Faculty of Environmental and Life Sciences

School of Psychology

Experiences of secure patients within forensic settings.

by

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Thesis for the degree of Doctor of Clinical Psychology

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Abstract

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This thesis looks to explore the experience of forensic secure care, from the patients' perspective. The first chapter is a systematic review of the qualitative literature, covering high, medium and low secure settings, worldwide. The analysis was guided by thematic synthesis and generated a total of eight themes; from this, three different and separate experiences of forensic secure care were interpreted, with a further five themes which influence the experience. This new understanding of patient experience can lead to service improvements and staff training. The second chapter presents an empirical paper exploring six forensic secure patients' experience of the Corona virus disease 2019 (COVID-19) whilst detained in a secure setting through the pandemic. Semi structured interviews were analysed using Interpretive Phenomenological analysis (IPA). The themes generated, provided insight into the experience '*treading water'*, how the patients managed through the experience '*learning to swim'*, and what was helpful during this time '*in the same boat'*. Findings are particularly timely in terms of how we may be able to better support forensic secure patients through this uncertain time.

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Research Thesis: Declaration of Authorship

Print name: Karen Humphries

Title of thesis: Experiences of secure patients' in forensic settings.

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

I confirm that:

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2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. None of this work has been published before submission.

Signature: ..... Date: .....

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Chapter 1 Patients' experiences of forensic mental health inpatient care: a systematic review and thematic synthesis of qualitative literature.

This paper has been prepared in the format required by the 'Journal of Forensic Psychology Research and Practice'

1.1 Abstract

Purpose: The purpose of this paper is to develop an understanding of the experience of secure care, from the patients' perspective. **Design/methodology/approach:** A systematic review of qualitative literature was conducted. The data was sourced from the electronic databases: PsychINFO, CINAHL, Medline and the Web of Science Core Collection, using pre-defined search terms. A total of 17 studies, conducted in various countries worldwide and covering high, medium and low secure inpatient settings, were included for review. The analysis involved integrating findings from across the literature and was guided by thematic synthesis. **Findings:** A total of eight themes were generated from the data; three of which provided an understanding of the experience of forensic secure care (*'feeling stuck', 'playing the game',* and '*positivity & hope'*); the remaining five themes provided an understanding of the factors which may influence the experience of secure care (*'having a voice', 'social connections', 'my own safe space', 'meaningful activity', and 'relationships with staff'*). **Implications:** Developing understanding of patients' experience can lead to service improvements, potentially impacting on patients' motivation, engagement and thus reducing admission times, potential recalls and recidivism. **Originality/value:** To date, this is the first

systematic review to exclusively explore the broad topic of the patients' experience of secure mental health care.

1.2 Introduction

Since the 1950s there have been dramatic changes in the way that patients with mental health needs are cared for (Novella, 2010). The main change being a move away from institutional care, towards increasing the therapeutic approaches provided in the community (Freeman, Fryers, & Henderson, 1985). Despite this change, inpatient care remains a necessity for some individuals with mental health needs due to the level of risk posed to themselves or to others (NHS England, 2018a).

One population who continue to require inpatient care are patients in forensic secure hospitals. These are individuals diagnosed with severe and enduring mental health difficulties or personality disorder. The majority of secure patients will have entered the criminal justice system due to their offending behaviour and be detained under forensic sections. A smaller group of secure patients are detained under civil sections and deemed suitable for this level of security due to challenging behaviour (Galappathie, Khan, & Hussain, 2017). There are international variations in the legal frameworks which govern how and where forensic secure patients receive treatment (Jansman-Hart, Seto, Crocker, Nicholls, & Côté, 2011). Whilst some countries do not provide specific forensic mental health provision (Nedopil, 2009) for those that do, there are shared characteristics across settings. Ultimately, forensic secure services bridge the gap between general psychiatry and prison settings; providing a hospital environment designed to meet the mental health needs of the patient, whilst ensuring the appropriate level of security (Robertson, Barnao, & Ward, 2011).

In the UK, forensic secure hospitals are organised into three different levels of security: high, medium and low. High secure provides the most stringent measures for those patients deemed to 'pose grave and immediate danger to the public'(Rutherford & Duggan, 2008). The lower levels provide a route for progression through services with a stepped reduction in security. Running in parallel to these, are Women's enhanced medium secure services[1] (Edge et al., 2017).

Rutherford and Duggan (2008) reported a year-on-year increase in the amount of people requiring secure care, totalling a 45% increase over a ten year period from 1996 to 2006 (Rutherford & Duggan, 2008). In 2018, there were approximately 7700 forensic secure beds provided by the NHS (NHS England, 2018c), with further provision offered by the private sector. The annual cost of forensic secure provision to the NHS in England has been recorded to reach £1.2 billion per annum (G. Durcan, Hoare, T. & Cumming, I., 2011). The increase in the number of people requiring this provision is mirrored in other countries worldwide (Seppänen, Törmänen, Shaw, & Kennedy, 2018).

The aim of these services is to improve mental health and minimise the risk of recidivism, to ensure the successful reintegration of patients back into society. However, transition through secure services is often a lengthy process and delays are common (Rutherford & Duggan, 2008). Some of the barriers to patients moving on are reported to be: the patients'

[1] Women's enhanced medium secure services (WEMSS) is a model of care aimed at providing a more appropriate level of security for women and, in so doing, reducing the number of women in high secure psychiatric services. In 2007, three Department of Health commissioned WEMSS pilots became operational in the UK.

lack of awareness of their offence, difficulty relating to others and non-responsiveness to medication (Maden, Curle, Meux, Burrow, & Gunn, 1993). There are further systemic barriers, including; high occupancy of beds causing a lack of availability, limited appropriate community placements, and limited specialist forensic community provision (G. Durcan, Hoare, T. & Cumming, I., 2011).

When patients experience a prolonged time segregated from society, in a restricted, routinized environment, they can experience institutionalisation. This is when patients become socially isolated and lose their independence, becoming reliant on how the institution operates and unable to function without it. Institutionalisation has been linked to poorer satisfaction and quality of life (Chow & Priebe, 2013) and is in direct contrast with the principles of recovery in mental health (Roberts & Boardman, 2013). Recovery involves fostering patient-centred care through collaborative working and building autonomy, agency and empowerment (Bonney & Stickley, 2008). Secure services operate within two conflicting demands: creating an environment conducive to the principles of recovery whilst upholding the rules and restrictions required to minimise risk and create an environment of safety (Livingston, Nijdam-Jones, & Brink, 2012; Pouncey & Lukens, 2010). In order to understand how secure services are managing this balance, it is important for us to understand the experience of being detained in forensic secure services from the patients who reside there.

Patients hold the unique perspective of being experts about their mental health, their need for care and the services they have experienced (Tait & Lester, 2005). In recent years, patient involvement has become central to research and the development of policy (Telford &

Faulkner, 2004), the planning and delivery of health services (Spiers, Harney, & Chilvers, 2005) and is believed to improve outcomes (Faulkner & Morris, 2003).

Qualitative studies are ideal for understanding patients' perspectives and have been used to explore the lived experience of forensic secure patients. Previous systematic reviews within secure care have focussed on exploring specific experiences, such as the social climate, restrictiveness and environmental factors. Broader systematic reviews of the general experience of involuntary detention have been conducted in general psychiatric settings (Wood, 2006) but have actively excluded the forensic secure population (Katsakou & Priebe, 2007; Seed, Fox, & Berry, 2016).

Akther et al. (2019) was the first systematic review to date to explore the general experience of detention across mental health services and to include the forensic population. This review identified 56 qualitative papers, 15 of which reported on forensic settings. Although the broad scale of the review may have lost some of the nuance detailing the forensic patients' experience, it did, however, provide a step towards inclusivity for the forensic population and reported several factors influencing patient experience of detention. Factors included: the level in which the patient felt involved in their own care; the information shared with them; the quality of the environment including aspects of safety and meaningful activity; the quality of the relationships with staff, as well as the impact on feelings of self-worth and emotional state (Akther et al., 2019).

Whilst the Akther et al. (2019) review provides important insights into the broad experience of detention across many inpatient mental health services (general psychiatry, specialist

eating disorder service, forensic etc), there is a gap in the literature for solely focussing on the exploration of patient experience within secure services. This is an important area of research, as there are characteristics that are unique to the forensic population which may provide a very different experience to patients being detained in alternative mental health services.

Firstly, in secure services the criminal sections of the Mental Health Act are imposed with no time limit. The average length of detention for a forensic secure patient is five years or less, however, more than a quarter will be detained for over ten years (Rutherford & Duggan, 2008). This is a stark difference from general psychiatry, where the length of stay aims to be a maximum of thirty-two days (NHS England, 2019).

Secondly, many forensic patients will face additional legal restrictions placed on them considering their offending, to maintain public safety. Restrictions can include: exclusion zones which patients are forbidden to enter; and community treatment orders, outlining sanctions that will warrant a readmission. These restrictions limit the patient's autonomy and liberty, perpetuating stigma, hopelessness and powerlessness (Corlett & Miles, 2010) which is counterintuitive to recovery. Unlike general psychiatric patients, the treatment and rehabilitation of forensic patients can involve input from the Ministry of Justice and the victim; who may hold different views regarding the importance of patient empowerment and choice in mental health recovery (Mezey & Eastman, 2009).

Thirdly, the index offence itself can create the biggest obstacle for patients to move forwards. Offending behaviour can compound feelings of shame, guilt and stigma. Whilst some will

experience bereavement and breakdowns in significant relationships (Corlett & Miles, 2010), most will experience social consequences occurring as a result of their offence (Drennan & Wooldridge, 2014). Ultimately forensic patients are recovering from mental health in parallel with recovering from the historical offence.

A review of the experience of forensic secure care, from the patient's perspective, has the potential to guide service improvement in the future, not only by highlighting potential positive aspects within this unique environment, that can be built upon and expanded, but also, by revealing areas of potential unmet need, where change may be necessary.

To date, reviews focussing on the general experience of detention have either excluded the forensic secure population, or combined them with general psychiatry and populations with different characteristics. The forensic population is unique considering the sections, restrictions, and the impact this has on the individual. Thus far, there has not been a review that has focussed solely on forensic secure patient's experience of inpatient care. Therefore, the aim of this paper is to conduct a systematic review and thematic synthesis of the qualitative literature exploring patients' perspectives on their experience of inpatient, forensic secure care, to answer the following questions:

Q1: What is the reported experience of being a patient, detained in secure care?

Q2: What influences the experience?

1.3 Method

1.3.1 Protocol

Details of the protocol for this systematic review were registered on PROSPERO (CRD42020219610, https://www.crd.york.ac.uk/prospero/) following a brief scoping search of the available literature using Google Scholar, in October 2020.

1.3.2 Search Strategy

A comprehensive search of the literature was conducted in November 2020 aiming to identify all relevant evidence for review. The electronic bibliographic databases: PsychINFO, CINAHL, Medline and the Web of Science Core Collection were searched from inception to the present day. The search strategy comprised of both free text, assimilating synonyms of 'forensic', 'mental health', 'inpatient' and 'experience' and the associated mesh terms, adapted to suit the requirements of the specific database. A full list of search syntax is available in Appendix 1.

Additionally, suitable papers meeting the inclusion criteria were hand searched for further relevant citations. Akther et al. (2019) is to date, the only systematic review to include forensic patients' experiences of being detained in their broad study of detention under the Mental Health Act. This review identified fifteen forensic papers and was therefore also hand searched for these and other relevant citations.

1.3.3 Study selection

The sample of studies selected for review were subject to an extensive inclusion/exclusion criteria developed using the framework PICoS (***P****opulation, phenomena of* ***I****nterest,* ***Co****ntext,* ***S****tudy design*) designed for guiding qualitative reviews (Stern, Jordan, & McArthur, 2014). There were no limitations set for the year of study, or geographical location.

Table 1.1 Inclusion/exclusion criteria outlined using PICoS framework (Population, phenomena of Interest, Context, Study design)

	Inclusion	**Exclusion**
P	Adult (aged 18+) forensic mental health inpatients. Detained (at the time of research) under the Mental Health Act in a secure/forensic setting.	Patients <18 years old Patients with an Intellectual Disability and/or Autism Spectrum condition. Staff views/accounts Family members/carers views/accounts Service provider views/accounts Experts by experience/peer mentors views/accounts. A mixed population where a percentage of participants meet inclusion criteria.
I	Expressed views/perspectives of the experience of being in secure care.	Views/perspectives of phenomena not related to the experience of being in secure care (such as views of illness, diagnosis, offense, self-harming behaviour, religion, specific interventions). Views/perspectives of transitioning to/from secure care.
Co	Forensic, inpatient, mental health settings/care.	Psychiatric hospitals not classed as forensic/secure. Community settings/forensic services. Prisons/correctional facilities. A mixed context where a percentage of the data is collected from a context meeting inclusion criteria.
S	Primary research studies, published as full-text paper in a peer-reviewed journal.	Quantitative studies using measures to understand experience. Mixed method studies. Non-English language papers.

Qualitative data – interview/focus group. Studies written in English language.	Commentaries, letters, editorials, short communications, professional magazines and unpublished data. Qualitative data collected through surveys and records.

A total of 3,164 articles were identified through searching electronic databases with a further 28 new articles identified through hand searching relevant article reference lists. This was a large number of identified articles, however, this was deemed necessary, given the broad topic of overall experience. The reference management software Rayyan (Ouzzani, Hammady, Fedorowicz, & Elmagarmid, 2016) was used to collate all articles and 1,294 duplicates were removed. The titles and abstracts of the remaining 1,898 articles were scanned for relevance by two independent, blind reviewers (authors KH & JS). Cohen's k was run to determine the inter-rater reliability between the two reviewer's decisions to include and exclude papers. There was a good agreement found, k = .646, p = <.001. The conflicting decisions were discussed between KH and JS which led to a mutual consensus, resulting in 1,835 articles being excluded.

The full-text of the remaining 63 papers were screened against the inclusion/exclusion criteria by the same two blind reviewers (KH & JS) and the reasons for exclusion recorded and discussed. Cohen's k was run to determine the inter-rater reliability, which was found to be very good, k = .886, p = <.001. Discrepancies were assessed by a third person (author

KW)[2] for clarification. A total of 17 articles were included in the systematic review. The process of study selection is illustrated in Figure 1.1 PRISMA flow diagram.

