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

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MANUSCRIPT DETAILS

TITLE: Patientsâ€™ experiences of forensic mental health inpatient care: a systematic review and thematic synthesis of qualitative literature.

ABSTRACT:

The purpose of this paper is to develop an understanding of the experience of secure care, from the patientsâ€™ perspective.

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.

A total of eight themes were generated from the data; three of which provided an understanding of the experience of forensic secure care, the remaining five themes provided an understanding of the factors which may influence the experience of secure care.

CUST_RESEARCH_LIMITATIONS/IMPLICATIONS__(LIMIT_100_WORDS) :No data available.

Developing understanding of patient experience can lead to service improvements, potentially impacting on patientsâ€™ motivation, engagement and thus reducing admission times, potential recalls and recidivism.

CUST_SOCIAL_IMPLICATIONS_(LIMIT_100_WORDS) :No data available.

To date, this is the first systematic review to exclusively explore the broad topic of the patient experience of secure mental health care.

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Introduction

Since the 1950s there have been dramatic changes in the way that mental health needs are met (Novella, 2010). The main change being a move away from institutional care, towards increasing therapeutic approaches in the community (Freeman *et al.,* 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 others (NHS England, 2018a).

One population continuing to require inpatient care are those in forensic secure hospitals. Secure patients are diagnosed with severe and enduring mental health and/or personality disorder, are deemed at risk of offending or challenging behaviour (Galappathie *et al.,* 2017) and are subsequently detained under the Mental Health Act. There are international variations in the legal frameworks which govern how and where forensic secure patients receive treatment (Jansman-Hart *et al.,* 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 *et al.,* 2011).

In the UK, forensic secure hospitals are organised into high, medium, and low security levels. High secure provides the most stringent measures for 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 this, 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. In 2018, there were approximately 7700 forensic secure beds provided by the NHS (NHS England, 2018b), with further private sector provision. The cost of forensic secure provision to the NHS in England has been recorded to reach £1.2 billion per annum (Durcan *et al.,* 2011). The increase in provision need is mirrored in other countries worldwide (Seppänen *et al.,* 2018).

These environments aim to reduce the distress associated with mental health and the associated behavioural consequences, thus reducing the risk of harm to the public (Department of Health, 2007). Transition through secure services can be a lengthy process and delays are common (Rutherford & Duggan, 2008). Some of the barriers are reported to be feelings of disconnect, hopelessness, negative identity as an offender, lack of meaning and disempowerment (Senneseth *et al.,* 2022). Further systemic barriers include; high occupancy of beds causing a lack of availability, limited community provision, and limited specialist forensic community input (Durcan *et al.,* 2011).

[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.

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, lose independence, and become reliant on how the institution operates, unable to function without it. Institutionalisation has been linked to poorer satisfaction and quality of life (Chow & Priebe, 2013). It is in direct contrast with the principles of recovery (Roberts & Boardman, 2013) which involves fostering patient-centred care through collaborative working and building autonomy, agency and empowerment (Bonney & Stickley, 2008). Secure services operate within these 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 *et al.,* 2012; Pouncey & Lukens, 2010). 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.

Patients hold the unique perspective of being experts about their illness, need for care and the services 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 *et al.,* 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 (Doyle *et al*., 2017; Robinson *et al*., 2019), restrictiveness (Tomlin *et al*., 2018) and environmental factors (Greenacre & Palmer, 2018). 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 *et al.,* 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, such as: co-production of care, information sharing, safety, meaningful activity, relationship with staff and the impact on self-worth and emotional state.

Whilst the Akther *et al.,* (2019) review provides important insights into the broad experience of detention across various inpatient mental health services (general psychiatry, specialist eating disorder service, forensic etc). We are yet to solely focus on exploring 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. Although the average duration of detention is five years or less, more than a quarter will be detained for over ten years (Rutherford & Duggan, 2008). This is a stark difference to general psychiatry, where the duration aims to be a maximum of thirty-two days (NHS England, 2019).

Secondly, many forensic patients will face additional legal restrictions due to offending and maintaining 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 psychiatry, 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 can be a barrier for patients moving forwards. Offending behaviour can compound feelings of shame and guilt. Some will experience bereavement and breakdowns in significant relationships (Corlett & Miles, 2010), and many will experience social consequences occurring as a result of their offence (Drennan & Wooldridge, 2014). Ultimately forensic patients are recovering from dual stigma of mental health in parallel with the 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. Highlighting potential positive aspects to be built upon and expanded, along with areas of potential unmet need, where change may be necessary. The onset of COVID-19 in the latter part of 2019 will have impacted patient experience of secure care and there is emerging evidence of this (Humphries *et al*., in press), for the purpose of this pater, this review will look to understand the experience prior to COVID-19.

