study employed a thematic analysis approach. Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data (Braun & Clarke, 2006). A recent study (Greenwood et al., 2009) used a thematic analysis approach with CBT for psychosis patients in analyzing data. Justification for using this method is provided in Chapter Nine.

7.3.2 Study centres

Three forensic National Health Services from different trusts in London were approached, of which only one participated in this study. There were two centres within the trust that participated. The other two forensic services (from West London and East London Secure services) were going to provide the majority of patients, but due to issues with Research & Development and security logistics, patients were not recruited. This will be discussed in the limitation section.

7.4 The process of recruitment

Recruitment of patients with a diagnosis of schizophrenia, schizo-affective disorder, psychosis and/or delusional disorders was conducted from December 2012 to December 2013 by approaching the Responsible Medical Officers (RMO) of the respective centres. The RMO and the team determined the suitability of potential patients based on the consultant information sheet provided (Appendix 9). In addition, patient information sheets (Appendix 10) were given by the RMO to suitable patients. The researcher did not approach potential patients until they had indicated interest in taking part to the RMO. Written informed consent (Appendix 11) was obtained from all patients by the RMO or a team member before recruitment.

7.4.1 Assessment and recording of patients' capacity

This was an important issue that was highlighted by the Ethics committee, given the vulnerability of this client group. Assessment of capacity was based on the five core principles of the Mental Capacity Act (2005). It was not assumed that a person could not make any decision because of their diagnosis, age or behaviour. The RMO was encouraged to take necessary steps in helping patients to make decisions. These steps included recognising language and cultural differences, giving patients the appropriate amount of time (e.g. twenty-four hours) and providing details of the study, checking for understanding and repeating information if necessary and/or involving an advocate. The RMO and the team were encouraged to record a summary of capacity assessment in the patient's clinical notes.

The researcher approached potential participants only if they indicated their interest in taking part in the study to their RMO and/or team.

7.4.2 Loss of capacity during research

In case of loss of capacity during the trial, participation would be withdrawn and the data collected up to that point would be anonymised.

7.4.3 Inclusion and exclusion criteria

Inclusion	**Exclusion**
Patients admitted to medium and low secure mental health services	Moderate to severe learning disability (if already documented or assessed during admission), if this prevents them from participating in the discussions.
Individuals between the ages of 18 and 65 with a diagnosis of schizophrenia, Bi-polar disorder and manic depression using ICD-10 criteria.	Severe illness which may affect capacity or markedly affect their ability to participate in rating assessments, e.g. very thought disordered or distressed by symptoms.
Held under the Mental Health Act 2007	Lacks capacity or not agreeing to consent. Patients who, in the opinion of the Responsible Clinician, would be expected to be distressed by the interview, e.g. those with low insight into illness
Willingness to participate in the study, be interviewed and have notes made and/or be tape recorded.	Likelihood of discharge within three months

Have capacity to consent and understand the interview. If capacity present, decision-making process around psychotherapy may be recorded	
Minimum duration of admission of six months and on stable medication for at least a month preceding therapy	

7.4.4 Randomisation process

Once written consent had been obtained, patients were contacted by the assessors for baseline assessment. This was followed by a randomisation process conducted externally by an independent professional. Due to the small number of patients and in order to maximise treatment experience, unequal randomization (2:1) was employed. This type of randomization may benefit studies with small numbers of patients who may receive an evidence-based treatment (Dumville et al., 2006).

The consort diagram below displays the recruitment and allocation of participants into the trial. A total of twenty-one participants were identified and screened for eligibility. Of those screened, nine were excluded for the following reasons: two declined to participate; three patients did not meet the inclusion criterion and the remaining four, who were eligible to participate, could not do so because the centre refused to randomise them. All patients were detained under the Mental Health Act forensic sections, e.g. 37 and 41. Eight patients were allocated to the CBTp-ss group and four to the TAU group. Post-treatment assessment was n = 8 in the CBT-ss group and n = 4 in the TAU group.

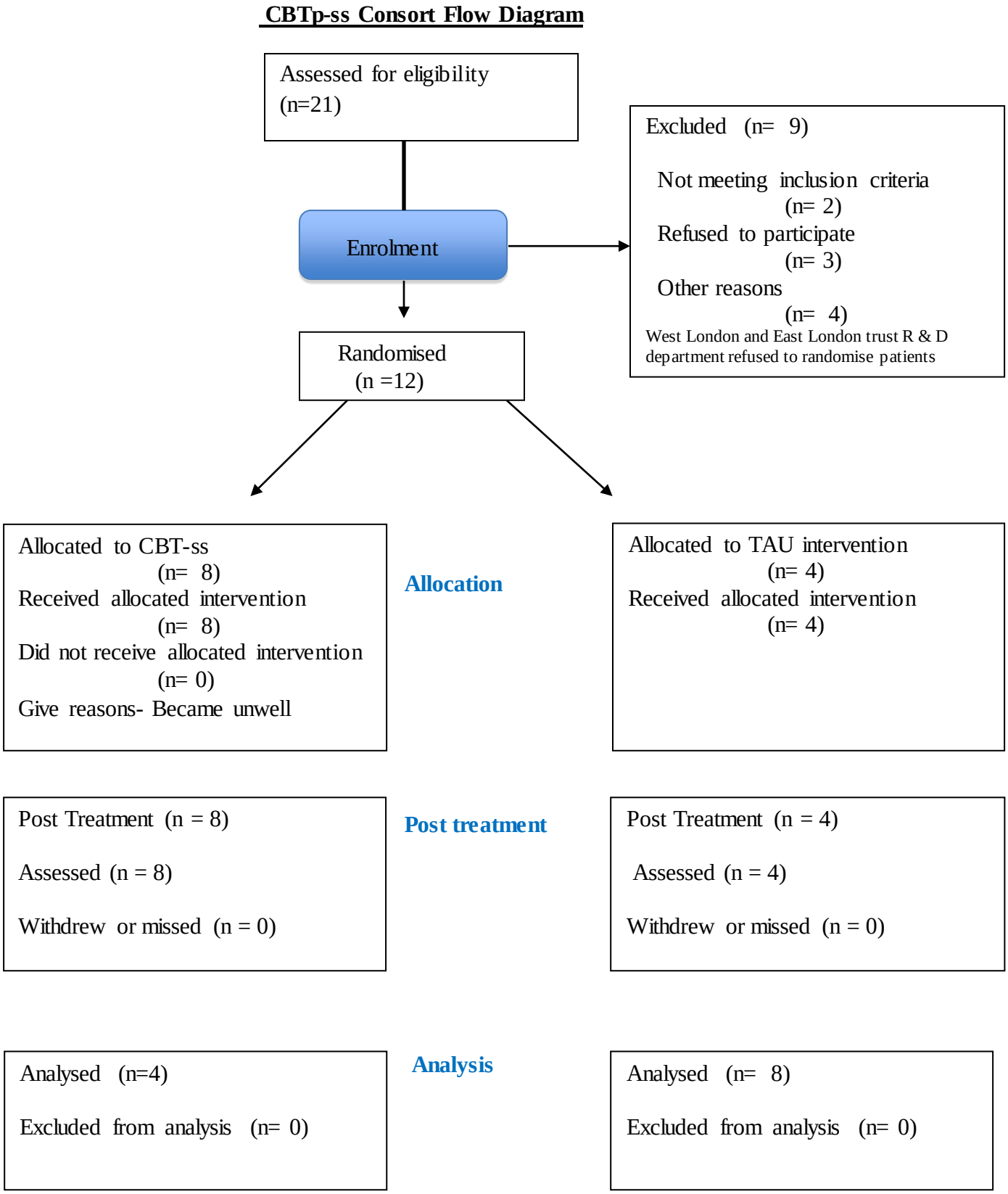

Figure 15 : Study Consort Diagram

7.5 Treatment and control procedures

The treatment arm group was offered twenty sessions of CBTp-ss over a period of twenty-to twenty-four weeks, delivered by the researcher, a Specialist Cognitive Behavioural Psychotherapist who has been working in secure services for ten years and is accredited by the British Association for Behavioural and Cognitive Psychotherapies (BABCP). Therapy was delivered on a weekly basis and varied in duration from thirty to sixty minutes. The researcher had access to the Kingdon and Turkington (2005) guide and adopted some of the core themes, such as the normalizing approach. Prior to the trial, the researcher received a few days' training on CBTp from Professor David Kingdon and ongoing supervision through telephone and face-to-face session on a fortnightly basis, lasting an hour each time. The table below illustrates different phases of the adapted intervention including other important issues such as personality traits. With regards to the TAU group, details of how to access CBTp-ss were provided at the end of the trial.

7.5.1 CBT for secure services adaptation guidance and manual

This guidance is a mix of existing manual Kingdon & Turkington (2005) and new elements from this research. The new points are highlighted in italics.

THERAPY PHASE	**CONTENT**
Pre -engagement	Recognising the interplay of conflicts between detention and care. Patients' views of secures services, e.g. lack of freedom, punishment, confinement, boredom and hopelessness. Social factors: environment and isolation. Help-seeking attitude within secure services. Welcome pack – information on ward rules and other useful information on mental health section, orientation and care pathway that outlines what assessment and treatment are

	available.
Engagement and Assessment	Building therapeutic rapport and recognising some of the problems within the secure services, e.g. risk versus care/security – the dual role Understanding engagement issues in secure services: *Socially desirable and faking bad* *Disclosure as a barrier to discharge* - *Stigma and shame (mad and bad)* - *Professionals' attitude towards mental illness offenders* - Confidentiality Assessment in secure services The interviewing style – collaborative, flexible, working with the patients Pace, pragmatism and working with patients' interpersonal style, cognitive abilities, culture, readiness. Information-gathering process (general assessment): circumstances leading to admission, personal, family, psychiatric, forensic, drugs and alcohol and medical history The questioning style and the psychometrics The narrative and open styles approach, e.g. what led to you hospital? The 5 Ws – where, what, when, why & how

	Development and circumstances leading to current problems, e.g. hearing voices and committed an assault. Elicit key themes, rules and beliefs. Psychometric assessments tools specific for psychosis and co-morbid problems: PANNS The Calgary Depression Scale The Culture Free Self Esteem Inventory Birchwood Insight Scale Recovery Style Questionnaire Personal Beliefs about Illness STAXI-2 Beck Hopelessness Scale Beck Suicidal Scale Psychometric tools specific to cognitions, violence and personality Personality Assessment Scale Psychopathy Checklist Revised – PCL-R Wechsler Adult Intelligence scale HCR-20 Assessment of strengths and protective factors, e.g. like reading. Developing the problem list based on a shared understanding. Presenting concerns Personal goal planning
	Care pathway approach in forensic settings, e.g. description of various care pathways within the Mental Health Act, the Criminal Justice system and the Ministry of Justice and their effect on the patient.

	Presenting the idea of a care pathway and showing where they are and how to get to the next stage. For example, sharing the minimum requirements to get leave, e.g. attending ward based activities,. Explaining institutional goals to the patients. Understanding institutional goals alongside personal goals to motivate the patient Forensic case formulation Understanding and sharing both mental health and offending behaviour formulation Identifying entitled and antisocial beliefs alongside mental health problems. Identifying predisposing, precipitating and perpetuating factors of mental health and offending behaviour Present the idea to the patient of how their attitude and mental health beliefs can lead them to distress and committing crime. For example, helping the patient to identify vulnerabilities, high risk situations, entitled thoughts, moods and strategies to avoid future dangerous behaviour.
Understanding entitled, antisocial and criminogenic needs and their impact on mental health	Understanding risk factors for crime, such as criminal history, antisocial personality pattern (stimulation seeking, low self control, hostility), antisocial beliefs (attitudes, values and thinking styles that support crime, e.g. misperceiving benign remarks as threats, demanding instant gratification) and antisocial peers. Other risk factors such as

	substance misuse, employment instability, family problems, and low engagement in pro-social activities. Treatment based on Risk, Need and Responsivity principles.
Overwhelming beliefs, perceptions and stigma	Exploration of the overwhelming beliefs. Sharing experiences and gradually working with the patient. Not confronting too early Going with the patient on their journey; getting the whole picture. Understanding their perspective or experiences regardless of whether or not it makes sense – at least at the start. *After each session, particularly when working with overwhelming beliefs, the therapist, with the agreement of the patient, may approach the nurse to discuss the content of the discussions. This may reduce patients' paranoia and enhance shared understanding among professionals including patients.* Explaining unhelpful thinking styles – personalising, jumping to conclusions, all-or-nothing thinking, over-generalising and minimising. Alternative explanations – Needs to carried out carefully only if the patient is ready. The therapist needs to make this judgement. *Behavioural experiments could be used in some situations, e.g. using ground leave to check out validity of their belief.* *The use of surveys, e.g. email, asking staff.*

	Recording audio or video tapes for self motivation and reinforcement of alternative explanations. The use of homework –thought record form. The use of 'Evidence for and against'. This exercise needs to be carried out with caution. This may be done if the therapist feels that the patient has some insight, has developed alternative explanations and can tolerate anxiety to move on to the next stage. Reality-testing exercises. *Hypothesising game – scenarios that encourage the patient to look and analyse different situations involving overwhelming beliefs. This will help them to adopt a problem-solving approach.* Building on existing and new coping skills Working with stigma: *Exploring the thoughts behind this feeling.* *Discuss the public perception, e.g. show video of famous people who hear voices and myths about mental illness. Discuss mental health offenders who have moved on in their lives.* Working with anger in psychosis problems - Exploring issues relating to the feeling of anger in psychosis and the use of emotional regulations Exploration of overwhelming perceptions - Discussing the development of the voices, e.g. environment, situation and culture.

	- Discussing the content and characteristics of the voices and what causes them, e.g. positive, negative and both. - Discussing how hearing voices effects functioning and impact on behaviour - Discussing the belief about voices – intensity, duration and frequency. Use Visual Analogue Scale. - Reality testing exercise on the ward. E.g. survey on other patients perceptions of voices Coping skills - Behaviour techniques – listening to MP3 player, talking to professionals on the ward. - Socialising – with other patients on the ward. Going out for leave to see friends - Cognitive techniques - mindfulness exercises, breathing exercises, acceptance, talking back to them in a calm way Working with negative symptoms - Using timetable of activities on the ward - Relate attending activities to discharge processes.
Recovery and staying safe	Wellness recovery action plan for mental health and offending behaviour. Early Warning signs How to stay safe in the future

7.5.2 Treatment as Usual

Definitions of TAU vary according to services in mental health. Generic TAU within the NHS mental health services involves pharmacotherapy, regular monitoring by a multi-disciplinary team, including outpatient follow-up appointments with a Consultant Psychiatrist. Patients in secure services receive some input from art and occupational therapies addressing vocational skills and art making.

7.5.3 Rater reliability

Both assessors were qualified mental health professionals working in secure services. One blind assessor was trained in conducting the PANNS, the Birchwood Insight Scale and the Social Functioning scale. The other assessor received training from the researcher in completing PANNS, the Birchwood Insight Scale and the Social Functioning Scale. The Ward Anger scale was completed by the patients' named nurses.

7.5.4 Monitoring medication during the trial period

Medication was recorded at baseline for all the patients. The researcher recorded any changes of medication during the course of the trial. Where data was missing from the assessment, the researcher liaised with named nurses and/or checked participants' electronic records (JADE system). Antipsychotic medication was calculated as chlorpromazine equivalents (mg/day) using the formulae recommended by Atkins et al. (1997).

7.6 Outcome measures and qualitative interview

Independent assessors blind to the treatment allocation conducted the following outcome measures. They were a consultant psychiatrist and a senior mental health nurse.

7.6.1 Positive and Negative Syndrome scale (PANNS; Kay et al., 1987)

PANNS is one of the most widely used measures of psychopathology of schizophrenia in clinical research. Since its development, it has become a benchmark when screening and assessing change, in both clinical and research patients. It is a thirty-item scale used to evaluate the presence, absence and severity of Positive, Negative and General Psychopathology symptoms of schizophrenia. The thirty items are arranged as seven positive symptoms subscale items, seven negative symptom subscale items, and sixteen general psychopathology symptom items. Each item has a definition and a basis for rating. All thirty items are rated on a seven-point scale (1= absent; 7= extreme). The strengths of PANSS include its structured interview, robust factor dimensions, good reliability (0.80), the availability of detailed anchor points and its validity (0.44).

7.6.2 Social Functioning Scale (SFS; Birchwood et al., 1990)

The SFS is a reliable measure designed to enable assessment of social functioning, relevant to the needs and impairments of individuals with schizophrenia. The questionnaire is divided into seven constructs:

1. Withdrawal\social engagement
2. Interpersonal communication
3. Independence-performance
4. Independence-competence
5. Recreation
6. Prosocial
7. Employment\occupation

Each section should be scored according to the scoring scale provided and raw scores can be totalled to provide an overall social functioning score. For example, raw scores for the subscale are converted to scale score equivalents with a mean of 100 and SD of 15 so that profiles can be developed. The questionnaire can be filled out by the participants and by assessors. This questionnaire has been widely used with patients who have major mental

disorders and has been shown to have good reliability (0.71) and validity (0.57) and to be sensitive.

7.6.3 Birchwood Insight Scale (BIS; Birchwood et al 1994)

The Birchwood Insight Scale consists of eight uncomplicated and direct statements that the patient rates on a three-point scale (agree, disagree, unsure). These items form three subscales, which are compatible with the frequently used factors of insight of illness (i.e. awareness of illness, attribution of symptoms to illness and need for treatment). This scale has good test retest reliability (0.90) and validity (0.42).

7.6.4 Ward Anger rating scale (WARS; Novaco and Taylor, 2004)

This scale has two parts (A and B). Part A consists of eighteen dichotomous ratings of verbal and physical behaviours associated with anger and aggression in the prior week. Five of the Part A items are summed for an "antagonistic behaviour" index concerning overt verbal and physical aggression directed at a person. These items are "verbally abused someone", "verbally threatened to attack a staff member", "verbally threatened to attack a patient", "physically attacked a staff member", and "physically attacked a patient". Part B consists of seven staff-rated "anger attributes" items rated on a five-point (0-4) scale (not at all, very little, sometimes, fairly often, very often). The sum of the seven Part B anger attribute ratings produces a staff-rated anger index. The WARS antagonistic behaviour and anger attribute indices have been shown to have high alpha and inter-rater reliability (0.82) and good concurrent validity (0.50) in studies involving mentally disordered offenders in forensic hospitals, both high security and medium security facilities (Novaco & Renwick, 2002). For the purpose of this study, the researcher looked at Part B, as it is staff-rated, as opposed to part A, which can be self-rated by patients. Due to the nature of patients' high co-morbidity problems and the tendency for some patients to portray a positive picture of themselves, it was felt that Part A might not serve the best interest and skew the data.

7.7 Blinding

The assessors were blind to allocation for the duration of the trial. However, because both assessors worked with the patients, it is possible that they might not have been completely blind. The researcher asked the assessors if they were aware of the patients' treatment conditions: both confirmed that they were not aware and did not ask patients about their groups. The therapist was blind to treatment and only became aware once the patients were assigned to treatment groups. The rationale for blinding was to reduce selection and outcome bias. The set of measures were completed at pre- and post-therapy.

7.8 Ethics considerations

Ethics approval for the trial was obtained from London Committee – Brent; REC: 12/LO1862. IRAS project ID: 112973. Research and Governance approval was granted at all sites. Confidentiality was protected by anonymisation of data, and only where written informed consent was unambiguously given were patients enrolled in the trial. Data was collected in a non-coercive manner.

7. 9 Adherence to treatment guidelines

Fidelity was measured by a review of therapy audiotapes and transcripts by an independent therapist. To evaluate adherence to the guidelines, a number of measures were assessed. All CBTp-ss treatment sessions were audio taped. Tapes were randomly selected, with attempts made to select sessions from the early (sessions 1 to 5) and the late (sessions 13 to 20) phase. These tapes were checked for manual adherence by an independent qualified mental health professional, guided by a checklist (Appendix 12). This checklist was specifically designed for this research: therefore, there are no norms to which it can be compared. After analysing the results using simple percentage calculations, the findings indicated that therapist followed the manual adherence list at least 80 per cent of the time for all the tapes.

The researcher (therapist) also made notes on treatment sessions as to whether the treatment was conducted according to the checklist, which were compared with ratings of the tapes.

7.10 Therapist competence

Therapist competence was measured using the Cognitive Therapy Scale for Psychosis (CTS-Psy: Haddock et al., 2001). The CTS-Psy demonstrates excellent inter-rater reliability, good validity, and sensitivity to changes (Haddock et al., 2001). Two randomly selected audiotapes were analysed by an independent therapist. The results are interpreted below:

	Tape 1	Tape 2
General skills		
Agenda	5/6	4/6
Feedback	5/6	4/6
Collaboration	5/6	5/6
Facilitative conditions		
Understanding	4/6	5/6
Interpersonal effectiveness	3/6	4/6
Collaboration	3/6	5/6
Specific skills		
Guided Discovery	4/6	5/6
Focus on key cognitions	6/6	4/6
Choice of intervention	5/6	4/6
Homework	4/6	3/6
Overall Total	46/60	43/60
Percentage	76.6	71.6

7.11 Statistical Analysis strategy

Intention to Treat (ITT) analysis was performed on the primary outcome measure of reduction in overall PANNS scores post-treatment. The ITT principle posits inclusion of all participants randomised to the trial to their assigned arm regardless of whether or not the intervention assigned is completed (Alteman et al., 2001): therefore, complete case analysis, which violates this principle, was considered unsuitable (Hollis & Campbell, 1999).