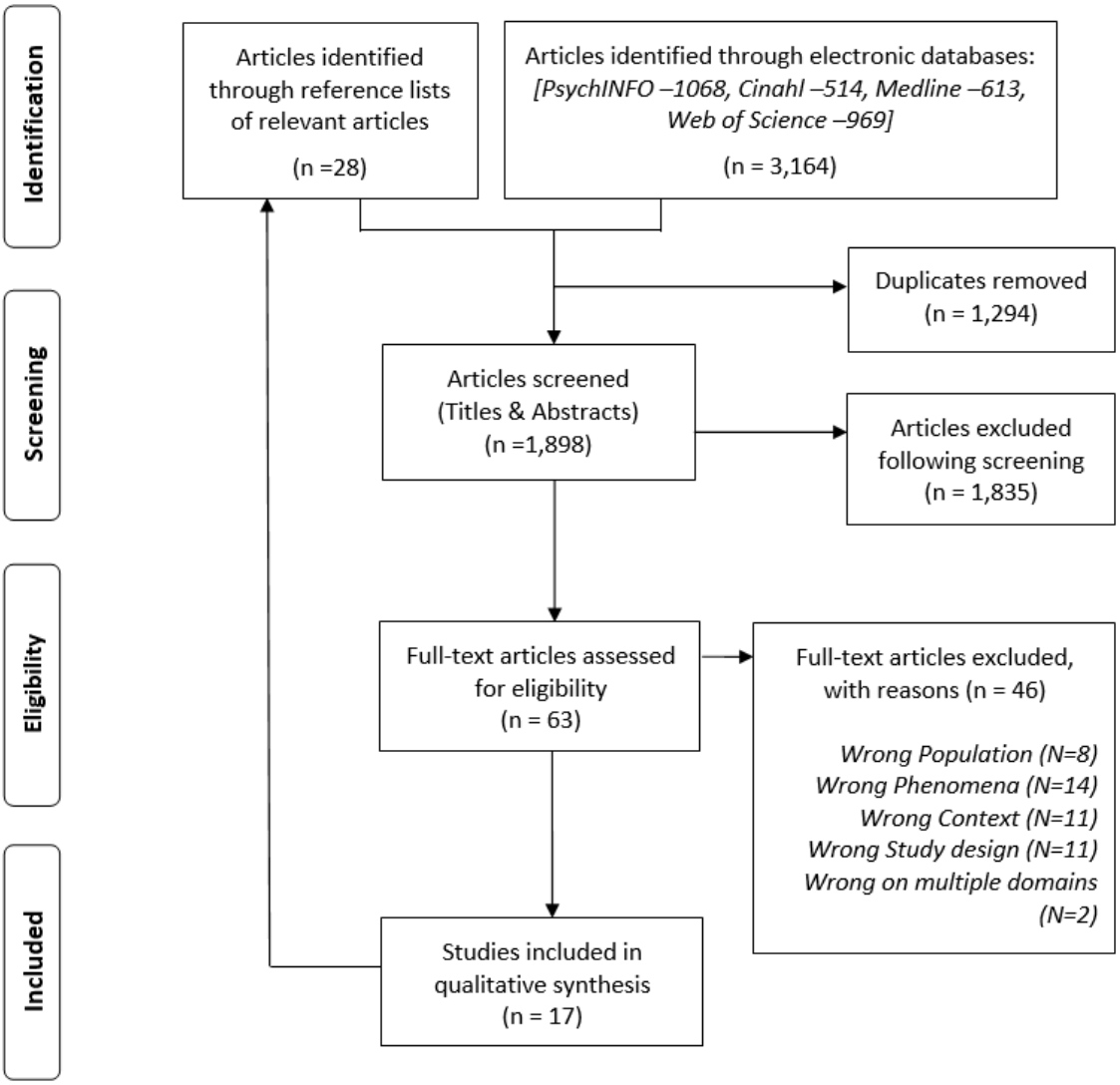


Figure 1.1 PRISMA flow diagram

1.3.4 Quality Appraisal

The Critical Appraisal Skills Programme (CASP) checklist for qualitative research was used as a tool to appraise the quality of each study included in the review (Critical Appraisal Skills

[2] Excluded based on phenomena of interest and context.

Programme UK, n.d.). This tool is widely used and recognised for being succinct yet effectively covering domains important within qualitative research (Nadelson & Nadelson, 2014). Assessors are guided to consider the presence or absence of quality markers such as: sufficiently rigorous analysis, clear statement of findings, rather than provide a numerical score of quality (Appendix B). Each of the 17 studies appraised at this stage were included in the review, regardless of quality, due to the lack of empirically tested methods to guide the exclusion of studies based on quality (Thomas & Harden, 2008).

The first reviewer, KH, assessed each of the 17 papers. The forth reviewer, JS assessed a random sample of seven papers, independent of the first review. Reviews were matched to ensure accuracy of the appraisal process and both reviewers agreed on the following:

Generally, the quality of the seventeen papers was very good. There were two domains however, found to be lacking in quality (Appendix B). The first was the researcher's consideration of their relationship to the participant and the clinical implications of this. Eight of the seventeen studies failed to acknowledge whether the researcher was known to the participant and a further two studies acknowledged the relationship, but failed to consider the implications of this. Gillard et al. (2012) found that the role of the researcher could influence qualitative findings and therefore omitting this in qualitative research is counterproductive for secondary analysis.

The second domain lacking in quality was the study recruitment strategy. Four of the studies reported a purposive method, but the remaining thirteen studies resorted to describing (in varying detail) their process of recruiting participants to the study. This generally appeared

to be patients identified by the Responsible Clinician as appropriate and those available at the time of recruitment. This may be reflective of a typically difficult to reach population but could also be indicative of bias within the sample.

1.3.5 Theoretical standpoint

The process of synthesising qualitative data can be either aggregative or interpretive. Thematic synthesis is positioned between these polar approaches and is ultimately led by the richness of the qualitative data available for synthesis (Boland, Cherry, & Dickson, 2017). Whilst an aggregative synthesis collates the data, an interpretive synthesis goes beyond the original studies, moving from the descriptive themes to analytical themes and allowing the creation of new meaning. (Thomas & Harden, 2008).

Each of the four reviewers approached this project with a psychological background and an interest in psychological processes and subjective meaning. Reviewers KH and CC both have clinical experience working in secure care in the UK and have an interest for advancing best practise through building understanding of patients' perspectives.

1.3.6 Data synthesis

The data synthesis was guided by the 3-stage method of thematic synthesis for qualitative research outlined by Thomas and Harden (2008)[3] and was conducted by the first author, KH. The initial stage of analysis was performed using the software package NVIVO (QSR

[3] Stage 1 - Free line-by-line coding of the findings of primary studies
Stage 2 - Organisation of these 'free codes' into related areas to construct 'descriptive' themes
Stage 3 - Development of 'analytical' themes

International Pty Ltd, 2018) which allowed for easy reading and labelling of codes. The data used in this analysis was drawn from all of the text within the 'results' or 'findings' sections of the final 17 papers. This included direct quotes, themes and authors' interpretations of their data. These sections were read and re-read by the author several times until fully immersed in the data (Willig, 2001).

Data which was deemed to reflect patient experience of forensic secure care was then coded line-by-line according to the meaning and content. This process identified a total of 92 codes. Codes were then organised and grouped into descriptive themes using post it notes and large wall space, allowing time to reflect on the themes and return to the data in an iterative process. A code book was then compiled of descriptive themes with the direct quotes feeding into each theme. This was shared with author CC and a discussion took place about the clusters of descriptive themes. This process aided the consolidation and interpretation to generate the final analytical themes (Thomas & Harden, 2008).

1.4 Findings

1.4.1 Overview of included studies

A total of 17 papers were included for review; study characteristics are summarised in Table 1.2. The majority of these studies were conducted in the United Kingdom (*N=9*) or Sweden (*N=4*), and a single study each was identified from Australia, China, New Zealand and Switzerland. Studies recruited participants from high secure (*N=3*); medium secure (*N=6*); women's enhanced medium secure (*N=1*); a range of security levels (*N=4*); or did not specify a security level (*N=3*). Study samples ranged from 2 to 27 participants (*Mdn =11*).

Participants' gender was found to be commonly reported across most studies (11 included both male & female; 4 included male only; 1 included female only; 1 did not report gender). Further reported demographics across the studies included participants' age (*N=13*) which ranged from 18 to 75 years; diagnosis (*N=11*) and length of time in hospital (*N=10*), with few reporting on participants ethnicity (*N=4*).

The most frequently used method of data collection was semi-structured interview (*N=12*), other reported methods included focus group (*N=2*); interview without specifying type (*N=2*); and photovoice (*N=1*). There was a range of reported data analysis methods, including: Thematic Analysis (*N=6*); Content Analysis (*N=5*); Interpretive Phenomenological Analysis (*N=2*); Thematic Decomposition Analysis (*N=1*); Thematic Network Analysis (*N=1*); Constant Comparative Analysis (*N=1*); and Reflective Lifeworld Approach (*N=1*).

Table 1.2 Summary of papers included in the analysis

Authors & date	Country of research	Participants included	Reported demographics	Method & Analysis
Askew et al. 2019	UK	7 patients recruited across 3 wards of a forensic medium secure unit	M/F 7/0	Semi structured interview, Interpretive Phenomenological Analysis
Barnao et al. 2015	New Zealand	20 patients recruited from a forensic inpatient service, comprising of 2 medium secure wards and a 'step down' rehabilitation ward with 'cottages' providing less security.	M/F: 17/3 Age: 27y – 75y (*M* = 44.2y) Ethnicity: Maori (10), Pacific Island or Mixed Pacific Island/Maori (4), European (6). Diagnosis: MMD with comorbidity (SM, PTSD, D, PD). Time in hospital: 6 months -2y (*M*=2y 4months)	Semi structured interview, Thematic analysis (Braun & Clarke, 2006)
Bowser at al. 2018	UK	8 patients recruited from a single-sex medium secure unit.	M/F 8/0 Age 20y – 50y (*M* = 35y) Diagnosis: P	Semi structured interview, Thematic analysis (Braun & Clarke, 2006)

Authors & date	Country of research	Participants included	Reported demographics	Method & Analysis
Brown et al. 2014	UK	20 patients recruited from 2 medium secure forensic mental health units.	M/F: 15/5 Age: 20y-55y Ethnicity: African (2), African Caribbean (9), White English (4), White Jewish (1), Mixed Caribbean & White English (1), Mauritian(1), Sri Lankan (1), Mixed Iranian, White British (1) Diagnosis: P or D Time in hospital: 2y-15y	Semi structured interview, Thematic Decomposition Analysis (Stenner, 1993).
Craik et al. 2010	UK	26 patients recruited from low & medium secure units were divided into 5 focus groups based on ward security level. 1 focus group was specifically for females.	M/F: 21/5 Time in hospital: 1-5y (11); 5-10y (2); >10y (4)	Focus groups, Constant comparative analysis (Silverman, 2000)
Lorito et al. 2018	UK	15 patients recruited from 3 forensic psychiatric settings: high (6), medium (7) & low (2) secure.	M/F: 13/2 Age: 50+y Diagnosis: PD (6), MMD (7)	Semi structured interview, Thematic analysis (Braun & Clarke, 2006)
Horberg et al. 2012	Sweden	11 patients recruited from a maximum (high) secure forensic psychiatric service	M/F: 6/5 Age: 21y – 42y Time in hospital: 3months - 6y	Semi structured interview, Reflective lifeworld approach (Dahlberg, 2008)

Authors & date	Country of research	Participants included	Reported demographics	Method & Analysis
Koller & Hantikainen, 2002	Switzerland	2 patients recruited from a forensic unit of a psychiatric clinic.	Diagnosis: S Time in hospital: 3+ months	Semi structured interview, Content analysis
Lord et al. 2016	UK	10 patients recruited from a medium secure forensic hospital.	M/F: 10/0 Age: 21y – 48y (*M* =27.5y) Diagnosis: MMD	Interview, Interpretive Phenomenological Analysis (Smith, 1996)
Marklund et al. 2020	Sweden	11 patients recruited from 4 medium-security wards at a forensic psychiatric clinic.	M/F: 11/0 Age: 30y -50y (*M* = 36y) Time in hospital: 1y - 20y (*M*=6.5y)	Semi structured interview, Content analysis (Graneheim & Lundman, 2004)
Meehan et al. 2006	Australia	27 patients in a high secure forensic facility were split into 5 focus groups of between 4 & 7 participants in each.	M/F: 22/5 Diagnosis: S (85%)	Focus group, Content Analysis (Morse & Field, 1996)
Mezey et al. 2010	UK	10 patients were recruited from a medium secure unit	M/F: 8/2 Age: 24y – 56y (*M* = 37.1y) Ethnicity: White (4), BAME (6) Diagnosis = S (7), SA (3) Time in hospital: 1y - 11y (*M*=4y)	Semi structured interview, Content analysis (Hsieh & Shannon, 2005)

Authors & date	Country of research	Participants included	Reported demographics	Method & Analysis
Olausson et al. 2019	Sweden	11 patients recruited from a forensic psychiatric hospital	M/F: 9/2 Age: 18y – 54y Diagnosis: P (4), MD (3), Neurotic/stress-related/somatoform disorder (2), PD (2) Time in hospital: <1y - 10y	Photovoice (Wang & Burris, 1997), Thematic analysis (Braun & Clarke, 2006)
Olsson, Strand & Kristiansen, 2014	Sweden	10 patients recruited from a maximum (high) security forensic psychiatric clinic	M/F: 8/2 Age: 26y – 62y (*M* = 36y) Diagnosis: PD Time in hospital: 3y - 7y (*Mdn* = 4.7y)	Interview, Content analysis
Tomlin, Egan, Bartlett & Vollm, 2019	UK	18 patients recruited from a secure forensic service, including low (6), medium (2) & high secure (10).	M/F: 16/2 Age: 30y – 64y (*M* = 44y) Ethnicity: White British (16), Not Reported (2) Diagnosis: MMD (14), PD (4)	Semi structured interview & focus group, Thematic Network analysis (Attride-Stirling, 2001)
Walker et al. 2019	UK	16 women from a women's enhanced medium secure service (WEMSS) & a standard medium secure service.	M/F: 0/16 Age: 18+y	Semi structured interview, Thematic analysis (Braun & Clarke, 2006)
Zhong et al. 2019	China	21 mentally disordered offenders from a Forensic Psychiatric hospital.	M/F: 19/2 Age: 33y–62y (*M*=45) Diagnosis: S Time in hospital: 8y-33y (*M*=13y)	Semi structured interview, Thematic analysis

Key: M = Male, F = Female, y = years, MMD = Major Mental Disorder, SM = Substance Misuse, PTSD = Post Traumatic Stress Disorder, D = Depression, PD = Personality Disorder, P = Psychosis, S = Schizophrenia, SA = Schizoaffective Disorder, MD = Mood Disorder.

An interpretive theoretical standpoint was taken due to the richness in the data. Rich data is defined in qualitative literature as having 'thick descriptions' which go beyond portrayals of experience at the surface level and move towards a deeper understanding of interpretations of impact and meaning (Holloway, 1997).

1.4.2 Overview of thematic synthesis results

The synthesis generated a total of eight dominant themes. The first three themes generated from the synthesis: 1) *feeling stuck,* 2) *playing the game* and, 3) *positivity and hope* represent three separate experiences perceived by patients in secure care (see 1.4.3. Experience themes).

A further five themes were generated from the data which appear to be influential to the experience of secure care. These were: 4) *having a voice,* 5) *social connection,* 6) *my own safe space,* 7) *meaningful activity* and 8) *relationships with staff*. These were present across each of the aforementioned 'experiences' but were reported differently dependent on the experience (see 1.4.4 Influencing factors themes). All of the themes are depicted in Figure1.2.

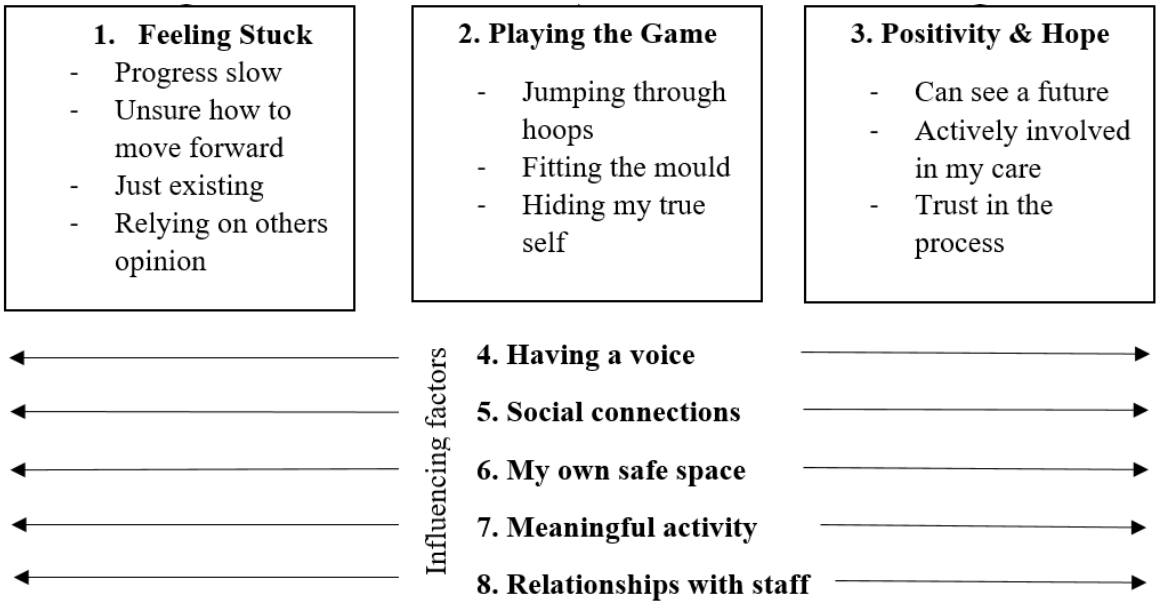


Figure 1.2 Eight overarching themes generated from the synthesis

1.4.3 Experience Themes

1.4.3.1 Feeling Stuck

The theme 'feeling stuck' was generated from the following descriptive themes: *progress being slow; unsure how to move forward; relying on opinion;* and *just existing* (Figure. 1.2).