To date, reviews focussing on the general experience of detention have either excluded the forensic secure population or combined different populations. 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, prior to the COVID-19 pandemic. Therefore, the aim of this paper is to conduct a systematic review and thematic synthesis of the qualitative literature exploring patient's 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?

Method

Protocol

Details of the protocol were registered on PROSPERO (CRD42020219610, https://www.crd.york.ac.uk/ prospero/) following a brief scoping search.

Search Strategy

A comprehensive search of the literature was conducted in November 2020 to identify all relevant evidence for review. The electronic databases: PsychINFO, CINAHL, Medline and the Web of Science were searched from inception to November 2020. Synonyms of 'forensic',

'mental health', 'inpatient' and 'experience' and associated mesh terms were used. Suitable papers meeting the inclusion criteria were then hand searched for further relevant citations.

Study selection

Studies selected for review were subject to 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 *et al.,* 2014), see supplementary material for full list. There were no limitations set for the year of study, or geographical location.

The process of study selection is illustrated in Fig. 1.1. An independent blind reviewer (Author JS) was used at each stage demonstrating good inter-rater reliability, with 3.3% conflict at screening and 4.7% at eligibility. Discrepancies were mainly managed through discussion, as often this involved exclusion information being missed. When required, a third person acted as mediator (Author KW) making the final decision. A total of 17 articles were included in the systematic review.

Quality Appraisal

The 17 articles were appraised for quality using the Critical Appraisal Skills Programme (CASP; n.d.) checklist, a widely used tool recognised for being succinct yet effective (Nadelson & Nadelson, 2014). The overall quality was found to be very good. However, there were two domains lacking: 1) the reporting of the researcher/participant relationship was unacknowledged in eight of the articles and failed to consider implications in a further two. 2) inadequate reporting of the recruitment strategy, perhaps a reflection of a typically difficult to reach population but could also be indicative of bias within the sample.

Each of the 17 studies appraised were included in the review regardless of quality, due to a lack of empirically tested methods to guide the exclusion of studies based on quality (Thomas & Harden, 2008).

Data synthesis

Data for analysis included all text under 'results/findings' including direct quotes and authors' interpretations. The data synthesis was conducted by first author KH and guided by the 3-stage method of thematic synthesis (Thomas & Harden, 2008)[2], allowing full immersion in the data (Willig, 2001).

A total of 92 codes were organised into descriptive themes using post it notes and wall space, allowing time to reflect and return to the data in an iterative process. A code book of descriptive themes with direct quotes was then disused with author CC generating the final analytical themes (Thomas & Harden, 2008).

Findings

[2] 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

A total of 17 papers were included for review. Study characteristics are detailed in Table 1.1. The synthesis generated a total of eight dominant themes. The first three themes: 1) *feeling stuck,* 2) *playing the game* and, 3) *positivity and hope* represent three separate experiences perceived by patients in secure care (see Experience themes).

A further five themes were generated which appear to influence 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 Influencing factors themes).

Experience Themes

1) Feeling Stuck

Patients' describing the 'feeling stuck' experience described a sense that progress was slow and "time wasted as their lives were passing by" (Marklund *et al.,* 2020). They expected to be in secure care for many years (Olsson *et al.,* 2014) and shared frustration that this was potentially longer than a prison sentence (Tomlin *et al.,* 2020).

There was reported uncertainly about how to progress towards discharge (Hörberg *et al.,* 2012; Lord *et al.,* 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 staff alone (Barnao *et al.,* 2015; Hörberg *et al.,* 2012). Some believed they would never be released (Marklund *et al.,* 2020; Zhong *et al.,* 2019).

There was a sense that staff were gate keepers who held the power; they held keys, made rules, kept notes on the patients and fed back to 'the doctor' (referring to the Responsible Clinician: RC). The RC was perceived to have 'the final say' which could influence progression (Craik *et al.,* 2010). But decisions made were experienced as arbitrary (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 a sense that life was somewhat on hold whilst they waited for discharge. There was no quality of life in secure care, and the powerlessness to make change led to a feeling that they were just existing. This compounded the feeling of shame surrounding the offence, and 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)

2) Playing the game

The 'playing the game' theme outlined a different experience. Patients reported some understanding of the requirements for progression, however the goals were experienced as staff-led. The descriptive themes: *jumping through hoops; fitting the mould*; and *hiding my true self*; contributed to this experience.