The outcome of the two groups was evaluated using mean, standard deviation and confidence interval post-treatment. All tests were completed using independent t-tests and all continuous outcome variables were checked for the assumption of normality. If the assumption was not met, data transformations or equivalent non-parametric tests were conducted. Analysis will estimate main effects for change in the two time points from baseline to post-treatment and change from baseline in the new intervention. The cost of intervention in both groups was analysed using independent t-tests. P-values of less than 0.05 were considered significant. IBM Statistical Package for Social Sciences version 21 for Windows (SPSS Inc., Chicago) was used for analysing quantitative results.

7.12 Power analysis

Due to the small sample size of patients in this study, a power analysis was not possible; however, future power analysis will be discussed in the discussion chapter (Chapter 10).

Chapter Eight: Results

8.1 Main analysis

Demographic data for this study were collected and coded from January 2013 to March 2014. Figure 16 displays the demographic characteristics of the participants. A total of twelve participants were randomly allocated to either the CBTp-ss group (n = 8) or the TAU group (n = 4). The mean (SD) age was 43 (9.60) years and all patients were male. In terms of ethnicity, there were six Black Caribbean patients (50%); one Black British. (8.4 %), three Mixed Race (25%), one Somalian (8.2 %) and one from Tigrinya (8.4%). The mean duration of illness was 17.6 years (SD = 7.8 years).

In order to assess the Gaussian distribution (to determine assumptions of normality and homogeneity of variance) of the data following allocation of participants to either the treatment group or the control group, graphical displays of histograms were generated. Data were normally distributed: the bell shape had a peak in the middle and showed symmetrical tails for variables such as age (Appendix 13).

The demographic characteristics in Figure 16 do not show p-values: at this stage, we are not testing baseline and patients were randomly selected, so the differences are entirely due to chance. A quick glance shows that black and ethnic minority patients are over-represented, a finding which is common in mental health services. Medication was higher in the CBTp-ss group by 12mg per day (chropromazine equivalent) and the mean duration of illness varied by 1.3 years, with the TAU group having more years of illness than the CBTp-ss group. Although the gap in duration of illness is not huge, it is important to note that this could have an impact on the findings. For example, patients with longer duration of illness may need less medication, as their mental state is stabilized with an appropriate antipsychotic medication. In addition, the average age of the CBTp-ss group was eleven years older than the TAU group: although there is a difference, this would not be likely to impact on the results in this population even after adjusting. The mean number of therapy sessions attended was 17.5 out of 20 sessions. As this is a pilot with a small number of participants, p-values were not adjusted for multiple comparisons. It is worth noting that the differences seen, if any, are entirely due to chance alone. In addition, it is worth noting that all patients were not employed during the time of this study.

Baseline demographic characteristic of the patients (figures are number and percentages unless stated otherwise)

	Total sample	CBT(ss)	TAU
Gender n (%)	(n=12)	(n=8)	(n=4)
Male	(100%)	8 (80%)	4(20%)
Age			
Mean age at trial entry (years)	43	47	36
Standard deviation	9.6	8.0	8.6
Ethnicity n (%)			
Black Caribbean	6 (50)	4 (33.3)	2 (50)
Black African	1 (8.4)	1(16.6)	0 (0)
Mixed race	3 (25)	1(16.6)	2 (50)
Somalian	1 (8.2)	1(16.6)	0 (0)
Other (Tigrinya)	1 (8.4)	1(16.6)	0 (0)
Duration of illness			
Years (mean)	17.6	17.2	18.5
Standard Deviation	7.8	8.3	8.0
CPZ equivalents			
Mean	675	680	668
Standard Deviation	329	362	300
Marital Status (%)			
Single	7(58.3)	4(66.6)	3 (50)
Married	2(16.6)	2(16.7)	0 (0)
Divorced	3(25.1)	2(16.7)	1 (50)
Employment status (%)			
Unemployed	12 (100)	8	4
Employed	0	0	0
Location of residence (%)			
Inpatient low secure	5 (41.7)	3 (36)	2(75)
Inpatient Locked Rehabilitation	7 (58.3)	5 (64)	2(25)
MH Section			
37/41	4(33.3)	2	2
37	8 (66.6)	6	2
Diagnosis			
Paranoid Schizophrenia	7 (58.3)	4	3
Schizoaffective Disorder	2 (16.6)	2	0
Paranoid Schizophrenia with antisocial personality disorder	3 (25.1)	2	1
Centre			
London (NWC)	7	5	2
Kingsbury	5	3	2

Figure 16: Basic demographic data

Outcome measures	Time point	CBT N=8 Mean	SD	TAU N=4 Mean	SD	Mean Diff	(CI 95%)	p
PANSS Total	Baseline	80.5	21.3	76.5	2.3	19		
	Post Treatment	71.2	21.8	86.5	19.4	2.4	-13.6 to 44.1	0.267
	Change fr B'line	9.25	19.1	10.0	17.5	1.6	-44.7 to 6.27	0.124
PANSS subscale	Baseline							
Positive		21.8	6.12	19.7	2.50			
Negative		19.2	5.23	20.5	3.60			
General		39.3	13.1	36.0	3.30			
	Post Treatment							
Positive		16.6	6.7	22.2	5.90	5.62	-3.3 to 14.5	0.191
Negative		17.7	3.53	24.0	4.80	6.25	0.83 to 11.7	**0.028**
General		37.0	12.2	40.0	10.2	3.25	12.7 to 19.2	0.660
	Change fr B'line							
Positive		-5.25	4.13	2.50	3.87	7.75	2.21 to 13.2	**0.011**
Negative		-1.50	4.17	3.50	4.5	5.00	-0.83 to 10.8	0.085
General		2.37	12.9	4.25	11.1	1.90	-15.0 to 18.8	0.803
SFS ≠	Baseline							
Withdrawal		8.90	1.34	8.25	1.50			
Inter Com'cation		8.25	1.03	6.50	2.60			
Independence								
-Performance		23.38	7.42	27.25	8.46			
-Competence		32.75	7.08	30.25	9.43			
Recreation		14.13	5.27	21.0	8.90			
Prosocial		13.75	3.53	22.2	8.20			
SFS	Post Treatment							
Withdrawal		10.13	0.83	8.00	2.30	-2.1	-4.09 to -0.15	**0.037**
Inter Com'cation		9.0	0.00	8.25	1.50	-0.75	-1.87 to 0.37	0.167
Independence								
-Performance		29.0	5.70	24.2	4.20	-4.75	-12.0 to 2.50	0.175
-Competence		34.3	2.97	24.7	3.50	-9.62	-13.9 to-5.2	**0.001**
Recreation		18.8	4.00	15.5	3.10	-3.37	-8.5 to 1.80	0.100
Prosocial		14.7	4.20	15.8	9.30	1.00	-13.1 to 15.1	0.798
	Change fr B'line							
SFS								
Withdrawal		1.23	1.16	-0.25	.95	-1.50	-3.01 to 0.01	0.051
Inter Com'cation		0.75	1.03	1.75	1.50	1.00	-0.62 to 2.62	0.201
Independence								
-Performance		5.62	10.5	-3.00	6.05	-8.62	-21.5 to 4.26	0.167
-Competence		1.60	5.20	-5.50	8.10	-7.12	-15.6 to 1.40	0.092
Recreation		4.70	5.82	-5.50	5.97	-10.2	-18.2 to -2.24	**0.017**
Prosocial		0.95	3.02	-6.40	4.20	-7.50	-12.1 to -2.83	**0.005**
Ward Anger Scale	Baseline							
Angry		3.00	1.15	2.00	1.15			
Irritability		2.50	0.75	1.75	0.50			
Resistant		2.25	0.70	1.25	0.95			
Impatient		1.87	0.64	1.75	1.25			
Tense		2.25	0.46	1.50	1.00			
Agitated		1.25	1.03	1.50	0.57			
Bitter		1.00	0.75	1.00	0.81			
Ward Anger Scale	Post Treatment							
Angry		0.87	0.64	1.50	1.00	0.62	-0.42 to 1.67	0.213
Irritability		1.12	0.64	1.50	1.00	0.37	-0.67 to 1.42	0.443
Resistant		0.87	0.99	2.00	0.81	1.12	-0.16 to 2.41	0.080
Impatient		0.75	0.88	1.50	1.00	0.75	-0.50 to 2.00	0.214
Tense		0.62	0.74	1.25	0.95	0.62	-0.48 to 1.73	0.238
Agitated		0.87	0.83	1.50	0.57	0.62	-0.42 to 1.67	0.213
Bitter		0.10	0.75	1.00	0.81	0.00	-1.05 to 1.05	0.100

	Change fr B'line						
Ward Anger Rating Scale							
Angry	-2.13	1.45	-0.50	1.00	1.62	-0.19 to 3.44	0.075
Irritability	-1.37	1.06	-0.25	1.25	1.12	-0.40 to 2.65	0.133
Resistant	-1.37	1.06	0.75	0.50	2.12	0.85 to 3.39	**0.004**
Impatient	-1.12	1.24	-0.25	0.50	0.87	-0.59 to 2.34	0.215
Tense	-1.62	-916	-0.25	0.50	1.37	0.26 to 2.48	0.200
Agitated	-.375	1.76	0.00	0.00	0.37	-1.64 to 2.39	0.688
Bitter	-000	1.30	-0.25	0.50	-.250	-1.79 to 1.20	0.725
Birchwood Insight ≠Baseline							
Scale							
Q1	1.75	0.70	1.75	0.50			
Q2	1.25	0.46	2.00	0.81			
Q3	1.88	0.83	2.00	0.81			
Q4	1.50	0.53	2.25	0.50			
Q5	1.75	0.70	1.75	0.95			
Q6	1.75	0.46	2.25	0.95			
Q7	1.50	0.53	2.25	0.50			
Q8	1.63	0.51	2.50	0.57			
Birchwood Insight Post Treatment							
Scale							
Q1	1.50	0.53	2.25	0.50	0.75	0.03 to 1.46	**0.042**
Q2	2.00	0.75	1.50	0.57	-0.50	-1.46 to 0.41	0.275
Q3	2.50	0.53	1.50	1.00	-1.00	-1.96 to -0.03	**0.044**
Q4	1.75	0.70	1.50	0.57	-0.25	-1.16 to 0.66	0.556
Q5	1.88	0.99	1.75	0.95	-.012	-1.46 to 1.21	0.839
Q6	2.38	0.74	2.25	0.95	-0.12	-1.23 to 0.98	0.807
Q7	2.13	0.83	2.50	0.57	0.03	-0.67 to 1.42	0.443
Q8	2.38	0.74	2.50	1.00	0.12	-1.00 to 1.25	0.811
Birchwood Insight Change fr B'Line							
Scale							
Q1	0.25	0.88	0.50	0.57	0.75	-.350 to 1.85	0.160
Q2	0.75	0.70	-0.50	0.57	-1.25	-2.16 to -0.33	**0.012**
Q3	0.62	0.91	-0.50	1.29	-1.12	-2.54 to 0.29	0.109
Q4	0.25	0.70	-0.75	0.95	-1.00	-2.07 to 0.07	0.066
Q5	0.12	0.64	0.00	0.00	-0.12	-.856 to 0.60	0.711
Q6	0.62	0.91	0.00	0.81	-0.62	-1.83 to 0.58	0.277
Q7	0.62	0.91	0.25	0.50	-0.37	-1.48 to 0.73	0.469
Q8	0.75	0.70	0.00	1.41	-.075	-2.07 to 0.57	0.237
Birchwood Insight Baseline **total score**	13.00	2.72	16.0	2.45			
Birchwood Insight Post Treatment **Total Score**	16.25	3.0	15.5	2.38	-.750	-4.66 to 3.16	0.679

Figure 17 : Summary of primary and secondary outcome measures at two time points and change from baseline
≠Lower values are significant in all measures except for the Social Functioning scale and the Birchwood Insight Scale, where higher values are significant
Statistically significant p = 0.05 (in bold)

8.2 Primary outcome analysis

The aim for the study was to test the feasibility of the new CBTp-ss manual. The findings from the quantitative study suggest that patients from the treatment group generally benefitted from the new intervention. It appears that the new intervention was acceptable, as there were no drop-outs. All patients in the treatment group attended more than sixteen sessions within a six-month period, a duration that is common when delivering CBTp (Rathod et al, 2010). Although not measured directly with psychometric tests, patients in the treatment group did not resist the treatment, suggesting that this intervention was sensitive to the patients' needs.

8.2.1 PANNS Scale total

The PANNS total post-treatment mean score was M = 71.2 for the CBTp-ss group and M = 86.5 in the TAU group. The total post-treatment mean difference for both groups (M = 2.4; CI -13.6 to 44.1; p =0.267) not significant. When the total score change from baseline was calculated, no significant change was found (CI = -44.7 to 6.27; p =0.124).

The analysis of the post-treatment PANNS subscale for the CBTp-ss group revealed values of M = 16.6 for positive, M = 17.7 for negative and M = 37.0 for general psychopathology symptoms. Analysis for the TAU group shows M = 22.2 for positive; M = 24.0 for negative and M = 40.0 for general psychopathology symptoms: an increase in all subscales. The mean differences were M =5.62 positive; (M = 6.25) negative and (M = 3.25) for general psychopathology symptoms. When differences between groups at post-treatment were tested, negative symptoms showed a statistically significant difference (CI = 0.83 to 11.7; p = 0.028).

We calculated change from baseline in both groups. No significant change was found for negative symptoms (CI = -0.83 to 11.7; p = 0.085). Interestingly, there was a statistically significant change in positive symptoms (CI = 2.21 to 13.2; p = 0.011). There was no significant change in general psychopathology symptoms (CI = -15.0 to 18.8; p = 0.803). Following the statistically significant change in positive symptoms above, we conducted an independent sample t-test of individual constructs of positive symptoms, which revealed statistically significant changes in the delusion (CI = 0.28 to 3.21; p = 0.024); excitement (CI = 0.01 to 2.23; p = 0.048) and persecution (CI = 1.06 to 3.43; p = 0.002) subscales.

8.3 Secondary outcomes

8.3.1 SFS

The employment subscale was excluded from the analysis, as all patients were unemployed, and results were analysed on individual subscales. The researcher did not employ the original method of analyzing the results as proposed by the author of the SFS, i.e. using a total score of 100 and SD (15), but compared the mean difference between the groups and change from baseline.

The mean difference between groups at post-treatment for the Withdrawal subscale were (M diff = -2.1); Interpersonal Communication (M diff = -0.75); Independence performance (M diff =-4.75); Independent Competence (M diff = -9.62); Recreation (M diff = -3.37) and prosocial (M diff = 1.00). There was a significant difference at post-treatment in the withdrawal subscale (CI = -4.09 to -0.15; p = 0.037) and in the independence competence subscale (CI = -13.9 to -5.2; p 0.011).

There was a statistically significant change from baseline scores on the recreation subscale (CI = -18.2 to -2.24; p = 0.017) and on the prosocial scale (CI = -12.1 to -2. 83). Similar to significant difference, at post-treatment, the change from baseline on the withdrawal subscale was approaching significance (CI= -3.01 to 0.01; p = 0.051).

8.3.2 WARS

There were no significant changes at post-treatment on this scale. When we calculated change from baseline, there was a statistically significant change on the resistance subscale (CI = 0.85 to 3.39; p = 0.004), although the mean scores of other subscales in the CBTp-ss group were lower than those in the TAU group, trending in a positive direction. There was no change in the bitterness subscale in the CBTp-ss group.

8.3.3 BIS

There were statistically significant differences in Q1 post treatment between the two groups (CI = 0.03 to 1.46; p = 0.042) and Q3 (CI = -1.96 to -0.03; p = 0.044).

The post-treatment mean differences for both groups were as follows: Q1 (M diff= 0.75); Q2 (M diff -0.50) Q3 (M diff= -1.00); Q4 (M diff = -0.25); Q5 (M diff = - 0.12); Q6 (M diff = -0.12); Q7 (M diff = 0.03) and Q8 (M diff = 0.12).

When change from baseline was calculated, the statistical differences in Q1 and Q3 were not maintained, although there was a statistically significant change in Q2 (C1 = -2.16 to -.0.33; p = 0.012). There were noticeable positive changes on other questions in the CBTp-ss group compared to the TAU group.

Total score at post treatment was not significant, although the CBTp-ss mean score was higher (M = 16.25), an increase of 4.25 units from baseline, compared to TAU (M = 15.5), a decrease of 0.5 units. As highlighted earlier, a higher score indicates better insight.

Using the criteria from the original authors of this questionnaire, a cut-off point of 9 was used to determine good insight. This reflected on patients having good 'awareness of illness', 'attribution of symptoms' and 'need for having treatment'. Splitting both groups according to the cut-off point, four patients out of eight from the CBTp-ss group gained good insight, whereas none of the TAU group achieved the cut-off point.

8.3.4 Cost of treatment

Economic evaluations of CBT interventions are in demand and cost factors require careful consideration. Generally, CBT interventions are costed on the basis of the salary of the professional involved (national insurance and superannuation contributions), including relevant indirect (administrative, managerial and capital) supervision and training costs (Barrett & Petkova, 2013). The cost in this study was worked out on the basis of six months' inpatient bed days (CBT therapy intervention time), therapist time for twenty sessions and supervision time (one hour on average) for five sessions over six months. Therapist cost was estimated at £71 per session (Band 7 equivalent) (Barton et al., 2009) and supervision cost was estimated to be £112 per session (Band 8a equivalent). This study did not include the cost of medication, as the pharmacist did not provide any information, although this is an important expense that would provide a precise estimate of real cost.

Patient	Group	Bed days	Site (Site 1 =£380) (Site 2 =£330) *Per night*	Therapist (per session (£71 x 20)	Supervision (Monthly) (£112 x 5)	Total (£)
P1	TAU	173	1			56744
P2	CBTp-ss	181	2	1420	560	70760
P3	CBTp-ss	176	2	1420	560	68860
P4	CBTp-ss	184	1	1420	560	71900
P5	TAU	184	1			60720
P6	TAU	184	2			58740
P7	CBTp-ss	182	1	1420	560	71140
P8	TAU	183	1			60390
P9	CBTp-ss	173	2	1420	560	67720
P10	CBTp-ss	184	2	1420	560	71900
P11	CBTp-ss	182	1	1420	560	71140
P12	CBTp-ss	171	2	1420	560	66960

Figure 18: Overall costing involved for all patients in the feasibility study

The total mean cost at six months was £59,148 per patient for the TAU group and £70,047 for the CBTp-ss group. The mean difference between the two groups was £10,899 (CI = -8307 to 13490; p = 0.00). In other words, the CBTp-ss group cost significantly more that the TAU group. In the best case scenario, CBTp-ss will cost £8,307, and in the worst-case scenario the cost will be no more than £13,490. These figures are important when planning for future studies and medication and other indirect costs should also be included.

8.4 Medication

Anti-psychotic medication was recorded at baseline and converted to CPZ equivalent doses. Analysis revealed that the mean dosage in the CBTp-ss group was 680 (SD 362.6), while in

the TAU group, the mean dosage was 668.7 (SD 300.1). The mean difference was 10.62 (CI= -481.7 to 460.5; p = 0.961). There was no noticeable difference between groups at baseline. The type of medication prescribed to patients at baseline was examined. Of the twelve patients, ten were on 2nd generation antipsychotic drugs (83.3%); one was on both 1st and 2nd generation antipsychotics (8.3%) and the other was on 1st generation antipsychotic (8.3%). When analysing post-treatment (six months) results, three patients had had their medication increased during the trial in comparison to one whose dose had been reduced. There were no changes in seven patients' medication and one had his medication changed to a newer antipsychotic. There were six patients (50%) who were maintained on clozapine throughout the trial.

The mean medication change from baseline was 6.87 (SD 183.6) for the CBTp-ss group and 18.7 (106.8) for the TAU group (p = 0.908). There was no significance change from baseline in either group, although the increase in medication in the TAU group was 11.8 units higher than in the CBTp-ss group.

8.5 Summary

Carrying out clinically focused research in this setting has highlighted the complexities of this population, including the environment and the implications this has for CBT treatment. Broadly, it is reasonable to say that the new CBTp-ss intervention has shown promising results with this population.

Whilst carrying out a quantitative study is important, they too have weaknesses: for example, the results produced may mask or ignore underlying causes or realities, and most importantly, this approach does not incorporate patients' views about therapy, e.g. what works. In order to strengthen the above results, a qualitative study is carried out to further validate these findings.

Chapter Nine: STUDY THREE
Post treatment qualitative interview and further process of adaptation of CBT in secure settings

9.1 Introduction

This chapter critically analyses the qualitative data and its findings. Most CBTp studies adopt quantitative methods when conducting RCTs and make no effort to incorporate patients' views of the therapy received, although this is an important part of the therapy process. Following the quantitative work described in the previous chapter, the researcher intended to ask patients in the CBTp-ss group about their views of therapy, to allow them to talk about the process and experience of the therapy and to elicit critical information concerning "what works". These data will be compared with the previous patient data (Chapter Five) to allow thorough data triangulation to take place, contributing further to validity. This will be reflected in the results section.

9.1.1 Data collection

The same method of interviewing as outlined in Chapter Three (section 3.2) applied to these post-trial interviews. As mentioned in Chapter Three, the researcher followed similar processes, taking a constructive approach, and data were again collected via one-to-one interviews, although these interviews were carried out by a staff member who was independent from the study.

In choosing the most appropriate approach to qualitative analysis, the researcher looked at various methods and chose thematic analysis (see Chapter Four for a discussion of this selection process). Thematic analysis is a flexible approach: it is not tied up with a particular theoretical model and does not focus too much on phenomenological experiences; most importantly, the stages allow a structure where all text can be analysed and the approach is compatible with the existing constructive position of the researcher (Braun & Clarke, 2006).