Patients described a sense of their progress being slow and of "time being wasted as their lives were passing by" (Marklund, Wahlroos, Looi, & Gabrielsson, 2020). There was the expectation that they would be in secure care for many years (Olsson, Strand, & Kristiansen, 2014) and a frustration that this was likely to be longer than a prison sentence (Tomlin, Egan, Bartlett, & Völlm, 2020). Some reported the belief that they would never, in fact, be released (Marklund et al., 2020; Zhong et al., 2019).

Patients reported ambiguity from staff regarding what they needed to do in order to progress through the service towards discharge (Hörberg, Sjögren, & Dahlberg, 2012; Lord, Priest, & McGowan, 2016; Zhong et al., 2019). The absence of a care pathway made it difficult for patients to assess whether progress was being made (Craik et al., 2010), and some had resigned to feeling that they actually had no influence over their progression and that this was in the hands of the staff (Barnao, Ward, & Casey, 2015; Hörberg et al., 2012).

There was a sense of the staff as gate keepers, who held the power; they had the keys, made the rules, kept notes on the patients and fed back to 'the doctor' (referring to the patients' Responsible Clinician: RC). The RC was perceived to have 'the final say' which could influence progression (Craik et al., 2010). However, decisions made were experienced as arbitrary in nature (Barnao et al., 2015) and this maintained the patients' perceived position as powerless and stuck in the system.

The experience of being stuck in secure care created for patients, a sense that life was somewhat on hold whilst they waited to get out. There was no quality of life in secure care, and the powerlessness to make change led to a feeling that they were just existing there. This compounded feelings of shame about their offence, and a negative self-perception:

> *"Patients describe how they try to escape from this negative existence by "switching off" as much as possible their thoughts and feelings. These patients describe themselves as something that is "not-living" in so far as they describe that they are not themselves anymore. In an emotional sense, they are sort of a*

> *vacuum, in a fragmented existence…[they] have lost their spirit and are now just existing".*
>
> (Hörberg et al., 2012)

1.4.3.2 Playing the game

The theme 'playing the game' appeared to describe a different experience of secure care. These patients report having some understanding of what they need to do to move forward, however the goals are staff-led rather than patient-led. The descriptive themes: *jumping through hoops; fitting the mould*; and *hiding my true self*; contributed to the experience called 'playing the game' (see Fig. 1.2).

Patients reported passively taking the steps recommended by their team and complying with rules in the hope that this might expedite their discharge (Barnao et al., 2015; Craik et al., 2010). Patients describing this experience struggled to see any value or purpose to what they were being encouraged to do, other than 'getting out': "*I've been sat there bored thinking, is this doing ought for me*" (Bowser, Link, Dickson, Collier, & Donovan-Hall, 2018).

The environment and the care from the staff, was experienced as predetermined and rigid. Patients described needing to adapt and change themselves in order to fit with the rules and expectations placed on them. One patient described having to "*fall into a template*" (Marklund et al., 2020) and there was a sense that patients must be moulded to fit the service. Interventions and groups were experienced as repetitive (Di Lorito, Dening, & Völlm, 2018) and not pitched at the right level (Craik et al., 2010; Di Lorito et al., 2018) and patients described being told what they need to do, and feeling coerced to attend (Askew, Fisher, &

Beazley, 2020; Barnao et al., 2015). There was little choice and life feels very controlled and restricted.

Some patients who live this experience will resist and fight back leading to increased restrictive practices. Others will passively comply, attending interventions they have little interest in and following rules they disagree with; over time, moulding themselves to the service expectations. These patients describe feeling that they have to hide or hold back how they truly think and feel. Some patients reported feeling that important parts of them are completely overlooked whilst in secure care (Brown, Reavey, Kanyeredzi, & Batty, 2014).

> *"participants who adopted a compliant approach reported doing what they thought was expected of them by those in authority (e.g., attending programs, abiding by the rules)…they considered that suppressing their frustration about their powerless position, cooperating with staff, and adhering to service policies would make institutional life more bearable and hasten their release…it all comes down to playing the game people talk about"*
>
> (Barnao et al., 2015)

1.4.3.3 Positivity and Hope

The theme 'positivity and hope' is a third experience of secure care, again this appears to be very separate from the feeling stuck experience and the playing the game experience. Those who describe positivity and hope begin to believe in a life outside of the hospital and can imagine what this will look like, which feels hopeful (Mezey, Kavuma, Turton, Demetriou, & Wright, 2010; Olsson et al., 2014). Interventions feel like they have genuine value; patients report utilising the strategies they have developed effectively (Barnao et al., 2015)

and the prospect of moving on and staying out of hospital feels possible (Di Lorito et al., 2018; Mezey et al., 2010).

Patients move to a position of being active in their own care (Di Lorito et al., 2018), setting their own goals (Barnao et al., 2015; Olsson et al., 2014) and some will take on extra responsibilities such as being employed into a unit job. These opportunities create a sense of achievement, improved self-identity (Bowser et al., 2018) and equip people for life outside.

Patients describing this experience report to have a good understanding of their illness and find their medication regime to be helpful (Mezey et al., 2010). Patients shared that they trusted staff, and expressed that a good relationship was necessary to work collaboratively.

1.4.4 Influencing factors themes

The following five themes were present across the experiences but reported differently dependent on the experience:

1.4.4.1 Having a 'Voice'

The studies reported that it was positive for patients to have a voice and be heard within a service; to "*speak out…appeal their stay, participate in care plans, alter day-to-day life on the ward, or express themselves more broadly*" (Tomlin et al., 2020). Those who reported not having a voice described feelings of hopelessness and inferiority (Marklund et al., 2020) and generally described being within the 'feeling stuck' experience. Some patients reported the initial stages of being helped and encouraged to make choices and be involved (Walker

et al., 2019), and how these opportunities could be experienced positively with a growing sense of control over their lives (Di Lorito et al., 2018). Other patients appeared to be further forward with this, reporting confidence in working collaboratively alongside staff, formulating their own goals, "*raising issues and requesting change*" in appropriate forums (Barnao et al., 2015) and were reporting the 'positivity and hope' experience.

1.4.4.2 Social connections

Maintaining connections with significant people outside of the hospital setting was deemed to be an important factor:

> *"if you haven't got friends and family or other positive relationships around you it can make you feel a bit down about life…you haven't got much care or love in your life you know…it makes you feel that you deserve something, that you're recognized as a person for who you are…you feel you have self-worth and that means you matter rather than not mattering at all".*
>
> (Mezey et al., 2010)

Studies highlighted barriers to this, in terms of: restrictions on visiting times and phone calls (Bowser et al., 2018); difficulties accessing services (Di Lorito et al., 2018; Tomlin et al., 2020); and patients' own feelings of guilt and shame surrounding their offending behaviour (Koller & Hantikainen, 2002).

Those patients reporting minimal social connections described a profound loneliness triggering a sense of hopelessness (Zhong et al., 2019) and their experiences were in line

with ‘feeling stuck’. When social connections were limited, hospital befriending schemes were reported positively (Di Lorito et al., 2018). Some patients developed connections with peers on their ward or unit and described a sense of ‘belonging’ (Hörberg et al., 2012), ‘*just like a family*’ (Walker et al., 2019), some of these relationships were maintained after peers had moved on (Craik et al., 2010).

1.4.4.3 My own safe space

The patient’s bedroom was identified as a place of both privacy and safety for the patient, creating a “*safe zone*” (Olausson, Danielson, Berglund Johansson, & Wijk, 2019). Some patients experienced their bedroom as a place of privacy, which provided a sense of relief from the perceived public space of the ward, where patients felt to be under continual surveillance from staff (Lord et al., 2016). Of course the patients’ bedroom does not promise complete privacy and some patients described embarrassing and humiliating encounters when staff observed them unexpectedly in the rooms (Brown et al., 2014). This can feel intrusive and there was a sense that patients craved privacy.

Many studies identified that the ward could, at times, feel unsafe due to unpredictable and volatile behaviour creating tension among patients (Koller & Hantikainen, 2002; Lord et al., 2016; Meehan, McIntosh, & Bergen, 2006; Mezey et al., 2010; Olsson et al., 2014; Tomlin et al., 2020). In contrast the patients’ room was experienced as a safe space:

> *"The patients' room becomes a refuge from undesired company, from the tough climate and the superficial relationships, and thus a retreat to self-chosen solitude, where one is able to feel like a human being"*
>
> (Hörberg et al., 2012)

Having a safe space to keep belongings was important to patients. Some patients reported a sense of pride in their rooms, which they had personalised to make this feel like their own space. Those who were not provided this opportunity reported a detrimental effect:

> *"The patients felt ignored by the caregivers when pointing out the needs they had to make their room a decent place in which to live. It made them feel resigned to their situation and gave rise to feelings of hopelessness, promoting the sense that they perhaps did not deserve to have a respectable place."*
>
> (Olausson et al., 2019)

1.4.4.4 Meaningful activity

Studies commonly reported that patients experienced a profound sense of boredom, whilst in secure care. Some services were reported to lack having activities for patients to engage in to occupy their time meaningfully:

> *"Participants described everyday on the ward as monotonous, boring, and slow, where there is not much to do and nothing much happens. They wished for more activities, to be able to do more, to be allowed more leave, and to have fun and experience joy"*
>
> (Marklund et al., 2020)

Boredom amongst patients was reported to be problematic as it could often lead to frustration and irritability, which could then spiral to aggression (Bowser et al., 2018; Meehan et al., 2006). This impacted on patients' sense of safety within the ward environment and created a source of ongoing tension:

> *"although aggression was inevitable, 'you never know when it's going to happen, you're on your guard all day'. This was a source of stress for many of the clients and created a tension within the units."*
>
> (Meehan et al., 2006)

Alternatively, boredom could lead to a lack of motivation and prolonged periods of time spent in bed (Bowser et al., 2018). Some patients reported feeling satisfied with a basic routine of *"day dreaming, drinking tea, smoking and listening to the radio"* (Craik et al., 2010). Whilst others preferred a busy schedule and described a range of educational, therapeutic, creative and skill based groups on offer (Di Lorito et al., 2018). For activities to be meaningful, they needed to be at the right level to challenge (Bowser et al., 2018), be enjoyable (Craik et al., 2010), and purposeful, in the sense that patients can see a benefit to them, particularly with regards to moving on from hospital (Di Lorito et al., 2018). Patients reported that they were engaging in meaningful activity at the positivity and hope experience.

Scheduled meaningful activities provided structure (Olsson et al., 2014), a sense of achievement and improved self-identity (Di Lorito et al., 2018; Tomlin et al., 2020). Staff

availability was noted to be a challenge for this (Craik et al., 2010; Meehan et al., 2006; Tomlin et al., 2020).

1.4.4.5 Relationships with staff

Patients' experience of their relationship with staff members was variable. On the one hand a good relationship was described, in which patients felt understood, supported, respected and treated as equal (Barnao et al., 2015; Marklund et al., 2020). When this care was experienced as genuine and consistent, it contributed to patients' willingness to try new ways of behaving.

Alternatively, relationships with staff were experienced as either controlling (Marklund et al., 2020) as staff adopted superior attitudes (Meehan et al., 2006), or lacking care (Craik et al., 2010; Lord et al., 2016), or at worse; neglectful (Askew et al., 2020). This could lead to a breakdown of trust whereby patients "*felt staff would be less likely to enable their progression through care"* (Tomlin et al., 2020). This affected patients' views of themselves: *"is it something that I've done, or something that is wrong with me"* (Mezey et al., 2010).

In summary, this review generated three distinct experiences of secure care, reported by patients. A further five themes were generated which appear to contribute to the experience for patients and appear to be changeable depending on the experience. A tentative hypothesis could be made that patients may transition through these experiences; from feeling stuck to playing the game, then from playing the game to moving forward. Hörberg et al. (2012)

describes what could be interpreted as patients moving from feeling stuck, to the experience of playing the game:

> *"there is a sense of tension within the individual between fighting for something and giving up. He or she balances between adapting him or herself and retaining dignity as a person, thus entailing a struggle with, or struggle against, a sense of resignation. This struggle, and the frustration it generates, "screams out loud" inside them, but is not heard by the professional carers"*
>
> (Hörberg et al., 2012)

Here, Barnao et al. (2015) describes what could be interpreted as the distinction between playing the game and moving forward:

> *"although some participants could see the intrinsic value in what they were doing, others appeared to be primarily motivated by a desire to do what was required to "get out".*
>
> (Barnao et al., 2015)

This study set out to explore the experience of secure care. Through this review, three very separate and distinct experiences have been identified. This has raised further questions regarding how these experiences fit together, whether patients transition through the experiences as part of their recovery journey and whether adapting the influencing factors could aid patients' transition through these experiences. This review did not set out to answer these questions and does not have the level of data required to do so but further grounded theory analysis would be beneficial in extending our understanding of this phenomena.

1.5 Discussion

1.5.1 Summary of main findings

This paper aimed to understand forensic patients' experiences of secure care and the factors which influence this. The search yielded seventeen qualitative studies which focussed on this phenomena, and were deemed suitable for review. Cumulatively, these studies shared the voices of 243 forensic patients, reporting on their experiences of a range of forensic secure inpatient services worldwide. Eight overarching themes were generated from the synthesis. The first three themes: *feeling stuck, playing the game* and *positivity & hope,* provided three separate experiences of secure care that patients' reported and identified with. The final five themes: *having a voice, social connection, my own safe space, meaningful activity* and *relationship with staff*, could be interpreted as factors which influence the experience of secure care, for patients'.

1.5.2 Interpretation of main findings

This review demonstrates that for some patients in secure forensic provision, their experience is one that is both positive and hopeful. They feel engaged in their own care and able to express their needs. They have developed trusting working relationships with the staff who care for them and they are engaged in activities that feel meaningful. They feel hopeful about the future and are working towards this. These findings suggest that there are forensic services that are managing the balance of successfully integrating principles of recovery; patient-centred care, autonomy and agency, whilst simultaneously managing the risk, a concept that was deemed counterintuitive (Livingston et al., 2012). This is a positive aspect to take forward in the design and delivery of future forensic services.

This review also demonstrates that there are patients in secure care who are not experiencing this positively. Some patients report feeling stuck in secure care, where progress feels slow and they are unsure how to move forward, and are just existing day-to-day. Other patients describe a different experience whereby they have little choice in a predetermined service where they feel coerced to passively comply with rules and attendance to groups. These two different experiences shed a negative light on forensic secure care provision and yet these were widely reported experiences across the studies. It is unclear from this review, whether patients transition through these different experiences, reaching the positive and hopeful experience, or whether they may remain feeling stuck or playing the game throughout their entire admission time. There were studies in which patients reported each of these different experiences, suggesting that a single service could be providing a positive experience for one patient whilst simultaneously providing a contrasting experience to another. This may be a reflection of individual differences between patients or there may be steps that services can actively take to improve experiences for patients. For example, one patient may find a particular activity on offer meaningful, whilst another does not. In order to meet all patients' individual needs the service would need to have a good understanding of that patient, which would require a trusting relationship, the patient to feel that they have a voice, and the patient to feel safe enough to share information. These are some of the influencing factors themes identified through this review.

The influencing factors themes (meaningful activity, positive relationships with staff, having a safe space, building social connections and having a voice) were all identified as contributing to a positive experience when present and as a negative experience when absent. These five themes and the notion that they influence the experience to be positive or

negative, was replicated in other reviews of patient experience of detention in general psychiatry and other inpatient settings (Akther et al., 2019; Katsakou & Priebe, 2007) and are highlighted as important components for secure patients' recovery (Clarke, Lumbard, Sambrook, & Kerr, 2016). Perhaps these components offer a framework in which services can adapt to identify and meet patients unmet needs within services.