Patients reported passively following team recommendations and complying with rules in the hope that this might expedite discharge (Barnao *et al.,* 2015; Craik *et al.,* 2010). These patients did not see any intrinsic value or purpose to what they are being encouraged to do: "*I've been sat there bored thinking, is this doing ought for me*" (Bowser *et al.,* 2018).

The environment and staff care are experienced as predetermined and rigid. Patients describe adapting to the rules and expectations placed on them, one patient coined this as having to "*fall into a template*" (Marklund *et al.,* 2020). Interventions and groups are experienced as repetitive (Di Lorito *et al.,* 2018) and not pitched at the right level (Craik *et al.,* 2010; Di Lorito *et al.,* 2018) and patients describe being told what they need to do, and feeling coerced to attend (Askew *et al.,* 2020; Barnao *et al.,* 2015). With little choice life feels controlled and restricted.

Some patients who live this experience will resist and retaliate leading to increased restrictive practices. Others passively comply, attending interventions with little interest and following rules they disagree with; over time, moulding themselves to the service expectations. These patients describe hiding or holding back how they truly think and feel. Some patients reported feeling that important parts of themselves are overlooked whilst in secure care (Brown *et al.,* 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)

3) Positivity and Hope

The 'positivity and hope' theme reflects a third experience of secure care. Here, patients describe beginning to believe in a life outside of secure care and imagining how this might look, which feels hopeful (Mezey *et al.,* 2010; Olsson *et al.,* 2014). Interventions have genuine value; patients report utilising the strategies developed effectively *(*Barnao *et al.,* 2015). 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 goals (Barnao *et al.,* 2015; Olsson *et al.,* 2014), taking on extra responsibilities (voluntary/paid employment). Opportunities create a sense of achievement, improved self-identity (Bowser *et al.,* 2018) and equip people for life outside.

Patients describe having a good understanding of their illness and satisfaction with medication (Mezey *et al.,* 2010). Relationships with staff are trusting and there is positive collaboration.

Influencing factor themes

The following 5-themes were present across the experiences but reported differently dependent on the experience:

4) Having a 'Voice'

Patients describing feeling stuck reported an absent voice creating feelings of hopelessness and inferiority (Marklund *et al.,* 2020). Others reported the initial stages of being helped and encouraged to make choices and be involved (Walker *et al.,* 2019). These opportunities were reported positively when there was a growing sense of control over their lives (Di Lorito *et al.,* 2018). Others were more aligned with positivity and hope, reporting confidence in working collaboratively with staff to formulate goals, "*raising issues and requesting change*" (Barnao *et al.,* 2015), having a voice to "*speak out…participate in care plans, alter day-to-day life on the ward, or express themselves more broadly*" (Tomlin *et al.,* 2020).

5) Social connections

Patients reporting minimal social connections described profound loneliness triggering a sense of hopelessness (Zhong *et al.,* 2019) in-line with 'feeling stuck'. Several studies acknowledged the barriers for patients to build and maintain connections, such as: restrictions on visiting times/phone calls (Bowser *et al.,* 2018); difficulties accessing services (Di Lorito *et al.,* 2018; Tomlin *et al.,* 2020); and patients' guilt/shame surrounding offending behaviour (Koller & Hantikainen, 2002). When social connections were limited, hospital befriending schemes were reported positively (Di Lorito *et al.,* 2018), as were peer connections, providing a sense of 'belonging' (Hörberg *et al.,* 2012), '*just like a family*' (Walker *et al.,* 2019) and some relationships were maintained after peers had moved on (Craik *et al.,* 2010). Maintaining connections with significant people external to the hospital 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)

6) My own safe space

The patient's bedroom was identified as a place of both privacy and safety, creating a "*safe zone*" (Olausson *et al.,* 2019). When experienced as a place of privacy, the room provided 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 (Brown *et al.,* 2014). This felt 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 (Koller & Hantikainen, 2002; Lord *et al.*, 2016; Meehan *et*

al., 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. Some patients reported pride in their rooms, which were personalised to 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)

7) Meaningful activity

Studies commonly reported a profound sense of boredom whilst in secure care. Some services lacked 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, leading to frustration, irritability and potentially spiralling to aggression (Bowser *et al.,* 2018; Meehan *et al.,* 2006). This impacted 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). Patients reported feeling satisfied with a basic routine of *"day dreaming, drinking tea, smoking and listening to the radio"* (Craik *et al.,* 2010).

Whilst some patients reported their attendance to groups was to complete what was asked of them, in the hope that this would be beneficial in the long term. Others reported to prefer 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). Scheduled 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).