9.1.2 Post Interviews

As mentioned above, the interviews were carried out by a staff member who was independent from the study. This was to ensure that there was no bias, to give patients a better chance to evaluate their experiences of therapy and importantly to eliminate any perceived need to say good things about the therapy, which might have arisen if the researcher were conducting the interviews. This process is comparable with the use of an independent blind assessor in quantitative work.

The researcher compiled a semi-structured interview (Appendix 14) which was cross-validated with his supervisor. A total of six out of the eight patients who had been in the treatment group provided their views of CBT treatment. The other two patients had been discharged and were not reachable. The interviews for the six patients were held in their place of residence. All interviews were audio-taped and transcribed by an administrative assistant. The administrative assistant acknowledged missing some words, as she did not understand or could not catch the phrases. The researcher re-checked typed transcripts for these omissions and corrected them according to the audio tape.

9.1.3 Stages of the analysis

The researcher followed the six steps advocated by Braun & Clarke (2006) and analysed data accordingly, with frequent discussion with a qualitative expert. The data were managed using a qualitative computer programme (NVivo 9) that allowed the text to be analysed using the six steps (Appendix 15). The software is useful as it provides a platform for consistency, generates initial codes, provides a trail for analysis, generates a thematic map, provides cloud tags, and importantly it saves time (Lewins & Silver, 2007).

9.1.4 Data credibility

As discussed in Chapter Four, triangulation is an essential aspect which looks at the reliability and validity of data. The researcher coded the transcripts and some of these were sent to two independent professionals (Consultant clinical psychologists) for triangulation. These transcripts were checked for coding and interpretation of themes and any uncertainty was clarified. For example, one patient talked about experiencing side-effects of medication

as an alternative explanation for his problems something which was clarified between the researcher and the independent professional. This ensured that the data were reliable and consistent and further reduced bias. The researcher also compared this data with previous qualitative patient data in Chapter Five, and this allowed thorough data triangulation to take place, contributing further to validity. This will be reflected in the results section.

9.2 Findings

Six patients from the treatment group were interviewed about their experiences of CBT treatment. The themes from the perspective of the patients are presented in Figure 19. These will be discussed together with the researcher's commentaries. The patients' verbatim quotes are in italics (e.g. *is helpful*).

Overarching Themes	Main Themes	Brief Quotation Illustration	Participant					
			P1	P2	P3	P4	P5	P6
CBT as platform of shared understanding and equals	Therapist characteristics	*He was good, you know, he was good all round. The therapist was alright, yes, good yes. He was curious and dug deep down. I would like to talk to someone like him as I would ask questions and he would listen*	✓	✓		✓	✓	✓
	Shared understanding	*It wasn't difficult to speak to him, and because of this we have an understanding, that is easy for us to perform together. Is like being equals.*		✓		✓	✓	✓
CBT as a structured learning process	Therapy homework helps	*Listening to tape was good, gave me a relief. It was good as it helped me to understand my problems, when writing down in my own language. Things that you read you can understand.*	✓	✓		✓		✓
	Learning process	*It has been a learning curve, learning about self using psychological map, drawings.*	✓	✓				✓

CBT improved understanding of symptoms and risk factors	Understanding risk factors, symptoms and behaviour	*I learnt not to go back to alcohol and drugs as that caused problems before. I'm going to keep myself out of troubled behaviour. To understand positive and negative symptoms. Talking about problems helps.*		✓		✓	✓	✓
	Behavioural tasks and rationalising	*I need to refer to other people, ask their opinion, so it might have use for itself. I did an experiment with staff here. The questions and the exercises, I can get to the problems I face.*	✓			✓	✓	✓
		My brain use to play game with me. To see the rationale about things that happened to me, maybe is a sign of getting old						
Therapy can be difficult	Sessions can be monotonous and difficult	*They are alright but they can be boring and repetitive sometimes*	✓	✓	✓			
		I just go with the flow and sometimes the therapist brings up things like the index offence, psychosis and things like that which is difficult to talk			✓		✓	

Figure 19: shows the frequency of the overarching themes and main themes across patients

9.2 Analysis of themes

Referring to the figure above, this section will review the themes in relation to patients' views of CBT intervention in secure services. Data will be also compared with previous qualitative patient data from Chapter Five.

9.3.1 CBT as a platform for shared understanding

Patients viewed therapy as a place to share their experiences. They attributed part of this to *'therapist characteristics'* and highlighted shared understanding of therapy as an integral part of their experiences.

Five patients, P1, P2, P4, P5 and P6, highlighted the importance of having a therapist who has characteristics such as being reflective and able to listen to them. They talked about the therapist's overall ability to relate to them and genuinely felt that the therapist was helpful in understanding their problems.

Definitely I would choose him, I would ask him questions and he would listen

P4, page 2

Speaking to him, it's like I've been given a chance you know. I trust him.

P5, page 2

He was good, you know, he was all round

P2, page 3

P1 provided a positive comment in relation to the interpersonal skills of the therapist.

He was really interested, confident and dug deep down to find out what was happening to me.

P1, page 3

A majority of patients reported that the nature of therapy allowed for *'shared understanding'* and that they were treated as equals when discussing their problems. This emerged as a valued aspect of engagement and there were no power issues between the therapist and patient.

I feel empowered when talking to my therapist

P5, page 2

I thought he was good you know, I quite liked him, we did get on when we doing therapy. He always asked for my views.

P4, page 3

It wasn't difficult to speak to him, and because of this we have an understanding, that is easy for us to perform together. Is like being equals

P6, page 3

This substantiates comments outlined in Chapter Three by four different patients, who reported that therapist characteristics were an important factor in allowing them to engage and freely discuss their issues. They reported that the therapist's interpersonal, professional skills and confidence were important in building a better therapeutic relationship and satisfaction with the therapist.

9.2.2 CBT as a structured learning process

The second theme that emerged from the analysis reflects on patients' views and understanding of therapeutic strategies in CBT. The main themes were divided into

'therapy work helps' and *'CBT as a learning process*'. The patients reflected their appreciation and understanding of the themes and for some, common outcomes were reflected, such as improvement in their psychological wellbeing. A majority of patients' views contained references about completing 'therapy work' outside therapy sessions. They talked about this work being helpful in maintaining focus and being able to present it in therapy sessions.

My therapist and I recorded an audio tape for me to listen when I'm in my bedroom. Listening to tape was good, gave me a relief.

P1, page 3

I mean the tasks that he asked me to do was questionnaires and writing things down, focusing on problem.

P2, page 3

It was good; it helped me to understand the meaning of my problems and also to get ready for next week's session.

P4, page 2

Yes, thinking what I know I've got notes on it I can read up. Yes and it was useful, yes, I did it at my own pace, it is a lot of thinking

P6, page 3

P2, P4 and P6 reported viewing CBT as a 'learning process' about their problems through psychological drawings and this contributed to the process of making sense of their experiences.

Being able to make a copy, draw my feelings, and the steps and perspective and open to understand, it's really helpful.

P6, page 2

It's just like, linking things you were reading, so you can understand yes, you see what I am saying and following care plan.

P2, page 3

CBT like understanding thoughts or, thinking, feeling, and behaviour and how this affected me before.

P4, page 2

Again, this is reminiscent of the three patients in the previous qualitative study who reported CBT formulation as a helpful technique in keeping their minds in check. They acknowledged the role of negative thoughts and their effect on feelings and behaviour, similar to the above patients. One patient found alternative explanation useful in that it changed the way she behaved, encouraging her to engage in positive behaviour. Other patients found the formulation approach to be a practical way to understand problematic behaviour.

9.3.3 CBT improved understanding of symptoms, risk factors and behaviour

The third overarching theme relates to CBT improving awareness of symptoms and understanding of the risk factors that led patients to risky behaviour. This theme plays a vital role, particularly in forensic settings, in that most patients had committed violent acts in the past and for some patients this was due to responding to overwhelming experiences. Main themes in this section are *'understanding risk factors, symptoms and behaviour'* and *'behavioural task, survey and rationalising*'.

P2, P4, P5 and P6's themes contained views about their awareness of risk factors that contributed to offending behaviour. P2 and P3 provided a narrative about specific factors that might have contributed to their index offence.

How to manage symptoms and not doing this, the index offence like before

P2, page 3

Because you learn about drugs and alcohol and about symptoms, um, and index offence, so it was helpful.

P4, page 3

Doing therapy gave me an understanding of not going back to alcohol and things like that, made me have problems in the past.

P5, page 2

You know, I'm going to keep myself out of problematic behaviour

P6, page 3

Along with discussions related to having insight into their symptoms and offending behaviour, some patients offered descriptions of the change mechanism *'behavioural task, and rationalising'* that helped them in achieving this understanding.

I need to refer to other people to find out what is the way of thinking: is that normal persons' reactions?

P6, page 4

The exercises, um, asking other patients about their thinking, I could get to my problems.

P1, page 4

I did an experiment with staff here and it was good

P4, page 3

P2, P4 and P6 expressed their views on being able to rationalise their concerns and being able to see alternative thoughts, which helped them to lower distress.

Rationalising my beliefs. For example, walking on the street, somebody talking behind you and you think like they are talking about you and you say "why they are talking about me?", but then I realise my brain used to play games with me. Now I'm more relaxed.

P2, page 2

To see the rationale, about things that happened and so I was thinking myself when I am in certain situations, and making it easier for myself.

P6, page 3

Like understanding of what things are from different point, a lot of things which are wrong way of thinking.

P4. Page 2

As in the previous qualitative work, a majority of patients talked about their experiences of gaining awareness and understanding of their problems, similar to the patients in these post-treatment interviews. Most patients in Study One talked about using a CBT model to understand their thought processes and behaviour and to approach situations like anger. Some patients talked about having a better understanding of their overwhelming beliefs that got them into problematic behaviour. A notable difference is that none of the patients in these post-treatment interviews talked about the direct role of psychoeducation in providing understanding of their symptoms. Similarly, none of the patients in these interviews actively talked about the role of normalisation.

9.3.4 Therapy can be difficult

The fourth overarching theme identified relates to the potential obstacles of engaging with the processes of CBT, something which was reflected by a few patients. Aspects

of CBT that were reported to be difficult were identified in terms of personal motivation to engage, recall of previous *'session content, which was perceived as monotonous'* and *'difficult to talk'*.

P1, P2 and P3 reported that therapy could be boring, as it required them to recall previous sessions' work.

Yeh, some of the sessions were kind of repetitive...

P1, page 2

They can be a bit monotonous sometimes, so it was difficult...

P3, page 4

A couple of patients found therapy challenging and found it difficult to tolerate conversation around their mental health and index offence issues.

I don't think much about the sessions, you know sometimes he brings up things like the index offence, psychosis and things like that, which is difficult to talk about.

P3, page 3

If there was help then the help was not beneficial to me as is difficult to talk about these issues

P5, page 3

In comparison with the previous qualitative work, it is interesting to note that none of the patients interviewed talked about the above difficulties. Patients in the previous qualitative work talked about difficulties engaging with the doctors and this was mainly attributed to power and control issues. CBT therapy work was seen as a positive way to understand the self.

9.4 Discussion of qualitative analysis; further refining the adaptation of CBT in secure setting

The themes discussed above were useful in that they were interwoven with those that emerged from the first qualitative study and thus provided rich and meaningful data. As one of the aims of this study is to refine the newly learnt components in CBTp-ss, it is essential to further adapt this to ensure a meaningful understanding of the new components, such as what works. It is important to note that some of the points discussed below are non-specific to CBTp-ss, although they are important elements that need to be discussed to get a fuller understanding when practicing CBTp in secure services.

This section describes potential obstacles and strategies that were gathered throughout this research that need to be adapted and which will be described using clinical case examples. Some of these refer to the types of presenting problems, some to the process of therapy and some to the constraints inherent in the environment. Using a structure of identifying the challenges and the suggested responses, and providing clinical examples, the researcher hopes to demonstrate that even within this unusual environment it is possible to circumnavigate the obstacles and create circumstances where the cognitive behavioural model can be applied. Often this involves returning to the theoretical basics and finding creative ways to use what we know and apply it to the people we are working with.

9.4.1 Engagement

Collaboration is fundamental to a CBT approach (Wright et al., 2009) and on first inspection this principle may seem immediately at odds when working with individuals who are detained under secure conditions, and who have not themselves instigated a referral. Initial engagement therefore forms an essential step before therapeutic work can commence. Many forensic patients who are referred struggle to form trusting collaborative relationships. Many have few positive experiences of such relationships to draw upon when encountering a new therapeutic relationship, and this poses a challenge in terms of patients' expectations of others. The cognitive model

describes core beliefs as the unconditional, deeply held and influential beliefs through which we understand the world and events around us (Beck, 1976; Young et al., 2003). Commonly held core beliefs encountered in this population include "Others will let me down, do not care about me, will give up on me, or will betray me".

As reported in earlier chapters, this situation is complicated by the dual role held by clinicians within secure settings: care versus security. Whilst we offer therapeutic spaces for patients, it is also expected that therapists do contribute to decisions to continue detention and to sanction (or not) leave and access to activities and other restrictions. Such a role can complicate the engagement process, trigger these core beliefs and prevent a person from considering engaging in therapy. The importance of risk management in forensic services will, at times, mean that therapy cannot maintain its normal confidentiality and information is more readily shared with the clinical team than in other environments. The limitations of confidentiality necessitated by the setting further impact on the process of engagement and formation of a therapeutic alliance.

Adaptation

Clinical experience and findings from this research offers a solution: to return to the basics of successful CBT and to give particular attention to forming a genuinely committed collaborative relationship and to being transparent about the process of therapy. Looking back to the literature in the field of CBT for psychosis, it stresses the importance of flexible approaches in order to build engagement (Kingdon & Turkington, 2005; Morrison, 2004). Given that the forensic population contains many individuals who have historically 'acted' rather than 'thought', the therapist's own actions demand specific consideration. Discussing the collaborative approach with patients explicitly, and then demonstrating your commitment to collaboration, is helpful. Concrete examples such as asking patients to write sections of their own reports, feed back to their key-workers, give handover to shift co-ordinators, and both therapist and patient completing homework tasks substantiate this. This not only demonstrates actively the practical differences between the CBT approach and other therapeutic models, but also links to the concepts of recovery, embracing a set of values about a person's right to build a meaningful life for themselves, with or

without the continuing presence of mental health symptoms. CBT supports self-efficacy, which forms a platform on which to build successful interventions.

In a population whose core beliefs about others (as outlined above) and interpersonal experiences are so negative, persistence in therapy gains particular salience. Clinical experience suggests that a therapist who persists in trying to work collaboratively, even when this is challenging, can serve as a successful model for patients to begin to consider an alternative perspective about others or themselves. The therapeutic experience itself can then be used as evidence to challenge assumptions, demonstrating the importance of keeping going through tough times, trying different approaches and overcoming obstacles. The therapist's action of keeping regular appointments and holding a therapeutic space, even if the client declines to meet, can be concrete evidence for use later in therapy. Keeping to a regular therapy slot increases the perception of the therapist as someone consistent, and demonstrates a genuine engagement and commitment from the therapist to trying to find solutions to the patient's distress.

In a similar way, 'sticking with it', even in the face of increased distress or periods of relapse where structured CBT becomes impossible, has allowed continuation of a meaningful engagement. This allows therapy to continue swiftly once mental state has improved, and has the dual benefit of providing a shared lived experience of what relapse looked like for both therapist and patient.

Being transparent regarding confidentiality is vital. Clarity from the outset about the limits of confidentiality, making clear statements about concerns related to risk, and being transparent about the agenda of outside influences (the team, the Ministry of Justice) have all proven particularly helpful and highlight that this is a collaborative approach where therapist and client will overcome barriers together, drawing upon motivational interviewing styles, as highlighted in the professionals' qualitative themes, by actively exploring concerns and attempting to resolve ambivalence, normalising concerns, reinforcing change-focused talk and encouraging autonomy within the limitations in which people live (Miller & Rollnick, 2002).

Finally, it is also noted that the process of dealing explicitly with worries about therapy in early sessions provides a model for behavioural experiments which can be drawn on later in therapy. Concerns such as "the team will stop my leave if I start talking to you about my beliefs", or "no-one can understand what I mean" can be broached openly, tested out, and considered in the light of clients' experiences. This often requires close working with the team and a clear understanding of the cognitive approach and rationale, but ultimately supports both engagement and clarification of goals.

Case Example

Abdul is a 35-year-old man who was referred by his team following a recall to hospital amid concerns of relapse of delusional beliefs. Abdul was unsure what CBT could offer him and whether he wished to discuss his symptoms in more detail, but spoke of paranoia having been a problem in the community. Accepting a common goal of demonstrating to the team that he was ready to leave, he was able to engage in therapy. A couple of months into the process, he experienced worsening voices and unusual beliefs, which prevented more structured CBT. However, sessions remained in place, focused on coping strategies for managing distress on the ward. Later therapy sessions revealed how helpful this "sticking with it" process had been, with Abdul stating, "Whenever I got ill before, people ran a mile: my psychology sessions carried on and showed I wasn't as scary as I thought". This allowed Abdul's beliefs to be explored and challenged collaboratively when he was more able to think in a structured way. Subsequent explicit, written agreements with the team permitted Abdul to discuss the content of his ongoing unusual beliefs in therapy without impacting on his leave status.

9.4.2 Creating goals

CBT as a therapeutic intervention is designed to specifically help someone to be able to make cognitive and behavioural changes which support them to meet their goals (Beck & Rector, 2005; Kingdon & Turkington, 2005). It aims to support people in overcoming the functional impacts of their mood disorder, or of their negative thinking patterns. For example, a person with social phobia may aim to be able to

make a presentation in their workplace, or someone with agoraphobia may aim to pick their children up from school. In the same way, patients in secure mental health services need to move towards goals, and therapy can support the processes of identifying, monitoring and reaching these goals. Symptom reduction or being well is often linked to attaining goals. An example of conceptualising this from a client's point of view might be "When I'm less worried about other people wanting to hurt me, I can relax more, I feel less anxious and I can go on leave without feeling bad". Achieving these goals fits with the team's aims of noting a decrease in paranoid behaviours, which allows them to feel more secure that the person's risk of violence towards others has decreased and increases their confidence in permitting leave.

One core feature in secure services is that, on the surface at least, the goals held by the team and the therapist may or may not align with those held by the client. Consistent with the first qualitative study, this theme was reported by the professionals: for example, the need for explicit consideration and management of risk in close parallel to the reduction of psychotic symptoms. Individuals are often referred for therapeutic work with team goals of a reduction in their risk of violence, improvements in their insight and compliance with team interventions. Mixed messages from teams and therapists can occur where we simultaneously ask patients to work to achieve independence whilst monitoring and often limiting their choices. Many of these limitations are necessary but can be imposed in a way that limits independence and prevents the experience of independent goal setting and personal efficacy.

Adaptation

The key factor to overcoming this difficulty has been a focus on transparency and collaboration. Haddock et al. (2004) describe an explicit focus on detention as a source of distress and this has been found to be extremely useful in establishing shared goals. The majority of patients are happy to agree a shared goal of leaving conditions of low security and are able to break down this bigger goal into smaller, more SMART (specific, measurable, achievable, attainable, realistic, time-limited) goals. As therapists, the curiosity and genuineness within the stance of sharing goals are often emphasised alongside commitment to a longer-term perspective, including staying safe in the community and not coming back to secure hospital. Sharing such a goal in an explicit and transparent way also aims to create hope and optimism in

therapeutic encounters. The monitoring of progress in terms of aspects which hold meaning for the client (i.e. increased leave, freedom to do activities, vocational progress) can help with the on-going engagement and motivation of patients who may easily become dispirited with the slow progress of the institutional setting.

The early stages of therapy often hold important groundwork for future aspects of the intervention. Keeping a focus on the goals is motivating, and consolidates engagement in the process. Within this client group, revisiting goals often, repeating the rationale and having clear diagrammatic formulations, including potential exits used in the sessions at all times, is helpful.

It is also important to consider the process of change itself. Trialling an early experience of a minor change (for example, how they make their tea or which hand they use to hold their toothbrush) can demonstrate the importance of motivation, habituation, and achieving goals in small steps. Within the sessions it was noted that frequent (and at times repetitive) debriefing of small key points or evaluations of behavioural experiments is essential to demonstrate the cognitive model for understanding how things are linked together, and where potential exits might be. Early and concrete changes in behaviour are seen as important in CBT approaches across a range of disorders, including depression, which has shown that early behavioural change leads to a better prognosis, and in anxiety disorders, where the importance of behavioural experiments has been demonstrated (Bennett-Levy et al., 2004).

In debriefing activities it is important to differentiate what was learnt, but also to emphasise how it was learned (a method of 'trying it out' and looking at the results). Early experience of change, how difficult it feels, and how central the reasons for change are also help with overall engagement, particularly when the patient starts to consider changing more important behaviours or thoughts. These are processes that therapy will return to again and again, and concrete experience of change is really helpful.