One reported experience that is not replicated in other mental health services, but solely reported in forensic secure care was the 'playing the game' theme. Secure patients experience adapting and changing themselves to fit in to the service. This involves hiding their true self (thoughts, beliefs) and passively complying with service expectations. This experience is perhaps a reflection of the longer admission times in forensic services; over time and through attempts to be discharged, patients may learn to behave in a way they believe will lead to them being expedited from hospital. It could also be a reflection of the lack of clear care pathways in secure care (Hall, 2012) that patients simply do not know what they need to do to move forwards and therefore will try anything.

1.5.3 Methodological considerations

The seventeen studies selected for review were all published between 2002 and 2020, and interestingly, over half of them were published within the last five years. Perhaps this reflects a move towards developing agency and autonomy in forensic patients. The studies covered secure care provision across various countries, with different mental health and legal systems in place. Despite this, there were shared characteristics reported across the settings. Zhong et al. (2019) was one study however, reporting findings not shared with other studies. This study was conducted with a Chinese population reflecting cultural differences in service

provision. Patients were typically returned to be cared for by relatives, following hospital admission, which seemed to compound feelings of loss, rejection and shame for those experiencing estranged and complicated relationships with families following their offending behaviour (Zhong et al., 2019). This study also reported that psychological interventions were lacking, yet desired by patients. As these points were exclusive to this study they were not influential in the analysis process, however, this paper also demonstrated consistent findings with other studies in the review and therefore was included.

There was consideration given to the title and focus of each study to assess for bias. Some of the studies reported specifically on experiences within secure care that could take a negative stance, such as: the seclusion room, causes of boredom, aggressive behaviour and restrictiveness. However, the focus of other studies was more positive, such as: perceptions of rehabilitation and recovery. Despite this, the findings demonstrated that the themes were relatively evenly distributed across studies, demonstrated in Table. 1.3.

Table 1.3 Distribution of themes across studies.

	The experience of secure care			What influences the experience of secure care?				
	Feeling stuck	Playing the game	Positivity & hope	Having a 'voice'	Social connection	My own safe space	Meaningful activity	Relationships with staff
Askew		✓						✓
Barnao	✓	✓	✓	✓			✓	✓
Bowser	✓	✓	✓		✓		✓	
Brown		✓				✓		✓
Craik	✓	✓			✓		✓	✓
DiLorito	✓	✓	✓	✓	✓		✓	✓
Horberg	✓	✓			✓	✓		✓
Koller					✓	✓		✓
Lord	✓	✓		✓		✓		✓
Marklund	✓	✓	✓	✓			✓	✓
Meehan	✓			✓		✓	✓	✓
Mezey			✓		✓	✓		✓
Olausson	✓		✓	✓	✓	✓		✓
Olsson	✓		✓		✓		✓	✓
Tomlin	✓	✓		✓	✓		✓	✓

Walker		✓	✓	✓			✓
Zhong	✓			✓		✓	✓

1.5.4 Strengths and limitations

There were a number of strengths to note. A robust search strategy was used, guided by an experienced librarian. The search strategy did not place any limits on the year or location of the study ensuring that all studies meeting the inclusion criteria were identified. An independent second reviewer contributed to each stage of the study selection and appraisal, demonstrating a high level of inter-rater reliability throughout. The few discrepancies identified were managed through consultation with a third reviewer. Supervision was also sought through the process of generating the codes and descriptive themes.

There were also limitations; for instance, this review did not analyse the data separately by grouping hospital security levels, country or patient characteristics (gender, ethnicity, diagnosis). There was also variance in the level of 'rich descriptions' between studies, leading to some studies becoming more influential in the analysis. The quality appraisal process identified two further limitations across the studies selected for review; firstly, several studies failed to report the relationship between researcher and participants which made it difficult to ascertain any prior involvement. Secondly, several studies were unclear of the recruitment process which impacts on how representative the sample was.

1.5.5 Clinical Implications

This is the first systematic review to focus specifically on forensic patients' experience of secure care. It provides an in-depth understanding of three distinct experiences that secure patients describe. This serves as a potential template for the multi-disciplinary teams supporting patients within secure care, providing understanding of where patients may be in terms of their experience. The five influencing factors also provide areas where improvement

in care could be made for individual patients to potentially improve the experience. Although further research is needed to understand whether patients transition through these different experiences, the understanding developed through this review has the potential to guide service improvement by providing a framework of where improvements can be made. nts

1.5.6 Future research

Future research should aim to further examine these three experiences of secure care and seek to find more about whether patients transition through these experiences. This review has also identified the 'playing the game' experience which is not replicated in other reviews of patient experience in other settings. This provides a new perspective on patients who 'tick the boxes' by attending groups and following rules but do not appear to engage. In a population where risk management is dominant, staff can be cautious at signs that a patient may be passively complying, this could be viewed negatively as the patient being deceitful and may impact on how staff manage this. Further research could look to explore staff perceptions of patients experiencing this and the impact of the relationship.

Chapter 2 Exploring the lived experience of secure patients during COVID-19.

This paper has been prepared in the format required by the 'Journal of Forensic Psychology Research and Practice'

2.1 Abstract

Objectives: In 2019, the world was hit by a life threatening severe acute respiratory syndrome causing a global pandemic named Coronavirus disease (COVID-19). In the UK, a nationwide 'lockdown' of public isolation and reduced social contact followed. We are yet to understand the experience of the COVID-19 pandemic and lockdown measures on forensic secure mental health patients. This study aimed to explore the phenomena of COVID-19 from the patients' perspective. **Methodology:** Semi-structured interviews were carried out between November 2020 and March 2021 with six patients from a Low Secure Hospital in the UK. Interpretive Phenomenological Analysis was used to generate themes from the data. **Findings:** Three superordinate themes were generated from the data. These themes provided insight into the experience '*treading water'*, how the patients managed through the experience '*learning to swim'*, and what was helpful during this time '*in the same boat'*. **Implications**: The findings demonstrate consistency with recovery literature in the forensic field and are particularly timely in terms of how we may be able to better support forensic secure patients through this uncertain time.

2.2 Introduction

In 2019, the world was hit by a global pandemic; Coronavirus disease 2019 (COVID-19), a life threatening severe acute respiratory syndrome. In the UK, the first confirmed cases of COVID-19 were recorded in February 2020, and by the following December the number of cases had risen to 1,869,670 with 64,402 fatalities (World Health Organisation, 2020) causing widespread fear and panic among the public.

In March 2020, in response to the rising hospital admissions and deaths, the UK government enforced a nationwide 'lockdown' of public isolation and reduced social contact, aiming to slow the spread of the virus and save lives (UK Government, 2020). Since then, there have been further lockdowns and restrictions of varying degrees continuing into 2021. Whilst the lockdown was initiated as a safety measure, quarantine itself is known to be detrimental to psychological health (Brooks et al., 2020)

We are yet to understand the full impact of COVID-19 and the lockdown measures on the mental health and well-being of society. Research suggests that the effects will vary widely between individuals (Mancini, 2020) and are likely to unfold over time. Common initial reactions in the general population include increased fear (Fofana, Latif, Sarfraz, Bashir, & Komal, 2020), symptoms of anxiety, depression (Rajkumar, 2020), and post-traumatic stress (Brooks et al., 2020). Whilst most people are likely to demonstrate resilience and experience a stable pattern of adaptive functioning (Bonanno, 2004), there are specific groups (elderly, homeless, etc) identified as being more vulnerable to the effects of the pandemic and the social distancing measures (Douglas, Katikireddi, Taulbut, McKee, & McCartney, 2020). A survey conducted in the initial six weeks of the first lockdown found those with pre-existing mental health difficulties were among the groups reporting the worst outcomes on measures

of anxiety, depressive symptoms, levels of defeat, entrapment and loneliness (O'Connor et al., 2020). Research into how societal groups have been affected (for example the elderly, teenagers etc.) has rapidly evolved since.

One population whose experience is yet to be explored, are those residing in forensic secure care. Secure patients experience severe and enduring mental health difficulties or personality disorder, and are detained in hospital settings for treatment under the Mental Health Act (The NHS Commissioning Board, 2013). Some secure patients have entered the criminal justice system due to offending behaviour, others are deemed suitable due to the level of risk they pose to themselves or to others (NHS England, 2018b). There are different factors at play when considering the impact that COVID-19 may have on this population, factors include: an increased risk of the illness (risk of exposure due to the environment, risk of transmission due to mental health vulnerabilities, & risk of poorer outcomes); and an increased risk from quarantine measures (risk of being disconnected from society, impact of staff burn-out on therapeutic relationships, significance of losing community leave, & witnessing rule breaking in the population). Each of these will be explored further.

2.2.1 Risk of illness

The detention of secure patients in hospital settings poses both practical and ethical concerns during an infectious disease pandemic. On a practical level, security measures such as locked wards, secure windows and limited time in outdoor space, reduces the ventilation within the hospital, thus elevating the risk of disease transmission (Russ, Sisti, & Wilner, 2020; Zhu et al., 2020). Alongside this, the working shift patterns of the hospital staff create an environment where people are repeatedly entering and exiting the ward, essentially ‘mixing

households' and further increasing the risk of transmission. One documented outbreak in a psychiatric hospital in China affected 80 patients and staff, and highlighted further challenges of potential non-compliance with self-isolation measures (Zhu et al., 2020). Feeling safe and secure within the hospital environment has been identified as a key component for patients' recovery (Lovell, Gardner-Elahi, & Callanan, 2020) which may be compromised given the heightened risk of COVID-19 transmission.

As the physical setting itself creates challenges, secure patients may also be disadvantaged by the very nature of their mental health illness. Diagnoses such as Schizophrenia and Bipolar Affective Disorder are associated with cognitive deficit, particularly in executive functioning skills such as memory, attention, planning and problem solving (Fioravanti, Bianchi, & Cinti, 2012; Torrent et al., 2006). These skills are necessary to understand, remember and implement new health behaviours aimed to reduce virus transmission, such as regular hand sanitisation, social distancing and wearing masks (Shinn & Viron, 2020). Cognitive deficit in executive functioning may mean that some patients are unable to follow guidance making them more vulnerable to COVID-19 transmission.

Whilst the risk of transmitting COVID-19 appears to be high for secure patients, further evidence suggests that they may also face poorer outcomes should the virus be transmitted. This is due to the higher prevalence of smoking (De Leon & Diaz, 2005), physical inactivity, unhealthy diet (Saxena & Maj, 2017) and comorbid health conditions such as diabetes (Ward & Druss, 2015) in patients with severe mental illness. These are all factors shown to increase the likelihood of poor outcomes from COVID-19 (Guan et al., 2020; Vardavas & Nikitara, 2020). Alongside this, medical interventions may pose a serious risk of drug interactions, as

many secure patients are already treated with complex medication regimes for their mental health and the treatment of COVID-19 is new and rapidly evolving (Stefana et al., 2020).

Each of these risk factors (risk of exposure to the illness, risk of transmission & risk of poorer outcomes) suggest that secure patients are a particularly vulnerable population living through the COVID-19 pandemic. There are further identified factors suggesting that secure patients may also be particularly vulnerable to the quarantine measures imposed by the COVID-19 lockdown conditions due to the already limited social connections and the significant role this has in patient's recovery.

2.2.2 Risk from quarantine

Social connection has long been recognised as a fundamental human need (Baumeister & Leary, 1995). As the various quarantine measures were enforced and the general public were physically segregated from each other, people adapted to using digital technologies and online means of communicating to maintain their social connections. We benefit widely from having social connection, it is found to positively influence both our physical health (Berkman & Syme, 1979) and our psychological health, by increasing resilience (Arewasikporn, Sturgeon, & Zautra, 2019) and predicting life satisfaction (Kim & Hatfield, 2004). Generally, secure patients report poorer-quality social networks than the general population (Simpson & Penney, 2011) and can face barriers to building connections, such as stigma and limited opportunities. Despite these barriers, social connection is recognised by secure patients as an important factor in their recovery (Clarke et al., 2016). Contact with family and friends, positive relationships with staff, and time spent outside of the hospital, termed 'community leave', are all potential opportunities for the development of social

connections. When the lockdown measures were enforced, these opportunities were significantly impacted for secure patients.

In secure services there are already rules and regulations in place which limit visiting times and the use of mobile phones, which can have an impact on the relationships patients are able to maintain with family and friends outside the hospital setting. Furthermore, some patients report that these relationships can also break down due to offense-related stigma and from being hospitalised in out-of-area placements that are some distance from loved ones. The lockdown measures may cause further complications with maintaining relationships at a time when these relationships are of paramount importance to patients. Secure hospitals may need to find safe ways of introducing the use of digital technology to bridge the gap whilst lockdown measures are in place (Galea, Merchant, & Lurie, 2020).

Over the lockdown period, patients continued to have social connections with the hospital staff caring for them. Positive relationships between patients and staff have been found to be crucial; predicting treatment adherence and outcomes (McGuire, McCabe, & Priebe, 2001) whilst being the main component driving patient satisfaction in secure services (Bressington, Stewart, Beer, & MacInnes, 2011). The 'boundary seesaw model' (Hamilton, 2010) purposes that healthy relationships are formed when the balance between treatment (care) and security (control) is maintained. This occurs when staff are open, reasonable, willing to negotiate, and can maintain boundaries (Hamilton, 2010). However, during times of stress, staff can experience 'burnout', a state of emotional exhaustion and compassion fatigue (Schulz, Greenley, & Brown, 1995) where they can become more risk-focussed and lose the ability to empathise with their patients (Coffey, 1999). Research indicates that burnout is already prevalent in healthcare professionals within secure services compared to other fields

of nursing (Mason, 2002). We are yet to understand whether COVID-19 has increased burnout in secure staff, or affected their ability to care for patients in secure settings; however, media reports suggest that COVID-19 has had a 'profound impact' on work related stress across National Health Service professionals (Parsons, 2021).

Furthermore, when drawing on studies that explore historical disasters, there is evidence that people who are unaffected by the disaster are emotionally able to provide support and aid to the affected group (Osofsky, Osofsky, & Mamon, 2020). Where COVID-19 is a global pandemic of epic proportion, this significantly limits the people who are unaffected. The staff working in secure services are simultaneously learning to personally navigate the pandemic, alongside professionally maintaining a therapeutic level of care. The introduction of protective clothing and masks to reduce the risk of virus transmission may create another barrier to connecting with patients. Masks can limit effective communication and be perceived as threatening, particularly to patients who may be emotionally dysregulated or experiencing paranoia (Lancet Psychiatry, 2020).

Alongside these potential changes in the staff-patient relationship, the lockdown measures also significantly impacted patients' community leave. Community leave from hospital is paramount for progression, it provides an opportunity to practice social skills and life skills whilst the clinical team can test risk (Dickens & Barlow, 2018). Leave is also important for patients emotional wellbeing, aiding their connectedness with society (Clarke, Sambrook, Lumbard, Kerr, & Johnson, 2017). Often community leave is long awaited and gradually increased in duration and distance depending on the individuals' stage of recovery. It can signify an important transition; the patients' return to the community. Losing leave can be detrimental to patients' mental health, and is often associated with punishment.

A further consideration, is the potential for secure patients to feel disconnected from the outside world, triggered by the highly publicised 'flouting' of the restriction rules by members of the public. Where secure patients are detained under the Mental Health Act (1983), in some cases given treatment against their will, and sanctioned heavily for non-compliance. Learning of rule-breaking with minimal consequences, may exacerbate feelings of powerlessness, oppression (Livingston & Rossiter, 2011) and lead to resentment, an increase in challenging behaviour and potentially further polarising secure patients' from the public.