8) Relationships with staff

Patients' reported relationships with staff were variable. A good relationship was identified as understanding, supportive, respectful and being treated as equal (Barnao *et al.,* 2015; Marklund *et al.,* 2020). When care was perceived to be 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 effected 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 appear to contribute to the experience and are 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 positivity and hope. Hörberg *et al.,* (2012) describes what could be interpreted as patients moving from feeling stuck, to 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 experiences were identified. This has raised further questions regarding how these experiences fit together, whether patients transition through experiences and whether adapting the influencing factors could expedite transition through 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.

Discussion

Summary of main findings

This paper aimed to understand forensic patients' experiences of secure care and influencing factors. The search yielded seventeen qualitative studies focussing on this phenomena and suitable for review. Cumulatively, these studies shared the voices of 243 forensic patients, reporting on experiences within a range of forensic secure inpatient services worldwide. Eight overarching themes were generated. 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.

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. Trusting working relationships have been developed with the staff and they partake in meaningful activity. There is hopefulness about the future, and patients are working towards this. These findings suggest it is possible to successfully manage integrating principles of recovery (patient-centred care, autonomy and agency), whilst balancing the management of risk in secure services, 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, where progress is perceived to be slow, and the route to progression is uncertain. Some patients describe just existing day-to-day; others describe having little choice in a predetermined service where they feel coerced to passively comply with rules and expectations placed on them. It is unclear from this review, whether patients' transition through these different experiences, reaching the positivity and hope experience, or whether it is possible to remain feeling stuck or playing the game throughout an entire admission. There were studies in which patients reported each of these different experiences, suggesting that a single service could be providing a positive experience for some whilst simultaneously providing a contrasting experience to another. This may reflect individual differences or there may be steps that services can take to improve patient experience. For example, one patient may find a particular activity on offer meaningful, whilst another may 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, as indicated by the 'influencing factors' themes identified in 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 *et al.,* 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 secure care was the 'playing the game' theme. Secure patients experience adapting and changing themselves to fit in to the service. 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.

Methodological considerations

The seventeen studies selected for review were all published between 2002 and 2020, yet over 50 % 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, that reported findings not shared with other studies. This was conducted with a Chinese population reflecting cultural differences in service provision. Patients were typically cared for by relatives following their hospital admission, which seemed to compound feelings of loss, rejection and shame for those experiencing estranged and complicated relationships with families following 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 studies reported specifically on experience 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: perceptions of rehabilitation and recovery. Despite this, the findings demonstrated that the themes were relatively evenly distributed across studies (See supplementary material).

Strengths and limitations

There were several strengths to note. A robust search strategy was used, placing no 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 high inter-rater reliability throughout. The few discrepancies that arose were managed through consultation and supervision was sought through the process of generating 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.

Clinical/research Implications

This is the first systematic review to focus specifically on forensic patients' experience of secure care. This review provides new understanding of how patients may experience secure care provision.

- The findings are consistent with recovery literature. Positive experiences appear evident when principles of recovery are reinforced and are less evident when not.
- Identifying that 'positivity and hope' is achievable in this setting may be a source of hope for professionals working in this challenging field. When applied to training this could increase motivation in staff teams.
- 'Playing the game' describes a group who are passively complying whilst not fully engaged. It may be plausible to suggest that this behaviour could negatively impact on staff perception of the individual, viewing the behaviour as deceitful. Increasing our understanding of staff perception of this experience is crucial, given that the staff/patient relationship is found to be an influencing factor.
- Emerging policy focussing on reducing restrictive practice (Lawrence *et al*., 2022) has the potential to help some of the negative experiences reported. For example, increased access to mobile phones supporting external social connections.
- This review suggests five influencing factors which provides a basic framework for service development initiatives.

Future research should look to explore retrospective experiences of service users discharged from secure care, forming a narrative of factors which aided transition. The onset of COVID-19 may have also changed the experience of secure care for this population.