Case Example

Tom is a 44-year-old man who was referred for CBT due to his distress regarding ongoing pains and sensations, which he believed were caused by other people and by mistakes that he had made in his interactions with them. Tom had spent considerable periods of time thinking about the pains, and concluded that it was essential for him to monitor his breathing, movements and speech to be sure that he did not cause pain in other people. These difficulties stopped him from taking part in social activities, and in particular from playing the guitar, which had previously been a valued activity at which he was extremely talented. Tom's overall goal was "to get out of hospital and stay out". The problem was that his distress, related to these thoughts, led to him looking threatening and engaging in strange interactions with others, which worried the team. His goal in therapy was therefore broken down into needing his clinical team to be less worried and for him to have more confidence in tasks of rehabilitation, including leave. During an early therapy session Tom was encouraged to trial an unrelated behavioural change: substituting sweetener for sugar in his tea. Debriefing this experiment revealed that "it was easy to go onto automatic pilot and do the same old behaviour", that change felt uncomfortable and he noticed the differences acutely at first, and that sometimes the change was too much and 'breaking it into steps' made it easier. Finally, Tom commented that that it had only been because his therapist had asked him to do this odd experiment that he had been encouraged to see that "you need a reason to change, otherwise you went back to your old habits". The importance of "reasons" allowed Tom to use future aspirations to motivate himself on more challenging tasks. These learning points became central motivators when considering starting to change minor elements of his behaviour, and an on-going example of the potential obstacles and impact of change over time.

9.4.3 The Environment

CBT requires the person to be able to gather information, evaluate it and change their behavioural response (Clarke & Wilson, 2008). However, there is a particular challenge within secure mental health services relating to the environment in which patients are usually resident. It is clear that at times other patients in secure services

can be unpredictable, unreasonable or unusual, which often makes it a difficult environment for testing out a person's assumptions or beliefs. Long-term stays and security restrictions in these units can limit opportunities for social interactions and behavioural experiments, such that, whilst it is possible to use behavioural experiments to test reality and gather information, the professional must recognise that people are living in an altered, prescriptive and unpredictable reality.

Adaptation

Engaging in the behavioural elements of CBT, particularly in relation to information-gathering exercises, is important from the outset. Such tasks make the formulation and overall model more understandable and create examples of success or the utility of completing such tasks to draw on for future challenges. Clinical experiences inform clients that it is possible to turn some of the limitations of the secure services environment to the advantage of the therapy. For example, whereas a formally set-up behavioural experiment (such as asking a question of a team member) may invoke paranoia and lead to doubt about the veracity of the information provided, the constant availability of staff can mean that these discussions can be conducted ad hoc. Asking someone an impromptu question or checking a detail can be easily done, and with proper debriefing, can identify such important key points as the value of checking things out and evaluating the veracity of automatic thoughts.

There is no doubt that there are difficulties in employing survey methods (a form of behavioural experiment) within this setting, as it is found that the patients we are working with often do not value the answers provided by others on the ward and doubt the truth of answers staff provide. Modification is the key here: for example, making extensive use of email surveys by the clinician or the patient depending on the availability of Internet access. This allows for the formulation of a question, printed responses, and anonymity. It has also been possible to target (with agreement) particular staff members whom patients admire, resent, or are puzzled by, to get a picture of their beliefs or behaviours. Nevertheless, the use of internet access as a way to test patients' beliefs needs to be carried out with caution; there need to be precautionary measures such as internet filters and the therapist needs to verify any contact with members of the public prior to testing.

Finally, therapists' contributions in making specific requests for therapeutic leave in order to facilitate behavioural experiments are inherent to the CBT approach, and as the knowledge and understanding this approach spreads through teams and into the Ministry of Justice, this has had an impact, leading to positive outcomes.

Case Examples

Tom (discussed earlier) believed he caused pain in others by the 'mistakes' he made in his breathing, posture, speech or movements. In discussion during sessions, he frequently asked his therapist if he were in pain, or discomforted at all, and at times was reassured by the information he was given. Spontaneously between sessions he began to ask others if they were experiencing pain when he was near them, and the results were carefully de-briefed in therapy sessions. In addition, we set up an email survey asking what causes back pain, expanding the generalisabilty of the comments he had been receiving on the ward by agreeing that the email would be sent to people not working in mental health settings. In this way, Tom gathered evidence for and against his beliefs and follow-up discussions were carried out carefully, using the guided discovery approach (Kingdon & Turkington 2005; Wright et al., 2009).

9.4.4 Structure

NICE guidelines recommending the use of CBT in schizophrenia are primarily based on randomised control trials using structured sessions and manualised interventions (NICE), with therapists using protocol-driven interventions. Literature and guidance on effective CBT continually refers to the importance of the structure of sessions, of setting and sticking to an agenda, and of setting and evaluating homework tasks (Morrison & Barratt, 2010). Therefore, this is the kind of therapy to which practising clinicians should aspire. Working in this population, it can be difficult to maintain the structure of the cognitive therapy approach. As discussed earlier, high prevalence of thought disorder, cognitive impairments, substance misuse and poor educational background can limit some patients' ability to recall information, to work in a structured fashion and to follow guided Socratic dialogue.

Adaptation

For many, the use of standard therapeutic tools, such as a therapy notebook, clear diagrammatic formulation and Socratic questions, can work well. However, clinical experience informs us that these can be supplemented, particularly where literacy or recall is poor. An audiotaped summary of the last session and plan for the next can be a helpful cue, particularly if the key points and plans are spoken aloud by the patient rather than the therapist. As reported by some patients in the qualitative study, diagrammatic formulations can make use of images, single words, lyrics or different colours, or become more meaningful and easily adapted with the use of sticky notes and moving characters. Complementing the formulation with examples of specific incidents, behavioural experiments and their results consolidates the work, and improves the structure of therapy and progress on agreed goals.

Additionally, the use of supervision is of importance to monitor the rationale for choices made in the agenda setting: to be sure that, for example, the patient's distractibility or impulsivity is not moving the focus too readily from the agreed goals and targets.

Addressing transparently the dilemma of sticking with an agreed agenda or dealing with an issue that has arisen in the session is helpful, and sometimes supplementing sessions with alternate spaces for emotional expression can help the session to remain on track.

Case Examples

With Dev (described above), maintaining structure was particularly difficult. To aid this, formulation was completed using pictures and symbols for concepts that had been explored in sessions (such as "messages from the past", assumptions, thoughts, feelings, behaviours). Key points were written in simple form at the end of each session and revisited at the start of the next. These would include statements such as "thoughts aren't facts" and "testing things out tells us if they are true or not".

In a different case, Ashley is a patient who had carried out a stabbing prior to his admission to hospital and believed that others are there to hurt him. In the sessions, he at times referred to the "jiggery pokery" of the therapist's behaviour. When this was explored, it became clear that the Socratic dialogue, whilst enormously helpful in the session, felt like a magic trick that allowed him to see things more clearly, but without giving him a sense that he would be able to repeat this process by himself. Given the importance of his own confidence in avoiding risky situations in the future, and the team's confidence in this to facilitate his progress, we spent time breaking down what questions were helpful. This allowed us to create a worksheet that he could take himself through in the future, either with or without the guidance of a therapist or key-worker.

9.4.5 Extreme Behaviour

CBT aims to formulate and understand behaviours in the context of the individual's beliefs, thoughts and feelings. Working in a context of ongoing risk assessment and management can pose challenges for adopting CBT in secure services. Histories of severe violence and other offending are common and such behaviour can appear difficult to understand and formulate.

Adaptation

Within secure mental health settings, it is not surprising to find patients who wish to avoid re-offending. Even in patients with a history of very anti-social attitudes and behaviours, such an aim is often present, even if the rationale is to avoid incarceration, rather than being related to more pro-social impulses. Being transparent about the importance of this goal in the individual's life introduces the opportunity to formulate their offending history, and to consider openly the role of psychotic symptoms within this. Referring back to the first qualitative study, professionals narrated the use of 'forensic case formulation' in understanding difficult and challenging behaviour, which formed part of the adaptation process.

The normalising approach frequently used in cognitive behavioural formulations (Kingdon & Turkington, 2005), whereby behaviour is seen as an understandable

result of thoughts (predictions) and feelings, can be logically extended, even when formulating extreme or risky behaviours. It is important to highlight that although the violent behaviour cannot be condoned and does not represent the best action they could have taken, that it can nevertheless be understood, given the beliefs that they held at the time. Such explicit formulation of violent behaviour can lead an understanding of maintenance cycles and factors which may increase future risk as well as pointing to exits or alternative virtuous cycles.

It is possible and useful to create functional analyses, such as the ABC approach, of even the most extreme situations and behaviours. For example, if the patient genuinely believes that his life is in danger, acting in self defence is a socially normal response. If the patient genuinely believes staff are plotting against him, or are deliberately acting against him, his anger is understandable. The use of ratings of the intensity of the belief, and noting the link to ensuing behaviours to highlight the role of thoughts, can open up discussion about how the person can be certain and the importance of being certain before taking action. In simple terms, this is about concluding that all thoughts are simply predictions which can be tested out.

Case Example

Following the example of Ashley, although the content of the formulation includes violence, the fundamental thinking errors that fuel the intense paranoia and fear are common: catastrophising, jumping to conclusions and making negative predictions, as can be seen in Figure 20 below.

Situation/Trigger	Prediction/belief	Emotional and Behavioural Consequence
Hear a voice: "go outside" "it's worse for you if you stay inside" "be prepared when you go out"	I'm going to be attacked if I go outside I have to go outside: I have no choice	Feeling: Dread, foreboding, constrained, frightened Behaviour: Go outside, take a knife with me
Stand outside. Don't know what to do / where to go See man – with friends, he starts singing	He's planning something	Feeling: Agitated, nervous, angry Behaviour: I go over to him, confront him
After I confront him, he says "I'm just trying to help you", then walks away	His walk is "menacing". He's going to get a sword	Feeling: Intense Fear Behaviour: Attack him from behind

Figure 20: The applicability of ABC formulation for extreme behaviour

Discussion of the formulation considered how Ashley's threat appraisal was made, including exploration of how individuals notice threat, the role of hypervigilance and attentional biases, the role of thinking errors, a historical review of the information available, behavioural experiments (noticing people frowning or smiling) and considering alternative explorations. Simple messages about the importance of these interpretations led Ashley to adopt a maxim. He should not "turn a crisis into a catastrophe", and when feeling threatened he should seek immediate assistance.

9.4.6 Shame and Guilt

Working in secure mental health services, clinical experiences inform us that some patients frequently encounter the difficulty of shame and guilt emerging as they gain more understanding of their own behaviour, particularly in relation to past offending. Many patients will have acted in violent or aggressive ways, directly or indirectly related to their psychosis. Therapy often formulates this behaviour but in doing so highlights thinking errors, misunderstandings and ways to change behaviour to prevent recurrence of troubled behaviour. In the general population, we have experienced formulations resulting in self-blame, with such statements as "why

couldn't I see this before?", "I was stupid to make such errors". Such understandings in patients in secure services can increase ideas of self-blame, shame and guilt. Shame and guilt are strong, complex emotions which are cognitively driven and which do not habituate over time (Gilbert & Irons, 2005). The first qualitative study highlights the theme of professionals' attitudes towards patients, which may trigger the feeling of stigma. Professionals working with patients who have the above concerns need to be extra careful, as this can contribute to a ruptured relationship. As highlighted in the previous chapter, stigma may inform the help-seeking behaviour of the patient and it is possible that patients may have a fall-out with the therapist at the start or even in mid-therapy. In order for therapy to progress, it is important that these issues are addressed.

Adaptation

Asking patients to compare and appraise what they know differently now, as compared to then, can be a helpful step in establishing the changes they have made and how this will affect their thoughts, feelings, choices and actions in the future. This approach, however, requires a realistic consideration of our own views as therapists and a commitment to holding hope in the presence of significant barriers.

An honest consideration of our personal views through supervision is helpful. In the same way, peer support from clinicians with an understanding of the principles of the approach is important, and informal peer supervision to discuss the therapy process and obstacles more frequently can improve progress and help both therapist and patient to persevere.

Surveys of others about 'second chances', people's ability to change, and what appropriate atonement might include can be helpful. So too can the chance to speak with people who have successfully moved on from such institutions, to ask questions or to hear how they have come to terms with their offending.

Taking this further, drawing on more generic literature in this field, the work of Paul Gilbert and Deborah Lee is particularly useful. This work focuses on bringing into therapy skills for building compassion, both towards the self and towards others,

based on Gilbert's Social Mentality theory (Gilbert, 1989). The development of compassion-focused therapy in the forensic environment is extremely important and may well produce a significant literature of its own (Laithwaite, 2009). In order to change or live better with emotions of shame and guilt, the patient is encouraged to engender a compassionate mind. In many of our patients, this is a difficult task. As noted earlier, these patients may have little experience of being the recipients of compassion. Techniques such as Lee's "perfect nurturer" (Lee, 2005), whilst extremely useful, are often challenging to implement, having been developed largely in relation to depressed clients, although they can be adapted. In particular, the reality of the client's own behaviour in the past can stand as a challenge to compassion, and a clear formulation of their action, linking circumstances, the beliefs they held and emotional states are important.

9.4.7 Therapeutic optimism

For both patient and therapist, the process of therapy can feel long and progress slow. At times it is difficult to maintain optimism. For therapists, the reality of long, difficult, repetitive work, in addition to regular setbacks, can make perseverance a challenge, particularly when patients expect and can seem to provoke rejection or failure. Additionally, the limited specific literature means that as a therapist, it is sometimes not unreasonable to act outside of the evidence base and it is possible to experience negative therapy-related beliefs such as "we are getting nowhere", "nothing is going to change". Such beliefs can also be reinforced by negative views from other colleagues, who may be ready to confirm to you that "CBT just doesn't work with these patients" or that "you can't just challenge this stuff away".

Adaptation

Support and supervision of clinicians can be vital in maintaining therapeutic optimism. Utilising a supervision model with a combination of colleagues who understand forensic settings and those who are experts in CBT has allowed the continuation in thinking about how best to adapt and apply CBT in this population and setting, and to overcome the obstacles outlined above. In supervision, frequently visiting the basics of good CBT and then working out ways to use what we know

from the literature in this setting can help therapists to find the path when they cannot see the wood for the trees. In line with the model, it is important to adopt a curious, collaborative and explorative approach, testing out strategies and reviewing their impact, allowing the literature for CBT with psychosis to be drawn upon in a creative, flexible and experimental approach.

Working in secure settings, we also need good self-care, peer support and experiences of success. For all of the discussion above, one central component is the use of CBT approaches in a way that enables them to be embedded in the wider multi-disciplinary team. In common with any inpatient setting, patients and their difficulties exist within a system, and pathways forwards are only enabled in the context of a supportive team who are able to hold in mind the rationale for the cognitive behavioural approach, its limitations, and its areas of success. This brings us to the higher order themes model of 'place of healing versus confinement' discussed in the earlier chapters. The model is a theoretical guideline which needs to be understood when working with this population. Professionals need a balance between care and security, and as discussed above, there is a need for integration and better communication amongst the MDT team. In practical terms, creating this within a forensic environment may translate to regular handover with staff on the ward, which increases a culture of consideration of these ideas and lays fertile ground for ongoing discussions between patients and those in regular contact with them. Involving other staff in testing, surveying and behavioural change techniques works for patients, and for therapists in the future, in helping staff and fellow patients to see the fundamental tenets of the approach.

Similarly, the presentation of the CBT approach on a case-by-case basis can provide concrete demonstration of how it can be helpful, and encourage some of its principles to become more embedded within the service.

Traditionally, success in psychiatric services has focused on the need for cognitive change: for example, the client "needs to know that they are having delusions". Learning from this research and clinical experiences suggests that where psychological interventions are most helpful is not in persuading people to accept others' understanding, but to find their own. What makes the most difference is when

patients are able to manage their distress and take steps towards significant behavioural change based on experiential learning.

The messages drawn from the CBT literature related to simple anxiety disorders remain fundamental and this is something that is consistent with the themes identified in the qualitative work at the beginning of this research. Just as intelligent people with panic disorder 'know' that a panic attack will not kill them, in the moment they continue to 'believe' that it will. Successful treatment comes from experiential learning, the testing out of predictions (Wells, 1997). Similarly, when considering psychosis and risk issues, cognitive behavioural therapy needs to understand and formulate the processes that maintain distress or problematic behaviours, to plot maintenance cycles, and to break these cycles experientially. This is the process that results in cognitive, emotional and behavioural change.

Despite the increasing awareness of the CBT approach to psychosis, it is not surprising that we continue to encounter a common misperception of the key elements of this approach. In both Tom's and Dev's cases, some staff repeatedly spent considerable time challenging their beliefs, telling them "it isn't like that". For example, with Tom, "we told him his pain didn't come from there" and with Dev "we keep telling him we like him but he won't believe us". The ongoing hope is that these messages alone, in combination with medication, will suffice to change their point of view and create change. Part of CBT in secure mental health settings is continuing to work with teams not just to understand the principles of the approach, but recognise the delicate, structured approach that will allow it to succeed and to recognise, within our formulations, that the problems are formed and maintained by psychological processes and by the way in which the person gathers and processes information.

Despite first impressions, these complex patients can respond to traditional CBT approaches, including behavioural activation, experiential learning and cognitive restructuring. The barriers to engagement and collaboration can be overcome using a mixture of the ideas above, with a dose of enthusiasm, tenacity and perhaps most importantly the support of colleagues.

9.4.8 Referrals

Receiving referrals for psychological interventions within secure services has often been the topic of mid-corridor musings and the suggestion that psychology could be tried as a "last resort". Patients have rarely presented themselves with an identified problem that they wish to work on, but more often are asked to see a therapist or a psychologist after a care planning meeting or team discussion. Key difficulties which initiate referrals by the team are often ongoing distress, concerns about risk – of in-patient violence, of self-harm or long-standing risk of violence – or because of non-remittance of positive symptoms despite lengthy and extensive anti-psychotic treatment regimes.

Safran et al. (1993) have suggested that factors predictive of good outcome in short-term cognitive therapy include individuals being easily able to access their thoughts and emotions and having an ability to articulate them clearly. In addition, they note more success in individuals who accept their own responsibility for change, understand the cognitive model, and who are committed to the active tasks of the therapeutic work (such as homework or behavioural experiments). Finally, they recommend working with individuals who can raise any concerns about therapy actively. Clearly such recommendations are based on non-forensic out-patient populations, and there continues to be a real need for evidence of what can work outside of the limited population of the randomised control trial. For further discussion of this issue in relation to anxiety disorders, see McManus, Grey and Shafran (2008).

Working in forensic settings, we often recognise our patients more clearly from the list of factors which predict poor outcome (Blenkiron, 1999). Tangential talking, poor focus, raising multiple problems, significant personality difficulties, and externalising responsibility and blame are features that are common within this population. These features are partly compounded by a system that at times hinders individuals from taking an active role in their treatment and recovery. Roth & Fonagy (2006), in their publication "What works for whom", describes common features of successful interventions in this population, including being intensive, conducted over the long term, theoretically coherent, well structured, and importantly interventions which

engage the patient and make sense to them, taking account of their hopes and aspirations, as well as being well integrated with other services and tied into follow-up care.

Adaptation

Educating the MDT about the approach of cognitive behavioural therapy, its applications, and clinical experiences of success has been vital in finding those individuals who may be able to benefit from this approach. This involves case presentations that bring clinical material to life and has been helpful to explicitly acknowledge the limited evidence for this approach with clinicians. Much as within the therapy sessions themselves, the therapist needs to hold an open discussion about the approach and acknowledge that it may or may not be helpful, and a collaborative, curious approach across the team is essential.

In addition, early discussion with teams and patients about possible referrals has been helpful in considering and formulating how individuals and teams have become stuck in their attempts to move forward, and where the major barriers and obstacles lie. This often involves exploring past experiences of therapy and interactions with teams, which may have shaped beliefs about the potential utility of psychological interventions.

It is important to adopt a pragmatic approach and part of this is meeting the teams to discuss anyone on their caseload, attending ward rounds or care planning meetings where this seems helpful. Liaison with occupational therapists where they are encountering obstacles to progress has been particularly helpful in terms of clarifying the presenting difficulties. As mentioned in the first part of this research project, the above appears to fulfil the qualitative theme of "integrative work" within the team.

Recent CBT research postulates that CBT works best to formulate and treat specific problems and distress rather than attempting to formulate the whole person (Clarke & Wilson, 2008). In a forensic setting, taking into account the diversity of presenting problems, one could look for referrals where there are particular problems, even if the person cannot immediately identify these. A process of extended assessment can be

used to work with the patient, trying to establish such problems and form specific, shared goals. This is easily achievable, as staff are fortunate not to be limited by strict rules on turnover of cases or limits on the number of sessions, which allows a proper exploration of referrals with the clients.

Having said the above, it is not practical to rule out referrals where the poor prognostic factors are present as long as there is at least some evidence of the positive prognostic factors. Referrals are also sought where there is a relative, rather than absolute, presence of the attributes which are thought to increase the utility of CBT. It is essential to utilise knowledge and interactions of the patient and of the MDT to understand such things as the patient's ability to form relationships and to think and interact flexibly, working alongside MDT colleagues to engender the skills and attributes that enhance the chances of therapeutic success. Rather than excluding those who are "not suitable", it is recommended to work, for example, with OT colleagues to try and enhance cognitive flexibility and frequently with key workers to work on the skills of recognising and identifying thoughts and emotions. This preparatory work is often essential in the effort to engage patients and to establish collaborative goals, a challenge which is expanded on below.

Case example

Some of the facets of this approach are demonstrated in the example below.

Dev, a 20-year-old man, was referred for psychology work without a specific focus. Dev is under a mental health section in secure service and has a history of severe self-harm, aggression, drug misuse and psychosis. He also has a mild learning disability. Initial assessment revealed numerous potential areas for intervention, eventually narrowed to a starting point regarding his belief that "everyone hates me", which had fostered aggressive behaviour towards others. His goal was to "feel more comfortable on the ward and to get out", which required decreased aggression.