2.2.3 Potential Implications

Each of these factors (increased risk of exposure, transmission & poorer outcomes; increased risk form quarantine of social disconnect, altered relationships with staff and losing leave) has the potential to impact on patients' mental health in secure care. The impact will likely vary among patients, with some groups potentially more at risk of destabilisation, for example, those with a diagnosis of Emotionally Unstable Personality Disorder may be particularly triggered by the lockdown due to the characteristics of this diagnosis: *fear of abandonment, hyper-responsiveness to stress and chronic emptiness* (Choi, 2020). Others may be at different stages of their recovery and therefore the lockdown may be experienced as more detrimental, for example those who are close to moving on, who regularly use community leave independently to access meaningful activities such as college and new placements.

The lockdown is likely to increase boredom and frustration, which is shown to increase the likelihood of aggression and violence in secure settings (Bowser et al., 2018; Dickens, Piccirillo, & Alderman, 2013). Increased aggression and violence creates a cycle of negativity; impacting on peers' mental health, triggering further stress and burn-out for staff and potentially reducing progression through services. Delays in patients being discharged from secure services has further systemic implications of creating a back-log of patients' potentially residing in inappropriate settings, such as prisons (G. Durcan, 2011).

There are further clinical implications to consider with this specific population, in light of Hirschi (2017) Social Bonding Theory. Social bonding theory purposes that the pro-social bonds we build with other people are crucial in us maintaining healthy social behaviour. This theory suggests that there are four areas in which we have the opportunity to build pro social bonds: Firstly, through our close *'attachments'* to others we begin to consider and care about others expectations of us which influences the pro-social choices we make. Secondly, through *'commitment'* we dedicate time and energy to finding conventional activities to take part in, this gives us something we have worked hard towards that we don't want to risk losing. Thirdly, we experience '*involvement'* in which we are engaged in activities (work, education), therefore we have less time to engage in antisocial behaviours. Finally, through our '*belief system*' which is the extent to which we endorse the morals and rules of society, we begin to respect authority (Nijdam-Jones, Livingston, Verdun-Jones, & Brink, 2015). When considering social bonding theory in this context, the social connections being made (through engaging in community leave, building relationships with staff and connecting with society) are not only valuable in terms of providing meaningful activity and opportunity to develop skills, they are also a crucial element in developing and maintaining healthy social behaviour in secure patients. Without these opportunities there may be a decline into more antisocial behaviour in this population.

2.2.4 Study aims

This study aims to explore the lived experience of the COVID-19 pandemic in a secure hospital setting in the UK in order to develop a greater understanding of the impact on this population.

2.3 Methodology

A qualitative design was used; the data was generated through semi-structured interviews and analysed using the method of Interpretive phenomenological analysis (IPA) (Smith, 2012). IPA is a useful method for understanding how people make sense of a life experience. As it allows for a deeper level of reflecting by examining the interpretation of the event itself but also how the event is linked to 'parts of life' separated in time but linked with a common meaning (Smith, 2012).

As a researcher using IPA, there is consideration given to the 'double hermeneutic' at play, whereby the participant is interpreting the event whilst the researcher is interpreting the participant's account of the event (Smith, 2012). With this considered, an epistemological position of constructionism was adopted by the researcher; a 39-year old, white British, female, with experience of working in forensic mental health settings. Whilst acknowledging that researcher biases may influence findings, efforts were taken to embed quality assurance into the process of data generation and analysis (Shaw, 2010) to minimise this. A reflective diary was kept throughout the data collection and analysis process and supervision was sought regularly from an experienced IPA researcher.

2.3.1 Ethical Considerations

Ethical approval was granted by Wales Research Ethics Committee and the Health Research Authority; REC Reference: 20/WA/0272 (Appendix C). The host NHS trust provided research and development approval and the University of Southampton acted as sponsor.

2.3.2 Setting

The Low Secure Forensic hospital is a 28-bedded unit with three wards and one step-down flat. Two of the wards were specifically for males (10-bed & 9-bed) and one ward for females (7-bed). The wards did not differ on their admission criteria or pathway through the service. The flat was situated within the Hospital with capacity for two patients, although at the point of research this was vacant due to the Hospital not running at capacity.

A multidisciplinary team (MDT) of professionals work collaboratively with patients. The team includes Psychology, Psychiatry, Social work, Occupational Therapy, Nursing, and Health Care Support Workers. This Low secure hospital has less facilities than medium and high secure, or other more long term low secure settings, as the emphasis is placed upon supporting patients to access facilities safely in the community.

2.3.3 Participants

Six participants were recruited via a convenience sampling method, ensuring suitability, willingness and availability of participants (Etikan, Musa, & Alkassim, 2016). All participants met the following inclusion criteria: a) aged 18+ years, b) detained under the Mental Health Act (1983), c) within the service for a minimum of 6 months, d) have adequate

understanding of spoken and written English, and e) have capacity to give informed consent (assessed by their Responsible Clinician). There were no exclusion criteria applied.

Table 2.1 summarises details of individual participants and pseudonyms are used to protect participant's anonymity. At the time of recruitment, a total of 24 of the 28 beds were filled. Of these: *N=7* did not meet the inclusion criteria; *N=7* declined to take part; and *N=2* were unable to make pre-arranged interview times.

Table 2.1 Participant Demographics

Participant	Pseudonym	M/F	Age	Ethnicity	Primary Diagnosis	Section	Total Length of current admission
1	Drew	M	55	Black British	PS	47/49	23 years
2	Amy	F	27	White British	EUPD	3	12 years
3	Mike	M	27	White British	PS	37/41	7 years
4	Elliot	M	56	White British	PS	37/41	4.5 years
5	Kate	F	44	White British	SA	37/41	4.5 years
6	Bert	M	60	White British	PS	37/41	4 years

Key: M/F = Male/Female; Age in years; EUPD = Emotionally Unstable Personality Disorder; PS = Paranoid Schizophrenia; SA = Schizoaffective Disorder; Section 3 = hospital order; Section 37/41 = hospital order with restrictions; Section 47/49 = removal to hospital of prisoners with restrictions.

2.3.4 Procedure

2.3.4.1 Identifying Participants

Responsible Clinicians were contacted in the first instance, with details of the study, and identified suitable participants. Posters with information about the study (Appendix D) were displayed on ward areas and the project was discussed in ward community meetings.

2.3.4.2 Approaching Participants

Due to COVID-19 restrictions recruitment was carried out by the fourth author (SC), an Assistant Psychologist working within the service and known to patients'. SC informally discussed the nature of the study and what would be required from participants.

Eligible and interested participants were given a written information sheet (Appendix E) about the study. This informed them of how their anonymity would be protected, their right to withdraw and how their decision to take part would have no bearing on their treatment or care in hospital.

Participants gave their written informed consent (Appendix F) to take part and received £10 as an incentive (British Psychological Society, 2014). This was provided in the form of a voucher for the hospital shop; the only accessible shop during lockdown.

2.3.4.3 Data Collection

Participants were given the option of an in-person interview (ensuring COVID-19 safety guidance was met) or via secure video technology. A suitable date and time was then agreed.

Three video interviews were conducted in November 2020 during the lockdown period and three in-person interviews were conducted in March 2021, once restrictions allowed this. To ensure the safety of all involved, national and local COVID-19 safety guidelines were strictly adhered to.

All interviews were conducted by first author (KH) who was independent of the service. Video interviews were conducted in a private room within the hospital, with SC present to provide emotional and technological support to participants, if required. In-person interviews were carried out in a private outdoor space located within the hospital grounds. For consistency, SC was also present for these.

All interviews were audio recorded using a dictaphone and stored securely. Interviews lasted between 30 and 60 minutes. Participants were advised that they could end the interview at any point, take a break and/or ask questions. All participants were debriefed following interview (Appendix G).

2.3.4.3.1 The interview schedule.

An interview schedule was developed using the suggested 5-step sequence by Smith, Flowers and Larkin (2009, p.61). The final interview schedule included six open and expansive questions about the impact and effect of COVID-19 to encourage participants to talk at length (Appendix H). The schedule was not intended to be prescriptive, and further follow-up questions were used flexibly at the interviewers' discretion when exploring topics raised by the interviewee.

2.3.4.4 Data Analysis

Interviews were transcribed verbatim by the researcher (KH). Transcripts were then read and re-read several times whilst listening to the Dictaphone recording, a process which allows the researcher to fully immerse in the data. Analysis was conducted by hand, one transcript at a time. Exploratory comments about the descriptive and linguistic content, and conceptual understanding were recorded in the left-hand margin of the transcript. Themes were noted in the right hand margin as they were generated (Smith, 2012). Initial themes were then written on post-it notes to create a visual map which was reviewed and reorganised. Emergent superordinate and subordinate themes were recorded in a Word document along with the supporting quotes from across all transcripts (Appendix I) and then discussed with supervisor CC. This process created space to consolidate patterns and map ideas, whilst remaining close to the data, which then aided the generation of the final themes.

2.3.4.5 Validity

An audit was carried out on a subset of the data to ensure that the interpretations made were representative of the participants' responses. This audit was carried out by a member of the research team (SC) who was independent from the analysis process. All quotes were mapped onto the matching themes which demonstrated a high degree of validity.

2.3.4.6 Quality Assurance

A reflective diary was kept by the researcher following each interview and throughout the analysis process. This helps to identify and 'bracket' any preconceptions about the narratives shared by participants and minimise their influence (Smith, 2012)

2.4 Findings

Participants described their experiences of being in the secure care environment during the COVID-19 pandemic. Their accounts offered insight into how the atmosphere of the ward changed during lockdown through a collective feeling of fear and sadness, despite this there was a sense that they needed to maintain the prior progress they had made *('treading water').* They described ways that they adapted to the new reality and new regime in place *('learning to swim').* They also identified that feeling connected to humanity *('in the same boat')* either through relationships with staff and peers, or through the shared experience with the wider community, this was an important factor in managing the adversity. All the themes are presented in Table. 2.2 along with the pseudonyms of the participants that supported the theme.

Table 2.2 Superordinate and subordinate themes with the participants who supported these themes

Superordinate Theme	Subordinate Theme	Participants supporting the theme
Treading water	- Anticipating conflict	Drew, Amy, Elliot, Kate,
	- Fear of illness spreading	Drew, Mike, Elliot
	- A sense of what has been lost	Drew, Amy, Mike, Elliot, Kate, Bert
Learning to swim	-Riding the wave: accepting the changes and finding new ways to manage	Drew, Amy, Mike, Elliot, Kate, Bert
	- Caught in a rip tide: forced to comply	Drew, Amy, Elliot, Kate, Bert
In the same boat	- Feeling cared for by staff	Drew, Mike, Elliot, Bert
	- Pulling through together	Drew, Amy, Mike, Elliot, Bert

2.4.1 Theme 1: Treading water

Participants described how the atmosphere of the ward changed due to the lockdown period. This was influenced by three subordinate themes: anticipated conflict on the ward, a fear of the illness spreading and a sadness about what had been lost due to the pandemic and the lockdown measures. Kate used the phrase "*treading water*" (P5, 137) which seemed to characterise the struggle that participants described between maintaining prior progress, whilst being constantly reminded of the precarious nature of the ward environment.

2.4.1.1 Sub theme: Anticipating conflict

Participants described a change in the ward atmosphere in which there was a felt sense of tension. Although there were no accounts of actual violence or aggression, this was anticipated which made the ward feel unsafe:

> ***Drew:*** *"because of the COVID, people are getting upset over petty things, err, and err, sometimes it gets sorted out, sometimes they keep it to themselves or with their peers, and it sort'a like unbalances the ward, if you like" (P1, 181-183)*

Drew's use of the word 'petty' implies that even minor events could be a trigger for peers, highlighting the fragility of the ward environment during this context. Drew is unsure how much detail to share about the petty things that people are upset over, this is demonstrated in his hesitation through his use of the repeated filler word 'err'. Perhaps this feels too unsafe for Drew and he opts to change the focus to how the situation is managed.

Although Drew is not directly involved in what he is describing in this quote, rather it is something happening around him, he implies that it still impacts on him personally. Issues experienced on the ward cannot happen in isolation, they cause a ripple effect, affecting everybody and creating an 'unbalanced ward'. This is a reflection of the small confined ward environment, where there are limited options to move away from any tension, instead it is endured.

2.4.1.2 Sub theme: Fear of illness spreading

Participants witnessed the virus spread through the hospital and described a sense that they were just waiting to become ill themselves. Elliot recalled the sound of coughing coming from the bedrooms and the fear that this elicited in him each day. He was acutely aware of the seriousness of catching the virus:

> ***Elliot:*** *"there was the fear of COVID hanging around all the time. I used to wake up early in the morning and I'd think; is this the day when I'm gonna get it really bad? y'know, could it possibly kill me? y'know" (P4, 83-85).*

Elliot's use of the phrase 'hanging around' describes a sense of perceived inevitability that the virus will reach him; there is no way of him avoiding this. His narrative of waking early to think about worst case scenarios demonstrates the level of anxiety he was experiencing about catching the virus and becoming ill. His use of questions illustrates his uncertainty which maintained his fear.

For Mike, the illness spreading across the ward and how this was managed may have created a fear replicated at other times in his life:

> ***Mike****: Two of them had it on the wards and had to self-isolate, then like a week later I caught it. A few of the other guys had it. Then 8 patients (pause) EIGHT [emphasis] of us had it…So the whole ward had to go in lockdown…there was a sign by the door saying do not enter, COVID, and all that" (P3, 35-39).*

Mike expresses how he witnessed the virus spread across the ward affecting more and more people including himself. His emphasis on the word 'eight' (which is almost all of the 9-bed ward) implies that he too believed it was inevitable that the virus would reach everybody and conveys his disbelief and fear. An important part of Mike's narrative was when he spoke of the 'do-not-enter' sign on the locked door segregating those with the virus and protecting those who were still healthy. Here he expressed shock, fear and disbelief that this was happening to him, appearing to find the situation surreal. He seemed uncomfortable with these emotions and composed himself with his "and all that" comment. The act of being locked on the ward, segregated as part of the unwell group, may link to other memories for this population. Forensic patients have often suffered multiple traumas and this experience may trigger previous memories of detention, past abuse or neglect creating a deeper level of fear.

2.4.1.3 Sub theme: A sense of what has been lost

All of the participants shared stories of loss. On the surface level, they gave examples of: losing their leave from hospital; missing contact with family; losing certain privileges such as cooking independently; a reduction in therapeutic activities; and feeling stuck in one place, like many others experiencing lockdown in the general population. However, on a deeper level, their stories stressed the significance of what these experiences had meant to them, as secure patients, who had already faced a life under restrictions prior to the pandemic.

> ***Elliot**: "not being able to go out to the community, that was just so, SO [emphasis] hard to take y'know. It took me YEARS [emphasis] to get unescorted community leave…and it just got cut off" (P4, 293-296).*

Here, Elliot stresses the time it had taken him to be granted his leave from hospital through emphasising the word ‘years’. Elliot’s journey through the system has been long, taking him through prison, medium secure and finally to low secure. Throughout this time he has worked hard to gradually gain privileges such as his leave, by engaging in therapy and consistently following rules. He conveys the magnitude of losing his leave by stressing the word ‘so’ and linguistically through his tone dropping as he talks of his leave being ‘cut off’, conveying his sadness. His choice of the phrase ‘cut off’ also signifies how definitive this was for him; one moment he had it all and the next it had gone, leaving a void of uncertainty of when or how he might get this back.

In secure services, privileges such as leave are scaled back in response to unwanted behaviours and patients can work to earn them back. Leave being cut off may be associated with punishment making this more difficult for forensic patients to manage. Furthermore, in the pandemic, patients no longer have the control to earn their leave back, this is no longer in their hands.

2.4.2 Theme 2: Learning to swim

Participants described a sense that they were finding a way through this experience. A process that involved them adapting to their new reality, whether this was by accepting the changes and finding new ways to manage, or feeling forced into compliance.