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Fig. 1.1 PRISMA flow diagram

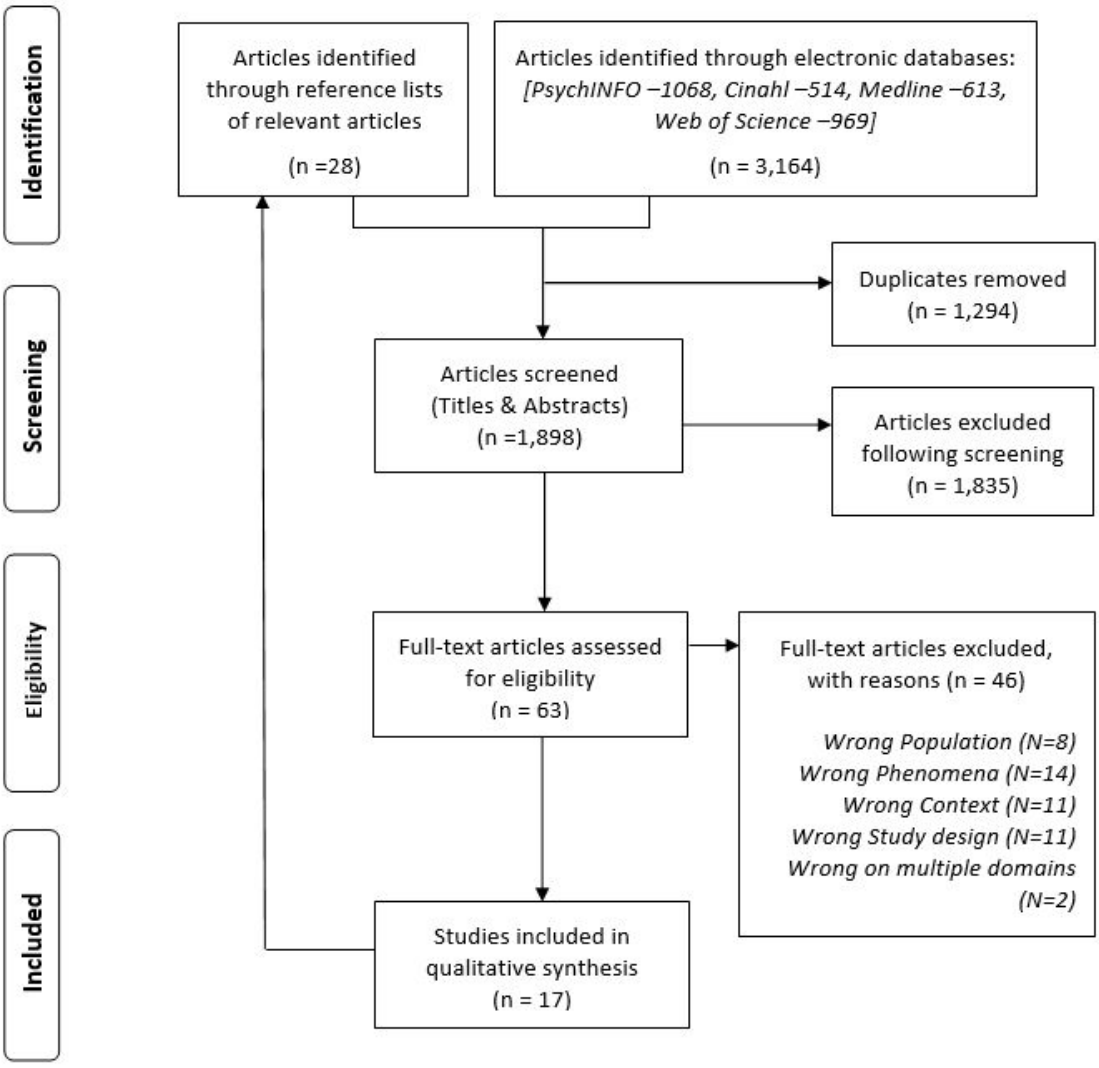

Table 1.1 Summary of papers included in the analysis

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 *et 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)
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	M/F: 21/5 Time in hospital: 1-5y (11); 5-10y (2); >10y (4)	Focus groups, Constant comparative analysis (Silverman, 2000)

		security level. 1 focus group was specifically for females.		
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)
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)

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 (N=2), PD (2) Time in hospital: <1y - 10y	Photovoice (Wang & Burris, 1997), Thematic analysis (Braun & Clarke, 2006)
Olsson *et al.,* 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 *et al.,* 2020	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

Supplementary material

Table 1.2 Inclusion/exclusion criteria outlined using PICoS framework (**P**opulation, phenomena of **I**nterest, **Co**ntext, **S**tudy 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/perspective of the experience of being in secure care, prior to COVID-19.	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. Qualitative data – interview/focus group. Studies written in English language.	Quantitative studies using measures to understand experience. Mixed method studies. Non-English language papers. Commentaries, letters, editorials, short communications, professional magazines and unpublished data. Qualitative data collected through surveys and records.

Supplementary Material

Overview of CASP appraisal of selected papers for review.

	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	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
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	✓	✓	✓