Dev believed people hated him because of his "gut feeling", which he felt was a special power, although he acknowledged the potential that this related to his life experiences of people hating him.

In early sessions he was reluctant to engage or to think of specific problems. We spent time discussing with the team and managed to form a focus on distressing paranoid beliefs. The therapist presented to the team on CBT approaches to working with paranoia and encouraged them to use Dev's language of feeling hated, rather than talking about his "paranoid delusions". This allowed all working with him to use a similar approach and to find a useful focus for work. His case was presented at an academic case presentation, using this as an opportunity to present both the research evidence and details of appropriate referrals to the wider staff group.

Chapter Ten: Discussion

This chapter examines the findings in relation to all three studies. It begins by revisiting the first study, looking at the importance of patients' and professionals' views of secure services and extracting key ideas in CBT that were used to generate the guidance manual for CBTp-ss. Following this, the discussion will focus on the feasibility trial (Study Two) and make comparisons with other studies in similar settings. The third study's results are discussed to further strengthen our views on what is supportive in CBT in secure services, ending with suggestions of implications, limitations and recommendations for future studies.

The main objective of this research was to establish a guidance manual for CBTp in secure services through exploring patients' and professionals' views of supportive and non-supportive work in CBTp. Themes elicited were adapted to form a guide, which was trialled in a pilot RCT followed by a final qualitative study to elicit patients' views of what works within CBTp.

The first study in this thesis explored patients' and professionals' narratives of secure services and supportive and non-supportive work in CBTp. The findings of this study produced important themes in terms of patients' views of secure services and CBTp; as a practical approach to keep their minds in check and solve problems and as a psychoeducational process to provide insight, and also elicited views about therapy as equals and about feeling stigmatised. Some of these themes overlap with those elicited from professionals, who talked about CBT for co-morbid problems and problem-solving, working with overwhelming beliefs, perceptions and risk factors, and therapeutic mutuality.

Following this, an overarching model was produced, focusing on secure services as a place of confinement versus a place of healing and consolidation. CBT was modelled as a mediator between confinement and healing. Holmes et al. (2002) reported similar findings, where the therapist was able to create the parameters of a secure base and a place of healing. The environment and staff attitudes in secure services play a major role in shaping the overarching theme of 'place of confinement', which has an impact on interpersonal relationships with staff and therapeutic processes. The environment,

by its very nature, does not motivate patients to feel empowered to engage with staff and power struggles between patients and staff have been an important issue that has been overlooked in secure services.

This finding is consistent with a recent study that looked at the relative contribution of perceptions of the ward climate of patients with psychosis in a male inpatient service, and highlighted that staff have an active role and powerful personal influence on treatment (Campbell et al., 2014; Holmes, 2002). The overarching model in the first study provided an important understanding of how other factors can influence the therapeutic processes in secure services and importantly how therapy such as CBT emphasises shared understanding, which could aid patients to achieve their recovery and reach a place of healing.

The professionals' themes in this study help to further clarify what works in secure services and importantly in CBTp. The overlapping themes between professionals and patients provided stronger evidence towards what is supportive in CBTp. These views contributed to the development of the CBTp-ss guidance manual, which provided a base to work with patients in secure services. Initially, adaptations were made to clarify important processes in secure services, such as maintaining a balance between caring and risk management and understanding patients' journey right from start of their offending behaviour, as well as the contribution of overwhelming beliefs and co-morbid problems. Amongst others, the above factors were adapted according to therapy phases in CBTp-ss.

Following this, a feasibility study of CBTp-ss in secure services was conducted and the results were encouraging. The aim of this study was to assess the feasibility of the new CBTp-ss guidance and whether it reduces psychotic symptoms, anger and overall inpatient stay compared to TAU. Reflecting on Chapter Eight, the findings from this study are timely, given on-going attempts by the DOH to increase psychological therapies for mental health problems. Pilot sites have been established for Improving Access to Psychological Therapies (IAPT) for severe mental illness and efforts are currently underway. In this study, the CBTp-ss group did not achieve a significant improvement in the overall primary outcome, although significant improvements were found in Negative subscale in post treatment and Positive subscale when change from baseline was calculated. The demographic characteristics of this study revealed

similarities with the work of Haddock et al. (2009), in that there were a significant number of unmarried males, a majority of them resided in secure services, antipsychotic medication at baseline was above 400mg (Chlorpromazine equivalent) and both interventions were manualised and delivered by therapists who met the minimum standard of the British Association of Behavioural and Cognitive Psychotherapies (BABCP). There were notable differences: a majority of patients in their study were white and the mean age was 35.7 for the CBT group and 33.9 for the active control group, compared to our study, which had no white patients and in which the mean age was 47 for the CBTp-ss and 36 for the TAU group. Duration of illness was not mentioned in their study; however, patients in our study had been ill for an average of 17.6 years. A study by Kennedy et al. (1995) found a statistically significant relationship between length of stay in hospital and duration of illness, although findings from another study revealed no clear relationship (Edwards et al., 2002). In a recent study (Shah et al., 2011), it was reported that stays of more than two years in a medium secure unit were associated with a diagnosis of psychotic disorder, multiple previous admissions, detention under hospital and restriction orders with a moderate history of violent offending behaviour. It is not surprising that a combination of these factors could predict the length of stay; however, there is a lack of research in the area of duration of illness and outcome in secure services.

To the researcher's knowledge, the last RCT of CBTp in secure services was completed in 2009 and there has been no large-scale research completed in this area; this could be partly attributed to the difficult nature and complexities involved in treating this population.

Haddock et al. (2004) carried out a pilot case study with three patients using similar outcome measures to those applied in our study. All three patients were treated with at least thirty sessions: ten sessions more than our CBTp-ss treatment. The PANNS total mean scores for all patients at baseline were higher than those for patients in our study, and the scores deceased at follow-up, meaning that there were some improvements, although due to sample size, these results were not generalisable. Looking at their data, these improvements were largely related to negative symptoms compared to positive and general symptoms, a result which was consistent with the CBTp-ss group post treatment our study.

In a subsequent study, Haddock et al. (2009) completed the first single blind RCT in forensic settings, evaluating the effectiveness of CBT with an active control group of social activity therapy. Some of the measures employed in their study were similar to ours. On the PANNS scale, their baseline total scores were lower in both of their treatment groups compared to our CBTp-ss group, although they were not significantly different. This suggests that our patients may have higher psychopathological symptoms at baseline. The symptoms severity of our patients is not attributable to being relatively well at study baseline and may correspond to a moderately ill population according to the threshold for the PANNS (Leucht et al., 2005).

Consistent with our study, their end-of-treatment and follow-up total scores decreased at a slower pace but this was not significant. It is noteworthy that similar improvements were noticed in the first RCT of CBT for schizophrenia spectrum disorders for patients who were not taking antipsychotic drugs (Morrison et al., 2014). Their total PANNS score decreased significantly ($p=0.003$) with a small to moderate effect size, although it was not clear whether the patients treated had been admitted to secure services.

Haddock et al., in their 2009 study, also employed other measures that looked at patient symptoms, such as the Psychotic Symptom Rating Scale (Haddock et al, 1999) and in their CBT group they found significant reductions in the delusions subscale but not the auditory hallucinations subscale at the end of treatment, although these were not maintained at six-month follow-up. These are interesting observations, as they reflect on the dynamics of symptom change in this population, a trend that was also observed in our study. For example, in our PANNS results, we noticed a significant difference in post-treatment negative symptoms; however, these were not maintained when we looked at change from baseline, and interestingly, there was a change in the positive symptoms. One possible explanation for improvement in negative symptoms could be that using CBT intervention, such as behavioural work, together with other supportive work, such as occupational therapy, together might have provided motivation for patients to engage in vocational activities on and off the ward, hence leading to an improvement in negative symptoms. Equally, for patients who have co-

morbid problems such as depression, psychoeducation might have provided awareness and lifted their mood, encouraging them to engage in meaningful goals (Walker, 2006).

As highlighted in previous chapters, patients in secure services face multiple problems, such as co-morbidity, environment and chronicity of illness; it is possible that the dynamic interaction of all three factors might have influenced patient general wellbeing and subsequently impacted directly on mental health symptoms. The continuation of CBT treatment even at times when patients are distressed might affect their wellbeing: in this case, through improvement in positive symptoms (Clarke & Wilson, 2008), although it is difficult to pinpoint the exact mechanism that might have contributed to this improvement.

A similar effect was noted in a recent study by Williams et al. (2014) in secure services, where patients' positive and negative symptoms improved post-treatment and a reduction in overall interpersonal problems was noticed. Laithwaite et al. (2009) conducted a study looking at recovery after psychosis with patients in high secure services. Interestingly, they found no improvement in either negative or positive symptoms, but noticed progress in general symptoms at the end of treatment and in the follow-up period.

As regards secondary outcomes, at the SFS, CBTp-ss group data revealed significant differences in some of the constructs, such as 'withdrawal' and 'independence', and it is reasonable to speculate that the differences were in the positive direction. Surprisingly, change from baseline score indicated positive results in that statistically significant changes were seen on 'recreation' and 'prosocial' constructs, although the 'withdrawal' construct's significance was not maintained ($p = 0.051$). Haddock et al., in their 2009 study, employed a general functioning scale and the results indicated some signs of improvement, although they were not statistically significant at the end of treatment or at follow-up. It is important to point out that their scale has limited inter-rater and test-retest reliability and validity, and importantly, it has lower reliability when used in clinical settings (Dimsdale et al., 2010). Laithwaite et al. (2009) focused on a recovery-focused group with patients from high secure services and used social comparison and self-esteem outcome scales. Similar to Haddock et al., they did not employ any functioning or recovery scale *per se*. The recent upsurge

regarding social outcomes in schizophrenia is exciting and timely and is considered as an important aspect of personal and social recovery. One noticeable point from our study is that we achieved positive results despite the fact that the scale had not been developed or adapted to Black Minority Ethnic (BME) groups, suggesting that this scale is flexible. Our results did not account for the employment subscale and yet we achieved significant results for some of the constructs, although it is important to acknowledge that this scale was administered by professionals, thus limiting its reliability. In the researcher's knowledge, social functioning in secure services is an important contributor to meaningful recovery and has been overlooked in the past: future studies should make efforts to accommodate this (Addington & Gleeson, 2005).

The WARS psychometric results of our study were rather interesting and exhibited a positive trend. Out of all the constructs, the 'resistant' construct change was significant ($p = 0.004$): in other words, patients in the treatment group were less resistant at post-assessment. This finding was somewhat similar to the Haddock et al. (2009) study, where the overall scores decreased at the end of treatment and follow-up, although there were no significant time 1 or time 2 group interactions and they concluded that there were no differences on this outcome. In our study, results for this scale did not achieve overall significance, although it is reasonable to report that the CBTp-ss intervention reduced patients' anger in the treatment group more than in the TAU group and no aggressive behaviour was reported in either group.

Following their study, Haddock et al. (2009) reported a total score for their WARS psychometric, whereas our study reported the individual constructs, which allowed analysis of the difference and change from baseline. Importantly, the difference in individual constructs may be useful to inform future treatment. For example, except for the 'resistant' construct, which was significant at change from baseline in the CBTp-ss group, all other constructs were not significant and future studies may need to take this into account, particularly when thinking about alternative avenues and adaptation processes.

Another study that employed WARS was carried out with male offenders who had learning disabilities and assessed anger and aggression (Novaco & Taylor, 2004). The

results predominantly looked at correlation with other anger psychometrics and WARS was significantly correlated with the number of hospital physical assaults. The WARS scale has not been used widely in the UK secure services but is an important psychometric that could be incorporated as a regular post-admission assessment that could inform appropriate psychological treatment. These results could also be interpreted as an achievement of one of our hypothesis: the new intervention may reduce patient anger.

The BIS results were interesting, as there were significant differences in post-treatment scores in some of the questions for the CBTp-ss group. Q1 and Q3 achieved statistically significance differences, although these were not maintained at change from baseline. Q2 achieved statistically significant results when compared to baseline ($p = 0.012$). As discussed earlier, when analysed using the criteria from the original authors of this questionnaire, Q1 came under the 'attribution of symptoms' cluster, Q3 under 'need for treatment' and Q2 under 'good awareness of illness'. Taken together, they all contribute towards the insight score. It is noteworthy that all three constructs were statistically significant at different time points and it is possible that these might be due to the new intervention, although it is difficult to provide a definitive conclusion at this stage. We looked at the subscale insight score in the PANNS scale to observe difference; the mean score of the CBTp-ss group was lower ($M=2.75$) than that of the TAU group ($M=4.25$) at post treatment and the p-value was not significant ($p=0.051$) and this was not maintained when we looked at change from baseline ($p= 0.185$). There appears to be a trend towards the positive direction and it is anticipated that a more extensive study is needed to demonstrate this.

Studies of CBTp outside the UK are limited, although there is some evidence of positive movement (Wright et al., 2009; Knabb et al., 2011). So far, there is one study outside the UK that has looked at using CBTp for patients in secure services. Gareth & Lerman (2007) used CBTp to treat eight forensic patients in an inpatient unit in the US and the results were encouraging. The authors did not report any use of psychometrics but concluded that six out of eight patients benefitted from CBT intervention informed by the model of Kingdon and Turkington (2005).

The use of CBTp in specialised services such as adult mental health is on the rise and there is growing literature in the area of third wave CBT (Clarke & Wilson, 2008; Maitland et al., 2014). Most of these studies were carried out in a group setting and there are some similarities and notable differences when doing CBTp in secure services compare to acute psychiatric setting, as 'one size does not fit all'. Literature in CBTp for secure services is limited in the UK and so are empirical studies. So far, the use of CBTp in forensic settings has not gained much interest in the international arena, partly due to the lack of evidence-based studies and the limited theoretical underpinnings to which professionals can refer, although there seems to be movement in this direction with the new IAPT – serious mental illness initiation.

As discussed in previous chapters, schizophrenia and related psychotic disorders are among the most disabling illnesses worldwide and pose a considerable economic burden to current healthcare systems (Mangalore & Knapp, 2007). They cost the public approximately £105 billion every year though lost productivity and avoidable costs for the criminal justice system, as well as the costs of care and support (Department of Health, 2011).

In our study, we detailed the approximate cost of bed days, including CBTp-ss intervention costs, for six months, excluding medication, and these figures are important when planning for future studies on cost-effectiveness. Recent research has shown the number of patients who are being detained in secure services for longer than two years is increasing (Rutherford & Duggan, 2007): there are approximately 5,000 patients detained in medium secure services, costing on average £200,000 per person, per year (Walker, 2012), and this excludes patient from high and low secure services. These services are expensive and treat small numbers of patients at a relatively high cost compared to other mental health services, and with the current downturn in the NHS finance, there is concern about the continued expansion of these services (Center for Mental Health, 2011). There is considerable pressure from the NHS, which is commissioning specialist groups demanding savings from these services, topped by greater pressure from the DOH to make another £15-20 billion in savings by 2015.

Currently secure services are adopting PBR care clustering and therefore the psychological and other treatment offered to this population needs to be clinically effective and cost efficient, with appropriate targets such as discharging patients within two years or before that.

As one of our hypotheses is that CBTp-ss will reduce inpatient stay, we analysed overall inpatient stay for both groups. Comparisons were made based on some information from inpatient bed days and interaction with patients' clinical teams. Four patients in the CBTp-ss group were stepped down. Two of the patients stepped down to community-supported services and the other two went to an open rehabilitation unit. The latter two patients were eligible for community support placement, but remained in the open unit due to lack of placement available. The other four patients remained in secure services at the time of completion of this study. Out of four patients in the TAU group, only one stepped down to community services and the rest remained in secure services. Thus, half of the patients in the treatment group stepped down compared to one from TAU. It is possible that there may be other factors, such as adhering to care plans, that contributed to the patients stepping down and it is difficult to attribute this to the new intervention.

In a continuous process to assess the further adaptation and workability of the CBTp-ss, the third study was commissioned to look at patients' views of CBTp, importantly gathering their views of what is supportive in the new intervention. Important themes were extracted and clustered into main themes with overarching themes. Four overarching themes were formed: (1) CBT as a platform of shared understanding and equals; (2) CBT as a structured learning process; (3) CBT improved understanding of symptoms and risk factors; and (4) CBT therapy can be difficult. These themes provided a greater understanding of the new intervention.

When the first theme was analysed, CBT was seen as a base where both patient and therapist had a similar understanding. This skill is important, particularly in secure services, partly due to the frequent problem of power imbalance between staff and patients. A mutual understanding and agreement builds patients' motivation to work towards personal and institutional goals and to some extent this may be mediated by the interpersonal skills of the therapist. Coming from a different angle, patients'

motivation to achieve goals could be seen as an impact of a positive therapeutic alliance with the therapist (Sivec & Montesano, 2012). As discussed earlier, a similar theme was recorded in the first qualitative study where patients valued being seen as equals. Messari & Hallam (2003), in their study, found a similar theme where patients valued being viewed as 'equal human beings'.

Some studies have found that a good therapeutic relationship between patient and therapist informs the outcome of therapy (McGowan et al., 2005; Kilbride et al., 2012) and it is possible that positive relationships with patients in this study might have contributed towards patients' understanding of the processes of therapy and of their symptoms, and improved social functioning. Patient in secure services often come from difficult backgrounds and have deficit in social skills, and the offending pathway often adds into their difficulty and sense of being stigmatised. The environment in secure services is restrictive, so the therapist seeing the patient as an equal is empowering, while paying respect is an essential skill that enhances patients' trust towards the therapist and other staff. This skill is important and fits in well with the 'place of healing' theme in the overarching model in the first qualitative study, which further confirms the validity of the model.

The second major theme that emerged from our analyses reflected on the structure of CBT, which helped patients to focus on therapy tasks - formulation and homework. This is an important area in CBTp which has been linked to outcome (Kilbride et al., 2012). Patients in this study narrated their experiences, viewing formulation as a way to understand the meaning of these experiences, and in a broader sense, "writing things down and draw my feeling and behaviour". Formulation work emphasised understanding past experiences that contributed to the development of mental health experiences and personality-related thinking patterns that promote crime. Work on formulation may have created a change in attitude towards mental health and a better understanding of offending behaviour (Sturmey & McMurran, 2011).

In this respect, the impact of formulation work could be seen as an agent that not only provides insight into patients' problems but also offers an insightful link to engage in their care pathway towards discharge. Some patients acknowledged the importance of linking therapy to their discharge processes, meaning that attending therapy sessions

was seen as a route to get more leave, and hence a structured way to get discharge and direction in life (Greenwood et al., 2010). Messari & Hallam (2003) found a similar theme, except that CBT participation was seen as a compliance with powerful medical establishment and as a possible means of speeding discharge from hospital. A notable difference from our study is that the patients in their study conveyed the theme by expressing the power differential between therapist and patients and not finding therapy enjoyable.

Power imbalance is an important issue, particularly in secure services, and to deliver CBTp, the therapist needs to have a wider awareness of the system and the environment, as they too contribute to this issue.

The third major theme related to patients having an awareness of their symptoms and understanding of their risk factors. This, to the researcher's knowledge, is a novel finding which relates to patients using CBTp to gain insight into the risk factors of offending behaviour. This could be attributed in part to the adaptation of the CBTp processes that allowed therapist and patient to talk about the impact of acting on delusions and importantly about contributing risk factors such as illicit substances that may have exacerbated the problem. So far, no other qualitative studies in CBTp have addressed issues with risk. Patients in this study narrated their experiences of understanding the processes of their index offence, referring to internal experiences and the role of illicit substances in exacerbating their offending behaviour. Some of the experiences, particularly the role of illicit substances in mental health, were conveyed by learning from leaflets and discussion with therapist, although this was not reported by all patients. Revisiting the first qualitative study, CBT as a psychoeducational process and a means to provide insight fits in well with this theme, and similar to this study, patients in the first study reported their views in this vein, in that they perceived psychoeducation as a platform to learn about mental illness and identify risk factors. A similar theme was also prominent in the professionals' views in the first study, and the latter, e.g. patients understanding risk factors, was stressed as an important aspect of therapy work.

Patients talked about their experiences of improving personal understanding of their symptoms by gaining a different perspective on psychosis through CBT. Recent qualitative studies in CBTp have shown that this is an important ingredient of the process of therapy and potentially a change mechanism that contributes to new thinking (Messari & Hallam, 2003; McGowan et al., 2005; Kilbride et al., 2012). Broadly, to date, there have been few studies addressing risk factors issues in CBTp in secure services and there is a lack of consensus among professionals about the use of a single theoretical orientation to address complex issues (Sturmey & McMurran, 2011).

The fourth major theme to emerge from this analysis was related to obstacles in therapy. Similar to other CBTp qualitative studies, a minority of patients in this study reported difficulties in engaging with therapy processes. A few patients indicated that they found therapy repetitive, mostly relating to difficulty in tolerating conversations around their mental health and offending behaviour. As discussed in earlier chapters, the complexity of patients' presentation can hinder therapy processes and some patients find it difficult to tolerate conversations about their mental illness and offending behaviour. Although this is not a novel finding, it is an important aspect to be considered when delivering CBTp. Messari and Hallam (2003) highlighted a similar issue in their study and recommended therapists 'being open and honest' as a way to relate and normalise patients' experiences. A similar stance was used in this study and patients' expectation of therapy was interwoven with goals to discharge; nevertheless, some patients found it difficult to process the content, particularly relating to their index offence. Working with such patients requires careful therapeutic skills, and as reflected in the professionals' narratives in the first qualitative study, jumping in too early to challenge patients beliefs may damage the relationship with the therapist (Kingdon & Turkington, 2005; Wright et al., 2009).