2.4.2.1 Sub theme: Riding the wave - accepting the changes and finding new ways to manage

Participants expressed that they had accepted the new rules and the new way of living, despite this being difficult, and were finding ways to manage the lockdown:

> ***Drew**: "I arranged a thing called the three-week challenge, and err, it was for patients and staff to join in…they had to walk around the courtyard, doing laps…the gist of it was to build up ourselves, for physical and mental health wellbeing…I did posters to like, let people know…and with the help of the OT staff, we did the challenge, so like yeah, I got a, they do this gold star awards thing here and, I got a gold star for that" (P1, 124-130).*

Drew became animated when he shared his narrative about his three-week challenge. He demonstrates pride through his repeated use of the pronoun 'I' to show what he accomplished. Drew's account shows that he was able to find an activity that was meaningful to him, with some guidance from the staff. This filled his time through lockdown with something that gave him a sense of purpose and accomplishment, which was positive for him. When activities were meaningful, participants engaged and this improved the experience of lockdown for them. This was echoed by other participants:

> ***Amy**: "I bought a series …we were watching that together me and one of my friends…that was all good" (P2, 73-75).*

Not all participants reported that they were able to find something to engage in meaningfully. Here, Kate shares that despite her efforts she felt unsatisfied with the options she had:

> ***Kate**: "I was trying to keep as busy as I could, there's only so much you can do when there's no groups. I mean I'm part of the newsletter group and I've never had a discussion with any of the rest of the group because they're male and from another ward" (P5, 116-118).*

Here, Kate comments that despite being part of a group, she still experienced being an outsider due to the restrictions with the mixing of wards. Kate's quote is explicitly different to Amy and Drew, who both form closer connections to other people through their chosen activities (Amy watching TV with her friend, and Drew arranging the three-week challenge with staff for other people to take part). In contrast, Kate's activity highlights the isolation she is experiencing, having to do the work alone with no communication. This implies that social connections are important in making activities more meaningful for patients.

2.4.2.2 Sub theme: Caught in a rip tide - forced to comply

Participants also reflected on a power dynamic between staff and patients, in which the patients expressed powerlessness to oppose any rules because the consequences of doing so would be detrimental for them:

> ***Elliot**: "you feel reluctant to make a complaint, so, basically all the staff here have got power over you. You're pretty powerless. If a staff member said something, to do something y'know, you can chose not to do it but that will go against them and if you go against the staff, it acts as a black mark against you and (pause) it might end up on (electronic notes system). It can work against you so you've got to be so careful how you tread. You have to just accept it, there's*

> *no use complaining. But I fully understand why they put these restrictions in place. It was for our safety as much as anybody else's (P4, 134-140).*

Elliot reflects on the notion that he has little freedom to make choices in this environment. That he is always considering the consequences of his actions and therefore the choices he makes are not his own. In this quote, as Elliot explores the notion of having an opposing view to the staff he uses the pronouns 'you', 'they' and 'them', effectively distancing himself from this viewpoint. However he changes to use the first person narrative at the end when he talks about fully understanding authoritative decisions, aligning himself with this viewpoint. In this way Elliot expresses his powerlessness to oppose staff decisions or rules. Elliot also comments:

> ***Elliot**: "I realise that we are forensic patients and (pause) we've got a lot of restrictions on our freedom, y'know on our lives basically" (P4, 122-123).*

In this quote Elliot's expression of the term 'forensic patients' carries negative connotations in terms of a wider societal context. His tone drops and he pauses, he appears to convey the meaning that as a forensic patient he is of little worth and therefore it is understandable that he will be treated differently to the rest of society. Elliot is referring to the double stigma carried by secure patients of both mental health stigma and offence related stigma. In this sentence he is referring to when the first lockdown ended and people were starting to go out but restrictions were yet to lift in the hospital. At this point secure patients were being treated differently to the rest of society however Elliot felt unable to refute this, for fear of this jeopardising his progress, instead he feels forced to comply.

2.4.3 Theme 3: In the same boat

Participants described the positive effect of feeling connected to other people through the pandemic. Bert referred to this as: *"everybody is in the same boat…it's probably a good place to be…surrounded by other people"* (P6, 70-77) which was echoed by other participants.

2.4.3.1 Sub theme: Feeling cared for by staff

Participants shared accounts of the times that they felt cared for by the staff. For Elliot, the level of care he received, given the context of a pandemic, came as a surprise to him:

> ***Elliot**: "before this blew up I said in a patient community meeting – what happens if somebody gets it on the ward? Will the staff not want to come in, you know, to care for us? And actually it was the exact opposite…the staff were wearing masks, almost like a chemical suit…going in to the bedrooms to deal with the patients who were self-isolating. It was quite frightening" (P4, 25-31).*

Elliot's use of the phrase 'blew up' implies the level of destruction he was anticipating with the pandemic approaching. His main concern was that there would be nobody to care for them. He appears to find it difficult to ask about this care in the meeting, demonstrated through his slight hesitation in his sentence. Perhaps, as a man of his age it is difficult to ask for this care, for others to know he needs this care. This highlights the significant role that the care staff have in forensic patients' lives; they are dependent on staff care.

As Elliot gave his account of the staff being 'the exact opposite' of 'not wanting to care' this suggests that the care received was viewed positively. Eliot describes the staff wearing protective clothing and going into isolated areas, there is a tone of admiration for the staff, particularly when he recognises his own fear in this context.

2.4.3.2 Sub theme: Pulling through together

Participants described feeling connected to others through the shared experience of the pandemic and the lockdown:

> ***Drew**: "everyone sort'a like got together and did their lockdown, stayed at home…that really surprised me, like, the country was sort'a like undivided…everyone sort'a like pulled together and understood, and stayed at home. I think that was really positive, the whole country to like do something like that, felt like we were all connected." (P1, 240-244)*

Despite the lockdown involving segregation within society, Drew uses phrases such as; 'got together', 'pulled together' and 'undivided' to describe his perception of the lockdown. Drew has been detained for many years, disconnected from society. However, through the experience of the lockdown he has witnessed how society joined him in this detention and he expresses that he feels really positive that the whole country did this. Through this experience he feels more connected to society. This has a powerful effect on Drew who later described how this connection has changed his general perception of society:

> ***Drew**: "when this is over I'll think to myself, I'm lucky to be alive. Lots of other people are lucky to be alive, err, y'know, it's something that, isn't gonna be*

forgotten in a hurry. It's something that is making me feel a bit more considerate with people, so I'll be that way. Like we've got this understanding with other people" (P1, 223-227).

This is a significant shift for Drew, he expresses that he will make a conscious effort firstly to remember this sense of connection but also to actively be more considerate with people. Feeling a sense of connection to the community is documented as an important factor in secure patients' recovery, it seems the shared experience of the pandemic and lockdown measures have helped to foster this sense of connection with society.

2.5 Discussion

This research aimed to understand the experiences of the COVID-19 pandemic from the perspective of a group of secure patients, detained in a low secure hospital. Six patients volunteered to take part in semi-structured interviews and share their experience. The transcripts of these interviews were analysed using Interpretive Phenomenological Analysis which generated three main themes. These themes offer insight into how the ward environment was experienced through lockdown (*treading water*); how patients reportedly managed the experience (*learning to swim*); whilst highlighting what was helpful during this time (*in the same boat*).

2.5.1 Interpretation of main findings

The findings of this study imply that the pandemic and the lockdown measures did have a considerable impact on these patients, which then affected the general ward milieu and created an environment that no longer felt as safe as it once did. Early literature exploring

the effects of COVID-19 and the lockdown identified people with pre-existing mental health disorders as a vulnerable group in the wake of the virus (O'Connor et al., 2020). Several other factors suggested that this specific population could be at risk from the virus and the lockdown measures (Russ et al., 2020; Zhu et al., 2020). However, through this study, patients demonstrate a remarkable level of resilience through the pandemic; in the way that they managed their personal feelings of anxiety and loss, whilst simultaneously managing the change in the ward atmosphere.

It is interesting to consider the way that this group of patients were able to adapt to the new regime in place and were accepting of the new 'normal', which included restrictions on daily activities, leave and isolating on single wards or in rooms if symptoms were present. It was suggested that past experiences in more secure institutions may have prepared this population for a lockdown. Alternatively, the lengthy process through secure care to reach this point may have created a determination to maintain the progress made and not behave in any way that would undo this. Low secure is often the final step before transitioning into the community and often patients have waited a long time to reach this place. Despite there being a sense that other peers may not be coping and may be on the precipice of conflict, there were minimal accounts of actual reported violence or aggression on the wards, suggesting that all patients were in fact, managing the changes well.

The alternative idea to patients accepting the changes, was that patients followed the new regime because they felt they had no other choice. This raises interesting questions about the notion of recovery in secure services and how successful services have been, in imbedding principles of recovery into practice. Empowerment, self-advocacy and working in partnership are all central to fostering the recovery approach within mental health services

(Roberts & Boardman, 2013). However, there have always been challenges to implementing this way of working in forensic settings where this needs to be balanced with the management of risk (Livingston et al., 2012). These two somewhat opposing concepts can cause tension and affect patient choice. This current study suggests that there is a notable power imbalance between staff and patients, particularly evident throughout the pandemic and that during this time patients reported feeling that they have very little choice and are forced into compliance. This could be a reflection of the circumstances; with new government guidelines for all to follow. Alongside this, patients also reported that the level of care they experienced from the staff was a main positive factor for them. This suggests that although part of the experience was that patients felt forced to comply, this did not affect the quality of the care received for those patients or the relationships that they had.

The importance of feeling safe and secure on the ward was highlighted as a key finding. The model proposed by Lovell et al. (2020) suggests that safety and security is developed through two core aspects: the environment, with clear boundaries and routine and connectedness with staff. This current study also highlighted that the emotions experienced by peers on the ward was also prominent in determining the ward milieu which impacts on feelings of safety and security.

Finally, the sense of social connection was found to be prominent for these patients through the pandemic. Social connection is recognised as an important aspect in secure patients recovery (Clarke et al., 2017) whilst social bonding theory identifies that the presence of positive social connections can aid in the development and maintenance of healthy social behaviours (Hirschi, 2017), this study reports that despite the isolation measures and the minimised social contact, patients felt an increase in their experienced connectedness to the

wider community. These social connections may have developed through: a sense of shared adversity or the general population experiencing incarceration and aligning with secure patients' experience. At present, the factors which are contributing to the increase in experienced social connection between secure patients and the wider community, are unknown. However, this suggests that social connections may be developed creatively, particularly in times when patients do not have access to community leave.

2.5.2 Strengths and limitations

There were various strengths to this study. The main strength being that, to our knowledge, it is the first study to explore secure patients' experience of COVID-19 from the patients' perspective, within a population often neglected within research (Smith, 2011).

The IPA methodology allowed for an in-depth exploration of the lived experience of a small group of specific people within a specific service, which was the aim of this study. Interviews were participant-focussed with open and expansive questions. The small 'concentrated' sample size allowed thorough examination of data whilst avoiding data overload (Smith, 2012). The convenience sampling was appropriate for recruiting a typically hard to reach population. A reflexive diary was kept to identify potential researcher biases for further consideration. An independent audit of themes increased the validity of findings and supervision from an experienced IPA researcher was sought throughout the analysis process. A further unanticipated strength was the use of online video interviews, which allowed us to reach participants who preferred to maintain safe distance at a time of uncertainty during the COVID-19 pandemic.

There were also limitations to note; a time delay between interviews was unavoidable when adhering to COVID-19 restrictions. The interview format varied (face-to-face & online) which potentially impacted on engagement, data collection and findings. COVID-19 is an ongoing pandemic, and therefore this study provides a snapshot from within the experience rather than a reflection following an experience; patients' experience may change as the pandemic continues.

2.5.3 Clinical implications and future research

As mentioned, the COVID-19 pandemic is ongoing, therefore these findings are particularly timely in terms of how we may be able to better support forensic secure patients through this uncertain time. However it is acknowledged that patients' lived experiences and needs may change as the pandemic progresses and post-pandemic further qualitative research will be needed to address these questions.

These participants referred to the importance of security and safety within the ward environment, which also supports the assertions of the recovery model. Therefore if these factors are integral to recovery and alluded to in the lived experiences of patients it is important for services to explicitly consider this. Further research should look to explore how we can maintain safety and security on the ward at a time of global uncertainty.

A further important finding was that patients feel reportedly more connected to the general public since the COVID-19 pandemic. Social connections for forensic secure patients' is documented as an important feature in recovery particularly when reintegrating back into the community. It may be assumed that these connections are created via physical distance

(having community leave) and communication with people outside of hospital, however this study demonstrates that the connection can increase with a shared experience. Future research should aim to explore factors which increase a sense of connection between secure patients and the general population, with the aim for services to promote this continuing.

Appendix A Table of Search Syntax

Database	Syntax
PsychINFO	TI (forensic OR secure) OR AB (forensic OR secure) AND TI ("mental health" OR "mental* ill*" OR psychiatr*) OR AB ("mental health" OR "mental* ill*" OR psychiatr*) OR DE "Mentally Ill Offenders" AND TI (involuntary OR detain* OR detention OR inpatient* OR incarcerat* OR hospital* OR institution* OR held) OR AB (involuntary OR detain* OR detention OR inpatient* OR incarcerat* OR hospital* OR institution* OR held) OR DE "Legal Detention" OR DE "Involuntary Treatment" OR DE "Commitment (Psychiatric)" OR DE "Hospital Environment" OR DE "Psychiatric Units" OR DE "Psychiatric Hospitals" AND TI (experienc* OR perspective* OR attitude* OR view*) OR AB (experienc* OR perspective* OR attitude* OR view*) OR DE "Narrative Analysis" OR DE "Qualitative Methods" OR DE "Qualitative Measures" OR DE "Thematic Analysis" OR DE "Grounded Theory" OR DE "Interpretative Phenomenological Analysis" OR DE "Phenomenology"
Medline	TI (forensic OR secure) OR AB (forensic OR secure) AND TI ("mental health" OR "mental* ill*" OR psychiatr*) OR AB ("mental health" OR "mental* ill*" OR psychiatr*) OR (MH "Commitment of Mentally Ill") AND TI (involuntary OR detain* OR detention OR inpatient* OR incarcerat* OR hospital* OR institution* OR held) OR AB (involuntary OR detain* OR detention OR inpatient* OR incarcerat* OR hospital* OR institution* OR held) OR (MH "Hospitals, Psychiatric") OR (MH "Inpatients") OR (MH "Involuntary Commitment") OR (MH "Hospitalization") OR (MH "Involuntary Treatment, Psychiatric") AND TI (experienc* OR perspective* OR attitude* OR view*) OR AB (experienc* OR perspective* OR attitude* OR view*) OR (MH "Qualitative Research") OR (MH "Hermeneutics")
CINAHL	TI (forensic OR secure) OR AB (forensic OR secure) AND TI ("mental health" OR "mental* ill*" OR psychiatr*) OR AB ("mental health" OR "mental* ill*" OR psychiatr*) OR (MH "Mentally Ill Offenders") OR (MH "Involuntary Commitment") AND TI (involuntary OR detain* OR detention OR inpatient* OR incarcerat* OR hospital* OR institution* OR held) OR AB (involuntary OR detain* OR detention OR inpatient* OR incarcerat* OR hospital* OR institution* OR held) OR (MH "Inpatients") OR (MH "Involuntary Commitment") OR (MH "Hospitals, Psychiatric") OR (MH "Hospitalization") OR (MH "Involuntary Treatment") AND TI (experienc* OR perspective* OR attitude* OR view*) OR AB (experienc* OR perspective* OR attitude* OR view*) OR (MH "Phenomenological Research") OR (MH "Qualitative Studies") OR (MH "Phenomenology") OR (MH "Grounded Theory")

Appendix A

Database	Syntax
Web of Science	TOPIC: (forensic OR secure) AND TOPIC: ("mental health" OR "mental* ill*" OR psychiatr*) AND TOPIC: (involuntary OR detain* OR detention OR inpatient* OR incarcerat* OR hospital* OR institution* OR held) AND (experienc* OR perspective* OR attitude* OR view*)