Broadly, results from this study are pointing in the positive direction and indicate that as hypothesised, the CBTp-ss intervention attained a significant level of symptomatic reduction in post-treatment primary outcome measures in comparison to the TAU group. The researcher has demonstrated that CBTp-ss is an acceptable intervention for a population that is very challenging to engage, with low rates of drop out and withdrawal. Future studies need to be considered: the researcher has calculated that in

order to get an 80% power with mean difference of 3 and SD not greater than 6, the CBTp-ss trial would need 64 patients per group to demonstrate a significant p-value. The trial would need to cater for a 20% drop-out rate and needs to be multi-centre.

10.2 Implications

Individuals detained in forensic mental health services present with a unique and challenging constellation of difficulties. Diagnoses are usually of severe mental illness, primarily schizophrenia, schizo-affective disorder and bipolar disorder, and of personality disorder. Concurrent substance misuse and depression are widespread and a personal history replete with examples of abuse, neglect and abandonment is the norm. These early life and ongoing adult experiences often result in complex trauma reactions and impact significantly on personality functioning (Van der Kolk, 1994). Service admission criteria dictate that individuals will have demonstrated significant risk behaviour, usually towards others, often also towards themselves, and many have been convicted for serious violent and/or sexual offences.

Treatment in such settings has historically relied heavily on medication to treat psychotic symptoms. Whilst psychotherapeutic interventions have been available, they have relied on limited specific evidence for this population. Alternative approaches have often used manualised interventions, providing psycho-education drawing on CBT principles. These are often comparable to the group-based interventions used in the prison system, where substantial evidence for reduced recidivism has been building (Green, 2010).

Cognitive behavioural interventions within a low and medium secure setting focus primarily on individuals where formulation of risk, or of ongoing distress, has highlighted the role of symptoms, including hearing voices, unusual beliefs or paranoia. Lacking a specific evidence base for a forensic population, literature supporting the use of CBT for specific diagnostic categories (NICE Guidelines for Schizophrenia, 2009), in in-patient settings (Clarke & Wilson, 2008) and within the offending behaviour literature (Hollin & Palmer, 2006) has been drawn upon.

10.2.1 Clinical

This research has attempted to bridge the gap and has produced an acceptable CBT treatment that may address mental health problems and risk-related issues in these settings. As discussed in previous chapters, patients' and professionals' views informed the foundation of this thesis in understanding important issues that need to be taken into account prior to doing psychological work. CBTp has been shown to benefit patients with severe mental illness and our study has added to the literature and importantly has demonstrated the efficacy of our new intervention in this population. A service philosophy of care is important and can determine ward climate and the style in which patients respond to treatment. Most importantly, it can also contribute towards balancing the longstanding issue of 'care versus security'. The model of service delivery needs to promote principles of 'care', such as a compassionate approach, and to provide a secure base and empower patients whilst providing a safe environment.

Central to this is that the MDT (therapist, medical and nursing staff) needs to work collaboratively in understanding each other's work, and in this situation, having an understanding and incorporating a CBTp framework may enhance their knowledge and contribute to patients' recovery as a whole. All staff need to have the awareness that they are working in a team towards one goal: treating patients' mental health problems and issues with risk. In order to promote a balanced and healthy environment, it is necessary to create awareness amongst professionals through training and the wider system (Kingdon and Turkington, 2005).

Working in difficult environments with patients who have complex needs, therapists may face issues such as feeling demotivated, experiencing depersonalisation and possibly even the phenomenon of "malignant alienation" (Watts & Morgan, 1994). A combination of these concerns may contribute to therapist burnout. Therapists need to engage in frequent supervision and reflective practice, in a group or individual format that allows time to reflect on these issues. In addition, supervision is also a platform for formulating and discussing difficult therapy-related issues alongside other procedural and relational problems (Taylor & Sambrook, 2012). CBTp training is more widely available and some mental health professionals in secure services have

already qualified in their respective professions but need top-up training, as this would help them to understand and work with patients more effectively.

With regard to doing CBT therapy, one of the key parts of the work is understanding the whole system, including the MoJ pathway and how this affects patients' wellbeing, particularly stigma. The therapeutic relationship is of utmost importance, and for therapists, working in these settings requires flexibility and patience, as some patients are unpredictable, complex and challenging and hence require careful attention: for example, going at the patient's pace when doing therapy. Co-morbidity problems are often present and therapists need to be diligent in recognising symptoms, as they do overlap, such as depression and negative symptoms. Working on shared understanding based on patients' goals and interweaving them with the discharge planning, such as institutional goals, is a key part which not only contributes to patients' recovery but also provides motivation to progress. Lastly, work on overwhelming beliefs and risk-related work could be completed once there is a good therapeutic rapport, ending with a relapse prevention plan, which is normally passed on to the next receiving professional in the community: in this case, the care coordinator.

10.2.2 Service

There are implications for services to further develop local policies and incorporate evidence-based psychological modalities to support non-qualified professionals to develop their understanding of CBT theory and practice. Secure services cost the NHS more than any other mental health services and one way to reduce this cost is to train more staff to deliver evidence-based therapy practice such as CBT, as this would, at least in the longer term, help to reduce patient readmissions, while shorter hospital stays would contribute towards savings.

10.3 Limitations of the studies

There were several limitations to the methodologies employed in our study. It is essential to acknowledge these limitations, as they inform how to improve future studies.

10.3.1 First study

As discussed in Chapter Six, it is possible that the researcher carrying out interviews with patients from his workplace might have introduced a bias and that the patients might have responded positively in the hope that they might be granted quicker discharge. This bias was reduced by the interview transcripts being coded by patients, the researcher and professionals for the professional transcripts. In addition, frequent clinical supervision from a qualitative expert from the University of Southampton provided a space to discuss difficult issues. The researcher used two different approaches to analyse patients' and professionals' data. Whilst this can be seen as confusing, the qualitative mixed technique is now a common method used in some qualitative studies (Johnson & Onwuegbuzie, 2004; Kurtz & Jeffcote, 2011).

10.4.2 Second study

RCT has been known to provide the best evidence on the efficacy of health care interventions. Whilst we used this method, there are a few limitations that need to be acknowledged. Firstly, as acknowledged in Chapter Seven, both assessors had worked with the patients in the treatment group, although they were independent from the study. It is possible that they might not have been completely blind to patients' groups and might have introduced a rater bias. Both raters confirmed that they were not aware of the patients' groups and rated patients to the best of their knowledge.

Secondly, the researcher did not carry out an inter-rater reliability test. This would have provided a clearer picture of agreement of reliability of the assessment between the raters, thus cutting out potential bias, although it is noteworthy that both raters were senior mental health professionals with more than eight years of working experience. In addition, stress due to mental health problems is one important area that needs to be addressed and most studies employ questionnaires to measure the outcome. This is something that we did not address in this research, as the use of too many questionnaires may cause discomfort and patients "don't really like them", as reported in the professionals' narrative in study one. Instead, the researcher relied on patients' qualitative views, using a subjective rating of distress. Distress in this population can be attributed not only to mental health but also to other environmental

issues. It is also important to note that there is no self-rating scale for distress in these settings.

Thirdly, the recruitment of patients in this study was limited due to organisational and logistic issues within other secure services. The researcher approached two different medium secure services in London – one from east and another from west London. The former medium secure services stated that they already had a CBTp group programme running and refused to inform the researcher about the CBTp model that they were using or whether they offered one-to-one CBTp work. In addition, they required the researcher to be present on site for at least fifteen hours per week in order to meet security requirements, a requirement that is not practiced in west London's secure services. Thirdly, they were concerned that the TAU group would have their progress delayed by a period of almost a year whilst they waited to be offered treatment. The researcher informed them that the TAU patients could be seen after six months, but to no avail. They stated that psychologists and other staff might have limited time to do pre- and post-treatment assessments, when they may already be doing some of them, as in west London, where similar psychometrics to those used in our study are already applied. Lastly, they queried how the researcher would feed back to the MDT team to help them to track progress. The researcher reassured them of his experience working in secure services and his understanding of the importance of feedback, but without success.

The west London service was mostly concerned with the randomisation process, fearing that some patients might not receive useful treatment and this might jeopardise their treatment and progress. With further discussions, this service agreed to randomise patients who dropped out of their CBTp group programme. It is important to note that the negotiation process took several months and due to time constraints, the researcher had to end this study. In total, the researcher missed seeing at least ten patients from each site, which could have benefitted both professionals and patients. Interestingly, patients from the west London group agreed to participate in this research.

Due to the small sample size, unequal randomisation was used to maximise treatment experience. However, this type of randomisation is not ideal in terms of, for example, predictability of allocation, and may have affected the outcome, favouring the

treatment group, although it can benefit studies with small numbers of patients (Dumville et al., 2006). There are several types of randomisation and ideally future studies could look at using one-to-one randomisation stratified by type of secure services (e.g. low or medium).

The RCT method is scientifically a gold standard procedure, although the process of randomisation is still seen as a barrier by some services and professionals (Tobias, 1992). The idea of treatment being left to chance can be uncomfortable for those whose wellbeing depends on a one-to-one chance. Services with long waiting lists refused the randomisation process: this could be attributed partly to pressure from the organisation to see patients for psychological treatment according to their treatment package, which includes guidelines such as completion of initial assessment within twelve weeks and moving on to treatment.

Although promising, the results in this study are not generalizable and there is a need for a bigger study to demonstrate the real effect of this intervention on the outcome measure. The use of effect size was not considered due to the sample size and the fact that studies with poor methodological rigour are more likely to produce larger effect sizes, although the relationship is weak (Wykes et al., 2008).

10.3.3 Third study

As in the first study, the researcher transcribed patients' scripts and might have introduced a bias. This was minimised by conducting a thematic triangulation with two clinical psychologists and further discussing the themes with a qualitative expert. To minimise post-interview bias, all patients' interviews were conducted by an independent professional, who could also be seen as an independent assessor, as in quantitative work.

10.4 Future studies

This study has demonstrated that CBTp is effective in secure settings and is an acceptable modality that can be used in this population. As reported earlier, there is a lack of studies in this area and further research is needed to demonstrate the true

effect of this intervention. Ideally, a full RCT of CBTp-ss versus an active control with a cost effectiveness study is suggested, as this would not only demonstrate the effectiveness of CBTp-ss but would also evaluate the true cost efficiency in these services.

10.5 Conclusions

In summary, this thesis has looked at patients' and professionals' views of secure services and what is supportive and non-supportive in the work of CBT. These views are valuable, as they provided an insight into the reality of the use of CBT in these services, alongside other factors that could enhance and hamper therapy processes. Our results are timely given the DOH's current investment in evidence-based psychological modalities for treating individuals with severe mental illness. CBT treatment can be delivered by non-experts in the mental health profession providing they have some training in this modality. Further research into the efficacy of the adapted manual is necessary and it is anticipated that this would take the form of a Phase II full randomised controlled trial. Future implications may involve a training package for the adapted intervention. Our study has contributed to the growing evidence for the application of CBTp in the real world.

Broadly, it is not unreasonable to conclude that the CBTp approach works in this population and that a manualised treatment can be adapted, and this too will contribute to a systematic approach in future studies, as endorsed by NICE guidelines. Lastly, it is proposed that "one size does not fit all" but that this approach can be adjusted and customised according to individual needs.

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Appendices

Appendix 1

THEMATIC ANALYSIS		GROUNDED THEORY
Familiarising self with data comparison)		New Data - Open Coding (Constant
Generating initial code sampling)		Emerging core categories (Theoretical
Searching for themes Coding/Themes and memoing)		Data saturation and forming - Selective Core categories/themes (constant comparison
Reviewing themes		Basic social process - Theoretical Coding (Sorting, writing, theorizing with literature)
Defining and renaming final themes		Final themes and theoretical model

Appendix 2

NHS
National Research Ethics Service

East London REC 3
REC Offices
Block A, South House
Royal Free Hospital
Pond Street
London
NW3 2QG

Tel: 020 7794 0500 x34836

01 March 2011

Mr Gurmit Dhillon
22, New Road
Ilford
Essex
IG3 8AP

Dear Mr Dhillon

Study title:	**Developing a CBT manual (for psychosis) for inpatients secure services. Exploring patients and therapist views on CBT for psychosis.**
REC reference:	**10/H0701/120**
Amendment number:	**1**
Amendment date:	**23 February 2010**

Thank you for your letter of 23 February 2010, notifying the Committee of the above amendment.

The amendment has been considered by the Chair

The Committee does not consider this to be a "substantial amendment" as defined in the Standard Operating Procedures for Research Ethics Committees. The amendment does not therefore require an ethical opinion from the Committee and may be implemented immediately, provided that it does not affect the approval for the research given by the R&D office for the relevant NHS care organisation.

Documents received

The documents received were as follows:

Document	Version	Date
Protocol	2	24 September 2010
Notification of a Minor Amendment	1	23 February 2010

Statement of compliance

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

10/H0701/120:	Please quote this number on all correspondence

Yours sincerely

L. Keegan.

Laura Keegan
Committee Co-ordinator

E-mail: laura.keegan@nhs.net

Copy to: Prof David Kingdon

Appendix 3

Hampshire Partnership NHS Foundation Trust

UNIVERSITY OF Southampton School of Medicine

BRENT MENTAL HEALTH SERVICES

Park Royal Secure Services
Acton Lane off Central Way
London
NW10 7NS
United Kingdom
Tel +44 0208 955 4506

Version 2 on 15th October 2010

PATIENT CONSENT FORM **DATE**

Study: **Exploring patient and therapist views on CBT for psychosis in secure services**

RESEARCHERS: Gurmit Dhillon & Prof. David Kingdon
ETHICS NUMBER:
VERSION: 1

Please tick box:

(1) I confirm that I have read and understand the information sheet - dated / / - for the above study and have had the opportunity to ask questions. ☐

(2) I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason, and without my medical care or rights being affected. ☐

(3) I understand that sections of any of my medical notes may be looked at by the researchers or responsible individuals from regulatory authorities where it is relevant to my taking part in the research. I give my permission for these individuals to have access to my records. ☐

(4) I agree to take part in the above study. ☐

_____	_____	_____
Name of Patient	***Date***	***Signature***
_____	_____	_____
Researcher	***Date***	***Signature***

P.I.N. for this trial: _____ 1 for patient, 1 for researcher, 1 to be kept with hospital notes

UNIVERSITY OF Southampton
School of Medicine

Hampshire Partnership NHS
NHS Foundation Trust

BRENT MENTAL HEALTH SERVICES

Park Royal Secure Services
Acton Lane off Central Way
London
NW10 7NS
United Kingdom
Tel +44 0208 955 4506
E-mail iattmc@nhs.net

Version 2 on 15 October 2010

PATIENT INFORMATION SHEET **DATE**

Study Title: Exploring patient and therapist views on CBT for psychosis in secure services

1. RESEARCHERS: Gurmit Dhillon & Prof D. Kingdon
ETHICS NUMBER:
VERSION: 2

2. **Invitation paragraph**

You are being asked if you would agree to take part in a research study. Before you decide about this, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

3. **What is the purpose of the study?**

We are investigating the views of patients who have ***received psychological therapy (Cognitive Behaviour Therapy*).** This is to assist in having an understanding of your views regarding CBT

For example, what works and do not work within this therapy. Understanding this better may help you and mental health staffs make choices about treatment and could improve the treatments available.

4. **What will I be asked about?**

You will be asked questions which will be looking at your views on psychological therapy particularly Cognitive Behaviour Therapy.
Some questions you will be asked are similar to those generally asked within mental health services. You do not have to answer any questions that you don't want to and can stop the interviews at any time.

5. Why have I been chosen?

We have asked your consultant if we can approach you to ask you to take part and they have given consent to this. We are now asking you if you agree to participate in an interview with the staff doing this research.

6. Do I have to agree?

It is up to you to decide whether or not you take part. If you do decide to, you will be given this information sheet to keep and be asked to sign a consent form. You are still free to withdraw that consent at any time and without giving a reason. If you do so, you will be asked if you consent to the information that you have already supplied being included in the study or not. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

7. What will happen to me if I take part?

- If you decide to take part in the study, you will be approached for a date and time for me to visit you. The study will be explained further and any questions you may have will be answered. If you are happy to continue, you will be asked to sign a consent form and to complete the research task. This involves a task of answering a set of questions looking at your views on psychological therapy. This task is not expected to take more than one hour, and I will be present throughout to ensure that you understand what you are asked to do and to answer any questions you may have. Due to nature of this study which looks at your views it is difficult to capture all information during the interview therefore, interview will be tape recorded to carry out a thorough analysis. However, personal information will not be released to or viewed by anyone other than researchers involved in this project.

8. What do you have to do?

You will be invited for a meeting and to answer questions which are posed to you. This is similar to what your mental health professionals may have been doing.If you don't want to answer any question, you do not have to do so. Your care would not be affected in any way by this.

9. What are the possible disadvantages and risks of taking part?

This is a interview study so there are no significant risks or disadvantages of participating. If you should get distressed, tell the staff who has instructions in how best to reduce this and who will contact his supervisor and make sure that your care coordinator, consultant and GP are made aware of this.

10. **What are the possible benefits of taking part?**

We hope that this study will eventually help you. However, this cannot be guaranteed. The information we get from this study may help us to treat future patients with mental health problems better.

11. **What if something goes wrong?**

If you should have any complaints about this study, these will be documented by the staff and passed to the Complaints Officer, Central and Northwest London Trust, Hampshire Trust, Southampton or you can write to them directly yourself.

12. **Will my taking part in this study be kept confidential?**

All information which is collected about you during the course of the research will be kept strictly confidential. Any information about you will have your name and address removed so that you cannot be recognised from it. **Data will be destroyed once interviews are transcribed.**

13. **What will happen to the results of the research study?**

The results of the research will be submitted for publication to scientific journals and may be presented at conferences when the study is finished within the next three years. A copy of the published results will be available at that time from the staff . You will not be identified in any report/publication.

14. **Who is organising and funding the research?**

This is part of the postgraduate study research with the University of Southampton.

15. **Who has reviewed the study?**

This study has been reviwed by East London 3 Research Ethics Committee.

Contact for Further Information: if you would like more information now or in the future, please contact Gurmit Dhillon (02089554516).

Thank you for your help.
You will be given a copy of the information sheet and a signed consent form to keep.

Appendix 4

UNIVERSITY OF Southampton School of Medicine

Hampshire Partnership NHS
NHS Foundation Trust

BRENT MENTAL HEALTH SERVICES

Park Royal Secure Services
Acton Lane off Central Way
London
NW10 7NS
United Kingdom
Tel +44 0208 955 4506
E-mail jattmc@nhs.net
Gurmit Dhillon, BSc, DIPHE, MSc
Prof. David Kingdon, MD MRCPsych
Professor of Mental Health Care Delivery

Version 1 on 24th September 2010

STAFF CONSENT FORM **DATE**

Study: **Exploring staff views on psychological therapies for psychosis in secure services**

RESEARCHERS: Gurmit Dhillon & Prof. David Kingdon
ETHICS NUMBER:
VERSION: 1

Please tick box:

(1) I confirm that I have read and understand the information sheet - dated / / - for the above study and have had the opportunity to ask questions. ☐

(2) I understand that my participation is voluntary and that I am free to withdraw at any time. ☐

(3) I agree that my meeting will be tape recorded and tapes destroyed once transcribed ☐

_____ _____ _____

Name of staff ***Date*** ***Signature***

UNIVERSITY OF Southampton
School of Medicine

Hampshire Partnership NHS
NHS Foundation Trust

BRENT MENTAL HEALTH SERVICES

Park Royal Secure Services
Acton Lane off Central Way
London
NW10 7NS
United Kingdom
Tel +44 0208 955 4506

Version 1 on 15th October 2010

STAFF INFORMATION SHEET **Date:**

Study Title: Exploring therapist views on CBT for psychosis in secure services

1. RESEARCHERS: Gurmit Dhillon & Prof D. Kingdon
ETHICS NUMBER:
VERSION: 1

2. **Invitation paragraph**

You are being asked if you would agree to take part in a research study. Before you decide about this, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

3. **What is the purpose of the study?**

We are investigating the views of staff who have been working with patients using psychological therapy (Cognitive Behaviour Therapy) for psychosis. This is to assist in having an understanding of supportive and non supportive work within this therapy in secure services. Understanding this better may help staff make choices about treatment and could improve the treatments available.

4. **What will I be asked about?**

You will be asked questions which will be looking at your views on psychological therapy particularly Cognitive Behaviour Therapy.

5. **Why have I been chosen?**

We are looking to recruit staff that has experience in delivering CBT for psychosis in secure services.

6. **Do I have to agree?**

It is up to you to decide whether or not you take part. If you do decide to, you will be given this information sheet to keep and be asked to sign a consent form

7. **What will happen to me if I take part?**

- If you decide to take part in the study, you will be approached for a date and time for me to visit you. All participants will be asked questions surrounding CBT for pyschosis and your views on what works and do not work within this therapy in secure services.This task is not expected to take more than one hour, and I will be present throughout to ensure that you understand what you are asked to do and to answer any questions you may have. Due to nature of this study which looks at your views it is difficult to capture all information during the interview therefore, interview will be tape recorded to carry out a thorough analysis. However, personal information will not be released to or viewed by anyone other than researchers involved in this project.

8. **What do you have to do?**

You will be invited for a meeting (focus group) and to answer questions which are posed to you.

9. **What are the possible benefits of taking part?**

We hope that this study will eventually collate views of all staff working in secure services and delivering CBT for psychosis. These views will be analysed to provide more understanding of what works within this therapy in secure services.The information we get from this study may help us to treat future patients with mental health problems better.

10. **What if something goes wrong?**

If you should have any complaints about this study, these will be documented by the staff and passed to the Complaints Officer, Central and Northwest London Trust, Hampshire Trust, Southampton or you can write to them directly yourself.

11. **Will my taking part in this study be kept confidential?**

All information which is collected about you during the course of the research will be kept strictly confidential. Any information about you will have your name and address removed so that you cannot be recognised from it.'

13. **What will happen to the results of the research study?**

The results of the research will be submitted for publication to scientific journals and may be presented at conferences when the study is finished within the next three years. A copy of the published results will be available at that time from the staff. You will not be identified in any report/publication.

14. **Who is organising and funding the research?**

This is part of the postgraduate study research with the University of Southampton.

15. **Who has reviewed the study?**

This study has been reviewed by East London 3 Research Ethics Committee.

16. **Contact for Further Information**: if you would like more information now or in the future, please contact Gurmit Dhillon (02089554516).

Thank you for your help.
You will be given a copy of the information sheet and a signed consent form to keep.

Appendix 5

Interview Guide – Patients in category 1 and 2 (face to face individual interviews)

Thank you for agreeing to meet with me

I know that we have sent you some information and that your doctor has discussed the study with you but before we go ahead with the interview I would just like to go over exactly what is going to happen today and ask you to sign a consent form to say that you are willing to take part. You still do not have to take part and you may ask to stop at any time.

Explain the study – including taping the interview and the reasons why this is being done

Ask if everything is understood. Has the participant any questions?

Take consent.

Begin the interview

Could you briefly describe how you first became aware that you need to see a doctor about your problems?

Prompts;

At the time, what did your family /friends think was happening to you?

What did you think was happening at the time?

At the time, what did you think was causing this problem?

Did you consider, or did anyone suggest that you should seek help from anyone apart from the doctor (e.g. clairvoyant, healer, guru and etc)

Did anyone suggest any other ways of helping you with this problem? (Who and what?)

Which explanations made you feel better?

Did you feel that the therapist/doctor understood your account of your problems? (If no... explore further)

How do you now view things?

Throughout the interview use the phrases such as:

That is very interesting can you tell me more about that?

Really and how does that make you feel?

Going back to the point about … what do you think might make it better for you?

More specific questions

How do you feel about coming for the appointments/meeting?

What do you think about being in secure services?

Can you tell me how you feel about your treatment? (Doctor/therapist or nurse trying to help in your in treating you?

Do you find it difficult to talk to the person who is treating you?

Have you been offered CBT and did you accept?

If you have received it, did you find it helpful?

How many sessions have you had?

What can you recall from your treatment?

What was most helpful within the therapy?

Can you tell me how you find your therapist?

If not- why not?

Did you find their explanations regarding your symptoms similar to those offered by family and friends?

What would have made it acceptable?

OTHER THERAPIES

Are you getting any other therapy?

What type of therapy?

What did you find useful within the therapy? E.g. assessment, engagement, work with delusions, voices, relapse.

If another fellow patient approaches you because of similar experiences and they were wondering what to do, what advice regarding treatment would you give them.

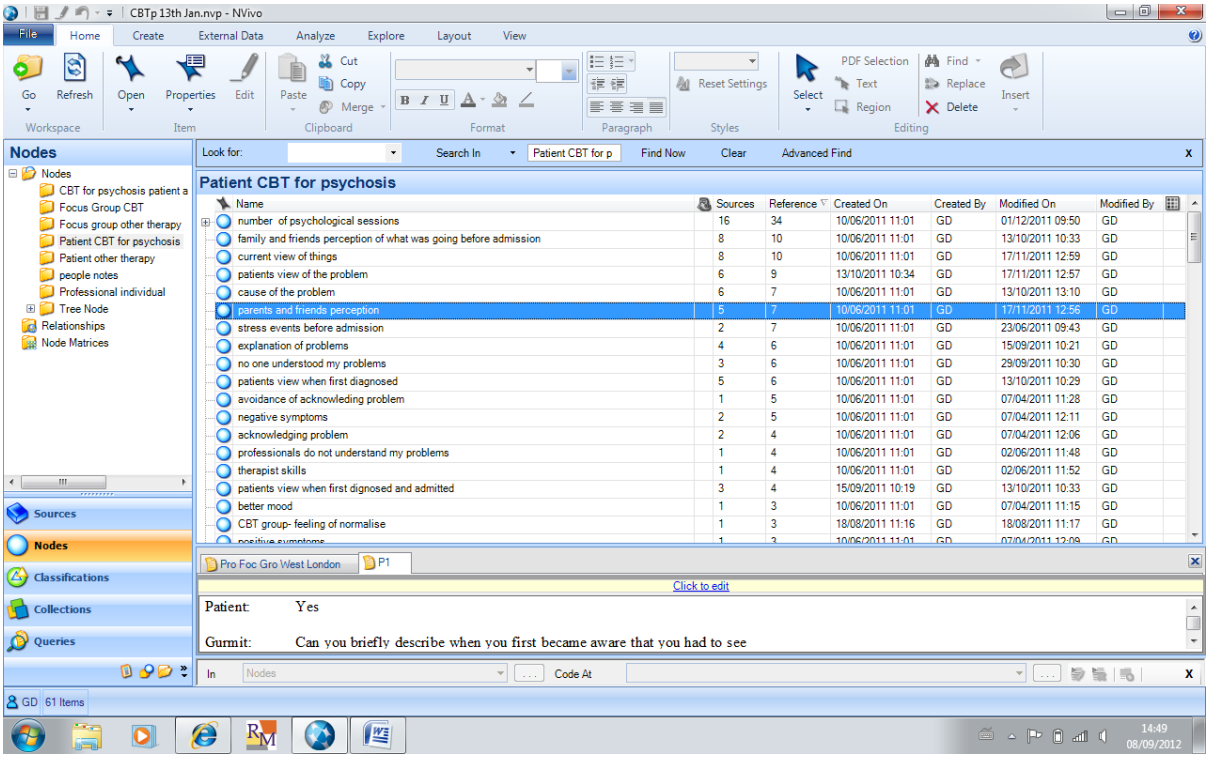
Prompts

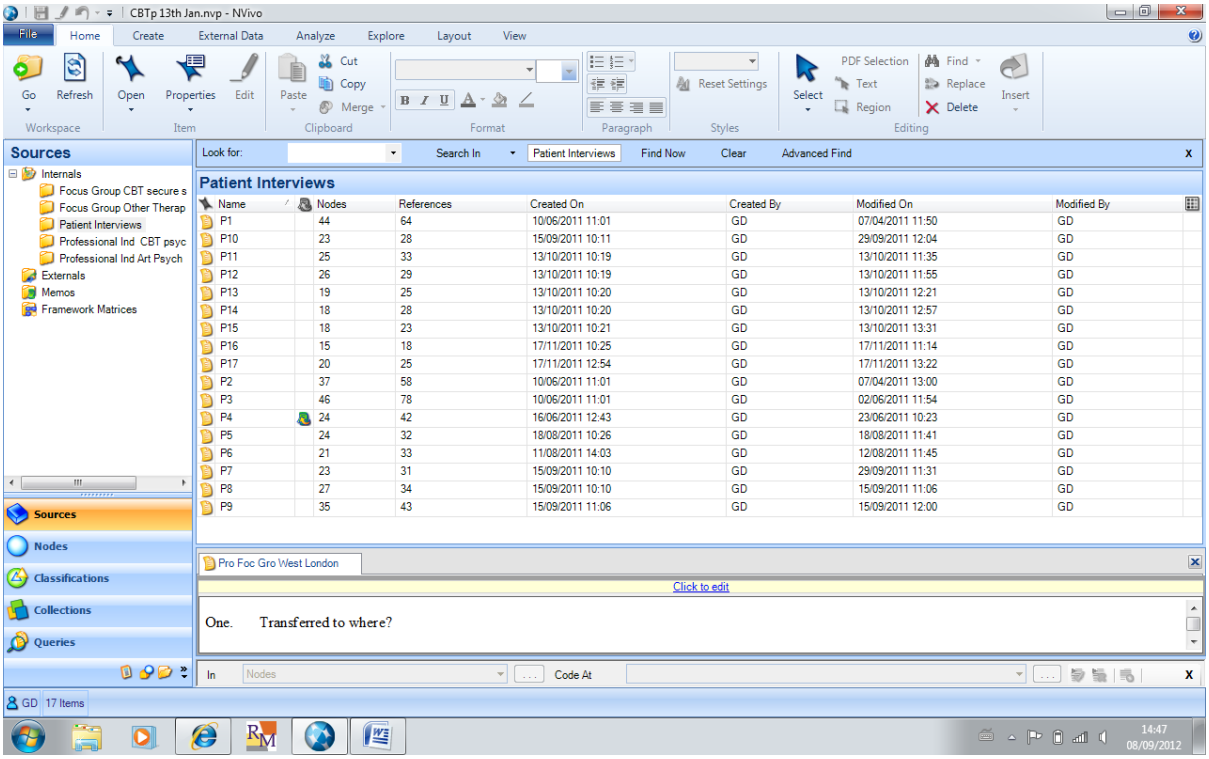
What do you find particularly useful/ not useful?

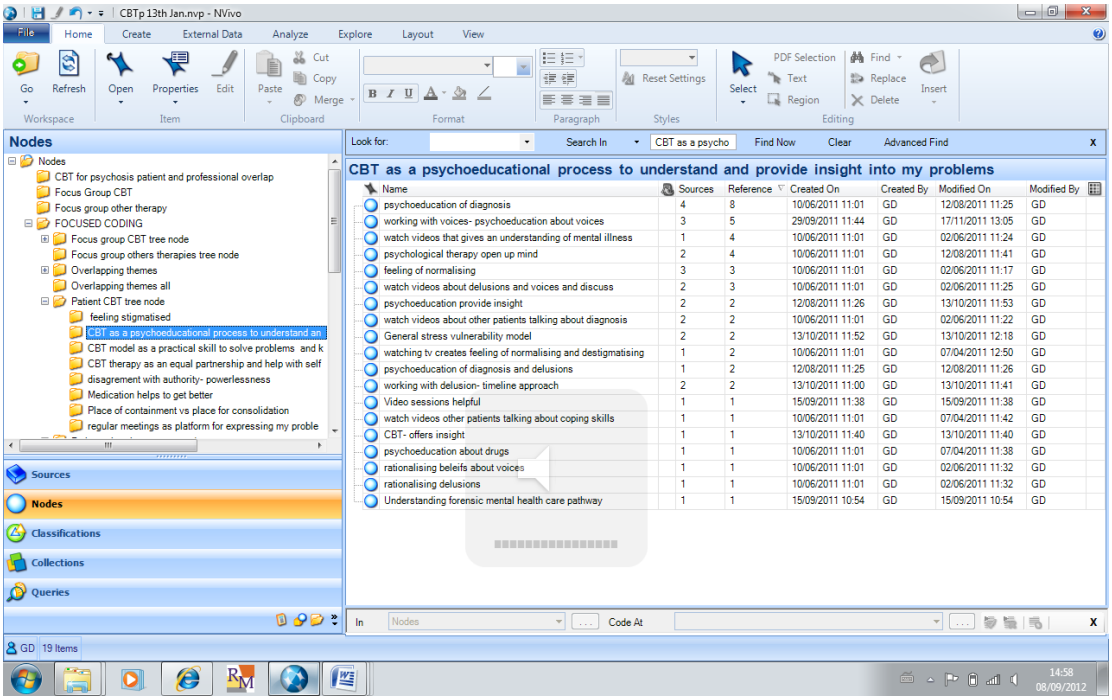
Can you tell me what have you found particularly useful.

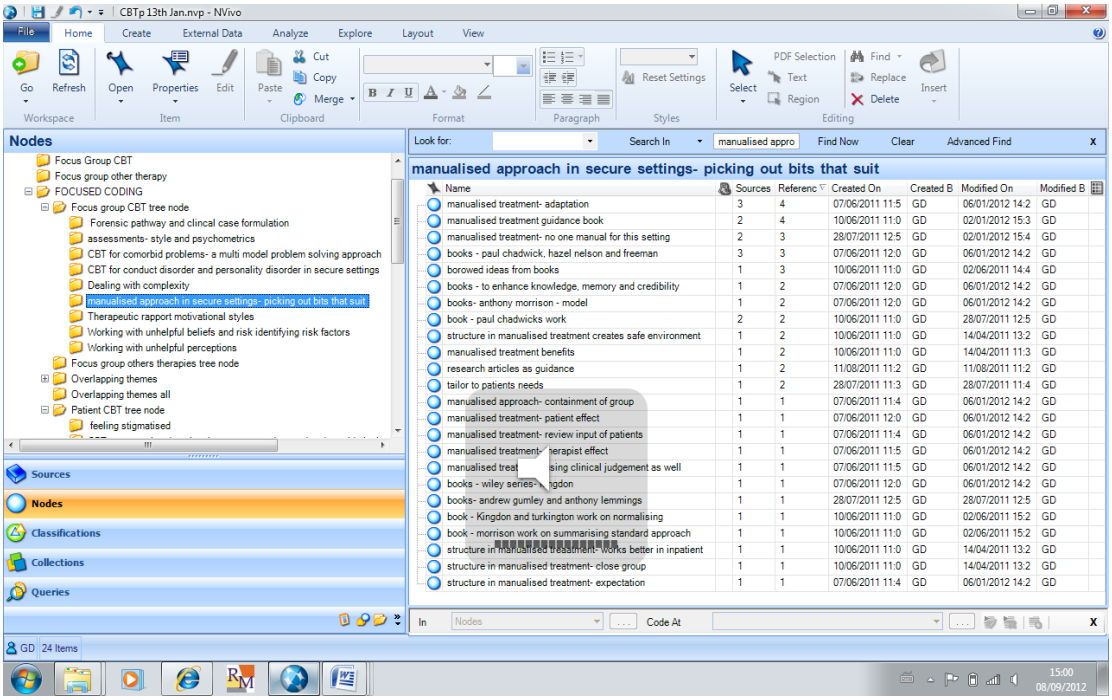
Can you tell me what kind of person you would prefer when choosing a therapist?

Appendix 6


CBTp 13th Jan.nvp - NVivo
Nodes
Patient CBT for psychosis
Name
Sources
Reference
Created On
Created By
Modified On
Modified By
number of psychological sessions
family and friends perception of what was going before admission
current view of things
patients view of the problem
cause of the problem
parents and friends perception
stress events before admission
explanation of problems
no one understood my problems
patients view when first diagnosed
avoidance of acknowleding problem
negative symptoms
acknowledging problem
professionals do not understand my problems
therapist skills
patients view when first dignosed and admitted
better mood
CBT group- feeling of normalise
Patient: Yes
Gurmit: Can you briefly describe when you first became aware that you had to see


CBTp 13th Jan.nvp - NVivo
Sources
Patient Interviews
Name
Nodes
References
Created On
Created By
Modified On
Modified By
One. Transferred to where?


CBTp 13th Jan.nvp - NVivo
Nodes
CBT as a psychoeducational process to understand and provide insight into my problems
Sources
Nodes
Classifications
Collections
Queries


CBTp 13th Jan.nvp - NVivo
Nodes
manualised approach in secure settings- picking out bits that suit
Sources
Nodes
Classifications
Collections
Queries

Appendix 7

Interview Guide - Health Professionals who has experience in delivering CBT (focus groups) (Category 3)

Group discussion, ideally would be 4 – 5 in a group. Tape record, allow 1.5 hours to include preparation of room and equipment, introductions, tidying up etc. Interview itself no longer than 1 hour. Ideally, two researchers - 1 to lead and one to scribe, manage tape recorder, prompt etc.

Good morning/afternoon, thank you for coming.

Introduction – The researcher explains the purpose of the focus group and how it will be conducted

The researcher should give an explanation of the research giving the reason, procedures and outcome. Ask participants to say their name before speaking. This may be a pseudonym if preferred or sometimes it is beneficial to give participants a number to use before speaking.

Consent

For the focus groups the discussion will probably be directed mainly by the participants. However, the researcher should have questions to keep the discussion focused on the research aim. The participants will be allowed to introduce topics that are of importance to them.

The researcher will ask the questions and direct the focus group. If more than one person is speaking at the time the facilitator must help the researcher to try to get participants to speak individually. The facilitator should note who is speaking at any one time.

General questions to follow up what someone has said:

That is interesting can you tell me more about that
Does anyone else have anything to say about that?
What do you think would help?
Has anyone else found or have the similar experience?
How did you deal with this?

Specific questions

Can anyone begin by telling me their experiences of conducting CBT with patients in secure services– name them?

Are there any specific approaches which were useful in assessment, engagement, work on delusion, voices, goal settings and relapse work?

Is anyone using a manualised approach? How did you find following the manual when working with people with psychosis in secure services.

If we take the manual approach can you tell me which approach was more appropriate than others and why?

For those who don't use a manual is there any guidelines or books which you refer to. What is particularly useful in the book?

Has anyone worked with dual diagnosis, trauma, anxiety, and depression in relation to psychosis? What was your experience and which approach did you find useful?

Has anyone worked with patients who have conduct disorder and psychosis using CBT?

What was your experience in which approach did you find useful?

What do you think about treating them using CBT?

Prompts

What did you find particularly useful?

What have you found particularly difficult?

Has anybody else experienced this?

If there were problems – did you find anything that made this easier?

Has anyone else found ways to deal with this?

For good points – would you recommend this as a way for dealing with people with psychosis in secure services?

Have you any explanations or common themes for these similarities and differences?

Appendix 8

Interview Guide - Health Professionals who has NO experience in delivering CBT (focus groups) (Category 4)

Group discussion, ideally would be 4 – 5 in a group. Tape record, allow 1.5 hours to include preparation of room and equipment, introductions, tidying up etc. Interview itself no longer than 1 hour. Ideally, two researchers - 1 to lead and one to scribe, manage tape recorder, prompt etc.

Good morning/afternoon, thank you for coming.

Introduction – both of the researcher and the facilitator. Explain the purpose of the focus group and how it will be conducted
The researcher should give an explanation of the research giving the reason, procedures and outcome.

Ask participants to say their name before speaking. This may be a pseudonym if preferred or sometimes it is beneficial to give participants a number to use before speaking.

Consent

For the focus groups the discussion will probably be directed mainly by the participants. However, the researcher should have questions to keep the discussion focused on the research aim. The participants will be allowed to introduce topics that are of importance to them.

The researcher will ask the questions and direct the focus group. If more than one person is speaking at the time the facilitator must help the researcher to try and get participants to speak individually. The facilitator should note who is speaking at any one time.

Specific questions

What are things you find useful about your therapy. What are the difference within your therapy and CBT?

Is there any aspect you conduct your therapy differently maybe assessment, engagement and treatment. For example working with delusions and hallucinations and relapse prevention.

Can anyone begin by telling me their views about patients who should have received CBT for psychosis? Patients who haven't been referred and why not? Patients who was referred and did not receive? Drop outs?

Are they are guidelines or books which you refer to? Further explanations for common themes and dissimilarities How do you think this might be different for secure services?

General questions to follow up what someone has said:

That is really interesting can you tell me more about that.
Does anyone else have anything to say about that? What do you think would help?
Has anyone else found or have the similar experience? How did you deal with this?

Prompts What did you find particularly useful? What have you found particularly difficult? Has anybody else experienced this? **If there were problems** – did you find anything that made this easier? Has anyone else found ways to deal with this?

For good points – would you recommend this as a way for dealing with people with psychosis in secure services? Have you any explanations or common themes for these similarities and differences

Appendix 9

Central and North West London NHS
NHS Foundation Trust

CNWL NHS Foundation Trust
Offender Care Service Line

Park Royal Secure Services
Acton Lane off Central Way
London
NW10 7NS

Tel: 02089554506
Fax: 02088381405

www.cnwl.nhs.uk

UNIVERSITY OF Southampton
School of Medicine

CONSULTANT INFORMATION SHEET

18th October 2012

Study Title: ***Feasibility study of Cognitive Behaviour Therapy for Psychosis – secure service manual with service users in secure services: A pilot study and cost effectiveness analysis***

RESEARCHERS: Gurmit Dhillon and Professor David Kingdon
ETHICS NUMBER:
VERSION: 2

Dear Colleague,

We would like to invite patients under your care to join the above study.

There are limited studies demonstrating the effectiveness of Cognitive Behaviour for Psychosis in secure services. Our research group has therefore recently conducted a qualitative study to develop Cognitive Behaviour Therapy for Psychosis in secure services (CBTP-ss) by exploration and incorporation of service users' and health professionals' views and opinions. We have subsequently developed an adaptation of CBTp specifically for patients in secure services. The purpose of this study is to pilot this intervention for patients in secure services.

Your patient(s) has been chosen because they have at some stage been given a diagnosis of schizophrenia, schizoaffective disorder or delusional disorder and are currently residing in secure services under your care. It is up to you to decide whether or not potential participants should be invited to take part. If you agree, arrangements will be made in collaboration with your team, to discuss their participation in the study.

If your patient agrees to take part in the study a member of staff who is independent of this study will ask them to complete validated measures (pre and post) in order to assess their progress over the study period. The participants will continue with their usual treatment and in addition, following randomisation, may also be offered the modified Cognitive Behaviour Therapy CBTp-ss.

If they are allocated to receive CBTp-ss , they will be offered up to 20 sessions by a trained therapist over a six months period. The therapist will meet them individually on a regular basis for therapy. Each therapy session will last up to 45 minutes. However, participants will be free to withdraw at any point without giving any reason, or without their medical care or legal rights being affected.