Appendix B Table of CASP results

	1) Was there a clear statement of aims of the research?	2) Is a qualitative methodology appropriate?	3) Was the research design appropriate to address the aims of the research?	4) Was the recruitment strategy appropriate to the aims of the research?	5) Was the data collected in a way that addressed the research issue?	6) Has the relationship between the researcher and participant been adequately considered?	7) Have ethical issues been taken into consideration?	8) Was the data analysis sufficiently rigorous?	9) Is there a clear statement of findings?	10) How valuable is the research?
Askew	✓	✓	✓	Can't tell	✓	✓	✓	✓	✓	✓
Barnao	✓	✓	✓	Can't tell	✓	✓	✓	✓	✓	✓
Bowser	✓	✓	✓	Can't tell	✓	✓	✓	✓	✓	✓
Brown	No	✓	✓	✓	✓	Can't tell	✓	Can't tell	No	✓
Craik	✓	✓	✓	Can't tell	✓	✓	✓	Can't tell	No	✓
DiLorito	✓	✓	✓	Can't tell	✓	No	✓	✓	✓	✓
Horberg	✓	✓	✓	Can't tell	Can't tell	No	✓	✓	✓	✓
Koller	✓	✓	✓	Can't tell	✓	No	Can't tell	✓	✓	✓
Lord	✓	✓	✓	Can't tell	✓	No	✓	✓	✓	✓
Marklund	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Appendix B

	1) Was there a clear statement of aims of the research?	2) Is a qualitative methodology appropriate?	3) Was the research design appropriate to address the aims of the research?	4) Was the recruitment strategy appropriate to the aims of the research?	5) Was the data collected in a way that addressed the research issue?	6) Has the relationship between the researcher and participant been adequately considered?	7) Have ethical issues been taken into consideration?	8) Was the data analysis sufficiently rigorous?	9) Is there a clear statement of findings?	10) How valuable is the research?
Meehan	✓	✓	✓	Can't tell	✓	✓	✓	✓	Can't tell	✓
Mezey	✓	✓	✓	Can't tell	✓	✓	✓	Can't tell	No	✓
Olausson	✓	✓	✓	✓	✓	No	✓	✓	✓	✓
Olsson	✓	✓	✓	Can't tell	✓	No	Can't tell	✓	✓	✓
Tomlin	✓	✓	✓	✓	✓	No	✓	✓	✓	✓
Walker	✓	✓	✓	✓	✓	Can't tell	✓	✓	✓	✓
Zhong	✓	✓	✓	✓	✓	No	Can't tell	✓	✓	✓

Appendix C Ethics approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Mrs Karen Humphries
Trainee Clinical Psychologist
University of Southampton
School of Psychology (Faculty of Environmental and Life Sciences)
Building 44
Highfield Campus, Southampton
SO17 1BJ

Email:
HCRW.approvals@wales.nhs.uk

06 October 2020

Dear Mrs Humphries

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

Study title:	**Exploring the lived experience of secure patients' during COVID-19.**
IRAS project ID:	**283880**
Protocol number:	**N/A**
REC reference:	**20/WA/0272**
Sponsor	**University of Southampton; Research Integrity and Governance**

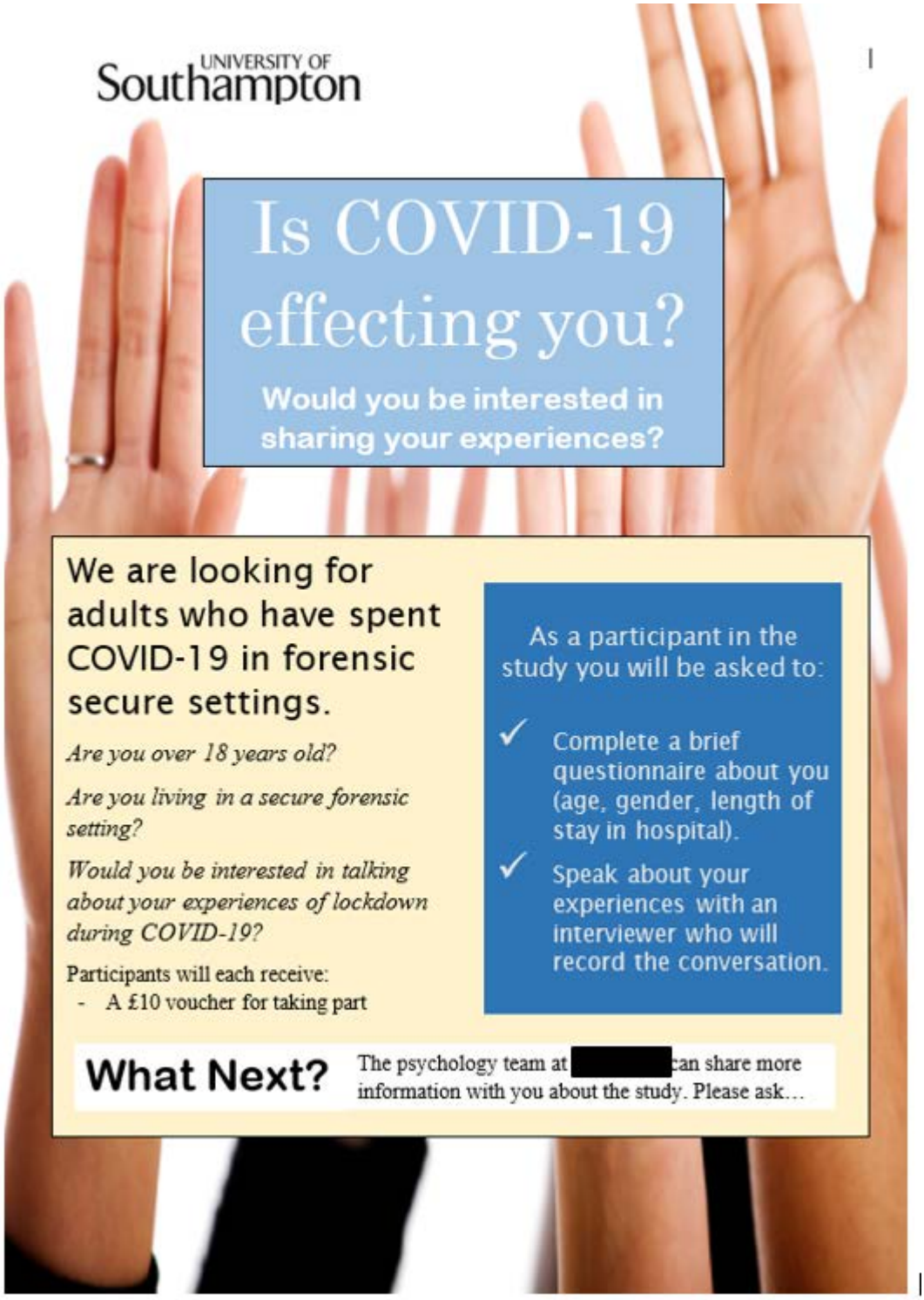
I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further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

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report

Appendix D Recruitment poster



Appendix E Participant information sheet

UNIVERSITY OF Southampton

Participant Information Sheet

Study Title: Exploring the lived experience of secure patients during COVID-19.
Researcher: Karen Humphries, Dr Caroline Clarke, Dr Kate Willoughby & Sophie Collingwood
ERGO number: 56635

You are being invited to take part in the above research study. It is important that you understand why the research is being done and what it will involve before you decide whether or not you would like to take part.

Please read this information carefully. If you have any questions, or something is not clear, please ask for more information.

Key Points

This study looks to understand more about how COVID-19 has affected people in secure hospitals.

It is your choice to take part; it will not affect your care and you can change your mind about this at any point.

The study will involve a 45-minute face-to-face interview. This will be recorded. You will also be asked to complete a questionnaire about you.

You will not be asked to talk about anything that you do not want to.

The interviews will most likely be carried out by Sophie Collingwood (Assistant Psychologist at Southfield) or Karen Humphries (researcher).

The information you share will not affect your care at [redacted] nor will it be shared with your clinical team (unless you say something, which effects yours or others' safety).

The information collected will be written up in a study. Your name will not be used so it cannot be linked to you. You may request to have a copy of the study when it is finished.

You will receive a £10 store voucher or tuck credit as a thank you for your time.

If you find the interviews upsetting, the researcher and the ward staff will support you with this.

There is more detailed information about the study, here:

[01.10.2020] [Version number: 6] [IRAS number: 283880]

UNIVERSITY OF Southampton

What is the research about?

This study looks to understand more about the impact of COVID 19 on people living in forensic secure hospitals. We are particularly interested in the changes you have experienced since COVID 19, how it has affected you and your care, along with how you have been managing.

The study is being carried out by Karen Humphries, who is training to become a clinical psychologist. It is being undertaken as part of an educational qualification. Karen is passionate about improving the quality of care experienced by people living in forensic settings.

Why have I been asked to participate?

You are invited to take part in this study because you spent COVID-19 lockdown in a secure hospital. We hope to find 6-10 people for the study who experienced this, from the 28 people in [redacted]

What will happen to me if I take part?

Once you have read this information you may want to ask some questions or have a think about taking part. It can be a good idea to talk to someone about this decision. You can speak to someone from the research team or your own care team.

If you decide to take part, you will be asked to fill in some information about yourself (age, gender etc.) and give your written consent to take part.

The interview will be on a day that is convenient for you. You will be asked questions about your experiences of being in a forensic hospital during COVID 19. The interviewer will be Assistant Psychologist Sophie Collingwood unless lockdown restrictions ease; in which case it will be Karen Humphries. The interview will be audio recorded using a Dictaphone. You will be told when the recording starts and when it stops. It may take approximately 45 minutes. You may ask for breaks.

The information you share at interview will not affect the care you receive and will not be shared with your clinical team, unless you say something, which effects yours and others' safety.

Following the interview: a debrief about the study will be read out (you may have a paper copy of this); you will have an opportunity to talk about how you have found the interview and how you are feeling.

Should you feel in any way upset by the interview please tell the interviewer. They will offer you further support with this.

The recording of the interview will be kept safe and then typed up. Once it has been typed the audio will be destroyed. The typed version will have no information that personally identifies you.

You will receive a store voucher or tuck credit worth £10 as a thank you for your time.

The interview data will be analysed and then presented in a research article for the university. It may also be published in an academic journal for others to learn from.

Are there any benefits in my taking part?

You may find it helpful to reflect and think about your experience of COVID-19. You will also receive a £10 store voucher/tuck credit as a thank you for your time. The information you provide us may also help professionals working in forensic settings to understand how they can improve the support they offer during difficult times.

Are there any risks involved?

Talking about personal experiences always has potential to cause some emotional discomfort or distress. You will not be asked to talk about anything you do not want to, please only share what

you feel comfortable with in the interview. There will be an opportunity to talk about how you have found the experience afterwards. This will not be recorded.

The interviewers will follow both national and local COVID restrictions in order to minimise risk of infection.

What data will be collected?

The study needs some demographic information about you (age, gender etc.) and an audio recording of your interview.

Will my participation be confidential?

Your participation and the information we collect about you during the course of the research will be kept strictly confidential.

Only members of the research team and responsible members of the University of Southampton may be given access to data about you for monitoring purposes and/or to carry out an audit of the study to ensure that the research is complying with applicable regulations. Individuals from regulatory authorities (people who check that we are carrying out the study correctly) may require access to your data. All of these people have a duty to keep your information, as a research participant, strictly confidential.

Do I have to take part?

No, it is entirely your decision whether or not you take part. It will not affect the care you receive at [redacted] in any way. You will be asked to complete a consent form before the interview can go ahead.

What happens if I change my mind?

You have the right to change your mind and withdraw from the study without giving a reason. This will not affect the care you receive at [redacted]. If you withdraw from the study after the interview has been completed we will keep the information we have already obtained for the purposes of achieving the objectives of the study only.

What will happen to the results of the research?

Your personal details will remain strictly confidential.
Direct quotes (what you have said) may be used in the results of the research. This means it will be available in reports or publications about the study however, this will not include information that can directly identify you. You may request to have a copy of the study when it is finished.

Where can I get more information?

The psychology team within [redacted] can give you more information and answer any questions you may have about the study. Please inform a member of your ward team that you would like to speak to Sophie Collingwood, Assistant Psychologist or Caroline Clarke, Clinical Psychologist at [redacted]

Alternatively you may wish to speak directly to the researcher Karen Humphries who can be contacted at k.humphries@soton.ac.uk or Dr Kate Willoughby at k.willoughby@soton.ac.uk.

What happens if there is a problem?

If you have a concern about any aspect of this study, you should speak to the researcher who will do their best to answer your questions: Karen Humphries (K.Humphries@soton.ac.uk).

If you remain unhappy or have a complaint about any aspect of this study, please contact the University of Southampton Research Integrity and Governance Manager (023 8059 5058, rgoinfo@soton.ac.uk).

UNIVERSITY OF Southampton

Data Protection Privacy Notice

The University of Southampton conducts research to the highest standards of research integrity. As a publicly-funded organisation, the University has to ensure that it is in the public interest when we use personally-identifiable information about people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use information about you in the ways needed, and for the purposes specified, to conduct and complete the research project. Under data protection law, 'Personal data' means any information that relates to and is capable of identifying a living individual. The University's data protection policy governing the use of personal data by the University can be found on its website (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page).

This Participant Information Sheet tells you what data will be collected for this project and whether this includes any personal data. Please ask the research team if you have any questions or are unclear what data is being collected about you.

Our privacy notice for research participants provides more information on how the University of Southampton collects and uses your personal data when you take part in one of our research projects and can be found at http://www.southampton.ac.uk/assets/sharepoint/intranet/ls/Public/Research%20and%20Integrity%20Privacy%20Notice/Privacy%20Notice%20for%20Research%20Participants.pdf

Any personal data we collect in this study will be used only for the purposes of carrying out our research and will be handled according to the University's policies in line with data protection law. If any personal data is used from which you can be identified directly, it will not be disclosed to anyone else without your consent unless the University of Southampton is required by law to disclose it.

Data protection law requires us to have a valid legal reason ('lawful basis') to process and use your Personal data. The lawful basis for processing personal information in this research study is for the performance of a task carried out in the public interest. Personal data collected for research will not be used for any other purpose.

For the purposes of data protection law, the University of Southampton is the 'Data Controller' for this study, which means that we are responsible for looking after your information and using it properly. The University of Southampton will keep identifiable information about you for 10 years after the study has finished after which time any link between you and your information will be removed.

The NHS will keep the following identifiable information about you from this study: it will be documented in your clinical notes that you have given consent to take part in the study and met with the assistant psychologist to carry out the interview. The content of your interview will remain confidential unless you were to report risk to self or others. In this case, the assistant psychologist would have a duty of care to share this with your clinical team.

To safeguard your rights, we will use the minimum personal data necessary to achieve our research study objectives. Your data protection rights – such as to access, change, or transfer such information - may be limited, however, in order for the research output to be reliable and accurate. The University will not do anything with your personal data that you would not reasonably expect.

If you have any questions about how your personal data is used, or wish to exercise any of your rights, please consult the University's data protection webpage (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page) where you can make a request using our online form. If you need further assistance, please contact the University's Data Protection Officer (data.protection@soton.ac.uk).

Thank you.

Appendix F Consent Form

UNIVERSITY OF Southampton

CONSENT FORM

Study title: Exploring the lived experience of secure patients during COVID-19.

Researchers name: Karen Humphries, Dr Caroline Clarke, Dr Kate Willoughby & Sophie Collingwood.
ERGO number: 56635
Participant Identification Number (if applicable):

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

I have read and understood the Information sheet (*Version 6, dated 01.10.2020*) and I have had the opportunity to ask questions about the study.	
I agree for my interview to be audio recorded for the purpose of this study. I will be told when the recording starts and when the recording stops.	
I understand that my recording will be transcribed (typed up), anonymised (any names removed) and then analysed by the researcher Karen Humphries.	
I understand that special category information (i.e. gender, ethnicity etc.) will be collected about me to achieve the objectives of the study.	
I agree to take part in this research project and agree for my data to be used for the purpose of this study.	
I understand that I may withdraw from the study at any point. Should I withdraw once the interview is completed, the information collected may still be used to complete the study.	
I understand that what I have said may be quoted directly in reports of the research but that I will not be directly identified (e.g. my name will not be used).	
I wish to be sent the anonymous findings or have someone from my team share this with me.	

Name of participant (print name).....

Signature of participant.....

Date.....