If they are not offered the therapy, they will continue with their usual treatment. Details of how to access the adapted therapy will be provided to them at the end of the study.

If they agree, we would also like to audiotape the therapy sessions for the purposes of supervision and part of the study design to measure therapist competence and adherence to the manual. If they do not agree to audio taping, they will still be able to participate in the study. The recordings will be kept in a locked cabinet in the Therapy Department, Park Royal Secure Services.

No adverse effects of taking part in this study are anticipated. If the researcher (who is a trained practitioner) notices deterioration in the mental status of the any of the participants during the study they will inform you or your clinical team in the unlikely event that participants become unduly distressed.

If you or they should have any complaints about this study, these will be documented by the researcher and passed on to the Complaints Officer, of the CNWL trust. Details are available on the trust website. Complaints can also be made directly.

The results of the research will be submitted for publication to scientific peer-reviewed journals and may be presented at conferences when the study is finished in the next two years. A copy of the published results will be available at that time from Gurmit Dhillon. Any personal information about you or the participants will not be disclosed in any report/publication.

This is part of the Doctoral study at the University of Southampton.

If you would like more information now or in the future, please contact by email or phone jattmc@nhs.net ; 02089554506

Yours sincerely,

Gurmit Dhillon and Professor David Kingdon

Appendix 10

Central and North West London NHS
NHS Foundation Trust

UNIVERSITY OF Southampton
School of Medicine

CNWL NHS Foundation Trust
Offender Care Service Line

Park Royal Secure Services
Acton Lane off Central Way
London
NW10 7NS

Tel: 02089554506
Fax: 02088381405

www.cnwl.nhs.uk

PATIENT INFORMATION SHEET 18th October 2012

1. **Study Title:** ***Feasibility study of Cognitive Behaviour Therapy for Psychosis – secure service manual with service users in secure services: A pilot study and cost effectiveness analysis***

RESEARCHERS: Gurmit Dhillon and Professor David Kingdon
ETHICS NUMBER:
VERSION: 2

2. **Invitation paragraph**

You are being asked if you would agree to take part in a research study which is entirely separate from the treatment you are currently receiving. Before you decide about this, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

3. **What is the purpose of the study?**

Our research group has recently adapted an established talking therapy - Cognitive Behaviour Therapy (CBT) for psychosis so that it is sensitive to patients who resides in secure services by exploration and incorporation of service users' and health professionals' views and opinions. The purpose of this study is to test this modified therapy.

4. **Why have I been chosen?**

We have asked your consultant if we can approach you to ask you to take part and they have given consent to this. At some stage you have been given a diagnosis of psychosis and currently residing in secure services. We are now asking you if you agree to participate in this pilot study.

5. Do I have to agree?

It is up to you to decide whether or not you take part. If you do decide to, you will be given this information sheet to keep and be asked to sign a consent form. You are still free to withdraw that consent at any time and without giving a reason. If you do so, you will be asked if you consent to the information that you have already supplied being included in the study or not. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

6. What will happen to me if I take part?

A member of staff who is independent of this study will meet you to ask about your problems and experiences using measures to assess progress over the study period. This will be done before and after you received the therapy. You will continue with your usual treatment and in addition, you may also be offered the modified talking therapy.

If you are allocated to the modified talking treatment you will be offered up to 20 sessions by a trained therapist over a six months period. The therapist will meet you individually on a regular basis for therapy. Therapy sessions will last up to 45 minutes but you will be free to leave at any point. Whether you are offered therapy at this stage is determined by chance (random allocation).

If you are not offered the therapy, you will continue with your usual treatment. Details of how to access the adapted therapy will be provided at the end of the study.

If you agree, we would also like to audiotape the therapy sessions for the purposes of supervision and part of the study requirement to see if the therapist adhered to the manual. If you do not agree to audio taping, you can still participate in the study. The recordings will be kept in a locked cabinet in the Therapy Department, Park Royal Secure Services. The audiotapes will be destroyed once transcribed or at the end of the period specified by the Research Ethics Committee.
At the end of all therapy sessions, an independent staff will ask a set of questions looking at your views of this therapy. This is to ascertain if this therapy has worked or if not how can it be further improved.

7. What do you have to do?

If allocated to the therapy, you will work together with your therapist to understand and develop ways to address your difficulties and reduce levels of distress. Both you and the therapist will play an active role in therapy and you will be asked to practice some of the strategies learned in therapy outside of therapy. This would not affect your usual care in any way.

8. What are the possible disadvantages and risks of taking part?

If you should get distressed, tell the person interviewing you who has instructions on how best to reduce this. They will make sure that your, clinical team/ Consultant Psychiatrist is made aware of this.

9. **What are the possible benefits of taking part?**

The information we get from this study may help you to acknowledge and overcome your problems and help us to treat future patients who find that CBT for psychosis is currently not sensitive enough to their needs.

10. **What if something goes wrong?**

If you should have any complaints about this study, these will be documented by the researcher and passed to the Complaints Officer, CNWL trust; complaints.cnwl@nhs.net or call them at 02032145784.

11. **Will my taking part in this study be kept confidential?**

All information which is collected about you during the course of the research will be kept strictly confidential. Any information about you will have your name and address removed so that you cannot be recognised from it. Data will be destroyed once interviews are transcribed.

12. **What will happen to the results of the research study?**

The results of the research will be submitted for publication to scientific journals and may be presented at conferences when the study is finished within the next year. A copy of the published results will be available at that time from Gurmit Dhillon. You will not be identified in any report/publication.

13. **Who is organising and funding the research?**

This is part of the postgraduate study research with the University of Southampton

14. **Who has reviewed the study?**

Research Ethics Committee will review this study.

15. **Contact for Further Information**

If you would like more information now or in the future, please contact Gurmit Dhillon (02089554516)

*You may obtain independent information or advice about your rights as a research participant or about being involved in this particular research study, by contacting The **Patient Advice and Liaison Service (PALS)** on:*
Telephone: 0203214 5773
Fax: 0203 214 5892 **Email:** pals.cnwl@nhs.net

Thank you for your help: you will be given a copy of the information sheet and a signed consent form to keep.

Appendix 11

Central and North West London NHS
NHS Foundation Trust

UNIVERSITY OF Southampton
School of Medicine

CNWL NHS Foundation Trust
Offender Care Service Line

Park Royal Secure Services
Acton Lane off Central Way
London
NW10 7NS

Tel: 02089554506
Fax: 02088381405

www.cnwl.nhs.uk

PATIENT CONSENT FORM

1. **Study Title:** ***Feasibility study of Cognitive Behaviour Therapy for Psychosis – secure service manual with service users in secure services: A pilot study and cost effectiveness analysis***

RESEARCHERS: Gurmit Dhillon and Professor David Kingdon
ETHICS NUMBER:
VERSION: 1

Please initial box:

(1) I confirm that I have read and understand the information sheet - dated / / 2012 - for the above study and have had the opportunity to ask questions. ☐

(2) I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason, and without my medical care or rights being affected. ☐

(3) I agree to take part in the above study. ☐

(4) I agree to audio taping of the interview for the purposes of this research project. I understand that sections of any of my medical notes may be looked at by the researchers or responsible individuals from regulatory authorities where it is relevant to my taking part in the research. I give my permission for these individuals to have access to my records ☐

_____	_____	_____
Name of Patient	***Date***	***Signature***
_____	_____	_____
Researcher	***Date***	***Signature***

P.I.N. for this trial: _____ 1 for patient, 1 for researcher, 1 to be kept with hospital notes

Appendix 12

CBTp manual adherence guidance. This list is divided into three parts, assessment, formulation treatment and relapse prevention. Please complete (circle the appropriate answer) based on the questions in this session.

Therapist Name: **Date:**

Patient Code: **Session no:** **Time:**

Assessments

1. Setting the structure of the session: To what extent did the therapist try to set the agenda with input from the patient? Appeared to be implicitly set via workbook

1	*2*	*3*	*4*	*5*	*6*	*7*
not at all		*a little*	*somewhat*	*considerably*		*extensively*

2. To what extent did the therapist attempt to explore the patient's views of his/her problems (at their pace, flexible) using appropriate questioning style and psychometrics.e.g. socratic, direct and open style e.g. what, where, why when and how? Reviewed understanding at the start of the session and linked to previous session

1	*2*	*3*	*4*	*5*	*6*	*7*
not at all		*a little*	*somewhat*	*considerably*		*extensively*

3. To what extent did the therapist discuss any high-risk situations the patient encountered since admission? E.g. offence related behaviour.

1	*2*	*3*	*4*	*5*	*6*	*7*
no discussion		*a little discussion*	*some discussion*	*considerable discussion*		*extensive discussion*

4. To what extent did the therapist develop a problem list/goal setting based on a shared understanding?

1	*2*	*3*	*4*	*5*	*6*	*7*
not at all		*a little*	*somewhat*	*considerably*		*extensively*

5. To what level did the therapist respond empathically to the patient (e.g., through a non-judgmental approach, showing genuine warmth and concern, working with the patients abilities and culture)? Lots of good examples through-out the session

1	*2*	*3*	*4*	*5*	*6*	*7*
not at all		*a little*	*somewhat*	*considerably*		*extensively*

6. To what extent did the therapist refer to material discussed or experiences of past sessions (contents) as a means of building continuity across sessions (e.g., by exploring what worked in the past – coping strategies, others attitudes)? Again reviewed understanding from previous session and asked client what they remembered as summary used workbook as aid

1	*2*	*3*	*4*	*5*	*6*	*7*
not at all		*a little*	*somewhat*	*considerably*		*extensively*

Formulation and Treatment

7. To what extent did the therapist attempt to explore whether the patient had a good understanding of his/her problems e.g. using psychoeducation and normalizing approach. Use of stress vulnerability model

1	*2*	*3*	*4*	*5*	*6*	*7*
not at all		*a little*	*somewhat*	*considerably*		*extensively*

8. To what extent did the therapist attempt to explore and discuss the patient's problems using general and specific CBTp/forensic formulations on a shared understanding e.g. Using culturally specific and HCR-20 formulations. N/A

1	*2*	*3*	*4*	*5*	*6*	*7*
not at all		*a little*	*somewhat*	*considerable*		*extensively*

9. To what extent did the therapist use the clinical care pathway to show them their current stage in the system and how to move to the next stage (institutional goals) using motivational approaches?

1	*2*	*3*	*4*	*5*	*6*	*7*
not at all		*a little*	*somewhat*	*considerable*		*extensively*

10. To what extent did the therapist use other specific formulations (physical and psychiatric) when working with co morbid problems e.g. Anger, PTSD, anxiety, depression and the role of diabetes and hypertension in mental health? Used discussion around drugs and alcohol

1	*2*	*3*	*4*	*5*	*6*	*7*
not at all		*a little*	*somewhat*	*considerable*		*extensively*

11. To what extent did the therapist review or reformulate patients current problems and goals for treatment, if the therapy is not going as planned? Worked well with client to discuss difficult subjects

1	*2*	*3*	*4*	*5*	*6*	*7*
not at all		*a little*	*somewhat*	*considerable*		*extensively*

12. To what extent did the therapist attempt to explore model and discuss specific skills with a shared understanding (e.g. coping with voices and stress, problem solving skills, evidence for and against and normalizing)? Stress model and normalising

1	*2*	*3*	*4*	*5*	*6*	*7*
not at all		*a little*	*somewhat*	*considerable*		*extensively*

13. To what extent did the therapist use a specific/integrated care plan for the patient e.g. involving and informing other MDT staff? Referred to care-plan and team

1	*2*	*3*	*4*	*5*	*6*	*7*
not at all		*a little*	*somewhat*	*considerable*		*extensively*

14. To what extent did you the therapist use behavioural experiments as mode of working with overwhelming beliefs and perceptions?

1	*2*	*3*	*4*	*5*	*6*	*7*
not at all		*a little*	*somewhat*	*considerable*		*extensively*

15. To what extent did the therapist use homework/assignments for the patient as a mean to engage in between the sessions? Continued to use workbook as foundation for therapy

1	*2*	*3*	*4*	*5*	*6*	*7*

not at all *a little* *somewhat* *considerable* *extensively*

16. To what extent did the therapist evaluate the patient's reactions to the homework, explore or address any difficulties encountered in carrying out the assignment and/or provide a rationale for homework and/or reinforce the importance of practical skills in homework e.g. breathing skills, mindfulness.

1 *2* *3* *4* *5* *6* *7*
not at all *a little* *somewhat* *considerably* *extensively*

Relapse – How to stay well

17. To what extent did the therapist discuss relapse prevention strategies in mental health and offending behaviour (high risk situations) and how to manage them effectively in the future? Stress vulnerability model will provide basis for further work

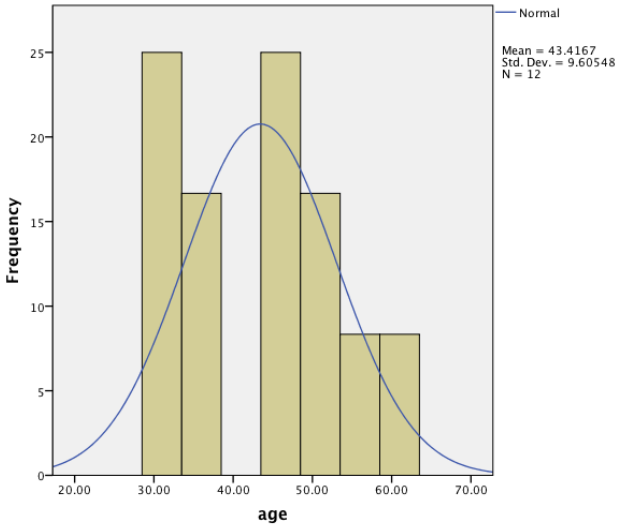
1 *2* *3* *4* *5* *6* *7*
not at all *a little* *somewhat* *considerably* *extensively*

18. To what extent did the therapist discuss the termination of the therapy (e.g., encourage the patient to discuss feelings or thoughts about termination, discuss plans for further treatment e.g. handover of the blueprint of therapy work.

1 *2* *3* *4* *5* *6* *7*
not at all *a little* *somewhat* *considerably* *extensively*

General comments

Appendix 13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70.00
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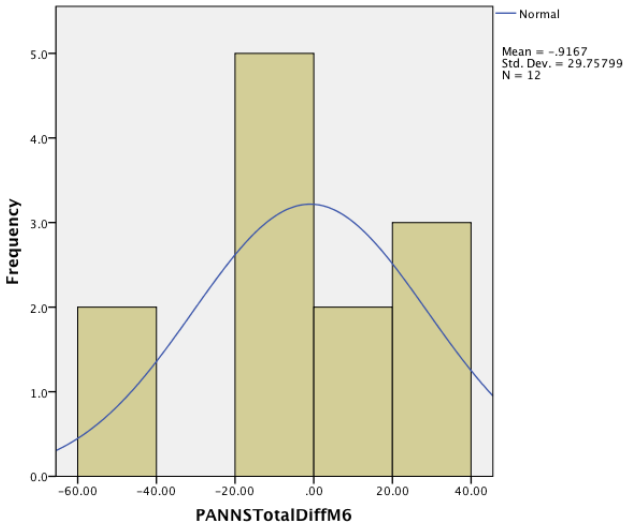
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40.00
PANNSTotalDiffM6

Appendix 14

Post therapy Interview Guide – Patients (face to face individual interviews) after completing the CBTp- ss

VERSION: 1

18/10/12

Thank you for agreeing to meet with me

I am aware that you have recently completed CBT for psychosis therapy on a one to one basis. Part of the study (as mentioned in your information leaflet) involves finding out about your views on the therapy. I would like to go over what is going to happen today. I will ask you questions to get views on what you think is supportive and non supportive of the therapy.

You do not have to take part if you don't feel like and you may ask to stop at any time.

Explain the study – including taping the interview and the reasons why this is being done.

Ask if everything is understood. Has the participant any questions?

Begin the interview

Could you briefly describe how do you feel about being in secure services?

Prompts;

Did anyone suggest any other ways of helping you with this problem? (Who and what?)

Which explanations made you feel better?

Did you feel that the therapist/doctor understood your account of your problems? (If no... explore further)

How do you now view things?

Throughout the interview use the phrases such as:

That is very interesting can you tell me more about that?

Really and how does that make you feel?

Going back to the point about … what do you think might make it better for you?

More specific questions

How do you feel about attending therapy sessions?

How many sessions did you have?

Can you tell me how you feel about this therapy?

Did you find it difficult to speak to the person who treated you?

How did you find the therapist?

Do you think the therapist helped you in understanding your problems?

If yes …. Can you explain how?

Is there anything specific that you found useful in the therapy?

What was most helpful within the therapy?

What did you think about the homework/diaries given by the therapist?

What did you think about the behavioral test/ experiment if any?

Prompts

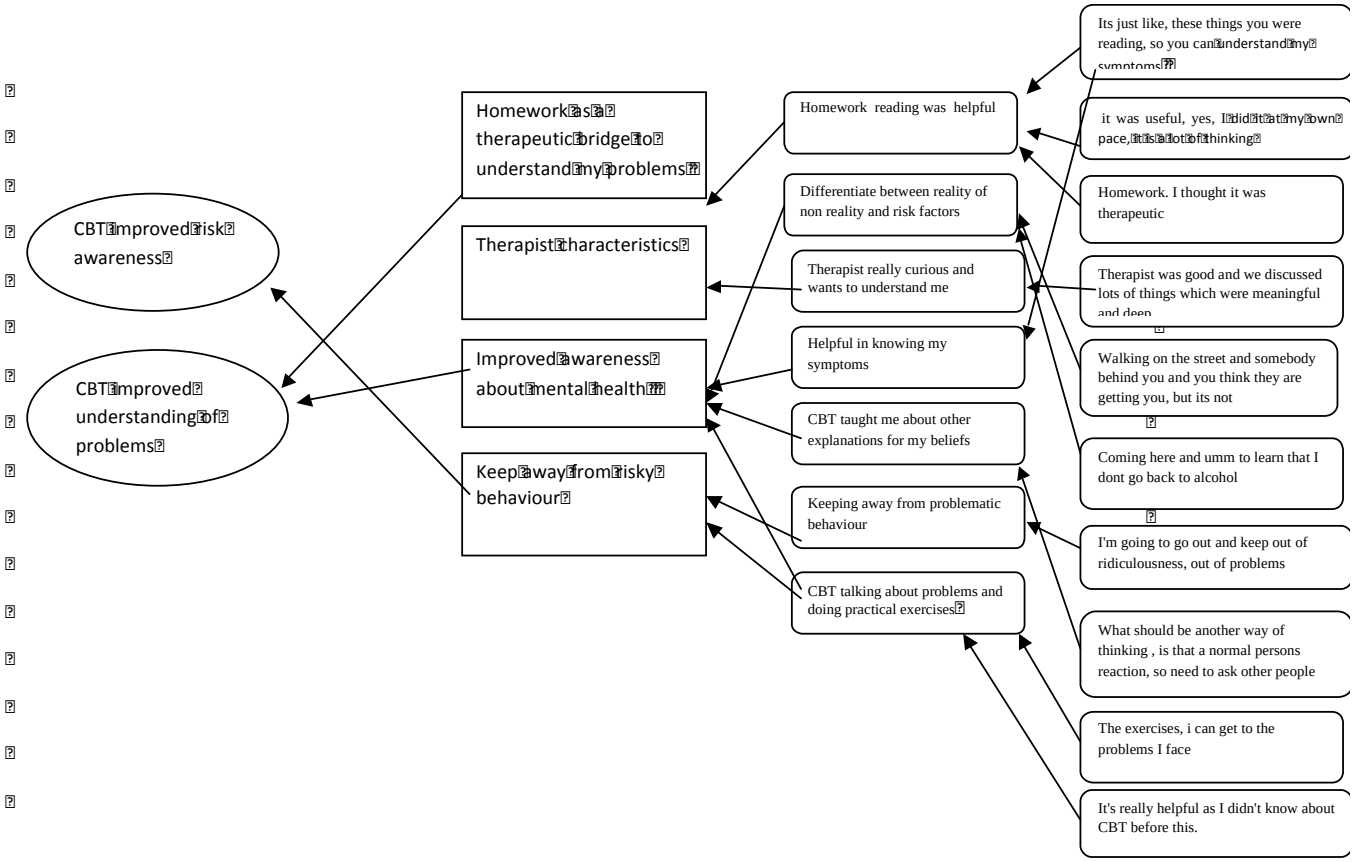
What do you find particularly useful/ not useful?

Can you tell me what have you found particularly useful.

Can you tell me what kind of person you would prefer when choosing a therapist?

Appendix 15

Process	No.	Criteria
Transcription	1	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'.
Coding	2	Each data item has been given equal attention in the coding process.
	3	Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive.
	4	All relevant extracts for all each theme have been collated.
	5	Themes have been checked against each other and back to the original data set.
	6	Themes are internally coherent, consistent, and distinctive.
Analysis	7	Data have been analysed – interpreted, made sense of - rather than just paraphrased or described.
	8	Analysis and data match each other – the extracts illustrate the analytic claims.
	9	Analysis tells a convincing and well-organised story about the data and topic.
	10	A good balance between analytic narrative and illustrative extracts is provided.
Overall	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.
Written report	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated.
	13	There is a good fit between what you claim you do, and what you show you have done – i.e., described method and reported analysis are consistent.
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis.
	15	The researcher is positioned as *active* in the research process; themes do not just 'emerge'.



Simplification of initial mind mapping/coding