Name of Researcher (print name).....

Signature of researcher .....

Date.....

Appendix G Debriefing statement

(Version 3, Date: 19.06.2020)

UNIVERSITY OF Southampton

Debriefing Statement *(verbal and written)*
ERGO ID: 56635

Dear participant,

Thank you for taking part in the study: "**Exploring the lived experience of forensic inpatients during COVID-19**".

The aim of this research was to learn more about your experience of COVID-19 whilst in a forensic secure hospital. By sharing your experience, you are helping us to understand how COVID-19 affected you and your recovery. We also hope to understand more about what was helpful and unhelpful for you during this time.

Just to remind you; this study may publish direct quotes that you have said during your interview but it will NOT include your name or anything that identifies you. All quotes will be anonymous. Deception was not part of this study, which means you have been told everything about it.

If you feel upset after your interview or you find that you are thinking about it too much, please speak to a member of the psychology team or your care team who will be able to offer you support.

This summary will be read to you following your interview; you may also have a paper copy. If you are interested in the findings of the study, you can choose to have the anonymous findings sent to you.

For any further questions, please contact Karen Humphries at: k.humphries@soton.ac.uk
Thank you for your participation in this research.

Signature _____ Name_____ Date _____

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the University of Southampton Research Integrity and Governance Manager (023 8059 5058, rgoinfo@soton.ac.uk).

Appendix H Interview Schedule

Say at the beginning:

"I am interested in **you**, and your experiences" "there are no right or wrong answers" "this may feel a little bit like a one-sided conversation; I will ask some questions, but otherwise I hope to say very little, because I would really like to hear from you" "Take your time with thinking and talking, we have plenty of time"

1. Can you describe to me your experience of COVID-19, as a secure inpatient?
2. What, if anything, has changed for you since the COVID-19 pandemic started?
3. What is the ward environment like during lockdown?
4. In what way, if any, has COVID-19 impacted your recovery/care pathway?
5. In what way, if any, has COVID-19 impacted your relationships with staff?

For the last question, I am going to ask you something similar to the first question. You might find your answer is the same as before, you might find it's different having talked about it in more detail, or it might be somewhere in between. Any of these is fine.

6. How would you describe your experience of COVID-19 as a secure inpatient?

Appendix I Table of Themes and illustrative quotes

Superordinate Themes	Subordinate Themes	Illustrative Quotations
Treading Water	Anticipating conflict	"*because of the COVID, people are getting upset over petty things, err, and err, sometimes it gets sorted out, sometimes they keep it to themselves or with their peers, and it sort'a like unbalances the ward, if you like*." (P1, 181-183) "*things just switched and it was really hard. Staff obviously weren't happy, we weren't happy. So that was very difficult, that was probably one of the most difficult things, it's very hard being on a ward with an atmosphere*." (P2, 64-67) *"when we were told that we had to do all of the COVID tests and stuff like that, she's a bit rebellious, and it made, she refused to have it done, and it made the other patients resent her, because none of us could go out, so it does cause friction between patients at times…walking on eggshells all the time*" (P5, 101-106) *"I've always been observing people all my life, yeah, their actions, their words, err, their general sort'a like (pause) especially living in these sort'a conditions, y'know, being in hospital, being locked up an'that. Why they sort'a might like, fly off the handle, patients, even staff as well in other hospitals"* (P1, 193-196) *"I know there's the potential for other people to kick off, cause they can't take being locked up. Which did happen, so, if I don't feel safe I just take myself to my room...You're just waiting. Sometimes I just watch tele or play loud music to distract myself (pause) from the noise"* (P5, 85-94)

	"we were only allowed one delivery a week and at one point he was getting three or four deliveries a week even though the rules were one. They threatened to take away his smartphone and all that, stop him ordering anymore stuff and, there was animosity between him and staff about that, there was a lot of ill feeling". (P4, 226-230)
Fear of illness spreading	"*there was the fear of COVID hanging around all the time. I used to wake up early in the morning and I'd think; is this the day when I'm gonna get it really bad y'know, could it possibly kill me, y'know*" (P4, 83-85)
	"*Two of them had it on the wards and had to self-isolate, then like a week later I caught it. A few of the other guys had it. Then 8 patients (pause), EIGHT [emphasis] of us had it…So the whole ward had to go in lockdown…there was a sign by the door saying do not enter, COVID, and all that*" (P3, 35-39)
	"*when I used to go out in the courtyard and exercise regularly every morning err I'd hear the other patients in their bedrooms coughing all the time (pause) it was quite horrendous hearing that (pause)*" (P4, 34-36)
	"*Yeah it was quite frightening because quite a few of the patients went down with it. We were just waiting for the next one to show symptoms. If they showed symptoms of a high temperature or a persistent cough they had to isolate in their bedrooms…patients were disappearing into their bedrooms*." (P4, 15-18)
	"it was a bit, a bit scary (pause) very scary, it wasn't just me, it was other patients on the ward as well. Four or five of us in all. So, anyway when I got it, I had to be isolated." (P1, 11-12)

A sense of what has been lost	"*I mean I had the opportunity to go out before, but like, the hardest thing is like, losing my sense of freedom, you know we can't just get the freedom"* (P1, 115-117)
	"*It was hard because I was nearly out, I was nearly out of here (pause) I still am nearly out, but (pause) it's just stressful*." (P2, 78-79)
	"*not being able to go out to the community, that was just so, so hard to take y'know. It took me years (emphasising length of time) to get unescorted community leave…and it just got cut off*" (P4, 293-296)
	"*we're just stuck on that ward, nowhere to go (pause) yeah I felt really bad because I missed the spring. Spring's my favourite time of year, and I couldn't see any trees with any leaves developing on the trees and that, because we were confined on the ward*" (P4, 57-59)
	"I was in the flat before COVID, and I had to come out coz they needed it. In there I was cooking for myself every day, doing most things, being independent really (pause) coz it's off the ward it's just two bedrooms and a lounge…So that was really frustrating" (P2, 116-119)
	"its difficult trying to stay in contact with my family, like face-to-face. It's really hard being here, and not being able to see them, we do like Zoom and all that but it's different. It's not the same. It's difficult. It's just difficult that all…I'm very close to my nephew and it's very difficult just not being able to have that close relationship. I get on really well with him. I've got a whatsapp but it's not the same. It's my nephews birthday soon and I'm not even gonna be able to see him. That's sad (pause)" (P2, 53-61)
	"Not having visitors, not meeting up with family and that (pause) I have visits a couple of times a month, they're important" (P3, 11-12)
	"We had to have our Christmas tree taken down because of COVID. Apparently, it's not COVID friendly. Don't know why they can't spray, you can clean it, little bit of spray. So I was really upset about that, I was crying, I cried to my mum, then my mum rang my sister and my sister rang up. But nothings changed, its come down, so we're all feeling shit, we're gonna take it further" (P2, 104-107)

		"when I first came, there was a poster of a therapy dog on a white board and I said "oh have we got a therapy dog?" [Excited voice] and they said: "no, no we haven't got a therapy dog because COVID" [deflated voice], and I was like: "oh do you do rambling?" [excited voice], there was a thing of rambling, "No, no we don't do rambling" [deflated voice] (laughter)(pause) I mean, I was getting all excited because they didn't have any of that stuff at the other place." (P5, 14-18) *"I don't think I was able to go the gym, because I felt so ill. I always like going to the gym, so I felt a bit put-out by that, umm but I just struggled through it really, it was hard"* (P6, 10-12)
Learning to swim	Riding the wave: accepting the changes and finding new ways to manage	"*What picked up for me a bit though, was, I arranged a thing called the three-week challenge, and err, it was for patients and staff to join in…they had to walk around the courtyard, doing laps…the gist of it was to build up ourselves, for physical and mental health wellbeing…I did posters to like, let people know…and with the help of the OT staff, we did the challenge, so like yeah, I got a, they do this gold star awards thing here and, I got a gold star for that*" (P1, 124-130) "*when we first went into lockdown I bought a series called Wentworth and we were watching that together and me and one of my friends was watching Game of Thrones. We watched series one in a night, so, that was all good"* (P2, 73-75) "*So if you get a chance to prevent it, you need to prevent it don't you, like sanitise your hands, wear a mask, distance, think about being alert, you know all that sort of stuff. You do what you have to do*." (P3, 109-111) *"It was pretty hard, but like I say, I understand why it had to be done and, it was due to the safety you know, of the staff. They were doing the right thing. I knew I had to stay in my room*," (P1, 62-63) *"I know that one day I'll get free, I'll be free of locked doors. That's what keeps me going, knowing that I'll be free, yeah*." (P4, 221-222)

	"it didn't really bother me that much cause I found other things to do y'know. After I had COVID I did other stuff, like other stuff, playing games stuff like that, listening to music stuff like that." (P3, 80-82) "*I was trying to keep as busy as I could"* (P5, 116) *"It's out of my control, so, it's nothing to do with me, it's just one of those things that everybody has to (pause) put up with, it's not just in this unit, it's everywhere."* (P6, 26-27)
Caught in a rip tide: forced to comply	"*Because of my past… I have to have my door open [expressed importance of this]. And obviously if we got COVID, they'd be funny about that, and that would be very difficult for me, I wouldn't be able to do it. (pause) I can do it during the day, but at night, I wouldn't be able to do it… she was like "if you refuse to have it shut or to stay in your room you'll end up in seclusion" and I was like: "that ain't fair*" (P2, 45-51) "*In a way it did feel unfair but I realise that we are forensic patients and (pause) we've got a lot of restrictions on our freedom, y'know on our lives basically… If I complained about it, or anything like that, the staff on the ward might have construed it as mental illness, y'know but, there's no point in complaining about it, it's just the way things are. You gotta accept it, and you gotta move, move forwards.*" (P4, 122-129) "*I was really enjoying it [a job] because it reminded me of a job I used to have when I used to work for Sainsbury's, and then, lockdown occurred and I wasn't able to go there anymore… it was out of my control. I mean I was enjoying it, but hopefully I'll be able to start doing it again after lockdown*" (P6, 56-60) *"we'd been using our ground leave but being allowed to go to a certain area to smoke and literally I was fine on my birthday, I dressed myself up and wanted to feel good then just before we went on leave a staff member came down and said we couldn't smoke. I was so*

		frustrated, obviously I'm addicted to smoking so that's not good for my brain, so I ended up inserting something into my arm" (P2, 16-20) *"you feel reluctant to make a complaint, so, basically all the staff here have got power over you. You're pretty powerless. If a staff member said something, to do something y'know you can chose not to do it but that will go against them and if you go against the staff, it acts as a black mark against you and (pause) it might end up on (electronic notes system). It can work against you so you've got to be so careful how you tread. You have to just accept it, there's no use complaining. But I fully understand why they put these restrictions in place. It was for our safety as much as anybody else's"* (P4, 134-140) *"I think the hardest thing is err, the fact that I can't go out, although I do understand why, you know, it's still hard because I'm physically being kept. I mean I had the opportunity to go out before, but like, the hardest thing is like, losing my sense of freedom, you know we can't just get the freedom."* (P1, 113-116) *"then we started having COVID swabs once a week, and stuff like that…they are horrible, you gag, you wanna sneeze, it's horrible…it's just invasive isn't it [matter of fact] you have to do it for everyone else, because if you don't do it, they could probably lock the whole ward down or just banish you to your room until you do have it kinda thing, not that they've said that to anybody, but that's in my head."* (P5, 67-73)
We're all in the same boat	Feeling cared for by staff	"*most of the staff are like that, caring, understanding people, but when it came to the coronavirus they were sort of, in it with us. I thought that was really great, I really appreciated it*." (P1, 101-103) "*Yeah they come in and did my obs like every 3 hours cause I had COVID, and that's the same as the others, they did our obs and that, like take our temperature, blood pressure, heart rate, oxygen saturation and all that. It was reassuring wasn't it, it showed they cared a bit. It was their job but then again, you think yeah thanks for checking on me, it's good to know, you know. Yeah they did what they did, what they could*" (P3, 73-77)

	"*It probably would've been harder not being, having, that sort of umbrella around me, or over me, as far as support is concerned…the security of being in (hospital) at the same time is a good thing.*" (P6, 111-118) *"Keeping us sort of like err, informed of government guidelines. If we weren't watching TV or didn't know something, we had these meetings where you know, they'd inform us of any changes and the reasons why. To get us to sort of understand exactly what they were saying, and why they were saying it, what it was for err, and err, just being kind and considerate. And just in general, you know they were just on top of everything, you know, from err, talking to us if we needed to talk, one-to-ones, err, keeping us as calm as possible and making sure that we were comfortable."* (P1, 105-110) *"(service name) had a good action plan in place to deal with us, because before this blew up I said in a patient community meeting: what happens if somebody gets it on the ward? Will the staff not want to come in to, you know, to care for us? And actually it was the exact opposite. The staff were coming in regularly and, there's, I don't think any staff member got COVID themselves, which was quite remarkable really. The staff were wearing masks and at times, some of the staff were wearing, almost like a chemical suit, having to go in to the bedrooms to deal with the patients who were self-isolating. It was quite frightening"* (P4, 25-31) *"I can only describe it as; it was us against them. I don't really know how else to describe it. There was a lot of grumpiness, arguments, yeah. There was an incident that happened where, a couple of us went to the managers and said staff shouldn't be eating with us. But the only reason we did that was that we was actually annoyed about corona, not about the staff eating with us (pause) so, that had nothing to do with the staff, everyone had just had enough. It kinda felt like staff had become a bit distant after that time; yeah that's the right word." (P2, 90-95)*
Pulling through together	"*when this is over, I'll think to myself, about what's just happened over the last year, cause it has been a shock to the system, err, I'll think to myself, I'm lucky to be alive. Lots of other people are lucky to be alive, err, y'know, it's something that, isn't gonna be forgotten in a hurry. It's something that is making me feel a bit more considerate with people, so I'll be that way. Like we've got this understanding with other people, and being thankful, yeah*." (P1, 223-227)

"*there was that level of anxiety among patients. We did chat about it, even one of the patients, I wasn't that friendly with him, but through COVID, I almost got a bond with him y'know, we chat and we can talk about COVID err, there were three of us who didn't have COVID and he was one of them similar to me…so I could speak to him about it. We could openly chat about it*" (P4, 338-342)

"*talking to other patients about COVID, sometimes that helps, when we do talk about it…so I'd much rather be in this unit, than my own place really*." (P6, 121-123)

"Luckily, when I had it they let me use my smart phone in my room. I could video chat my dad and my family so I could have contact with them while I had it. And yeah it made things a lot better." (P3, 51-52)

"I knew I'd be phoning my parents at certain times during the day as well, regular calls home, that helped immensely, talking to my parents regularly every day, same sort of time as well. Contact with my family is what's kept me going really… It's a stabilising factor y'know I can offload to my parents, speak to them… it's good to have that outlet, they know me better than anybody, they listen to me, they sympathise, they give me advise, help me out, yeah." (P4, 203-210)

"The first thing was err, the freedom I had, the freedom to be out of my room, to come on to the ward and be able to move about, be with patients err, talk to patients about what's going on, you know, all that kinda stuff. So, that was sort'a like a, re-introduction. Like being back (pause) unity." (P1, 48-50)

"Yeah, it makes me feel more, err, caring for people, y'know? All the people who went through it like me, or lost a loved one, it makes me feel more caring towards society as a whole, for what's happening, and what's going on, y'know, like I said, I'm watching the TV all the time, and I see it. Coronavirus is there all the time, and I'm watching it, and having my own thoughts and feelings about it." (P1, 210-214)

"when it first happened, everyone sort'a like got together and did their lockdown, stayed at home, in this country anyway, and that really surprised me, like, the country was sort'a like undivided. So, everyone sort'a like pulled together and understood, and stayed at home. I think that was really positive, the whole country to like do something like that, felt like we were all connected." (P1, 240-244)
"my friend on the ward has helped me get through it, we keep each other going, I go out on ground leave together and that" (P2, 118-119)"*everybody is in the same boat…in some ways, it's probably a good place to be in here, cause your surrounded by other people*" (P6 70-77)

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